Nebraska's Aging and Disability Resource Center Pilot

Final Evaluation Report

HCBS STRATEGIES INCORPORATED

HCBS.INFO

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ACRONYMS

Acronyms

- AAA- Area Agency on Aging
- ACA- Affordable Care Act
- ACL- Administration for Community Living
- ADRC- Aging and Disability Resource Center
- AIRS- Alliance of Information and Referral Systems
- AoA- Administration on Aging
- AOWN- Aging Office of Western Nebraska
- AP- Aging Partners
- BIP- Balancing Incentives Program
- BRAAA- Blue Rivers Area Agency on Aging
- CIL- Center for Independent Living
- CM- Care Management
- CMS- Centers for Medicare & Medicaid Services
- DBH-Division of Behavioral Health
- ENOA- Easter Nebraska Office on Aging
- EOC- Enhanced Options Counseling
- FFP- Federal Financial Participation
- I&A- Information and assistance
- I&R- Intake and referral
- IAP- Individual action plan
- IDD- Intellectual and developmental disability
- IT- Information technology
- LTC- Long term care
- LTSS- Long term services and supports
- MAAA- Midland Area Agency on Aging
- MCO- Managed care organization
- MDS- Minimum data set
- MIS- Management information system
- MoU- Memorandum of Understanding
- NAMIS- Nebraska Aging Management Information System
- NAPIS- National Aging Program Information Systems
- NASUAD- National Association of States United for Aging and Disabilities
- NENAAA- Northeast Nebraska Area Agency on Aging
- NWD- No Wrong Door
- OC- Options Counseling
- RFGP- Request for grant proposals
- RFP- Request for proposals
- SCNAAA- South Central Nebraska Area Agency on Aging
- SUA- State Unit on Aging
- TNoC- Trilogy Network of Care
- WCNAAA- West Central Nebraska Area Agency on Aging

Executive Summary

LB320 established the Aging and Disability Resource Center (ADRC) Demonstration Project Act in May 2015. The purpose of this Act was to evaluate the feasibility of establishing ADRCs statewide. ADRCs are intended to provide information about and help access both publicly and privately funded long term services and supports (LTSS) to all populations with disabilities.

HCBS Strategies was awarded a three-year contract to conduct an evaluation of three ADRC pilot sites that initiated their efforts in July 2016. HCBS Strategies produced the Initial Report on these operations at the end of 2016 and a second report in November 2017 that evaluated the ADRCs' performance through September 2017. This document represents the final report and examines data through September 2018.

HCBS Strategies' evaluation included a review of the ADRC program operations and analyses of available data produced by the ADRC initiative. This report discusses both components.

HCBS Strategies conducted on-site reviews of the ADRC operations in August 2016 and September 2017 and telephone review in September 2018. The reviews indicate that all sites were offering ADRC services in a manner consistent with the operations described in the Initial Report. Positive findings include:

- Key operations infrastructure, such as an information management system, operations manuals, and training materials, have been developed and are being used by ADRC staff.
- ADRC staff have been trained and have a good understanding of the work they are doing.
- The ADRCs have made progress in building relationships with other entities supporting individuals with disabilities, especially at the local level.
- The State Unit on Aging (SUA) and the ADRC are making progress on building infrastructure to support sustainability.
- The ADRCs have made significant progress in engaging disability partners at the local level.

The last two reports cited a reluctance by the Area Agencies on Aging (AAAs), in which the ADRCs are embedded, to make structural changes to more fully integrate the ADRC with other AAA operations because the ADRC was a pilot. Now that LB 793 has made the ADRC a permanent program, the AAAs have taken steps in this direction and have developed draft plans to complete this integration. The most tangible of these steps is an ADRC Action Plan that details the goals the ADRC should achieve and the tasks for doing so. Once successfully implemented, these plans should eliminate potential overlap between ADRC services, such as information and referral (I&R) and Options Counseling, and AAA services, notably Information and Assistance (I&A) and Care Management. The draft ADRC Action Plan could also

transform the ADRC initiative into a No Wrong Door (NWD) system similar to the one described in the *Nebraska Long Term Care Redesign Plan*.

The analyses of the ADRC data reveal the following:

- The SUA, AAAs/ADRCs, and partner agencies have expanded the number and types of resources that are available in the Information and Referral (I&R) database from 1,619 in September 2017 to 1,635 in September 2018.
- The ADRCs received 10,481 contacts from 7,002 individuals from October 1, 2017 to September 30, 2018. Of these contacts, 46% received basic information, 48% received I&R, and 6% received Options Counseling or Enhanced Options Counseling.
- From the 2017 to 2018 evaluation period, the number of ADRC contacts rose by 13% across all contacts and 2% for unduplicated individuals.
    - Much of this increase was driven by more individuals receiving only basic information, which saw the greatest increase (1,416, 41%),
    - The contacts for both Options Counseling and Enhanced Options Counseling decreased dramatically from the previous year (282 or 36%, 98 or 68%).
- The ADRCs had 808 (8%) contacts with people age 18-60 and 682 (7%) contacts that discussed mental health services. There were also a small number of contacts for children and individuals with autism spectrum disorders.
- ADRC staff are developing Option Counseling Action Plans for individuals that tend to include a variety of sources of support.
- The quality of these Action Plans is improving. Action Plans containing only person-centered goals increased from 8% in 2017 to 21% in 2018.

The data analyses raised the following concerns:

- The ADRC data only represents a small portion of the information and counseling being provided by the AAAs. Assistance provided under AAA I&A and Care Management make up the bulk of these services.
- The number of Options Counseling contacts decreased from 2017 to 2018. This is a significant concern because Options Counseling is one of the ADRCs' core services. The ADRCs attributed this decrease to factors such as staffing issues.
- Differences in how the AAAs have structured AAA I&A and Care Management and the relationship of the ADRC staff to these programs makes it difficult to make comparisons across ADRCs.
- Only 27% of Options Counseling contacts had informed consent and confidentiality of rights documented. While this is an increase from 12% during the previous evaluation

period, it is still a concerningly low number of individuals to receive this important information.

- There was a 10% drop in the percentage of individuals who received the requested follow-up in the 2017 report (99%) and the 2018 report (89%).
- The number of participant surveys was extremely small, especially for Options Counseling, making it impossible to generate valid conclusions.
- Only 54% of individuals identified for Options Counseling or Enhanced Options Counseling had a Plan developed. This a minor increase from the 2017 finding of 53%.
- Nearly half of the Action Plans included goals that only reiterated services.

The data analyses suggest that the ADRCs need to place a much stronger emphasis on improving the quality of their operations and consistent data collection.

BACKGROUND

Background

NATIONAL ADRC/NWD EFFORTS

Aging and Disability Resource Centers (ADRCs) were initially developed as a pilot by the State of Wisconsin in 1999. Recognizing this effort as a promising practice, the Centers for Medicare & Medicaid Services (CMS) and the Administration on Aging (AoA), now part of the Administration for Community Living (ACL), awarded a series of grants to states to develop ADRCs starting in 2003.

The original ADRC efforts tended to focus on developing an entity that would act as a **single-entry poin**t for individuals needing long term services and supports (LTSS). These single-entry points also tried to act as a **one-stop** for all services and supports that individuals with disabilities might need.

The federal requirement for the ADRCs was to serve older adults and one additional population with disabilities, typically adults with physical disabilities. This federal vision eventually evolved to include all populations with disabilities.

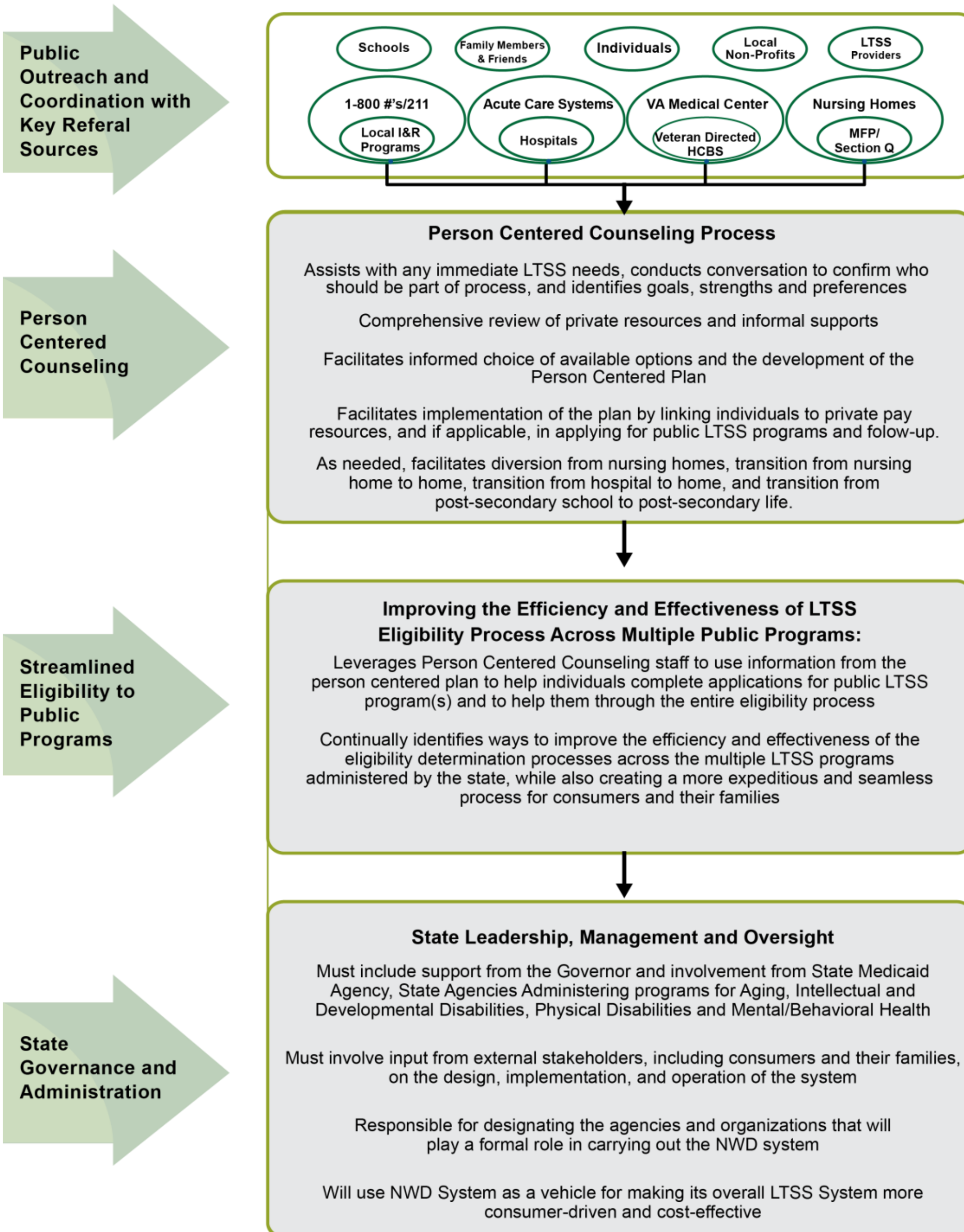
This evolution created challenges because most states had existing entities that provided ADRC-like services to other populations, such as individuals with intellectual and developmental disabilities (IDD). To accommodate this, the federal guidance has shifted to describing a No Wrong Door (NWD) network that includes ADRCs and other access points for LTSS. The Balancing Incentives Program (BIP), which was a component of the Affordable Care Act (ACA), included NWD as one of the required components.

No Wrong Door Schematic

Exhibit 1 presents a schematic promulgated by ACL that describes the core components of a NWD system. ACL has made available a wide array of information about NWD, including this schematic, at https://www.adrc-tae.acl.gov/tiki-index.php. This schematic identifies four primary functions for the NWD system, and informed Nebraska's efforts.

BACKGROUND

EXHIBIT 1: FEDERAL NO WRONG DOOR SCHEMATIC



Source: NWD website, https://www.adrc-tae.acl.gov/tiki-index.php?page=PlanningGrants.

BACKGROUND

ADRCs represent a widespread and diverse program. Per the fact sheet promulgated by ACL, 53 states, territories and DC have ADRCs. Many of these states, such as Wisconsin and Maryland, have established statewide ADRC networks. All states are working to define and enhance how the ADRCs and NWD efforts work. Each state and locality must determine how best to interpret and incorporate the ADRC/NWD requirements into operations. Because of this, there are major differences in the structure of and functions provided by the ADRCs/NWD networks across and within states.

NEBRASKA'S ADRC EFFORT

LB320 established the Aging and Disability Resource Center Demonstration Project Act in May 2015. The purpose of this Act was to evaluate the feasibility of establishing ADRCs statewide. These ADRCs are intended to provide information about and help access both publicly and privately funded LTSS to all populations with disabilities. The Act identified the following outcomes that are driving the need for this effort:

(1) Anticipating and preparing for significant growth in the number of older Nebraskans and the future needs of persons with disabilities, both of which will require costly long-term care services;
(2) Improving access to existing services and support for persons with disabilities;
(3) Streamlining the identification of the needs of older Nebraskans and persons with disabilities through uniform assessments and a single point of contact; and
(4) Creating statewide public information campaigns to educate older Nebraskans, persons with disabilities, and their caregivers on the availability of services and support.

LB320 required the Department to establish three pilot sites that would provide one or more of the following functions:

(1) Comprehensive information on the full range of available public and private long-term care programs, options, financing, service providers, and resources within a community, including information on the availability of integrated long-term care;
(2) Assistance in accessing and applying for public benefits programs;
(3) Options Counseling;
(4) A convenient point of entry to the range of publicly supported long-term care programs for an eligible individual;
(5) A process for identifying unmet service needs in communities and developing recommendations to respond to those unmet needs;
(6) Facilitation of person-centered transition support to assure that an eligible individual is able to find the services and support that are most appropriate to his or her need;

(7) *Mobility management to promote the appropriate use of public transportation services by a person who does not own or is unable to operate an automobile; and*
(8) *A home care provider registry that will provide a person who needs home care with the names of home care providers and information about his or her rights and responsibilities as a home care consumer.*

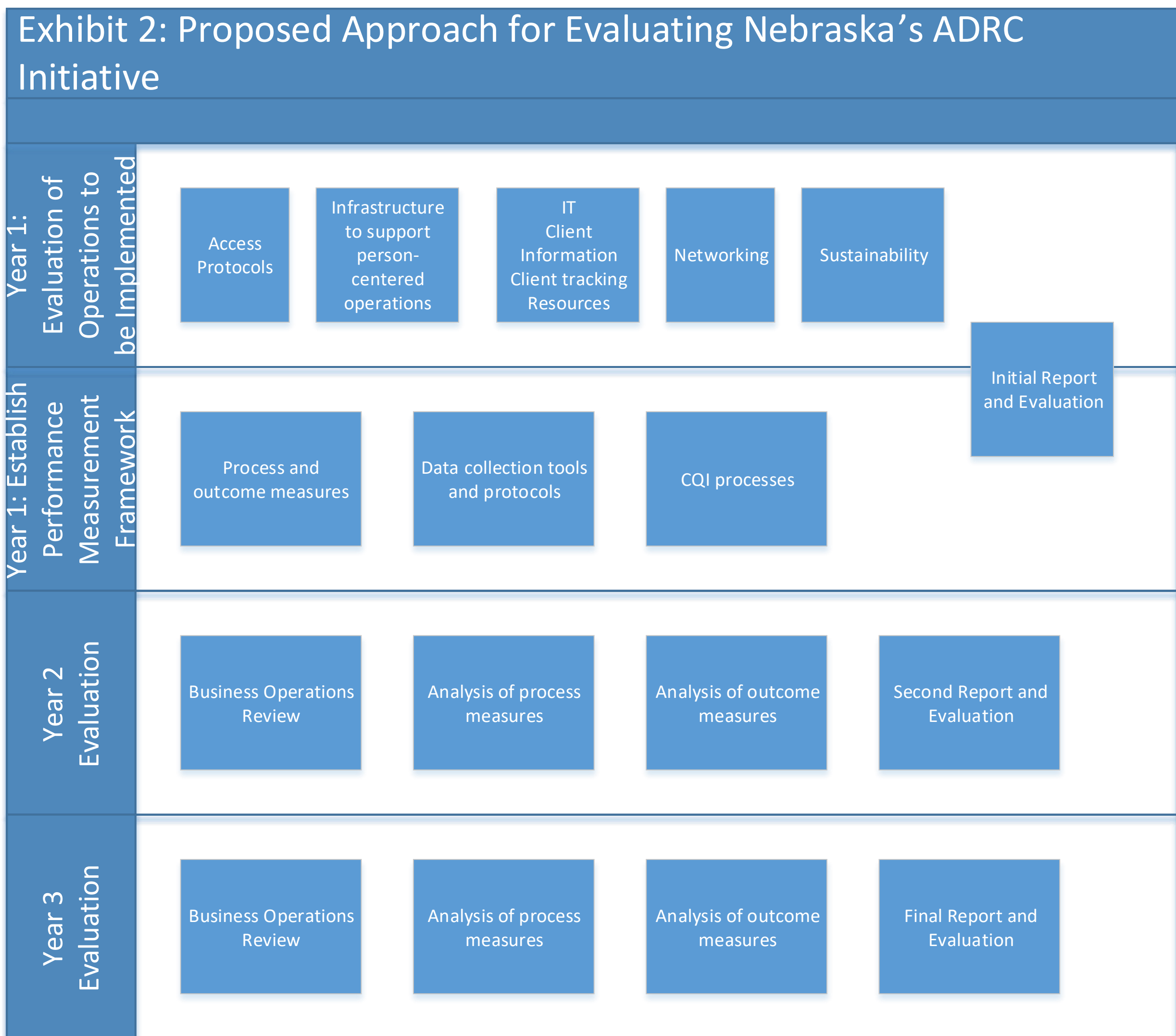
The legislation limited potential pilot sites to Area Agencies on Aging (AAAs). However, the legislation required that these AAAs coordinate with entities that support other populations with disabilities. The legislation does not specify what this coordination should consist of. Instead, it requires that applicants describe this in their solicitation responses.

LB 793, passed in 2018, transformed the ADRCs into a permanent program. The act appropriates funding for FYs 2019 and 2020 with a small increase over the funding provided during the pilot. It removes the limitation of only having three pilot sites but continues the practice of allowing the AAAs to form partnerships. As a result of this change, all seven AAAs who participated in the three pilot sites have their own individual subaward with the SUA. As was the case during the pilot, West Central Nebraska AAA has chosen to opt out of this effort. The legislation also requires that the state pursue Medicaid administrative claiming.

APPROACH FOR THE EVALUATION

Approach for the Evaluation

Exhibit 2 provides an overview of our proposed approach for the evaluation. The first year included the formative evaluation, in which we examined emerging and planned operations and plans for meeting the data collection requirements specified in the ADRC solicitation. This report includes summaries of annual reviews of the ADRC operations to evaluate how the development and refinement of operations are proceeding and analyzes data collected by the sites.



Business Operations Review

For this report, we built upon the information that we collected as part of the first two reports. We conducted telephone interviews with staff from all of the ADRC sites in September 2018. During these meetings, we addressed the following:

- Review of ADRC data and Action Plans completed by the ADRC
- Overview of operations- from initial phone call to triaging level of need to providing and recording outcomes
- Barriers and challenges to operating and building the ADRC
- Plans for operations now that the ADRC funding has been made permanent

The following exhibits describe the plans for building ADRC operations as of September 2018:

- ***Exhibit 3*** provides a brief description of the status of the development of core ADRC operations 1) as observed in August 2016 and included in the Initial Report and 2) as observed during the September 2017 site visit and September 2018 conference calls. We classified the status of plans for building the ADRC using the following categories:
    - No Plans
    - Developing plans
    - Draft plans
    - Finalized plans
    - Partially implemented, but plans are in flux
    - Partially implemented, but plans finalized
    - Fully implemented
    - Other
- ***Exhibit 4*** presents a flowchart that provides an overview of the ADRC operations model
- ***Exhibit 5*** is a table that summarizes the key components of the ADRC services

EXHIBIT 3: SUMMARY OF CURRENT AND PLANNED AAA/ADRC LTSS ACCESS BUSINESS OPERATIONS

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Status as of September 2018	Current Standardization	Documentation and Notes
Infrastructure for coordinating across sites	The AAAs have implemented a statewide ADRC Advisory Council and local Advisory Councils. These councils will facilitate collaboration among the AAAs and with other ADRC partners.	Finalized plans	Fully Implemented	Fully Implemented, though some AAAs considering merging local Advisory Councils with other cross-disability initiatives.	Standardized at state-level. Moving towards greater flexibility at local level.	We reviewed meeting minutes.
Outreach/Marketing	The AAAs have worked with the ADRC Coordinators to develop a formal marketing plan. It is envisioned that this marketing plan will be implemented once the operations of the ADRC are solidified. The AAAs will also be members in statewide and local ADRC Advisory Councils. These councils will help raise awareness of ADRC effort and enhance coordination with other State agencies and disability partners.	Draft plans	Fully Implemented	Fully Implemented	AAA specific	We reviewed plan and samples of marketing materials.
Linkages to Pathways to LTSS	The AAAs envision that they will continue to improve coordination efforts with health systems and discharge planners statewide to decrease hospital readmission through programs like AIMs.	Partially imp./plans in flux	Partially imp./plans in flux	Partially imp./plans beginning to solidify	AAA specific	Advisory Council Meeting minutes discuss coordination. ADRC staff were able to provide examples during onsite meetings and calls.

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Status as of September 2018	Current Standardization	Documentation and Notes
	They also envision strengthening the process of responding to individuals who are flagged in Minimum Data Set (MDS) Section Q[1] as wanting to leave a nursing facility. The AAAs are interested in examining how to implement and receive reimbursement for functions carried out by the ADRCs.					
Description of Intake Process	The AAAs envision that the ADRC intake functions will be blended into the AAA intake functions, rather than working in a silo. The coordination team is working to standardize these practices across agencies to the extent possible. There is also a vision of having a standardized tool for collecting initial information about the caller and having intake staff be familiar with the NAPIS[2] data requirements so that this information is captured in an efficient and effective manner.	Finalized plans	Partially imp./plans in flux	Mostly implemented in many AAAs and plans being developed for others	Partially standardized across all AAAs	Most sites that had fragmented intake processes had made significant progress integrating the ADRC over the previous year.

[1] The MDS Section Q is a mandated federal form that is completed for all residents of a nursing facility that received Medicare or Medicaid reimbursement.

[2] States are required to submit the National Aging Program Information Systems (NAPIS) State Program Reports to ACL. Nebraska's SUA must obtain this information from the AAAs and submit it to ACL.

BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Status as of September 2018	Current Standardization	Documentation and Notes
Ability to track individuals who contact the AAA/ADRC	The Trilogy system is sufficient for current practices, but an enhanced system to collect a wider range of metrics is desired by both the AAAs and the State. The State envisions implementing an Options Counseling module and developing further reporting capabilities within the Trilogy system. SUA is developing an RFP to procure a system that will better meet their needs. The coordinating team will continue to work with the AAAs to develop the contents of the dashboard and ensure that it is being utilized in a consistent manner.	Draft plans	Partially Implemented	Partially implemented	Partially standardized across all AAAs	While intake for the ADRC is standardized and data is being captured in the Trilogy system, AAA I&A is not being captured in this system by the AAAs. In addition, practices for collecting these data appear to differ. However, the SUA issued new guidelines for coding these services that should help alleviate this issue. The SUA is also planning on procuring a new system that integrates the AAA and ADRC reporting.
Triage: Processes for determining where to route people who contact the AAA/ADRC	The ADRC effort developed standardized guidance regarding how to triage people to other agencies or within the different ADRC offerings (e.g., information and referral (I&R), Options Counseling (OC), Enhanced Options Counseling (EOC)).	Draft plans	Fully Implemented	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Determination of who will get I&R, Options Counseling, Enhanced Options Counseling or another service	The ADRC effort has developed definitions for who should refer I&R, Options Counseling, and Enhanced Options Counseling. The definitions have been incorporated into ADRC operations.	Draft plans	Fully Implemented	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.

BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Status as of September 2018	Current Standardization	Documentation and Notes
Required timeframes	Participant identifying information (name and AAA) must be entered on the Dashboard by the close of business on the day contact was made. All participant information must be entered on the Dashboard within two business days following the contact	Developing plans	Fully Implemented	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Staff qualifications and training	Each ADRC developed standardized staff qualifications and training for each position that align with the requirements in the Request for Grant Proposals (RFGP).	Developing plans	Fully Implemented	Fully Implemented	AAA specific	Descriptions of staff qualifications were provided.
Description of the LTSS Options Counseling Process	The vision under the ADRC model is to delineate and define I&R, Options Counseling, and Enhanced Options Counseling to improve clarity about what Options Counseling is and when it should be provided. Training materials and accompanying tools have been developed for each of the options. All options may result a written document that summarizes the outcomes of the process.	Finalized plans	Fully Implemented	Fully Implemented	AAA specific	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.

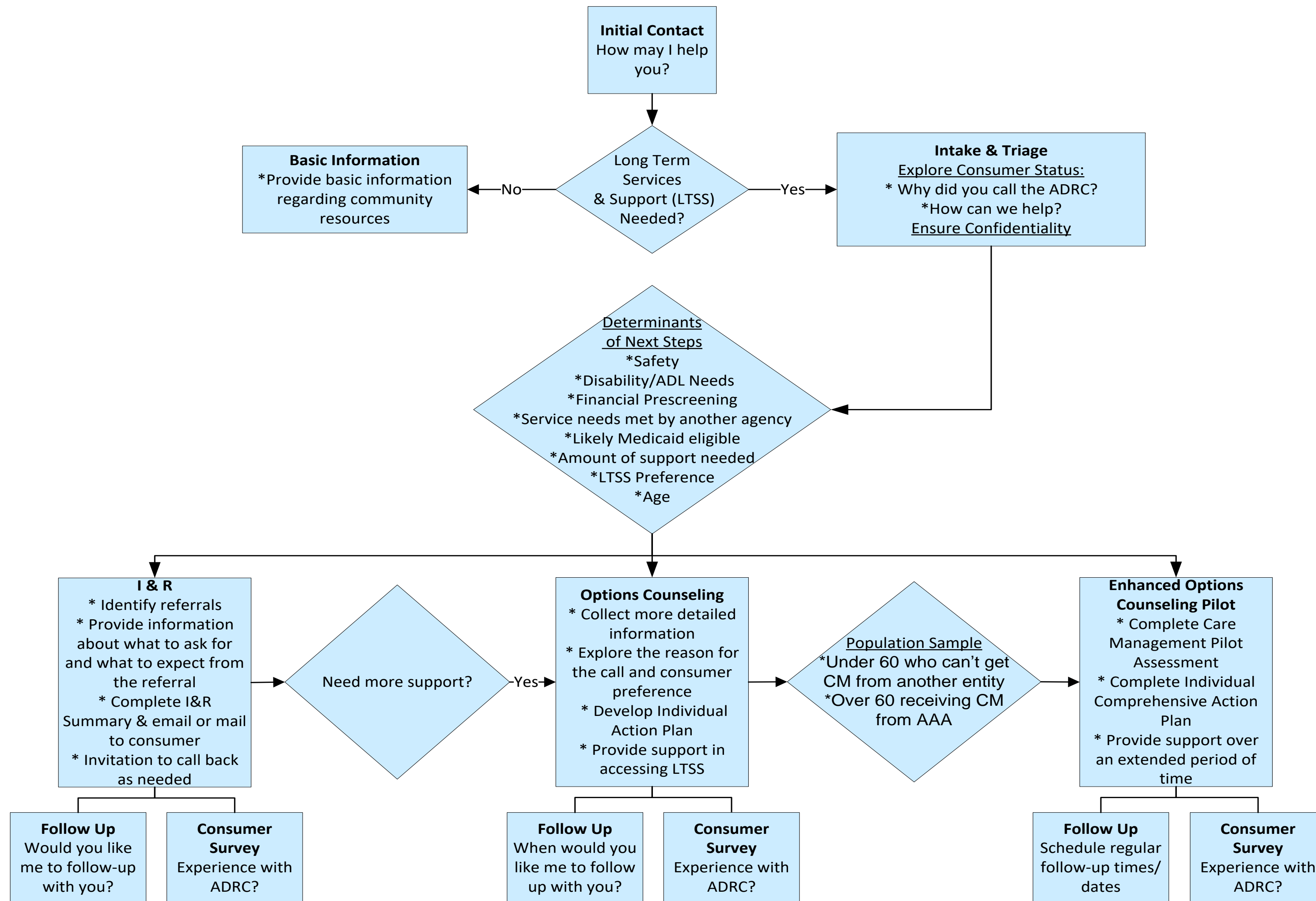
BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Status as of September 2018	Current Standardization	Documentation and Notes
Description of assessment	The pilot sites are using the AAA Care Management assessment as the tool for people who receive Enhanced Options Counseling under the pilot. The AAAs are only collecting high-level assessment categories for Options Counseling and I&R.	Partially imp./plans finalized	Fully Implemented	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Written plan or other instructions given to clients	The ADRC effort developed standardized template for written plans. Individuals receiving I&R are offered a document that summarizes the referrals, which can be either emailed or mailed to them. Individuals receiving Options Counseling are offered a written plan that identified goals and activities.	Finalized plans	Fully Implemented	Partially Implemented	AAA specific	Data in the Trilogy system and discussions during demonstrate this is occurring. ADRC Coordinators reported that written plans were offered to all individuals receiving I&R, however plans are not uploaded into the Trilogy dashboard and therefore are unable to be evaluated for volume or quality. Trilogy should develop the ability to upload I&R plans into the system for tracking.
Required timeframes	The ADRCs have established the following required timelines: • I&R information must be mailed or emailed to participant within three business days of contact. • The Individual Action Plan (IAP) must be mailed or emailed to the participant	Developing plans	Fully Implemented	Fully Implemented	Standardized across all AAAs	Review of the operations manual and discussions during the onsite reviews demonstrate this is occurring. Unfortunately, the Trilogy system was not capable of tracking these timeframes.

BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Status as of September 2018	Current Standardization	Documentation and Notes
	within five business days of the contact. • For I&R participants, the satisfaction survey is sent within two weeks of the date of service. • For OC participants, the satisfaction survey is sent within two weeks of when the OC case is closed.					
IT (use of NAMIS, Trilogy, and/or other IT)	The ADRCs are using the Dashboard function within the Trilogy system to track calls and clients. Written plans are either be completed using Microsoft Word or fillable PDF templates.	Partially imp./plans in flux	Fully Implemented	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Approach for updating LTSS resources in the Trilogy system	Several taxonomy categories were added to the database to identify the number of resources in a manner required by the RFGP. The State Unit on Aging (SUA) is producing reports that summarize these resources. The AAAs are using that information to address weaknesses within the database. To standardize processes, the AAAs are considering staff become AIRS-certified, an industry standard for providing quality I&R services.	Finalized plans	Fully Implemented	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring. Only one of the ADRCs has obtained AIRS-certification for its staff.

EXHIBIT 4: ADRC PILOT OPERATIONS MODEL



As shown in ***Exhibit 4***, the ADRCs offered four tiers of services during the pilot period:

- **Basic information** is provided to individuals who do not require any referrals or other counseling.
- **Information and Referral (I&R)** is similar to the assistance provided by the AAAs under I&A. The major changes from AAA practices are:
  - This service is available for all individuals with disabilities.
  - Individuals are offered a standardized written referral plan. The referral plan is included in ***Appendix 1***.
  - More data about the individual and the types of referrals are being tracked.
  - People who would benefit from more than just referrals are receiving either Options Counseling or Enhanced Options Counseling. Some of the individuals who currently receive more intensive assistance under AAA I&A may be triaged to Options Counseling.
- **Options Counseling (OC)** is an intermediate service that results in a standardized written plan that identifies the individual's goals and the action steps necessary to meet those goals. The most recent version of the Individual Action Plan (IAP) is included in ***Appendix 1***. This service is available to all populations with disabilities and their caregivers.
- **Enhanced Options Counseling (EOC)** is a more intensive service that was piloted with a limited number of individuals at two pilot sites (Aging Partners (AP) and South Central Nebraska Area Agency on Aging (SCNAAA)). EOC was discontinued in 2018. The ADRCs are either coding these contacts as Options Counseling or referring these individuals to Care Management.

EXHIBIT 5: DESCRIPTIONS OF THE ADRC SERVICES

Work Domains	Basic Information	Information & Referral (I&R)	Options Counseling	Enhanced Options Counseling (Has been discontinued)
Participant Status	Participant does not present as wanting anything more than specific information.	Participant may be potentially eligible for LTSS; already be receiving Medicaid or services through another LTSS program; or receiving no services.	Participant has little knowledge about their LTSS options and limited capability or interest in pursuing LTSS independently. They most likely have not received LTSS services in the past and find themselves at a loss of where to turn for help.	Participants under 60 with disabilities who are not currently eligible for AAA Care Management from any other LTSS program. Participants over 60 referred to an AAA Care Management program.
Information Requests	Participant requests only community resource or provider basic information such as location, business hours, or phone numbers.	Participant seeks information about LTSS. Information provided may range from simply describing a variety of LTSS options to detailed information about eligibility and referral processes.	Participants seek extensive information and/or decision-support about LTSS options including: how to plan for the future; information about Medicaid and other LTSS eligibility, application, options, and costs; and assistance determining their wants and needs.	Participants seek extensive information and/or decision-support about LTSS options including: how to plan for the future; information about Medicaid and other LTSS eligibility, application, options, and costs; and assistance determining their wants and needs.
Participant Assistance	Information is most commonly provided over the telephone.	Participant indicates preference for no or minimal assistance with contacting community resources and/or pursuing potential benefits.	Participant indicates preference or demonstrates the need for hands-on assistance with contacting community resources and/or pursing potential benefits. ADRC services are provided on a face-to-face basis and home visits are common.	Participant demonstrates the need for assistance to further explore preferences and LTSS needs. Participant is in need of hands-on assistance in following through with referrals to LTSS and following up with selection of LTSS providers. ADRC services are provided on a face-to-face basis and home visits may be required to monitor service provision.
Number of Contacts	Most typically only one	Contact is typically only one or two contacts over a limited length of time.	Contacts are multiple over a longer period of time (typically no more than 90 days).	Contacts are multiple over a longer period of time (typically more than 90 days).

BUSINESS OPERATIONS REVIEW

Work Domains	Basic Information	Information & Referral (I&R)	Options Counseling	Enhanced Options Counseling (Has been discontinued)
Nature of Contacts	Telephone	Telephone, email or face-to-face in the ADRC office	Telephone, email, face-to-face in ADRC office or in participant's home	Telephone, email, face-to-face in ADRC office and in participant's home
Assessment	None	Information on Dashboard	Information on Dashboard	Information on Dashboard Comprehensive assessment
Action Planning	None	The 'Information & Referral Summary' is completed and mailed or emailed to the participant. Participants are also offered a voluntary I&R Action Plan.	The 'Individual Action Plan' is completed with the participant face-to-face.	The Individual Comprehensive Action Plan is based on the person-centered planning philosophy and done in conjunction with the participant.
Follow Up	None	Follow-up is not needed or minimal based on participant preference.	Follow-up is ongoing until services and supports are secured by the participant.	Follow-up and monitoring is on-going until participant reaches stabilization with LTSS provided.
Documentation	Dashboard Information: Record AAA and designate as a basic information call	• Dashboard information • I&R summary • Referrals • Follow-up notes	• Dashboard information • Consent to release/receive information forms • Individual Action Plan • Referrals • Follow-up notes	• Dashboard information • Consent to release/receive information corms • Comprehensive assessment • Individual Comprehensive Action Plan • Referrals • Follow-up notes

PROGRESS MADE TOWARDS OVERCOMING CHALLENGES TO MEETING THE ADRC PILOT VISION IDENTIFIED IN THE YEAR 2 REPORT

In the previous reports, we identified the following challenges to implementing the ADRC pilot as originally conceived in the legislation and request for grant proposals (RFGP):

- Strengthening referrals to other access points to LTSS
- Clarifying and enhancing the role of the disability community within the ADRC/NWD network
- Ensuring the ADRC brand includes all people with disabilities

We discuss the progress that has been made in each of these areas below.

The most tangible sign of progress over the past year is the Action Plan the ADRCs developed which is included as ***Appendix 4.*** This plan could be a living document that will guide the transition of the ADRC into a permanent program that may fulfill the NWD vision included in the Medicaid transformation report.

STRENGTHENING REFERRALS TO OTHER LTSS ACCESS POINTS

In the Initial Report, we recommended the following should occur:

- The ADRCs should establish written agreements that include referral protocols and cross-training with disability partners and LTSS access points.
- Referral protocols should clearly identify who should be referred to each of the access points, how the referral should be made (including minimizing burden on the individual needing supports), and timeframes for addressing the referrals.
- These referral protocols should be translated into workflows that are incorporated into training and, once the ADRC is supported by a more sophisticated management information system (MIS), automated algorithms.

In the Year 2 Report, we found that the ADRCs made progress in building relationships with other entities supporting individuals with disabilities, especially at the local level. However, we did not observe progress being made in translating these relationships into ongoing policies and procedures and written agreements as recommended in the Initial Report. Some of the ADRCs identified "turf issues" with other disability agencies as one of the challenges. These issues may be resulting from not clearly delineating the roles of the various agencies supporting people with disabilities.

The most recent review found that relationships with disability partners continued to flourish at the local level. There did not appear to be much progress on formalizing these relationships

until the ADRC was granted permanent status. Since then, the AAAs have recognized the need to add greater structure to these relationships and capture this structure in writing. This is reflected in Goal 8 on page 10 of the ADRC Action Plan (***Appendix 4***). In implementing this goal, we encourage the ADRCs to balance the desire to have consistency statewide with respecting the relationships that have been built locally and the differences in urban and rural areas. In urban areas that have many agencies with a relatively large number of staff, having clear written decision criteria about who gets referred there will help prevent confusion and duplication. In rural areas in which the disability network includes a relatively small number of staff, the network needs to be flexible enough to compensate for changes in the capacity of one agency (e.g., someone going on maternity leave or a retirement). For these areas, it may be more practical to set regular meetings with standing agenda items to determine the optimal distribution of labor among the agencies.

Clarifying and Enhancing the Role of the Disability Community within the ADRC/NWD Network

While LB320 required involvement of the representatives of the disability community, the AAAs were allowed to define how the partnership should work. The ADRCs have established both State and local Advisory Councils and their membership is included as part of ***Appendix 2***.

In the Initial Report, we identified issues raised by the disability partners and recommended actions to be taken to address these concerns. ***Exhibit 6*** shows the original recommendations followed by the actions taken by the ADRCs to remedy these concerns in Years 2 and 3.

EXHIBIT 6: PROGRESS TOWARDS AND RECOMMENDATIONS FOR ENHANCING THE ROLE OF THE DISABILITY COMMUNITY WITHIN THE ADRC/NWD NETWORK

Recommendation in the Initial Report	Actions taken by the ADRC team	Recommendations in the Year 2 Report	Progress in Year 3
The disability partners should be asked to train ADRC staff on working with people with disabilities. The curricula could include topics such as disability etiquette.	Disability partners held several trainings for the ADRC team, including content on disability etiquette.	The ADRC teams should build off this success and develop a set schedule that includes scheduled core topics rather than holding trainings on an ad hoc basis.	Goal 6 of the Action Plan addresses enhancing training.

Recommendation in the Initial Report	Actions taken by the ADRC team	Recommendations in the Year 2 Report	Progress in Year 3
The ADRC effort should more clearly delineate the type of input needed from the disability partners that could be addressed at a State level and clarify when representatives from these partners should be included on local Advisory Councils.	Although there is not a document that clearly lays out the roles, the State Advisory Council has focused more on overall program operations, while the local agencies have focused more on cross training with local partners and collaborating on individual cases.	The ADRC should develop a policy that clearly lays out the expectations for both the State and local Advisory Councils.	Goal 7 of the Action plan addresses strengthening the statewide Advisory Committee. The Action Plan should be amended to include each ADRCs plans for getting input at the local level.
A stronger effort should be made to include disability partners that represent individuals with mental health issues.	The disability partners noted that this has occurred at the local level. Some of the disability partners expressed concern about mental health representation at the State level. The council roster includes a representative from the Division of Behavioral Health (DBH), however, the disability partners recommended including other individuals outside of DBH.	The ADRC team should strengthen the efforts to have mental health representation on the State Advisory Council.	Although the Statewide Advisory Council includes a representative from DBH, she has not been an active member. The Action Plan includes a comprehensive reevaluation of the Advisory Committee membership with the goal of increasing representation for mental health and other groups.

Ensuring the ADRC Brand Includes All People with Disabilities

The initial report recommended that the ADRC initiative should make sure the ADRC brand is identified as supporting all populations with disabilities. This is to be included in:

- Outreach efforts and marketing materials
- ADRC websites

- Protocols ADRC/AAA workers use for providing I&R and Options Counseling, such as:
  - When someone calls, does the person answering the call identify themselves as an ADRC worker or a AAA worker?
  - Do business cards and other identifying information identify workers as part of the ADRC or the AAA?
- Logos and other identifying information included on forms, templates, etc.

The ADRC logo and the website both clearly identify that the ADRC is for "seniors and people with disabilities". The agency is represented as the ADRC for individuals calling the ADRC 800 number. AAAs are answering phone calls using the AAA and ADRC name.

However, the data in the Year 2 Report and this year's data showed that most of the call volume is being entered as AAA I&A and not ADRC I&R, consistent with SUA policy. The new ADRC Action Plan appears to treat I&A and I&R as the same service. The AAAs should decide whether to count these as I&A for NAPIS reporting, I&R for ADRC reporting, or both.

POTENTIAL CHANGES TO THE ADRC MODEL

Our discussions with staff at the pilot sites for the Year 2 Report revealed that some of the support being offered by ADRC staff does not fit well with the categories of services included in the original ADRC model. This support appeared to fall into two categories: 1) Extensive assistance provided to individuals who are challenging to support; and 2) Assistance provided to individuals who are currently being served by another agency or agencies. The ADRCs did not refine their model to reflect this over the past year. This is understandable because, as the ADRC initiative became permanent, the more important issue has been integrating AAA and ADRC operations and building infrastructure to embed the ADRCs within a NWD Network. As this work is completed the need to classify these as separate services may diminish. For example, cases in which extensive assistance is provided to people with challenging circumstances may be routed to Care Management.

We encourage the ADRCs to explore whether refinements to the model are still necessary after the integration of the AAAs and ADRCs is completed.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Performance on Process and Outcome Measures

The ADRC effort is collecting data that allows us to assess its performance on the following types of measures:

- Process measures that assess how ADRC business operations are functioning (e.g., number of people served, timeliness)
- Outcome measures that evaluate the degree to which the ADRC is impacting outcomes (e.g., satisfaction)

This section summarizes the performance on these measures using data from the second year of the pilot. ***Exhibit 7*** provides a summary of the measures, the tools used to collect data on these measures, and the mechanisms for aggregating these data. We describe the data collection tools immediately after the exhibit.

EXHIBIT 7: PROCESS AND OUTCOME MEASURES

Measure	Data Collection Tool	Data Aggregation Mechanism
Process Measures		
Number of Resources in the I&R database by: • Resource type • Disability population(s) • Coverage area(s) • Whether updated in last year	TNoC database	Pulling raw data from database and extracting into s
Number of people receiving ADRC services by: • Type of support: I&R, Options Counseling, and Enhanced Options Counseling • Disability population(s) • Setting (hospital, rehab facility, nursing facility, home, other)	Trilogy Dashboard	Reports pulled from dashboard
Follow-up: • Number receiving • % in which follow-up was done consistent with agreement in original plan	Trilogy Dashboard	Reports pulled from dashboard
Number of people informed about informed consent and confidentiality rights	Trilogy Dashboard	Reports pulled from dashboard

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Measure	Data Collection Tool	Data Aggregation Mechanism
Number of people provided eligibility counseling and financial prescreening	Trilogy Dashboard	Reports pulled from dashboard
Unmet Need by: • Type of need • Disability population(s)	Trilogy Dashboard	Reports pulled from dashboard
Outcome Measures		
Individual and/or representative active in Options Counseling process	Participant survey	Extracted from fillable pdf
Individual and/or representative better informed about LTSS options as result of Options Counseling process	Participant survey	Extracted from fillable pdf
Individual and/or representative trust ADRC gave them objective, accurate and complete information	Participant survey	Extracted from fillable pdf
Individual and/or representative believes Action Plan reflects what is important to the person	Participant survey	Extracted from fillable pdf
Individual and/or representative believe ADRC service will help keep the person from going into a nursing facility	Participant survey	Extracted from fillable pdf
Degree to which plans include: • Multiple sources of support • Government-paid support • Privately paid supports • Unpaid supports	Action plan	Extracted from fillable pdf

DATA COLLECTION TOOLS

Tools for collecting data include:

- **Trilogy Dashboard-** The Dashboard is an electronic resource for staff to document and track participants and referrals. For each call received by the ADRC, staff use the Dashboard to develop a participant record and document referrals. Staff can also use the Dashboard to search for callers that have previously contacted the ADRC.

  The Dashboard consists of two primary components, the home screen and the call log. The home screen allows staff to see cases that have been assigned to them and/or those that require follow-up. The call log within the Dashboard is broken into four tabs:

  - **Caller-** Collects information about the caller and whether there is a concern about safety.
  - **Consumer information-** Collects information about the reason for the call, basic demographic information about the participant, disability status, and whether the participant has a legal representative.
  - **Referrals-** Allows staff to search the TNoC database by taxonomy categories to provide referrals. This screen will also note if previous referrals have been made.
  - **Finish call-** The final point of documentation, this screen allows staff to document the participant's unmet need, the outcome of the call, tasks for follow-up, and additional notes.
- **Trilogy Network of Care (TNoC) Database-** The TNoC database is a searchable database of service providers that can be accessed through the Dashboard and a public facing website (http://nebraska.networkofcare.org/aging). The database categorizes providers by the services they provide and the areas served. Staff can obtain contact information and agency descriptions to facilitate referrals.
- **Participant Survey-** The I&R and Options Counseling satisfaction surveys collect information about the caller/participant's interaction with the ADRC and suggestions for improvement. Feedback areas include adequacy of the information provided, clarity of the next steps that will need to be taken, and whether the interaction will allow the participant to stay within the community. The survey can be delivered by email or mail. The survey is included in ***Appendix 1***.
- **Individual Action Plans (IAPs)-** IAPs are fillable PDFs (also available as an automated form within the Trilogy system) that documents the participant's person-centered goals, action steps, funding sources, and progress towards the goal. There are different versions of the IAPs for Options Counseling and Enhanced Options Counseling. The most recent IAPs are included in ***Appendix 1***.

FINDINGS

This section provides summaries of the analyses of the process and outcome measures described in ***Exhibit 7***.

Process Measures

Process measures provide a snapshot of several key characteristics of the ADRC, such as the public's knowledge about the ADRC, market penetration, and overall utilization. These measures include:

- The number and types of resources to which a participant may be referred
- Contacts that the ADRC received or initiated
- The number of contacts that resulted in a request for follow-up and the timeliness of that follow-up
- Whether individuals received information about informed consent and confidentiality rights
- Whether individuals received eligibility counseling and prescreening for services and supports
- The extent and type of unmet need for individuals contacting the ADRC

Number and Types of Resources Included in the I&R Database

ADRC staff, ADRC participants, and potential participants can search the TNoC Resource Database to identify resources across the State and within their communities. This I&R database is divided into searchable taxonomy categories that allow users to search for several characteristics, such as service type and populations served.

The SUA, AAAs/ADRCs, and partner agencies have expanded the number and types of resources that are available in the database over the past year. The database now contains 1,635 different agencies that provide statewide or regional coverage, up from last year's total of 1,619. These resources cover 52 programs, services, supports, and other resource taxonomy categories and are searchable across 18 LTSS and other populations.

Exhibits 8-10 provide an overview of the resources available within the database as of September 30, 2018. The identified resources are broken down by AAA service region, including resources for the AAA region not participating in the pilot, West Central Nebraska Area Agency on Aging (WCNAAA). Resources are counted for the AAA region if they either 1) serve the entire State or 2) serve the specific region.

Exhibit 8 summarizes the resources available by AAA region**.** Because statewide resources are included in the counts for each region and some resources serve more than one region, the unduplicated counts for resources is significantly less than the totals across regions. Therefore, we do not include a total across AAAs and only include unduplicated counts.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 8: NUMBER OF RESOURCES AVAILABLE BY REGION

Region		Number of Resources in Database
Aging Partners Group	Aging Partners	372
	Blue Rivers	266
	Midland	263
Northeast Nebraska Group	Eastern NE	436
	Northeast NE	436
South Central Nebraska Group	South Central NE	338
	Western NE	269
AAA Not in Pilot, WCNAAA		180
Statewide		123
Total Unduplicated Resources		1,635

Number and Type of Resources by Taxonomy Category

Exhibit 9 summarizes the types of resources included in the database by AAA site, including the AAA not participating in the ADRC pilot, WCNAAA. Cells that are highlighted in yellow indicate that there are no resources in the database for that category in the AAA region. The ADRC Action Plan does include a component to regularly review the database to update and add resources.

The most common resources were:

- Assisted Living Facilities (284)
- Congregate Meals/Nutrition Sites (206)
- Nursing Facilities (206)
- Community Clinics (193)
- Leisure Activities/ Recreation (171)
- I&R (162)
- Home Delivered Meals (146)
- Home Health Care (136)

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 9: RESOURCES IN THE I&R DATABASE BY RESOURCE TYPE AND REGION

RFP & Taxonomy Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Category
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
Respite Care	1	1	1	1	1	1	1	1	1
Guardianship Assistance	12	9	11	11	12	12	11	10	25
Caregiver/Care Recipient Support Group	10	5	5	7	6	7	8	5	19
Crisis Intervention	4	4	3	5	4	5	4	2	15
Early Child Education	5	5	5	5	5	5	5	5	5
Special Education	2	2	2	2	2	2	2	2	2
Postsecondary Institutions	1	1	1	1	1	1	1	1	1
Career Counseling	3	3	3	7	4	4	5	3	11
Supported Employment	21	20	19	27	21	30	19	19	43
Vocational Rehabilitation	27	22	29	41	26	37	29	21	85
Utility Assistance	6	7	5	10	5	7	7	5	17
HCBS Waiver Program	1	1	1	1	1	1	1	1	1
Mental Health Support Services	13	6	7	19	9	11	5	4	40
Assisted Living Facilities	53	17	30	70	54	29	22	16	284
Community Clinics	23	24	19	20	61	33	26	1	191
Hospitals	20	11	8	28	30	15	11	1	117
Hospice Care	15	14	4	20	6	16	5	0	76
ICF-IDD	2	7	3	4	2	2	1	1	15
Nursing Facilities	34	20	19	42	44	23	20	11	206
Home/Community Based DD Program	12	7	11	22	9	10	11	6	46
Assistive Technology	8	5	6	13	6	11	8	4	29
Adult Day Programs	12	3	4	8	9	9	1	1	47
Rehabilitation/ Habilitation Services	11	13	7	21	13	17	8	6	54
Public Assistance Programs	10	9	10	10	10	11	10	9	16
Social Skills Training	8	8	11	16	10	19	11	7	40
Independent Living Skills Instruction	11	7	9	20	7	15	9	6	38
Centers for Independent Living (CIL)	1	1	2	2	1	2	3	0	9

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

RFP & Taxonomy Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Category
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
In-home Meal Prep.	9	6	4	11	7	5	5	2	27
Congregate Meals/Nutrition Sites	28	20	13	26	49	25	18	27	206
Food Pantries	14	12	10	11	8	20	9	3	64
Home Delivered Meals	15	23	12	10	40	12	21	20	146
Nutrition Education	8	1	4	4	8	4	2	0	30
Benefits Assistance/Benefits Counseling	30	18	17	22	22	20	21	14	62
Information & Referral (I&R)	72	38	35	44	40	47	64	30	162
LTC Options Counseling	2	1	2	2	2	2	2	1	7
Health/Disability Related Support Groups	11	6	9	10	6	14	12	6	34
Caregiver/ Care Receiver Support Groups	10	5	5	7	6	7	8	5	19
Bereavement Support Groups	5	6	6	7	14	7	5	5	20
Housekeeping Assistance	9	7	6	12	7	6	6	2	33
Personal Care	8	9	3	12	6	7	4	1	35
Home Health Care	26	15	14	62	26	10	7	3	136
Personal Alarm Systems	8	11	8	8	8	5	5	5	17
Homeless Shelter	1	3	2	4	0	2	1	1	14
Housing Authorities	12	12	14	10	28	26	15	1	111
Housing Counseling	15	9	8	6	7	9	8	4	36
Housing Expense Assistance	8	9	4	7	5	5	5	1	38
Low Income/Subsidized Private Rental Housing	12	14	14	16	27	25	3	1	106
General Minor Home Repair Program	2	1	2	4	1	1	2	1	7
Local Transportation	2	3	2	2	2	2	2	2	3
Volunteering Opportunities	18	29	12	23	9	15	16	4	98
Social Development and Enrichment	1	0	0	1	0	2	0	0	4
Leisure Activities/ Recreation	33	21	15	29	41	19	20	21	171

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Of the 52 taxonomy categories of resources, the database includes at least one resource in all seven of the AAA regions participating in the pilot for 96%, which is about the same as was found in the Year Two Report findings. Resources that were not found in all pilot areas were homeless shelters (1 area, NENAAA, with no resources) and social development and enrichment activities (4 areas, BRAAA, MAAA, NENAAA, and AOWN, with no resources).

Number and Type of Resources by Target Population

Exhibit 10 show the resources by the 18 population groups within the database. The database now includes a wide range of resources for all populations with disabilities. All AAA regions now include at least one resource for all target population categories. Many categories saw a substantial increase in resources from the Year 2 Report, such as IDD with nine additional resources and Alzheimer's disease and mental illness/emotional disabilities each adding eight resources.

EXHIBIT 10: RESOURCES IN THE I&R DATABASE BY TARGET POPULATIONS AND REGION

Population Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Population
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
AIDS/HIV	7	7	7	7	6	7	6	5	15
Alzheimer's Disease	26	6	12	29	4	5	9	3	67
Autism Spectrum Disorders	27	24	24	22	20	25	21	20	43
Brain Injuries	26	20	25	27	18	25	23	18	54
Caregivers	24	20	18	18	16	18	20	16	38
Hearing Loss	16	14	14	15	13	16	16	13	26
Holocaust Survivors	6	5	6	6	5	6	6	5	10
IDD	61	56	57	70	53	63	55	45	143
Mental Illness/ Emotional Disabilities	40	29	32	35	29	35	27	22	86
Native American Community	2	1	2	3	2	1	2	1	5
People with Chronic Illness	11	40	7	14	6	33	7	5	85
Physical Disabilities	23	52	19	21	14	45	22	13	114

Population Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Population
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
Speech Impairments	6	7	6	9	6	6	6	6	10
Spinal Cord Injury	17	14	13	18	13	13	13	12	27
Substance Use Disorders	8	5	5	13	7	6	7	4	24
Terminal Illness	18	25	8	27	9	33	7	2	109
Veterans	19	19	19	20	18	19	19	17	29
Visual Impairments	9	8	7	9	8	9	7	7	15

Summary of the Type of Contacts Received by the ADRC

The ADRCs received 10,481 contacts from 7,002 individuals from October 1, 2017 to September 30, 2018. Of these contacts, 278 (2.7%) did not capture the type of contact and were categorized as basic information for the analyses. 825 (8%) of the contacts had a variation of "Anonymous" as the name and 47 (.1%) entries did not include a name. ADRCs are not required to collect contact information for Basic Information calls, therefore, 17% of these calls had the name of "Anonymous" or did not include a name. In comparison, less than one percent of I&R and none of the Options Counseling contacts included "Anonymous" or had missing names.

For the remainder of this document, we discuss only contacts that were documented as basic information, I&R, OC, or EOC. Individualized counts only reflect contacts that had a unique name and exclude "Anonymous" and blank named contacts.

Exhibit 11 summarizes types of contacts documented in the Trilogy Dashboard. Most of contacts were categorized as basic information (46% of all contacts and 49% of unduplicated individuals) or Information and Referral (I&R) (48% of all contacts and 48% of unduplicated individuals). Options Counseling and Enhanced Options Counseling together accounted for 6% of the total contacts and 3% of unduplicated contacts.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 11: CONTACTS BY ADRC SERVICE TYPE

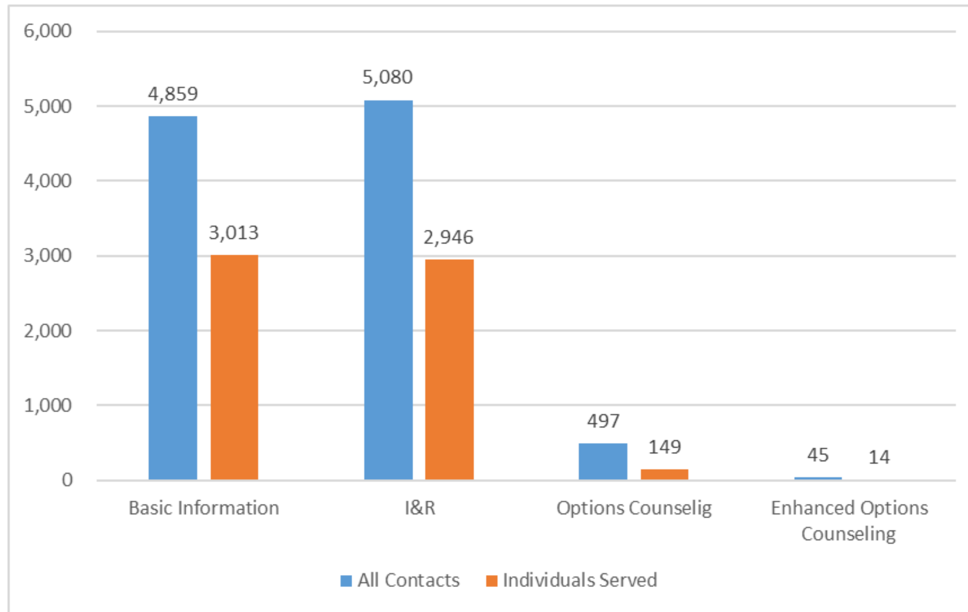
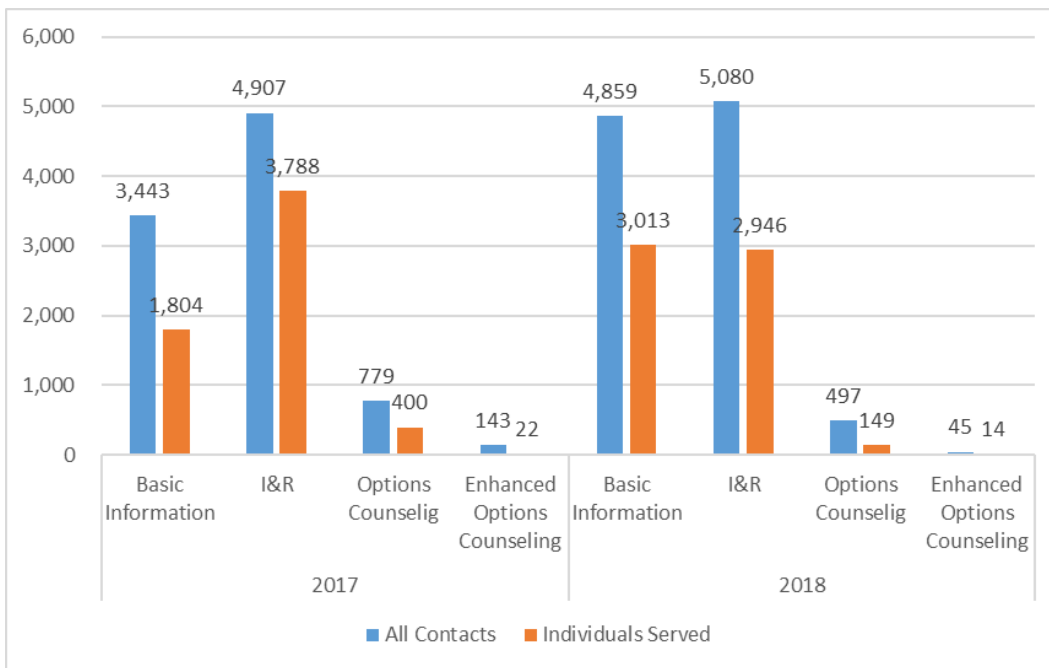


Exhibit 12 summarizes the changes in contacts between the 2017 and 2018 evaluation periods (October 1-September 30).

EXHIBIT 12: COMPARISON OF 2017 AND 2018 CONTACTS BY ADRC SERVICE TYPE



PERFORMANCE ON PROCESS AND OUTCOME MEASURES

From 2017 to 2018, the number of ADRC contacts rose by 1,209 (an increase of 13%) and the ADRCs served 108 additional unique individuals (an increase of 2%). The contacts for basic information saw the greatest increase (1,416 or 41%).

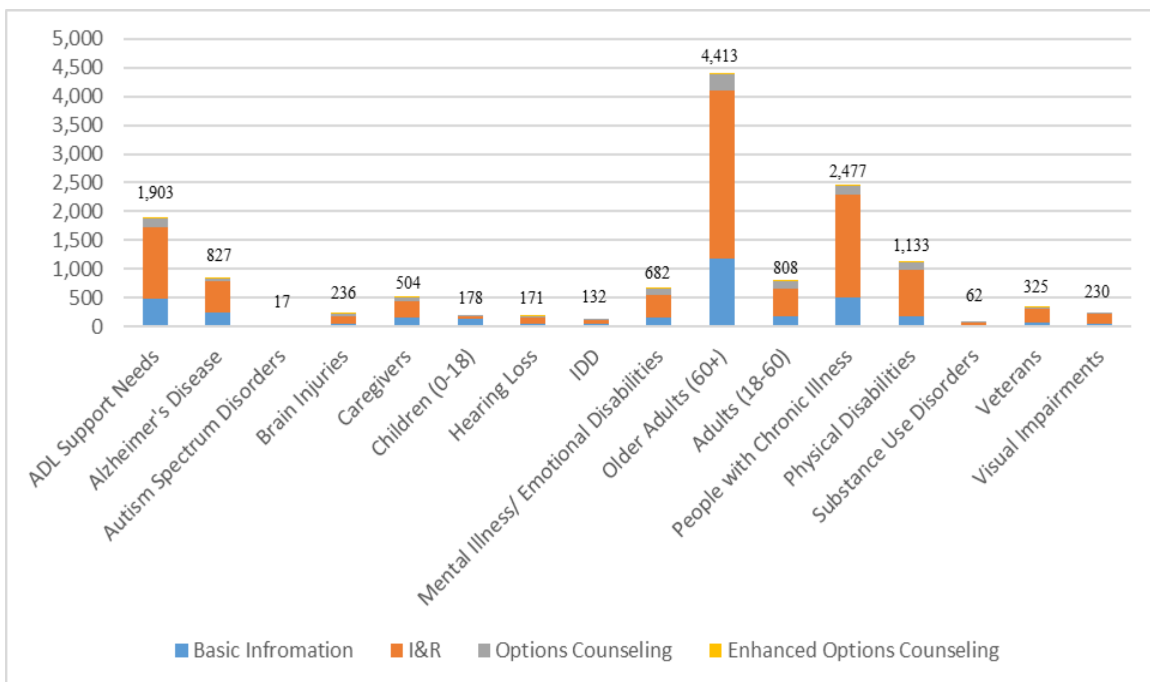
The number of both Options Counseling (decrease of 282 or 36%) and Enhanced Options Counseling (decrease of 98 or 68%) contacts decreased substantially from the previous year.

During HCBS Strategies' September 2017 site visit, staff reported that there was confusion around when a contact transitions from basic information to I&R and from I&R to Options Counseling. The increase in basic information contacts and relative stability of the I&R data and the decrease in Options Counseling contacts indicates that staff are now clearer as to how to categorize the calls. Additionally, Enhanced Options Counseling was discontinued in early 2018, so the decrease in this category was anticipated.

ADRC Contacts Across Populations

Exhibit 13 presents contacts by ADRC service type and disability populations. Because a participant may be identified as being in more than one population (e.g., many of the adults age 60+ also had chronic illnesses), the totals in this exhibit are larger than those in the previous exhibit.

EXHIBIT 13: CONTACTS BY POPULATION AND ADRC SERVICE TYPE



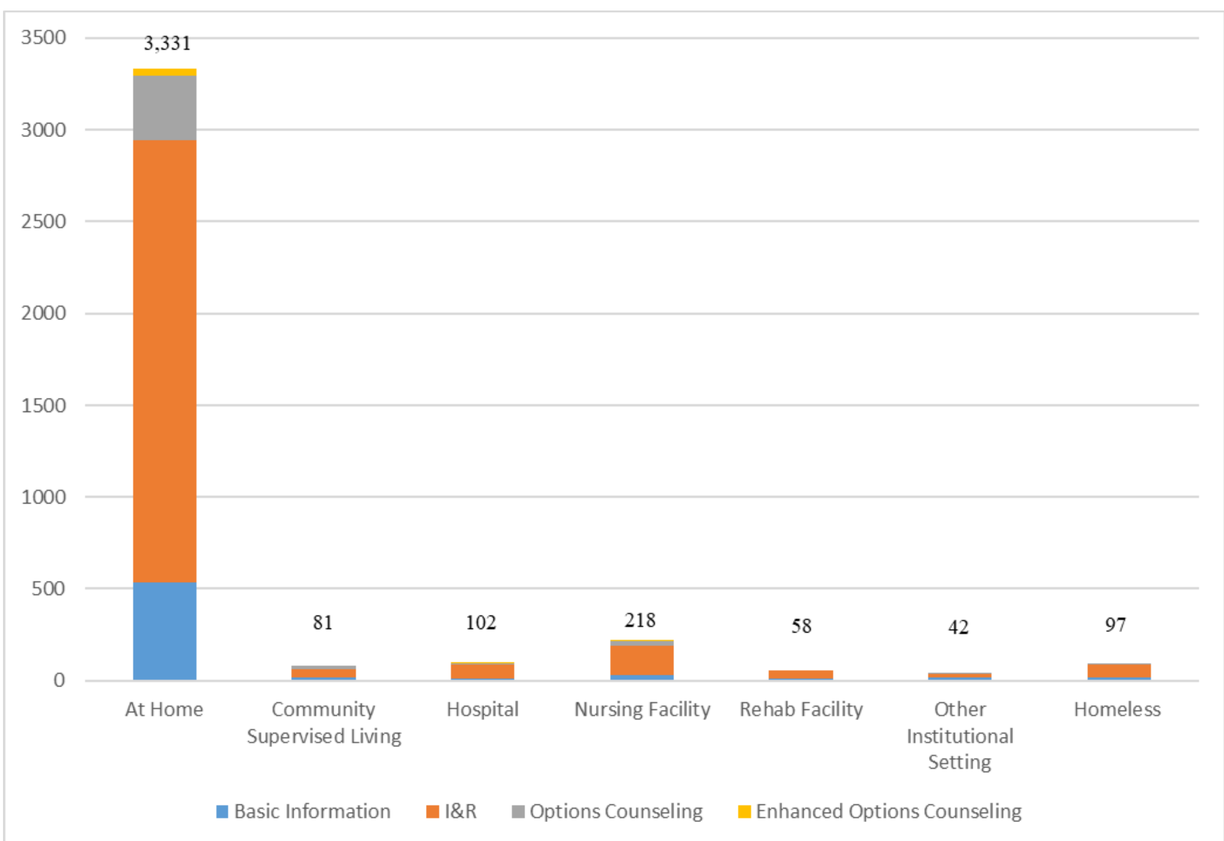
PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Although the populations traditionally served by the AAAs accounted for most of the contacts (adults age 60 and over (4,413 or 42%), people with chronic illness (2,477 or 24%), individuals with ADL support needs (1,903 or 18%), and individuals with physical disabilities (1,133 or 11%)), there were 808 (8%) contacts for people age 18-60 and 682 (7%) contacts for individuals with mental health needs. There were also limited contacts with children (178 or 2%) and individuals with autism spectrum disorders (17 or .2%).

ADRC Contacts Across Settings

85% of the people contacting the ADRC were living at home (see ***Exhibit 14***). Among the rest of the contacts, nursing facility (6%) and hospital (3%) were the most common settings. The ADRCs were mostly providing I&R (72%) to these participants.

EXHIBIT 14: ADRC CONTACTS BY SETTING TYPE



ADRC Contacts by Region

Exhibit 15 provides a breakdown of the type of ADRC contacts by AAA region.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 15: ADRC CONTACT BY REGION

Region Category		AAA Pilot Region Population	Basic Information		I&R		Options Counseling		Enhanced Options Counseling		All ADRC Contacts	
			Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	168	4.29	694	17.72	19	0.49	44	1.12	925	23.62
	Blue Rivers	73,282	188	25.65	88	12.01	0	0.00	0	0.00	276	37.66
	Midland	130,916	399	30.48	497	37.96	63	4.81	0	0.00	959	73.25
Northeast Nebraska Group	Eastern NE	808,222	3,433	42.48	861	10.65	1	0.01	0	0.00	4,295	53.14
	Northeast NE	205,999	510	24.76	1,102	53.50	127	6.17	0	0.00	1,739	84.42
South Central Nebraska Group	South Central NE	179,660	38	2.12	1,277	71.08	229	12.75	1	0.06	1,545	86.00
	Western NE	113,081	123	10.88	561	49.61	58	5.13	0	0.00	742	65.62
Pilot Area Total		1,902,778	4,859	25.54	5,080	26.70	497	2.61	45	0.24	10,481	55.08

Eastern Nebraska Office on Aging (ENOA) reported the largest number of overall ADRC contacts (4,295, 41% of overall contacts), with the majority coded as basic information (3,433, 71% of basic information contacts). South Central Nebraska AAA (SCNAAA) had the highest number of I&R contacts (1,277, 25%), followed by Northeast Nebraska AAA (NENAAA) (1,102, 22%). SCNAAA also had the greatest number of Options Counseling contacts with 229 or 46% of Options Counseling contacts.

Because some AAAs serve regions with substantially more people, we also weighted the findings by the number of people in each region using Census data (Note- For stable comparisons, we used the same population data as the 2017 report). Weighting the numbers by the region's population makes the contacts across AAAs more comparable. We have color coded these numbers with green representing a larger portion of the population served, red a lower portion, and yellow in the middle.

When looking at these weighted numbers, while overall contacts were roughly evenly distributed between Basic information and I&R, five of the ADRCs coded substantially more of

the contacts as I&R than basic information, while the other two coded substantially more contacts as Basic Information rather than I&R.

SCNAAA had the highest proportion of overall (86), I&R (71), and Options Counseling (12) contacts per 10,000 residents. ENOA had the largest proportion of Basic Information contacts (43), while Aging Partners (AP) had the lowest proportion of total contacts per 10,000 residents (24). This is shift from the 2017 evaluation, in which MAAA reported the highest proportion of total (76) and basic information (28) contacts per 10,000 residents. However, the 2017 findings of Aging Partners having the lowest proportion of total contacts (32) per 10,000 residents and SCNAAA having the largest proportion of I&R (41) and Options Counseling (11) contacts per 10,000 residents are consistent with the 2018 findings.

All of the ADRCs except for SCNAAA had substantial decreases in the number of Options Counseling contacts. AP had an 82% drop. BRAAA went from reporting 36 in 2017 to none and ENOA dropped from 354 to only one. In contrast, SCNAAA's Options Counseling contacts nearly tripled. Aging Partners was the only ADRC still reporting more than one Enhanced Options Counseling contacts and they also had a substantial drop (44 this year vs. 69 last year).

Comparison of ADRC and AAA Contacts Across Services

During our interviews with the AAAs in September 2018, we discussed the AAA and ADRC access processes. Those discussions suggested that most of the differences across the ADRCs' contacts may be caused by differences in how the AAAs record AAA I&A activities versus ADRC activities. All the AAAs are recording I&A outside of the Trilogy Dashboard and these numbers are not reflected in ***Exhibit 15***. The AAAs that are reporting more ADRC Basic Information and I&R contacts tend to be those that did not have separate I&A staff prior to the ADRC. In these AAAs, a much greater volume of the calls that are coming into the AAA are being routed to the ADRC. In AAAs with designated I&A staff, fewer of these calls are being routed to the ADRCs and recorded in the database.

A similar situation appears to be occurring for ADRC Options Counseling and AAA Care Management. As noted in the operational review, the AAAs have different policies for who is routed to AAA Care Management versus ADRC Options Counseling and these policy differences help explain the difference in data.

The SUA recognized the discrepancies in how AAAs were coding I&A contacts and Care Management hours, and on July 1, 2018 released a taxonomy to create greater standardization in how the AAAs and ADRCs code this information. The AAA and ADRC contact data from after the release of this updated taxonomy are provided in ***Exhibits 17 and 19*** and discussed further below.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Comparison of ADRC Total Contacts and AAA I&A Contacts

To estimate the total number of contacts, including both traditional AAA and ADRC contacts, we obtained data from the SUA on AAA I&A. ***Exhibit 16*** provides a breakdown of the total ADRC and the AAA I&A contacts. ***Exhibit 17*** provides a comparable breakdown of these contacts before and after the implementation of the new taxonomy.

EXHIBIT 16: AAA I&A AND ADRC CONTACTS BY REGION

Region Category		AAA Pilot Region Population	All ADRC Contacts		AAA I&A Contacts		Total Agency Contacts	
			Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	925	24	14,400	368	15,325	391
	Blue Rivers	73,282	276	38	2,896	395	3,172	433
	Midland	130,916	959	73	2,642	202	3,601	275
Northeast Nebraska Group	Eastern NE	808,222	4,295	53	9,419	117	13,714	170
	Northeast NE	205,999	1,739	84	4,782	232	6,521	317
South Central Nebraska Group	South Central NE	179,660	1,545	86	7,026	391	8,571	477
	Western NE	113,081	742	66	16,210	1,433	16,952	1,499
Pilot Area Total		1,902,778	10,481	55	57,375	302	67,856	357

EXHIBIT 17: MONTHLY AVERAGE AAA I&A AND ADRC CONTACTS BY REGION BEFORE AND AFTER THE JULY 1 IMPLEMENTATION OF THE NEW TAXONOMY

Region Category		AAA Pilot Region Population	Timeframe	All ADRC Contacts		AAA I&A Contacts		Total Agency Contacts	
				Avg. Monthly Contacts	Avg. Monthly Contacts/ 10000 Residents	Avg. Monthly Contacts	Avg. Monthly Contacts/ 10000 Residents	Total Avg. Monthly Contacts	Avg. Monthly Contacts/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	October 2017-June 2018	90.8	2.3	1,441.9	36.8	1532.7	39.1
			July-September 2018	36.0	0.9	474.3	12.1	510.3	13.0
	Blue Rivers	73,282	October 2017-June 2018	16.7	2.3	238.6	32.6	255.2	34.8

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Region Category		AAA Pilot Region Population	Timeframe	All ADRC Contacts		AAA I&A Contacts		Total Agency Contacts	
				Avg. Monthly Contacts	Avg. Monthly Contacts/ 10000 Residents	Avg. Monthly Contacts	Avg. Monthly Contacts/ 10000 Residents	Total Avg. Monthly Contacts	Avg. Monthly Contacts/ 10000 Residents
			July-September 2018	42.0	5.7	249.7	34.1	291.7	39.8
	Midland	130,916	October 2017-June 2018	75.3	5.8	217.2	16.6	292.6	22.3
			July-September 2018	93.7	7.1	229.0	17.5	322.7	24.6
Northeast Nebraska Group	Eastern NE	808,222	October 2017-June 2018	351.6	4.3	861.0	10.7	1,212.6	15.0
			July-September 2018	377.0	4.7	556.7	6.7	933.7	11.6
	Northeast NE	205,999	October 2017-June 2018	130.7	6.3	461.9	22.4	592.6	28.8
			July-September 2018	187.7	9.1	208.3	10.1	396.0	19.2
South Central Nebraska Group	South Central NE	179,660	October 2017-June 2018	123.2	6.9	606.7	33.8	729.9	40.6
			July-September 2018	145.3	8.1	522.0	29.1	667.3	37.1
	Western NE	113,081	October 2017-June 2018	58.6	5.2	1,687.0	149.2	1,745.6	154.4
			July-September 2018	71.7	6.3	342.3	30.3	414.0	36.6
Pilot Area Total		1,902,778	October 2017-June 2018	846.8	4.5	5,514.2	29.0	6,361.0	33.4
			July-September 2018	953.3	5.0	2,582.3	13.8	3,355.7	18.6

The total number of AAA I&A contacts from October 1, 2017 to September 30, 2018 was 57,375, which is approximately 5.5 times higher than the number of ADRC basic information, I&R, OC, and EOC contacts. This is consistent with the 2017 evaluation finding that AAA I&A contacts were nearly 7 times greater than the number of total ADRC contacts. However, after the implementation of the updated taxonomy, the difference between the number of ADRC and AAA I&A contacts shrank by 51% so that the AAA I&A contacts were just 2.7 times greater than ADRC contacts. After the implementation of the taxonomy, the number of contacts dropped for most of the AAAs, however this change is being most driven by Aging Partners and AOWN. The standard deviation in the average number of monthly I&A contacts across AAAs dropped from 48 to 11. While the three-month sample is a relatively short period of time, these data suggest the taxonomy updates are resulting in more consistent coding of I&A across AAAs.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

The Aging Office of Western Nebraska (AOWN) had the largest overall number of AAA I&A contacts (16,210, 28% of all I&A contacts) and the highest number of contacts per 10,000 residents (1,433). Because the proportion of AOWN contacts per 10,000 residents is over 1,000 more than the next AAA (SCNAAA with 477 per 10,000 residents), we have concerns about the data reported to the State. The State explained that AOWN reports combined contacts for the AAA and the senior centers that they operate, which may explain this discrepancy. However, this discrepancy appears to be corrected after the implementation of the taxonomy, where AOWN had the fourth most monthly I&A contacts (342.3, 13%), down from the outlier 1,687 (31%) monthly contacts that were documented during the initial nine months of the evaluation period prior to the taxonomy updates.

Beyond AOWN, across the entire evaluation year, Aging Partners (AP) had the greatest number of I&A contacts (14,400, 25% of all I&A contacts) and Blue Rivers (395) and SCNAAA (391) had the most contacts per 10,000 residents. After the implementation of the taxonomy, ENOA had the largest number of I&A contacts (1670, 22%), followed closely by SCNAA (1,566, 20%) and AP (1,423, 18%).

Across all AAAs participating in the ADRC pilot, there were a total of 67,856 ADRC and AAA contacts. AOWN (16,952, 25%) and AP (15,325, 23%) had the largest proportion of total contacts, and AOWN had the largest number of contacts per 10,000 residents (1,499). When looking at the change in overall contacts during the three months after the implementation of the taxonomy, the reduction of variability of monthly contacts per 10,000 residents across the AAAs/ADRCs following the implementation of the taxonomy indicates that the taxonomy is providing additional clarity for coding calls. However, a major concern was that Aging Partners experienced a drop of over 1,000 contacts per month from the first nine month of the evaluation period (1,532.7) and the three months after the implementation of the taxonomy (510.3). Because other agencies experienced slight changes of less than 300 monthly contacts, we encourage the State and ADRC Coordinators to explore with AP why this change after the implementation of the taxonomy was so dramatic.

ADRC Options Counseling and AAA Care Management

As we noted in the operational review, the AAAs had different practices for who was routed to AAA Care Management versus to ADRC Options Counseling. ***Exhibit 18*** presents information on both services for the entire evaluation year, while ***Exhibit 19*** presents information for the three-month period after the release of the new taxonomy. Note that because Enhanced Options Counseling was phased out prior to this period, we have only included Options Counseling contacts in this exhibit.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Unfortunately, because the ADRCs record Options Counseling using contacts as the unit of service and AAAs record Care Management using hours, we could not combine the numbers, nor is it possible to make direct comparisons.

EXHIBIT 18: ADRC OPTIONS COUNSELING CONTACTS AND AAA CARE MANAGEMENT HOURS BY REGION

Region Category		AAA Pilot Region Population	Options Counseling and Enhanced Options Counseling		Care Management	
			Total Contacts	Contacts/ 10000 Residents	Total Hours	Hours/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	63	2	15,179	388
	Blue Rivers	73,282	0	0	3,292	449
	Midland	130,916	63	5	3,842	293
Northeast Nebraska Group	Eastern NE	808,222	1	0	13,585	168
	Northeast NE	205,999	127	6	7,330	356
South Central Nebraska Group	South Central NE	179,660	230	13	3,569	199
	Western NE	113,081	58	5	3,479	308
Pilot Area Total		1,902,778	542	3	50,276	264

EXHIBIT 19: ADRC OPTIONS COUNSELING CONTACTS AND AAA CARE MANAGEMENT HOURS BY REGION AFTER THE JULY 1, 2018 IMPLEMNTATION OF THE NEW TAXONOMY

Region Category		AAA Pilot Region Population	Options Counseling		Care Management	
			Total Contacts	Contacts/ 10000 Residents	Total Hours	Hours/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	0	0	4,024	103
	Blue Rivers	73,282	0	0	938	128
	Midland	130,916	1	0	988	75
Northeast Nebraska Group	Eastern NE	808,222	0	0	3,731	46
	Northeast NE	205,999	49	2	1,865	91
South Central Nebraska Group	South Central NE	179,660	120	7	1,063	59
	Western NE	113,081	6	1	915	81
Pilot Area Total		1,902,778	497	3	13,524	71

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

AAA Care Management is a dramatically larger program than Options Counseling (50,276 hours versus 542 contacts for ADRC Options Counseling and Enhanced Options Counseling combined over the entire evaluation period, 13,524 hours vs. 497 ADRC Options Counseling contacts for post-taxonomy period). Generally, when weighted by the population in the region, the volume of Options Counseling and the volume of Care Management appeared to be inverted, with those AAAs that offered more ADRC Options Counseling tending to provide less Care Management. These data must be interpreted cautiously given the discrepancies in how the AAAs triage people to Care Management and Options Counseling; differences in how Care Management dollars are spent; and difference in the AAAs record the data. However, they highlight the need for greater standardization across AAAs in who is assigned Care Management versus Options Counseling.

While no significant changes to Care Management were noted before and after the implementation of the taxonomy, there was a significant reduction in one of the ADRCs' core services, Options Counseling, when compared to the data from the previous report. In the previous report, Options Counseling and Enhanced Options Counseling comprised 922 (10%) of the contacts, while this year they made up just 542 (5%). Even after the implementation of the taxonomy (***Exhibit 19***), Options Counseling contacts for all agencies except NENAAA and SCNAAA continued to fall. Particularly problematic are the findings that:

- MAAA and AP each reported 63 OC contacts during the first 9 months of the evaluation period, and after the implementation of the taxonomy MAAA only reported one contact and AP had none
- AP, BRAAA, and ENOA reported no OC contacts during the final three months of the evaluation period
- BRAAA reported no OC contacts and ENOA reported only one during the entire evaluation period

We analyzed the data to assess whether the reduction in Options Counseling could be explained because these contacts were being counted as Care Management. However, the total number of Care Management hours reported dropped by 25% from 2017 to 2018. These numbers dropped for all the AAAs except for South Central, which also reported higher numbers for ADRC Options Counseling.

Staff turnover appears to have contributed to the drop in ADRC Options Counseling and Enhanced Options Counseling. The ADRC Coordinators reported that four of the seven sites experienced staff turnover and one had an Options Counselor out for several weeks on maternity leave. This includes AP and MAAA shifting their Options Counselors to other positions within the AAA.

It is possible that some of the participants were triaged to another program in the AAA, such as waiver programs, or to a partner agency. These contacts were not provided as part of the evaluation analyses and therefore may account for some of the drop. Regardless of the explanation, the finding that Options Counseling contacts fell by over 40% is problematic. We recommend that SUA and ADRC Coordinators work with the ADRCs to better understand why this drop occurred and to provide training and support to ensure that this core service is more appropriately utilized moving forward.

Requests for and Timeliness of Follow-Up to ADRC Contacts

As part of each contact, ADRC staff document whether the participant requested that someone from the ADRC follow-up with her or him and the timeframe in which follow-up should occur. ***Exhibit 20*** provides an overview of the number of individuals who requested and received follow-up and whether the follow-up occurred within the timeframe that was identified.

Overall, 13% of individuals who contacted the ADRC requested follow-up. There were substantial differences in the percentage of people requesting follow-up across the AAAs ranging from .4% to 34%.

The percentage of individuals coded as requesting follow-up dropped from 23% in last year's report to 13% this year. The drop was observed across all of the ADRCs. For example, the percentage dropped from 67% for NENAAA last year to 34% this year while BRAAA dropped from 18% to .4%.

The variability and low rates of follow-up emphasize the need for continued training on this issue.

There was a 10-percentage point drop in individuals who received the requested follow-up from last year (99%) to this year 2018 (89%). During discussions with the AAAs, staff reported that while multiple follow-up attempts may be made, the remaining individuals are those who cannot be contacted. We encourage the State and ADRC Coordinators to further explore why follow-up is not consistently occurring and/or documented across all ADRC sites.

People generally received follow-up within the timeframe that they requested, these numbers were also not as good as last year's. Overall, 61% of the individuals who received follow-up received it within the requested timeframe (as opposed to 69% last year); 92% received follow-up within seven days of their requested timeframe (down from 95%); and 99% within 30 days (same as last year). While not as concerning as the overall drop in the number of Options Counseling contacts and follow-ups, these numbers also suggest that program operations have deteriorated.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 20: PEOPLE REQUESTING AND RECEIVING FOLLOW-UP BY REGION

Region Category		Requested Follow-up		Received Follow-up (% of total)		Follow-up Within Requested Timeframe		Follow-up Within 7 Days of Requested Timeframe		Follow-up Within 30 Days of Requested Timeframe	
		# of callers	% of callers	# of callers	% of callers	# of callers	% of callers	# of callers	% of callers	# of callers	% of callers
Aging Partners Group	Aging Partners	115	12%	103	90%	71	69%	97	94%	103	100%
	Blue Rivers	1	0.4%	1	100%	1	100%	1	100%	1	100%
	Midland	246	26%	207	84%	104	50%	179	86%	201	97%
Northeast Nebraska Group	Eastern NE	64	1%	62	97%	26	42%	49	79%	61	98%
	Northeast NE	597	34%	530	89%	324	61%	492	93%	528	100%
South Central Nebraska Group	South Central NE	192	12%	180	94%	153	85%	178	99%	179	99%
	Western NE	178	24%	152	85%	80	53%	136	89%	151	99%
Statewide		1393	13%	1235	89%	759	61%	1132	92%	1224	99%

Callers Receiving Information about Consent, Rights, and Eligibility

The original ADRC legislation required that the ADRCs track whether individuals calling the ADRC received information about informed consent and confidentiality of rights and whether they received eligibility counseling and financial prescreening to help them understand their service options.

Exhibit 21 provides a summary of the number contacts that received informed consent and confidentiality of rights information for Options Counseling. In the Year 2 report we provided percentages for individuals received I&R and Options Counseling, however, during this evaluation period the State established that only Options Counseling requires informed consent and confidentiality of rights. Therefore, we have limited our findings in this category to Options Counseling contacts.

Exhibit 22 displays I&R and Options Counseling contacts that received eligibility counseling and financial prescreening. This table excludes basic information because it is very unlikely that individuals would receive this information if they were calling with a simple question.

Receiving Informed Consent & Confidentiality of Rights Information

Exhibit 21 shows that only 27% of Options Counseling contacts had documented discussions around informed consent and confidentiality rights (an increase from 12% last year). There was

substantial variation in these numbers across the sites. Aging Partners was the only agency to provide this information to more than half of Options Counseling callers (51%).

These continuing low numbers are concerning. We encourage additional training to ensure that a greater proportion of individuals understand this information during the process.

EXHIBIT 21: PEOPLE RECEIVING INFORMED CONSENT & CONFIDENTIALITY OF RIGHTS BY REGION

Region		Total # of OC/EOC Calls	# of OC/EOC Calls Receiving IC & CR	% of OC/EOC Calls Receiving IC & CR
Aging Partners Group	Aging Partners	63	32	51%
	Blue Rivers	0	0	0%
	Midland	63	14	22%
Northeast Nebraska Group	Eastern NE	1	0	0%
	Northeast NE	127	5	4%
South Central Nebraska Group	South Central NE	230	61	27%
	Western NE	58	0	0%
	Statewide	542	112	21%

Receiving Eligibility Counseling and Financial Prescreening during ADRC Contact

Exhibit 22 shows that 73% of the individuals contacting the ADRC (excluding basic information) had documented eligibility counseling and financial prescreening. The eligibility counseling and financial prescreening count includes individuals who declined eligibility counseling and those already enrolled in Medicaid. While this number represents a substantial improvement over last year when this was reported for only 34% of individuals, this number should be close to 100%

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 22: PEOPLE RECEIVING ELIGIBILITY COUNSELING & FINANCIAL PRESCREENING BY REGION

Region		Total # of I&R Calls	# of I&R Calls Receiving EC & FP	% of I&R Calls Receiving EC & FP	Total # of OC/EOC Calls	# of OC/EOC Calls Receiving EC & FP	% of OC/EOC Calls Receiving EC & FP	Total # of I&R & OC/EOC Calls Receiving IC & CR	# of I&R & OC/EOC Calls Receiving EC & FP	% of I&R & OC/EOC Calls Receiving EC & FP
Aging Partners Group	Aging Partners	694	669	96%	63	61	97%	697	730	96%
	Blue Rivers	88	32	36%	0	0	0%	88	32	36%
	Midland	497	450	91%	63	62	98%	560	512	91%
Northeast Nebraska Group	Eastern NE	861	103	12%	1	0	0%	862	103	12%
	Northeast NE	1,102	638	58%	127	96	76%	1,107	734	60%
South Central Nebraska Group	South Central NE	1,277	1217	95%	230	226	98%	1,338	1443	96%
	Western NE	561	502	89%	58	56	97%	619	558	90%
Statewide		5,080	3611	71%	542	501	92%	5,622	4112	73%

There was a large variance, with four sites doing well with rates of 90% or higher and the rest being at 60%, 36% and 12%. We recommend additional training and enhanced monitoring of performance on these items for the poor performing sites, such as adding to the monthly reports.

Tracking Unmet Need

At the end of each contact, ADRC staff can document any needs that could not be addressed by the ADRC or through a referral to another agency. We have broken the areas of unmet need into 25 categories which can be collapsed into four higher-level categories:

- LTSS/LTSS Funding
- Housing Assistance
- Financial & Benefits Assistance
- Other

Exhibit 23 tabulates unduplicated responses for each unmet need item by the following populations: 1) older adults, 2) individuals with physical disabilities, and 3) all other populations and population unknown.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Overall, 3% of the all individuals identified at least one unmet need, down from 8% in the previous evaluation report. LTSS/LTSS Funding was most frequently identified as an unmet need (2%) followed by financial benefits (.9%), other (.8%), and housing assistance (.4%). We strongly suspect an increase in available LTSS is not responsible for this 2/3 drop in reported unmet needs. We offer two possible explanations for this decline. One, ADRC staff may have become more knowledgeable about available resources and were better able to identify potential services that might meet participants' needs. Two, this decrease reflects a deterioration in coding.

EXHIBIT 23: UNMET NEEDS BY POPULATION

Unmet Needs Category		Older Adults	Physical Disabilities	All Other Populations & Unknown	Total
LTSS/ LTSS Funding	Adult Day Services	5		2	7
	Assistive Technology	20	3	10	33
	Care Transitions	15	2	6	23
	Home/Vehicle Modifications	3	8	8	19
	Homemaker/Chore Services	33	7	14	54
	LTC/LTSS Funding	12	3	8	23
	Mental Health & Substance Use Services	4		6	10
	Personal Care	58	13	34	105
	Respite Care	7	2	4	13
All LTSS/LTSS Funding unmet need contacts		157	38	92	287
% of population contacts mentioning LTSS/LTSS Funding unmet need		3.6%	3.4%	1.1%	2.0%
Housing Assistance	Housing Assistance	20	11	20	51
	Utility Assistance	4			4
All Housing Assistance unmet need contacts		24	11	20	55
% of population contacts mentioning Housing Assistance unmet need		0.5%	1.0%	0.2%	0.4%
Financial & Benefits Assistance	Benefits Assistance	15	4	8	27
	Employment	1			1
	Financial Assistance	26	3	28	57
	Health Insurance Counseling & Enrollment	18	4	16	38

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Unmet Needs Category		Older Adults	Physical Disabilities	All Other Populations & Unknown	Total
	Prescription Drug Assistance	1			1
All Financial & Benefits Assistance unmet need contacts		61	11	52	124
% of population contacts mentioning Financial & Benefits Assistance unmet need		1.4%	1.0%	0.6%	0.9%
Other	Caregiving Support	3	1	4	8
	Dental Care	1	1		2
	Elder Abuse/Exploitation	1		4	5
	Food Assistance	10	1	4	15
	Legal Services			4	4
	Transportation	35	4	16	55
	Veteran's Assistance	1			1
	Youth Transition Services			2	2
	Other	16	2	8	26
All Other unmet need contacts		67	9	42	118
% of population contacts mentioning Other unmet need		1.5%	0.8%	0.5%	0.8%
Total Number of Unmet Need Contacts		247	54	189	490
Total Percent Total Contacts with Unmet Need		6%	5%	2%	3%

The higher-level category (e.g., LTSS/LTSS funding) total reflects the number of unduplicated individuals who reported an unmet need within the given population and category. A participant may be identified for an unmet need in multiple high-level categories, therefore the total unmet need contacts reflects the total unduplicated count for the population and may be greater than the sum of the categories.

In addition to documenting services and referrals that the person receives, it is also helpful to document needs that are not currently able to be met by the LTSS system. This 1) allows the State to understand where additional funding and programs may be needed to support individuals with LTSS needs and 2) identifies areas where staff training may be necessary to better understand available resources. Ongoing training should include training on the unmet need categories and how unmet need is used to inform the need for new services. Staff should understand that they are the first line in identifying gaps in the system and should be providing the State with data to support service requests.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Outcome Measures

To determine participant satisfaction with the services that the ADRC provides, each agency distributes a survey to individuals who receive I&R and OC/EOC. These voluntary surveys may be completed online or via mail and provide feedback on areas including if the participant was better informed about services and supports; if the referrals they received were helpful; and if the interaction helped them stay out of a nursing facility. Additionally, surveys capture who is completing the form, such as the individual receiving services or a family member, and allow for narrative feedback. These surveys allow the agencies to understand what they are doing well and how they can improve as they enhance ADRC operations.

In addition to the surveys, we have reviewed the Options Counseling IAPs that were developed by staff from October 1, 2017 to September 30, 2018. This section discusses the type and contents of the plans, including the supports that were identified and whether person-centered goals were incorporated.

I&R Participant Survey

The I&R Survey is sent to individuals who received I&R through the ADRC. ***Exhibit 24*** provides a count of the surveys that were received across the regions, the percentage of all surveys attributable to each agency, and the percentage of all I&R contacts that resulted in a completed survey. The ADRCs revised their sampling methodology for this evaluation period to offer to email the survey to 100% of I&R consumers if they receive an emailed I&R summary and 50% if they receive a mailed summary. The actual percentage received were 3% this year, up from 2% last year, however, last year the ADRCs did not start distributing these surveys until February. During last year's evaluation period, on average the AAAs received 15 surveys per month. Despite recommendations in the previous evaluation to increase the number of surveys received, the average monthly number of surveys fell to just over 13 per month.

These response rates are so low that it is hard to argue that they are a valid sample. In addition, more than half the sample came from a single ADRC. The low percentage of surveys returned enhances the potential for survey bias, in which people who have very good or very bad experiences being more likely to return a survey than those with a response that falls somewhere in between. We recommend increasing training and oversight to increase the percentage of surveys received.

There were substantial differences in the number of surveys received relative to the number of I&R contacts, ranging from a high of 8% to a low of 0%. However, this is consistent with the 2017 evaluation report where there was a range of 0% to 4%. NENAAA had the highest number of surveys received with 83. AOWN did not receive a survey response, while BRAAA received

one. Only two agencies had an increase in the number of surveys received; NENAAA (33 in 2017 to 83 in 2018) and MAAA (10, 12). Because NENAAA received 50 more surveys in 2018, we recommend that the ADRC Coordinators work with NENAAA to discuss how similar enhancements can be made statewide.

EXHIBIT 24: I&R SURVEY RESPONSES BY REGION

Agency	# Surveys Received	% of Total Surveys Received	Total I&R Contacts	Surveys Received as % of I&R Contacts
Aging Office of Western Nebraska (AOWN)	0	0%	561	0%
Aging Partners (AP)	11	7%	694	2%
Blue Rivers Area Agency on Aging (BRAAA)	1	1%	88	1%
Eastern Nebraska Office on Aging (ENOA)	17	11%	861	2%
Midland Area Agency on Aging (MAAA)	12	8%	497	2%
Northeast Nebraska Area Agency on Aging (NENAAA)	83	53%	1,102	8%
South Central Nebraska Area Agency on Aging (SCNAAA)	34	22%	1,277	3%
Total	158	100%	5,080	3%

Exhibit 25 provides a summary of the responses received across the items. Items address the participant's experience with the I&R he or she received and include:

- 2A- I am better informed about options for services and supports
- 2B- I was given objective, accurate, and complete information
- 2C- The referral(s) were helpful
- 2D- I was clear on how to contact the referral(s) and what to ask for

Survey responses are provided on a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). All items received an average score of 4.25 or higher, which falls between agree and strongly agree and is consistent with the 2017 evaluation report findings. An agency-specific breakdown of the responses can be found in ***Appendix 3***.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 25: I&R SURVEY ITEM RESPONSE SUMMARY

Response	2A- Better informed about services/ supports	2B- Given obj., accurate, complete info	2C- Referrals were helpful	2D- Clear on who to contact/what to ask
1 Strongly Disagree	3%	3%	3%	4%
2 Disagree	3%	3%	3%	2%
3 Neither Agree nor Disagree	3%	3%	7%	6%
4 Agree	43%	40%	36%	39%
5 Strongly Agree	48%	52%	50%	49%
# Responses Received	156	156	143	140
Average Score	4.29	4.35	4.25	4.25

The surveys that were received strongly suggested that participants believed that I&R was helpful with 91% believing they were better informed about their services and supports; 92% believing they received objective, accurate, and complete information; 86% reporting the referrals were helpful; and 88% reporting they were clear about who to talk to and what to ask when following up on a referral.

Exhibit 26 presents the survey responses received by survey respondent type (e.g., the participant, a caregiver). Because respondents could select more than one option, for example a respondent could be both a family member and legal representative, the total for the column (175) exceeds the number of surveys received (158).

More half the responses came from the person receiving I&R. More than 30% came from a family member.

EXHIBIT 26: I&R SURVEY RESPONDENT SUMMARY

Individual Completing the Survey	# Overall Responses	% of Responses
Person plan was made	82	52%
Caregiver	19	12%
Legal Representative	7	4%
Agency Representative	6	4%
Family Member	48	30%
Other	13	8%

In addition to the survey questions, respondents were given the opportunity to provide comments. These comments were almost entirely positive, and included comments such as:

- *It was awesome. It has been a crazy few days filled with a lot of questions on what to do with my dad. The information Erin provided was amazing on how to begin the process*

and how the process would work. She was compassionate and answered every question. She provided a valuable service.

- *Our family has been in contact with SCNAAA several times in the past 2 years. They are always very helpful and have great information. They are a great service in our community!*
- *The Staff was very professional and helpful. Afterwards there was a little confusion on our end but the entire team was very interested in making sure we understood that our questions and concerns were addressed and answered.*
- *Hayley did a fantastic job helping us find respite care for my mom. Dad had to go into the hospital and we needed immediate care for my Mom and were overwhelmed with the process. Hayley came over, made a ton of calls for us, and helped us find a place for my Mom to go. She was a huge blessing to my family!*
- *ADRC is an amazing resource and they have help guide and support our older aging patients. The support with a caring manor and offer hope to our rural community. They have helped my own father and many of our patients from the Avera Crofton Clinic.*

There was also constructive feedback about how the agencies could improve operations, including:

- *Advertise more! Get your name out there so that family members know who to contact to seek help to find retirement living options for loved ones.*
- *On the current website, it stated that you have to make an appointment first before being seen. I called and found out that wasn't the case. Documents were emailed to me for my review. I did meet with a consultant at ADRC who was very helpful in explaining the details of their program. I didn't qualify for any assistance. Since I moved to Nebraska from another state, qualifications are different because of their earned income.*

Options Counseling Participant Survey

The voluntary Options Counseling Participant Survey is distributed to individuals who received OC or EOC from the ADRCs. The survey provides feedback on areas including if the participant was better informed about services and supports; if the referrals they received were helpful; and if the interaction helped them stay out of a nursing facility. Additionally, surveys capture who completed the survey, such as the individual receiving services or a family member, and allow for narrative feedback.

Exhibit 27 provides a summary of the surveys received across the regions. Unfortunately, there were only 15 surveys completed, which is not a large enough sample from which to draw conclusions. The ADRCs increased the percentage of surveys sent from 50% to 100% of

participants receiving OC and all receiving EOC during this evaluation period. In total, there were 15 surveys submitted. During last year's evaluation period there were also 15 completed surveys, however surveys were not distributed until February 2017. During last year's evaluation period, on average the AAAs received just under 2 surveys per month, which was a concerningly low number. Despite recommendations in the previous evaluation to increase the number of surveys received, the average monthly number of surveys fell to just over one per month. We strongly encourage the ADRC Coordinators to work with the AAAs to ensure that there is a dramatically higher rate of return on the surveys or cease doing satisfaction surveys altogether. While we present summary findings, the sample size is not sufficient for drawing any conclusions.

Only 3% of people receiving OC or EOC completed a survey, which, largely because of the fall in OC and EOC contacts during the 2018 evaluation period, is an increase from the 2017 evaluation report of 1%. We strongly recommend that the ADRC effort increase its efforts to obtain more complete surveys. Of the 15 OC surveys that were received, NENAAA (7, 47%) had the highest number of submissions. BRAAA and MAAA did not receive a survey response. While three agencies (NENAAA, ENOA, and AOWN) had an increase in surveys, the greatest increase from NENAAA with three additional completed surveys does not indicate that any AAAs made significant changes to the surveying practices.

EXHIBIT 27: OC SURVEY RESPONSES BY REGION

Agency	# Surveys Received	% of Total Surveys Received	Total OC/EOC Contacts	Surveys Received as % of OC Contacts
Aging Office of Western Nebraska (AOWN)	2	13%	58	3%
Aging Partners (AP)	3	20%	63	5%
Blue Rivers Area Agency on Aging (BRAAA)	0	0%	0	0%
Eastern Nebraska Office on Aging (ENOA)	1	7%	1	100%
Midland Area Agency on Aging (MAAA)	0	0%	63	0%
Northeast Nebraska Area Agency on Aging (NENAAA)	7	47%	127	6%
South Central Nebraska Area Agency on Aging (SCNAAA)	2	13%	229	1%
Total	**15**	**100%**	**541**	**3%**

Exhibit 28 provides a summary of the responses received across the items. Items address the participant's experience with the Options Counseling he or she received and include:

- 2A- I am better informed about options for services and supports
- 2B- I was given objective, accurate, and complete information

- 2C- I was actively involved in developing my Individual Action Plan (IAP)
- 2D- My IAP reflects what is important to me
- 2E- Before I contacted the ADRC I was considering going into a nursing facility or other institution as an option
- 2F- My IAP will help me stay in my home or community setting

Survey responses are provided on a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). All items, except for 2E- considered going into a nursing facility, received an average score of 4.2 or higher, which falls between agree and strongly agree and is consistent with the 2017 evaluation report findings. An agency-specific breakdown of the responses can be found in ***Appendix 3***.

EXHIBIT 28: OC SURVEY ITEM RESPONSE SUMMARY

	Response	2A- Better informed about services/supports	2B- Given obj., accurate, complete info	2C- Actively involved in developing IAP	2D- IAP reflects what is important to me	2E- Considered going into NF before ADRC	2F- IAP will help stay in home or community
1	Strongly Disagree	0%	0%	0%	0%	15%	0%
2	Disagree	0%	0%	0%	0%	8%	8%
3	Neither Agree nor Disagree	0%	0%	7%	8%	38%	23%
4	Agree	27%	40%	36%	31%	8%	15%
5	Strongly Agree	73%	60%	57%	62%	31%	54%
	# Responses Received	15	15	14	13	13	13
	Average Score	4.7	4.6	4.5	4.5	3.3	4.2

Although the feedback about Options Counseling was overwhelmingly positive (there were no negative responses to any of the items), these results should not be used to gauge the actual effectiveness of the program given the extremely small number of surveys.

A core goal of the ADRC is to support individuals with LTSS needs with remaining in the community rather than entering an institution. Nearly 40% of the individuals completing the survey agreed that they were considering going into a nursing facility and only a quarter appeared to have ruled this out as an option. However, the limited number of surveys prevents us from making any conclusions.

Exhibit 29 provides a summary of the individuals who completed the OC survey. Respondents could select more than one option, for example if the respondent was a family member and legal representative, therefore there were 21 item responses although there were only 15 completed surveys. Of the 21 total item responses, over three quarters were completed by the person the

plan was made for (40%) or a family member (40%). Legal representatives and caregiver each comprised 27% of the responses, and agency representative made up the remaining 7%.

EXHIBIT 29: OC SURVEY RESPONDENT SUMMARY

Individual Completing the Survey	# Overall Responses	% of Responses
Person plan was made	6	40%
Caregiver	4	27%
Legal Representative	4	27%
Agency Representative	1	7%
Family Member	6	40%
Other	0	0%

In addition to the Survey questions, respondents could provide comments. This feedback was entirely positive, and included the following comments:

- *I consider Carol Sinner and Mandy Fertig messengers from God. I was facing a financial burden by having my husband staying at (NAME REDACTED PRIVACY) Care Center. They welcomed me and suggested (NAME REDACTED FOR PRIVACY) Care Center in (REDACTED FOR PRIVACY) because my husband is a veteran. Carol made numerous calls to help us. This was Thursday and on Wednesday my husband was in the new facility. I love these gals and appreciate all they did for us.*
- *Erin Davis and Cortney Swanson are so helpful and very efficient. When they say they are doing something, they do not procrastinate. Thank you both so much!*

Review of Options Counseling Action Plans

To understand the quality of plans that were developed during the OC process, we reviewed each Action Plan that was developed between October 1, 2017 and September 30, 2018. ***Exhibit 30*** summarizes the number of Options Counseling contacts that occurred, the number of Options Counseling sessions that were initiated in the Trilogy Options Counseling module, and the number of IAPs that were completed.

Statewide, 88 plans were completed. NENAAA had the highest number of completed plans (27) followed by Midland (26). Blue Rivers did not complete a single plan, and Aging Partners and ENOA each completed only one. Of greater concern was that of the 163 OC/EOC contacts, only 106 (65%) had an OC planning session initiated, and only 54% of the 163 individuals received a plan. This is a slight increase from the 2017 evaluation finding that 59% of participants

identified as OC or EOC had a planning session initiated and is only a minor increase from the 53% of individuals who received a plan after being identified for OC or EOC. We encourage the ADRC Coordinators to work with staff to ensure that when a participant is identified as requiring Options Counseling that the appropriate module in the Trilogy system is used and that a Plan is completed in or uploaded to the Trilogy system.

EXHIBIT 30: NUMBER OF ACTION PLANS COMPLETED BY REGION FROM OCTOBER 1, 2017 TO SEPTEMBER 30, 2018

Pilot Group	Site	Identified as OC or EOC	OC Session Started	% Identified for OC that Start Session	OC/EOC Plan Developed	% Identified for OC that Have Plan Developed	% OC Sessions Result in Plan
Aging Partners	AP	18	1	6%	1	6%	100%
	BR	0	0	0%	0	0%	0%
	MAAA	44	38	86%	26	59%	68%
NE Nebraska	ENOA	1	1	100%	1	100%	100%
	NENAAA	50	32	64%	27	54%	84%
SC Nebraska	SCNAAA	30	18	60%	17	57%	94%
	AOWN	20	16	80%	16	80%	100%
Total		163	106	65%	61	54%	83%

While there were fewer plans produced, the plans that were developed were stronger than last year. The Action Plans are structured so that they first list the participant's person-centered goals (a participant can have more than one goal). The plan then lists the action steps necessary to achieve the goals. These steps should identify: what the step is; who will provide the support; how much support will be provided; and when the support will be provided. In developing these action steps, ADRC staff should identify a variety of support sources to meet the individual's goals. This includes looking beyond government supports and incorporating family and friends (unpaid supports) and community services into the plan. For each goal that is developed, staff identify the sources of support that will be used to achieve the goal and classify these support sources into one or more of the following categories:

- Government paid
- Privately paid
- Unpaid
- Consumer self-support

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Exhibit 31 provides an overview of the types of support within each of the plans. ***Exhibit 32*** summarizes the number of goals included in the plans and whether the goals are truly person-centered.

Rows 2-5 of ***Exhibit 31*** display the percent of plans that include at least one goal that identifies each type of support. Plans may include more than one goal, and goals may utilize more than one source of support. For example, if an individual's goal is to attend church, he/she may utilize support in getting ready for church from both staff paid by Medicaid (government) and family (unpaid) and use a church-sponsored transit van for transportation (unpaid). This goal would include two sources of support, government and unpaid.

85% of the plans identified a support source that was funded by a government program. Privately paid supports were identified in 56% of the plans, consumer self-support in 70%, and unpaid supports in 75% of the plans. As discussed above, in the development of plans, staff are encouraged to consider options beyond government funds. Staff appear to be improving in this, as the number of plans that included government-paid supports decreased from 94% in 2017 to 85% in 2018.

The number of plans using all four sources of support increased from 12% in the 2017 evaluation to 36%. This indicates that staff are helping individuals use their own funds and unpaid sources of support to meet their needs. Only 13% of the plans included just one support source, which is an improvement from the 2017 finding of 42%. About one third included three types of supports (only 22% in 2017). MAAA the highest proportion of using 3 or more support sources (77%) across their 26 plans.

EXHIBIT 31: ACTION PLAN SOURCES OF SUPPORT BY REGION

Sources of Supports included in Action Plans	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		State Total
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	
Total number of plans	1	0	26	1	27	17	16	88
Government-paid support	100%	0%	100%	0%	78%	82%	81%	85%
Privately paid supports	0%	0%	50%	0%	67%	65%	44%	56%
Unpaid supports	0%	0%	92%	100%	85%	88%	19%	75%
Consumer self-support	0%	0%	58%	0%	67%	100%	75%	70%
1 Support Source	0%	0%	31%	100%	4%	0%	6%	13%
2 Support Sources	100%	0%	8%	0%	7%	0%	31%	11%

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Sources of Supports included in Action Plans	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		State Total
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	
3 Support Sources	0%	0%	23%	0%	41%	24%	31%	30%
4 Support Sources	0%	0%	54%	0%	30%	35%	25%	36%

Exhibit 32 summarizes the number goals within a plan and whether the goals were person-centered. While plans may have only one goal for individuals who have very specific and limited needs, a person-centered plan is likely to have more than one goal.

EXHIBIT 32: NUMBER OF ACTION PLAN GOALS AND WHETHER GOALS WHERE PERSON-CENTERED BY REGION

Number and Content of Goals in Action Plans	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		State Total
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	
Total number of plans	1	0	26	1	27	17	16	88
Average # of Goals	1.0	0.0	4.2	1.0	2.2	2.7	2.4	2.8
1 Goal	100%	0%	0%	100%	15%	0%	6%	8%
2 Goals	0%	0%	0%	0%	63%	29%	56%	35%
3+ Goals	0%	0%	100%	0%	22%	71%	38%	57%
Plans only with goals that reiterate services	100%	0%	62%	100%	59%	6%	38%	47%
Plans with goals that reiterate services and have person centered goals	0%	0%	35%	0%	30%	41%	50%	36%
Plans only with person centered goals	0%	0%	4%	0%	11%	53%	13%	17%

The average number of goals per plan increased from 2.2 in the 2017 evaluation to 2.8. The number of plans that had three or more goals increased from 50% in the 2017 evaluation to 57%, with MAAA (27 plans, 100%) and SCNAAA (17 plans, 71%) having the highest proportion of their plans within this category. 8% had only one goal, with ENOA and AP each having their one plan fall into this category, while 35% had two goals.

In addition to looking at the number of goals, we also looked at the degree to which goals reflected a person-centered goal versus a goal that simply reiterated a service. For example, "I want case management" or "I want to be clean" were classified as reiterating a service. Examples of person-centered goals include "I want to cope with the death of my spouse" or "I would like to attend college".

In the final three rows of ***Exhibit 32***, we classify the plans into the following categories:

- Plans only with goals that reiterate services
- Plans with goals that reiterate services and have person centered goals
- Plans only with person centered goals

Statewide, 47% of plans contained only goals that reiterated services, while 17% contained only person-centered goals. One agency, South Central (53%), had a majority of their plans include person centered goals, which shows improvement, as no agencies met this metric in the 2017 evaluation.

The 17% of plans containing only person-centered goals was a significant increase from 8% in the 2017 evaluation, however the State and ADRC Coordinators should explore options for providing agencies with person-centered training so that staff gain experience developing person-centered goals. Many plans included person-centered goals but also included goals such as "I want Medicaid" or "I want homemaker services". Plans should:

- Continue to move towards utilizing multiple sources of support, including family and other unpaid supports, to decrease reliance on government funded LTSS.
- Contain a majority of goals that are either person-centered or person-centered with some that reiterate services.
- Provide detailed action steps so the individual and other supports can immediately act.

Evolving the ADRC from a Program to a Network

In the Initial Report, we discussed the need for the ADRC to evolve into a NWD network. The Nebraska *Long Term Care Redesign Plan* by Mercer, in collaboration with the National Association of States United for Aging and Disabilities (NASUAD), reinforced this need. In the Year 2 Report, we discussed the implications of this report and the strengths and challenges of the ADRC initiative in meeting the requirements for a NWD network as envisioned in the redesign plan.

The Year 2 Report also identified that several challenges the ADRC faces could be alleviated by transitioning the pilot into a NWD network. This year, we found that the following noted challenges remained:

- The perception that the ADRC was invading the turf of other agencies by serving people younger than age 60: A NWD initiative could more clearly identify the roles and responsibilities of all agencies that are part of the network.
- Disability partners see the ADRC initiative as a AAA program: A NWD network initiative could allow these agencies to see themselves as full partners.
- The data being collected by the ADRC initiative only reflects a fraction of the assistance and counseling that is being provided to people with disabilities: A NWD network could standardize data collection across agencies and provide a picture of the total amount of support being provided.
- The ADRC effort has limited ability to streamline access to LTSS: A NWD network initiative would include (and in some cases, be led by) State agencies. This could allow for major changes in access processes that could make the system much more efficient.

Integrating and expanding the ADRC into a larger network is a major thrust of the Action Plan included in ***Appendix 4.*** The plan sets goals for clarifying the roles of the disability partners and more strongly integrating them into a network. The ADRCs should consider enhancing the Action Plan's ability to facilitate the transition of the ADRCs into a NWD network by adding the following tasks:

- Standardizing data definitions across disability partners to allow the development of reports that show all I&R and Options Counseling provided.
- Include disability partners in efforts to draw down Medicaid administrative match and use this funding as an incentive for participation in the network.
- Work with State agencies to determine ways to streamline access to supports and minimize duplication. These efforts could include standardizing and integrating assessment tools and refining workflows so that the network serves as a front door for services overseen by the State.

Integrating AAA and ADRC functions

In the first two reports, we identified that a central challenge to establishing the ADRC as a permanent program was to clarify the role of the ADRC versus the AAA. We phrased the following questions, "Is the ADRC another AAA program or subsidiary? Or is the ADRC a paradigm or different way of doing business that will transform all or some of the AAA operations?"

Our September 2017 site visit revealed that for most of the AAAs, the ADRC was operating as another AAA program, which created problems with duplication of services between the AAA

I&A and the ADRC I&R and the AAA Care Management and the ADRC Enhanced Options Counseling.

The Year 2 report recommended that the AAAs identify all functions the AAA provides (including those that are part of the ADRC pilot) that should be part of the ADRC or NWD network and integrate them to eliminate redundancies and clarify who should receive what services and supports. In the past year, the AAAs have begun to adopt many of the recommendations we made in that report:

- The AAAs have been making progress establishing protocols so that all calls for assistance go through an integrated process that screens and triages individuals to the most appropriate service. Completing this process is Goal 9 of the ADRC Action Plan.
- The AAAs are moving towards integrating AAA I&A and ADRC I&R staff, though, as the data shows, there is substantial room for improvement.
- The AAA and the ADRC services are being integrated into a tiered level of service. In addition to combining I&A and I&R, the ADRCs are eliminating Enhanced Options Counseling and rethinking how to assign people to Care Management so that it does not duplicate Options Counseling. We recommend that this restructuring of Care Management be more clearly included in the Action Plan (Goal 9 only discusses creating a screening protocol that includes Care Management).
- The AAAs/ADRCs have become more flexible about providing these services to younger adults.

Developing a Sustainability Plan that Minimizes the need for Additional State Funding

In the Initial Report, we discussed how offering person-centered Options Counseling to all individuals potentially in need of LTSS would likely require increased funding because: 1) there are gaps in the current system (e.g., little funding to provide counseling to non-Medicaid eligible younger adults with disabilities) and 2) person-centered Options Counseling likely requires more time and resources than traditional AAA I&A. In that report, we recommended the creation of a sustainability plan that:

- Projected the potential need for the ADRC services and created estimates of the costs to provide these services. These estimates would identify the gap between the available funding and the needed funding.
- Developed sustainable and diverse sources of funding, including:
  1. **Existing funding**: The plan should identify existing funding, such as Older Americans Act Title III, AAA Care Management, and local funding that can be integrated into the ADRC effort.

2. **Medicaid administrative claiming:** Many of the activities performed by the ADRC could qualify for matching funds (likely at a 50/50 rate) through Federal Financial Participation (FFP) because they could be considered as Medicaid-related. For example, Medicaid FFP pays for more than one-third of the funding for Wisconsin's ADRCs. The existing funding, including the AAA Care Management spending (which is all State funds), could be used as match for these programs.
3. **Other funding opportunities:** The ADRC initiative should explore capitalizing on the infrastructure being built for this effort to secure additional sources of funding. By standardizing and strengthening operations across AAAs, enhancing quality management and oversight, and adopting a person-centered approach, the AAAs are in a stronger position to obtain contracts and/or engage in common marketing for funding opportunities, such as:
    - Medicaid-managed care Choice Counseling – Under CMS' managed care rules, states must offer independent Choice Counseling to individuals considering or enrolled in Medicaid managed care. The AAAs will be in a stronger position to pursue this opportunity either for existing or future Medicaid managed care. This will be especially important if the State folds more LTSS into managed care.
    - Hospital transition – CMS has enacted rules that create incentives to reduce re-hospitalizations and proposed rules that require enhanced person-centered discharge planning. The AAAs acting as ADRCs should explore developing contracts to supply enhanced discharge planning and/or transition support after a discharge.
4. **Private pay:** – The ADRCs could offer Enhanced Options Counseling and ongoing case management as a private pay service.

In addition, we recommended that the ADRCs establish relationships and collect data to justify State investment. This would include developing measures that could demonstrate that the ADRC saves the State money by:

- Preventing or delaying the use of Medicaid LTSS by assisting people in developing plans for meeting these needs using their own resources.
- Demonstrating that the ADRCs are reducing burden on State agencies or other programs funded by the State. For example, as part of their intake and routing processes, the ADRCs could establish processes that more accurately target assessments for Medicaid waivers, reducing the number of unnecessary assessments. This would save the State

money and prevent individuals from having to go through assessments that result in denials.

During this year's review we found that little progress had been made with developing sustainability plans until the ADRC was established as a permanent program. Since that time, the following steps have been taken:

- Individual ADRCs have begun to think about the additional staffing they will need to meet the demand they expect to receive.
- The SUA has begun the process of securing a contractor to support the development of administrative claiming infrastructure.
- The SUA and the AAAs met with representatives from Medicaid on administrative claiming and Medicaid assigned a point-of-contact for this effort.

SUMMARY OF THE RECOMMENDATIONS

Summary of the Recommendations

The ADRC initiative has established standardized operations that are being followed by each of the sites. Staff at these sites are generally following the agreed upon models. We recommend making the following changes to enhance current ADRC operations by:

- **Informing Callers of Their Rights and Documenting Eligibility Counseling and Financial Prescreening-** Only 27% of Options Counseling contacts had informed consent and confidentiality of rights documented. While this is an increase from 12% during the previous evaluation period, this is an important component as the process proceeds past basic information, and the ADRC Coordinators should work with staff to ensure they are clear about the information to provide. While 73% of individuals received some sort of eligibility counseling, based on our conversations with staff we expected that this number would be significantly higher given the tasks that ADRC staff described performing. We recommend that staff are trained to document this information for each encounter.
- **Increasing the Number of I&R and OC Surveys-** To increase the number of I&R and OC surveys completed, we recommend increasing sampling, training on when to provide the survey, and monitoring of the number of surveys received.
- **Increasing the Number of Contacts Documented as Options Counseling that Receive a Plan-** Only 54% of individuals who were documented as receiving Options Counseling had an IAP developed, and only 65% had an Options Counseling session initiated in Trilogy. The ADRC Coordinators should ensure that there are clear guidelines for when an IAP should be complete and should provide tracking of Options Counseling contacts and IAPs completed within the monthly reports.
- **Refine ADRC Service Categories to Address Support that Does Not Fall within Existing ADRC Service Definitions-** In the 2017 report we identified two new potential ADRC services: 1) Extensive assistance provided to individuals who are challenging to support and are not receiving assistance from another agency; and 2) Assistance provided to individuals who are currently being served by one or more other agencies. We encourage the SUA and the ADRCs to explore whether refinements to the model are still necessary after the integration of the AAAs and ADRCs is completed.
- **Adding the Ability to Capture I&R Plans within Trilogy-** We saw no examples of I&R plans. If they are being created, staff are using paper forms that are not uploaded or integrated within the Trilogy automated system. The ability to upload and track I&R

plans will be another crucial measure to determine the outcome and effectiveness of I&R interactions.

The ADRC initiative has strengthened its relationship with its disability partners, especially at the local level. We recommend enhancing these relationships by:

- **Strengthening and Clarifying the Roles of the Advisory Councils-** Similar to the 2017 review, disability partners shared that the local Advisory Councils are streamlined and productive, while the purpose of the State Advisory Council meetings are less clear and can be redundant with the local meetings. The State should develop a written policy that more clearly sets expectations for both the State and local Advisory Councils. These policies should help members understand their roles and opportunities to provide feedback.
- **Streamlining Meetings with Local Partners-** The Disability Partners shared that they saw tremendous value in the local Advisory Committee meetings, however suggested that many other meetings with similar membership and relevant discussions are often occurring. They suggested to enhance coordination and participation by merging these meetings. We would encourage the ADRC Coordinators to work with the ADRC staff to determine the best path to streamline these local meetings.
- **Formalizing Partnerships with Community Partners-** While we did see evidence of the ADRC working collaboratively with disability partners, we did not observe progress being made in the previous reports' recommendation of translating relationships with disability and other community partners into ongoing policies and procedures and written agreements. These written agreements can be policies for cross-training and who and how to refer that are reviewed and agreed upon by all parties impacted. Eventually it would be helpful to have the agreements captured in a contract or updated Memorandum of Understanding (MoU) or a similar document.

We recommend that the ADRC initiative enhance staff training by:

- **Continuing the Development of Standardized Training Topics-** While there has been some progress in developing regular trainings for AAA staff, we encourage that the ADRC Coordinators continue to work with the AAAs/ADRCs to identify additional areas for training. Training topics that should receive special focus include:
    - Development of person-centered plans and goals
    - Tracking follow-up in Trilogy
    - How to provide and track discussions around informed consent, confidentiality rights, and eligibility counseling
    - Tracking unmet need in Trilogy

Training could also be enhanced by:

- **Clarifying the Differences Between Options Counseling and Care Management-** During our interviews with the AAAs in September 2018, the triage to Options Counseling or Care Management varied from site to site, with the majority not having a standardized process. For example, several agencies said that the triage depends on the intensity and duration of the support provided, while others said that the services that are requested are the only factor in this triage. Additionally, we saw that there was a 36% decrease in the number of Options Counseling contacts in this report when compared with the 2017 report. This suggests that while the differences between I&R and Options Counseling are clearer, one of the core services of the ADRC, Options Counseling, is decreasing and may be being counted as care management. As the ADRC becomes further integrated with the AAAs, the operations will need to be clarified to avoid redundancies and ensure callers are triaged appropriately.
- **Supplementing Training with Intra- and Inter-agency Peer Review of Action Plans-** During the September 2017 HCBS Strategies site visit, we recommended that ADRC staff meet regularly to review Action Plans and the development of person-centered goals. These reviews could occur within and across agencies. Staff at all agencies said that they felt this would be valuable. We repeat this recommendation in this report.

We recommend that the ADRC program evolve into a component of a larger NWD network consistent with the vision included in the *Long Term Care Redesign Plan*. Achieving this vision will involve the following changes:

- **Expanding the Relationships with the Disability Partners into a No Wrong Door Network-** This task will includes strengthening the network to include State agencies and more central roles for the disability partners.
- **Expand Sustainability Efforts Including Medicaid Administrative Claiming-** The ADRC sustainability plans should be expanded to include funds available from and for other components of the NWD network.

APPENDIX 1: CURRENT ADRC TOOLS

Appendix 1: Current ADRC Tools

Current versions of tools that have been developed for the ADRCs can be found in the ADRC Forms Manual below and include:

- ADRC Forms Manual
- ADRC Operations Manual

AUGUST 25, 2017

ADRC Nebraska

Forms Manual

ADRC FORMS MANUAL

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ADRC SATISFACTION SURVEY

- Sampling Process
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TRAINING REVIEW

ADRC Consumer Rights

As a consumer of ADRC Nebraska, you are entitled to certain rights as listed below. If you have questions about your rights, please contact the ADRC staff.

1. You have the right to receive services without regard to your race, color, sex, national origin, religion or disability.
2. ADRC services are voluntary. You have the right to accept or reject ADRC services.
3. You have the right to have your preferences respected.
4. You have the right to confidentiality. Your information will be kept confidential at all times and you may have access to your information, if desired.
5. You have the right to expect ADRC staff to respect your personal dignity.
6. You have the right to choose from the services available to you.
7. You have the right to choose who provides your services.
8. You have the right to register a complaint or file a grievance without discrimination or reprisal.

ADRC Locations

Norfolk
Northeast Nebraska Area Agency on Aging
402-370-3454

Omaha
Eastern Nebraska Office on Aging
402-444-6536

Kearney
South Central Nebraska Area Agency on Aging
308-234-1851

Scottsbluff
Aging Office of Western Nebraska
308-635-0851

Lincoln
Aging Partners
402-441-7070

Beatrice
Blue Rivers Area Agency on Aging
402-223-1376

Hastings
Midland Area Agency on Aging
402-463-4565

Aging & Disability Resource Center (ADRC) Information & Referral Summary Instructions for Form Completion

Purpose: The purpose of the Information and Referral (I&R) Summary Form is to capture information regarding referrals made for persons receiving Information and Referral services. **This is an optional form** to provide information for the consumer/representative as they consider their next steps. Other methods for providing this information include phone or in-person discussion, printing referrals from the Dashboard, or providing other available printed material regarding the suggested resources.

Distribution: Discuss with the consumer and/or representative their preference for receiving the information. Information should be provided to the consumer/representative within 3 business days of the call or meeting. Options include providing a printed hard copy if conducting an in-person meeting or sending via e-mail or U.S. mail. The "I&R Summary" cover letter may be utilized. A copy or notation that the information was sent will be kept for the OC files. *See below for instructions on saving the completed form.

Instructions for Completion

Name:	Consumer name
Address:	Consumer address
Date:	Date form is completed

Organization/Contact Information: Enter information about each organization for which a referral is made. Information to include:

- Name of organization
- Address
- Phone
- E-mail
- Website

Additional Information: Enter additional information that may assist when contacting the organization. This may include suggestions for what to ask or when to follow up, such as:

- "Inquire about program xyz."
- "Inform them of your need for xyz services."
- "Ask to talk with xyz in xyz department."
- "Contact this agency before contacting agency xyz."

For questions or more information, contact ADRC Nebraska staff: Enter OC's information.

Saving the form upon completion:
Click File/Save As to save the form, clearly named, such as "J. Smith 9.14.16."

Aging & Disability Resource Center (ADRC)
Information & Referral Summary

Name:____________________________ **Address:**____________________________________

Date: _____________________________ ___________________________________

Organization/Contact Information	Additional Information
Organization:____________________________________ Address:_______________________________________ City:____ Phone:____ E-mail:____ Website:_______________________________________	
Organization:____________________________________ Address:_______________________________________ City:____ Phone:____ E-mail:____ Website:_______________________________________	
Organization:____________________________________ Address:_______________________________________ City:____ Phone:____ E-mail:____ Website:_______________________________________	

For questions or more information, contact ADRC Nebraska staff:	
Name:____	**Phone:**___________________
Agency/Address:____	**E-mail:**___________________

Aging & Disability Resource Center (ADRC)
Information & Referral Summary

Additional Referrals

Organization/Contact Information	Additional Information
Organization:________________ Address:________________ City:________________ Phone:________________ E-mail:________________ Website:________________	
Organization:________________ Address:________________ City:________________ Phone:________________ E-mail:________________ Website:________________	
Organization:________________ Address:________________ City:________________ Phone:________________ E-mail:________________ Website:________________	
Organization:________________ Address:________________ City:________________ Phone:________________ E-mail:________________ Website:________________	

Date

Dear

It was a pleasure meeting with/talking with you and list others on date at location. The purpose of the Aging and Disability Resource Center (ADRC) is to provide information about services and support available in Nebraska communities for older Nebraskans, people with disabilities, and those who support them. I hope our discussion provided you with the information you needed.

As a result of our discussion, I have put together the attached 'Information and Referral Summary' document. As you'll see, this summary provides contact information for organizations that may be able to assist you. I've also included additional information that may be useful when you contact them.

Please feel free to contact me if you have questions about any of this information or wish to meet again. If you would like me to assist in contacting the listed organizations or in gathering more information, please let me know!

Closing,

Signature block

ADRC Locations

Norfolk
Northeast Nebraska Area Agency on Aging
402-370-3454

Omaha
Eastern Nebraska Office on Aging
402-444-6536

Kearney
South Central Nebraska Area Agency on Aging
308-234-1851

Scottsbluff
Aging Office of Western Nebraska
308-635-0851

Lincoln
Aging Partners
402-441-7070

Beatrice
Blue Rivers Area Agency on Aging
402-223-1376

Hastings
Midland Area Agency on Aging
402-463-4565

Aging & Disability Resource Center (ADRC) Individual Action Plan (IAP) Instructions for Form Completion

Purpose: The purpose of the ADRC Individual Action Plan (IAP) is to capture information regarding the goals and preferences of the consumer and/or their representative. The IAP reflects the services and supports important **for** the consumer to meet the needs as self-reported, as well as what is important **to** the consumer regarding preferences for the delivery of such services and supports. Action steps are defined to accomplish the goals, along with identifying who will complete the steps, a timeline, and potential funding sources. The Options Counselor (OC) completes the form in collaboration with the consumer and/or representative. **Note: The IAP may be completed as a separate document and uploaded to the Dashboard or completed directly in the Dashboard Options Counseling Module.**

Distribution: The OC will discuss with the consumer and/or representative their preferences for receiving the form. The completed IAP should be provided to the consumer within 5 business days of the call or meeting. Options include providing a printed copy if conducting an in-person meeting or sending via e-mail or U.S. mail. An electronic copy will be kept for the OC files.

Instructions for Completion

Name: Consumer name

Date of Original Plan: Date original IAP is completed
Plan Updated: Date(s) of update made to the IAP

Background/ Preferences:

The OC explains that the purpose of the plan is to discuss and identify what it will take for the consumer to live as independently as possible in the setting of their choice. The plan is to identify preferences, resources, and challenges and to set goals. The intent of the background section is to create a narrative that sums up the most salient points presented by the consumer. Utilize the consumer's own words to describe their background, such as nature of disability, current living situation, services, needs, etc. Also, document their preferences for how they would like to live in the future (e.g., with in-home supports, assisted living, nursing facility, etc.)

This brief narrative will describe the consumer's situation and preferences by answering the questions:

- "What brings me to the ADRC?"
- "What do I want for my life?"

Example: "I have cerebral palsy and I want to continue to live at home by myself. I have limited money to live on. I need someone to clean my house, help me buy groceries, and give me rides to do things in my community."

Goals: List very simple goals, such as: “I want to stay in my own home. I want help keeping my house clean. I want someone to help me with my finances.” Goals must make sense to the consumer and not be overly complicated. It may be necessary to discuss whether a goal is realistic and revisions may be necessary to make it achievable. Once achieved, mark “Goal Met”.

Action Steps: Action Steps define how the consumer will meet their goals and should be agreeable to the consumer.

What: Specific action to be performed
Who: Name/relationship of person responsible for the action(s)
How much: Frequency or level of service
When: Agreed-upon timeline for completion of the action(s)

Notes: List any notes regarding special requests, challenges, or progress toward meeting the goal.

Potential Funding: Check the potential source(s) of funding for meeting the goal. If “Other”, indicate other potential source. It is important to complete this section so there is a clear understanding of sources that may be used to pay for services or supports. This may be left blank if pursuing a goal for which funding is not necessary, such as ‘spend more time with family.’

Contact Information: Enter the Options Counselor’s contact information.

Saving the form upon completion:

Click “File/Save As” to save the form, clearly named, such as “J. Smith 9.14.16" and upload to the Dashboard. Or, the form may be completed directly on the Dashboard Options Counseling Module.

Aging & Disability Resource Center (ADRC)
Individual Action Plan (IAP)

Consumer Name:____ **Address:**_____________________________________

Date of Original Plan:_____________________________ **Date Plan was Updated:**_________________________

Background/Preferences:

Goals	Action Steps	Notes	Potential Funding Source
1. Goal Met:	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:_________________
2. Goal Met:	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:_________________

Goals	Action Steps	Notes	Potential Funding Source
3. Goal Met:	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:_________________
4. Goal Met:	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:_________________

These are the steps outlined to assist you in meeting the goals as discussed with ADRC staff.
If you have questions or want to change your plan, contact:

Name:____ **Agency:**____

Address:____ **Phone:**____

E-mail:____

Additional Goals

Goals	Action Steps	Potential Funding Source
5.	What, who, how much, and when:	Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:__________________
6.	What, who, how much, and when:	Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:__________________
7.	What, who, how much, and when:	Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:__________________
8.	What, who, how much, and when:	Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:__________________

Date

Dear

It was a pleasure meeting with/talking with you and list others on date at location. The purpose of the Aging and Disability Resource Center (ADRC) is to provide information about services and support available in Nebraska communities for older Nebraskans, people with disabilities, and those who support them. I hope our discussion provided you with the information you needed.

As a result of our discussion, I have put together the attached 'Individual Action Plan' document. As you'll see, this summarizes what we discussed as goals for you, action steps to meet those goals, and potential funding sources for services.

Please review this document and let me know if you have questions or if we need to make changes. I look forward to working with you on your plan. As we discussed, I'll be in touch on date to talk about our progress. If you would like me to assist further, please let me know.

Closing,

Signature block

ADRC Locations

Norfolk
Northeast Nebraska Area Agency on Aging
402-370-3454

Omaha
Eastern Nebraska Office on Aging
402-444-6536

Kearney
South Central Nebraska Area Agency on Aging
308-234-1851

Scottsbluff
Aging Office of Western Nebraska
308-635-0851

Lincoln
Aging Partners
402-441-7070

Beatrice
Blue Rivers Area Agency on Aging
402-223-1376

Hastings
Midland Area Agency on Aging
402-463-4565

INSTRUCTIONS FOR COMPLETION

Aging & Disability Resource Center (ADRC)
Individual Comprehensive Action Plan (ICP)
For Enhanced Options Counseling

Overview: Instructions for completing the plan are entered in red, italic font throughout the document. The ICP reflects the services and supports that are important ***for*** *the consumer to meet the needs identified through the Care Management Assessment, as well as what is important* ***to*** *the consumer with regard to preferences for the delivery of such services and supports. The ICP is to be completed after the Care Management Assessment has been administered. Documentation completed on this form must be written in first person language to paint the picture of telling their story in their own words. Others may be involved in developing the plan, if there is a legal representative or as desired by the consumer.*

Name: *Consumer Name*	**Address:** *Consumer Address*
Date of Original Plan: *Date plan was signed*	**Date of Plan Update(s):** *Date(s) the plan was updated with the consumer*

Instructions: This is your plan. Your ADRC Options Counselor will work with you to complete this plan, but it is your plan for the changes you need or want to make. You may wish to involve others who are important to you in developing your plan. It's up to you!

Explain to the consumer that a primary purpose of the plan is to discuss and identify steps and resources to help them live as independently as possible in the setting of their choice. The process will help them identify preferences, resources, and challenges and assist in setting goals. The first step is to have a clear picture of how their life is currently and what they want for now and in the future.

Part A. My Plans: Think about your life how it is now and how you want it to look in the future. You may not be able to get everything you want, but it helps to spell things out.

My Life Now	What I Want Now and in the Future
Home/Family	Home/Family
Recreation/Fun/Relaxation	Recreation/Fun/Relaxation
Community Involvement/Social/ Religious/Cultural	Community Involvement/Social/ Religious/Cultural
Work/Volunteer Activities/Learning	Work/Volunteer Activities/Learning

Part B. My Resources & Challenges

Ask the consumer the following questions and record their answers in their own words, using first person language. Check frequently to make sure you understand what they are telling you.

1. **Who is available to help me now and how do they help?** Think about those people who support you on a day-to-day basis. How do they help you? Will they be available in the future to assist you? This could be informal assistance provided by a relative, neighbor, friend or community member or it may be formal services or supports provided by an agency or program.

2. **What do I do well? What is working for me now in my life?** Think about what you're good at and what things are going well for you in your life now.

3. **What do I consider to be the biggest challenge(s) to living the life I want?** Think about what might be stopping you from doing the things you want to do now and in the future.

Part C. My Plan: Based on what you've identified, it is helpful to develop goals. **Goals** address what you want for your life. **Action Steps** are taken by you or someone else to help you meet those goals. You may have special considerations to write into the **Notes** section. You may also document progress or barriers to meeting your goal in **Notes**. Finally, think about **Potential Funding Sources** you need or that may help you reach your goal. How much will it cost? When you meet your goal, check the **Goal Met** box.

- *Goals: Enter very simple goals such as: I want to stay in my own home. I want help with keeping my house clean. I want someone to help me with my finances. Goals must make sense to the consumer and not be overly complicated. It may be necessary to discuss whether a goal is realistic and revisions may be necessary to make it achievable.*

- *Goal Met: When the goal is completed, document the date the goal was met.*

- *Action Steps: Action Steps define how the consumer will meet their goals and should be agreeable to the individual. Include what action will be taken by whom, how much, and when (to the extent possible).*

- *Notes: The Notes section is for documenting special requests, challenges, or progress related to the goal.*

- *Potential Funding Source: Potential Funding Sources are important to document so there is a clear understanding of sources that may be used to pay for services or supports. This may be left blank if pursuing a goal for which funding is not necessary, such as 'spend more time with my family.'*

My Goals	Action Steps	Notes	Potential Funding Source
Goal Met:	What, who, how much, and when:		Select all that apply to this goal: Government funds/program Private pay Unpaid supports Consumer self support Other:
Goal Met:	What, who, how much, and when:		Select all that apply to this goal: Government funds/program Private pay Unpaid supports Consumer self support Other:

My Goals	Action Steps	Notes	Potential Funding Source
Goal Met:	What, who, how much, and when:		Select all that apply to this goal: Government funds/program Private pay Unpaid supports Consumer self support Other:

Part D. My Risks: Even with a great plan, you may have other risks that affect your safety. Think about how those risks will be addressed. If you need help ensuring your safety, list who will help you.

Document any risks that the consumer identifies. If you, family members, or the legal representative identifies a potential risk, discuss and clarify this with the consumer and document here. Risks can be of varying nature. They represent anything that may threaten their independence.

My Risks	Addressing My Risks

Part E. My Supports
As an ADRC Options Counselor, I agree to assist (_______________) in completing this plan. We will review the plan, at a minimum, every six months to update and track progress toward meeting the stated goals.
If needed, the plan may need to be re-visited and updated more frequently. This should be at times agreed upon by the Options Counselor and consumer and/or legal representative.

Name:	**Agency:**
Address:	**Phone:**
Date:	**Email:**

Part F. My Agreement
I agree to this plan.

My Signature: **Date:**
Legal Representative Signature (if applicable): **Date:**
Part G. Other Participants in Plan Development (if applicable): **Date:**

Aging & Disability Resource Center (ADRC)
Individual Comprehensive Action Plan (ICP)
For Enhanced Options Counseling

Name:_______________________________________	**Address:**_______________________________________
Date of Original Plan:___________________________	**Date of Plan Update(s):**___________________________

Instructions: This is your plan. Your ADRC Options Counselor will work with you to complete this plan, but it is your plan for the changes you need or want to make. You may wish to involve others who are important to you in developing your plan. It's up to you!

Part A. My Plans: Think about your life how it is now and how you want it to look in the future. You may not be able to get everything you want, but it helps to spell things out.

My Life Now	What I Want Now and in the Future
Home/Family	Home/Family
Recreation/Fun/Relaxation	Recreation/Fun/Relaxation
Community Involvement/Social/ Religious/Cultural	Community Involvement/Social/ Religious/Cultural
Work/Volunteer Activities/Learning	Work/Volunteer Activities/Learning

Part B. My Resources & Challenges

1. **Who is available to help me now and how do they help?** Think about those people who support you on a day-to-day basis. How do they help you? Will they be available in the future to assist you? This could be informal assistance provided by a relative, neighbor, friend or community member or it may be formal services or supports provided by an agency or program.

2. **What do I do well? What is working for me now in my life?** Think about what you're good at and what things are going well for you in your life now.

3. **What do I consider to be the biggest challenge(s) to living the life I want?** Think about what might be stopping you from doing the things you want to do now and in the future.

Part C. My Plan: Based on what you've identified, it is helpful to develop goals. **Goals** address what you want for your life. **Action Steps** are taken by you or someone else to help you meet those goals. You may have special considerations to write into the **Notes** section. You may also document progress or barriers to meeting your goal in **Notes**. Finally, think about **Potential Funding Sources** you need or that may help you reach your goal. How much will it cost? When you meet your goal, check the **Goal Met** box.

My Goals	Action Steps	Notes	Potential Funding Source
1. Goal Met: ☐	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:___________________
2. Goal Met: ☐	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:___________________
3. Goal Met: ☐	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:___________________
4. Goal Met: ☐	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:___________________

My Goals	Action Steps	Notes	Potential Funding Source
5. Goal Met: ☐	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:___________________
6. Goal Met: ☐	What, who, how much, and when:		Select all that apply to this goal: ☐ Government funds/program ☐ Private pay ☐ Unpaid supports ☐ Consumer self support ☐ Other:___________________

Part D. My Risks: Even with a great plan, you may have other risks that affect your safety. Think about how those risks will be addressed. If you need help ensuring your safety, list who will help you.

My Risks	Addressing My Risks
1.	
2.	
3.	
4.	

Part E. My Supports
As an ADRC Options Counselor, I agree to assist (____) in completing this plan. We will review the plan, at a minimum, every six months to update and track progress toward meeting the stated goals.

Name:____	**Agency:** ____
Address: ____	**Phone:** ____
Date: ____	**Email:** ____

Part F. My Agreement
I agree to this plan.

My Signature: ____ **Date:** ____
Legal Representative Signature (if applicable): ____ **Date:** ____
Part G. Other Participants in Plan Development (if applicable): ____ **Date:** ____

Date

Dear

It was a pleasure meeting with/talking with you and list others on date at location. The purpose of the Aging and Disability Resource Center (ADRC) is to provide information about services and support available in Nebraska communities for older Nebraskans, people with disabilities, and those who support them. I hope our discussion provided you with the information you needed.

As a result of our discussion, I have put together the attached 'Individual Comprehensive Action Plan' document. As you'll see, this summarizes what we discussed. This includes a summary of your goals and action steps to meet those goals.

Please review this document and let me know if you have questions or if we need to make changes. I look forward to working with you on your plan. As we discussed, I'll be in touch on date to talk about our progress. If you would like me to assist further, please let me know.

Closing,

Signature block

ADRC Locations

Norfolk
Northeast Nebraska Area Agency on Aging
402-370-3454

Omaha
Eastern Nebraska Office on Aging
402-444-6536

Kearney
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Scottsbluff
Aging Office of Western Nebraska
308-635-0851

Lincoln
Aging Partners
402-441-7070

Beatrice
Blue Rivers Area Agency on Aging
402-223-1376

Hastings
Midland Area Agency on Aging
402-463-4565

Aging & Disability Resource Center (ADRC)
Satisfaction Survey
Sampling Process

Purpose: The purpose of the ADRC Satisfaction Survey is to gather feedback on the experience of participants who have interacted with an ADRC.

Notification: The Options Counselor (OC) will inform the consumer and/or representative that they may receive a Satisfaction Survey to complete, explaining the purpose and indicating that completion is optional. The OC will ask how they wish to receive the survey (via U.S. mail or email).

Sampling: Surveys will be distributed using the following sampling process.

Basic Information:	0%
Information and Referral:	100% of those receiving an emailed I&R Summary
Information and Referral:	50% of those receiving a mailed I&R Summary
Options Counseling:	100%
Enhanced Options Counseling:	100%

Process:

1. The consumer or representative will be asked to complete a Satisfaction Survey. If they decline, indicate this in the Notes section on the Dashboard.

2. The Satisfaction Survey may be mailed with a stamped, self-addressed envelope, with ADRC staff entering the pilot site location on the second line of the form prior to sending. Or, if the consumer prefers, a link to Formstack may be sent by copying and pasting the link into an email:
   I&R: https://hcbsstrategiesincorporated.formstack.com/forms/ne_adrc_i_r_satisfaction_survey_consumers
   OC: https://hcbsstrategiesincorporated.formstack.com/forms/ne_adrc_oc_satisfaction_survey_consumers

3. For I&R consumers, the survey will be sent within two weeks of the date of service. For those receiving Options Counseling, this will be sent within two weeks of when the OC case is closed.

4. A copy of each survey will be kept at the AAA. Survey results will be entered monthly into Formstack by non-ADRC staff in the AAA. To enter, go to (or copy and paste link into a browser):
   I&R:https://hcbsstrategiesincorporated.formstack.com/forms/ne_adrc_i_r_satisfaction_survey_staff_secondary_entry
   OC: https://hcbsstrategiesincorporated.formstack.com/forms/ne_adrc_oc_satisfaction_survey_staff

5. Monthly reports will be generated by Formstack.

6. A sampling of completed surveys may be reviewed as part of the Quality Assurance process to ensure consistency and accuracy of entries.

8.19.17

Aging & Disability Resource Center (ADRC) Information & Referral Satisfaction Survey

Hello! You recently contacted the Aging and Disability Resource Center (ADRC) located at: ____. We are pleased you contacted us and hope we were able to help.

The ADRC is a pilot project directed by the Nebraska Legislature. The goal is to support Nebraskans who are aging or have disabilities by providing information, assistance, and education on community services and long-term care options. We are dedicated to making this pilot a success so these important services for Nebraskans can continue in the future. Your input is valuable. Please take a few minutes to tell us how we did and return the survey to us in the envelope provided. Thank you!

In regard to my contact with the ADRC, I feel that:	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
1. I am better informed about options for services and supports.					
2. I was given objective, accurate, and complete information.					
3. The referral(s) were helpful.					
4. I was clear on how to contact the referral(s) and what to ask for.					

Please share comments regarding your ADRC experience or suggestions for improving the ADRC.

Identification of Person Completing this Survey

Please check what applies to you:

- ☐ Person for whom the plan was made
- ☐ Legal Representative
- ☐ Family Member
- ☐ Caregiver
- ☐ Agency Representative
- ☐ Other: (note)

Aging & Disability Resource Center (ADRC) Options Counseling Satisfaction Survey

Hello! You recently contacted the Aging and Disability Resource Center (ADRC) located at: ____________________________________. We are pleased you contacted us and hope we were able to help.

The ADRC is a pilot project directed by the Nebraska Legislature. The goal is to support Nebraskans who are aging or have disabilities by providing information, assistance, and education on community services and long-term care options. We are dedicated to making this pilot a success so these important services for Nebraskans can continue in the future. Your input is valuable. Please take a few minutes to tell us how we did and return the survey to us in the envelope provided. Thank you!

In regard to my contact with the ADRC, I feel that:	**Strongly Disagree**	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
1. I am better informed about options for services and supports.					
2. I was given objective, accurate, and complete information.					
3. I was actively involved in developing my Individual Action Plan.					
4. My Individual Action Plan reflects what is important to me.					
5. Before I contacted the ADRC, I considered going into a nursing facility or other institution.					
6. My Individual Action Plan will help me stay in my home or community setting.					

Please share comments regarding your ADRC experience or suggestions for improving the ADRC:

Identification of Person Completing this Survey

Please check what applies to you:

- ☐ Person for whom the plan was made
- ☐ Legal Representative
- ☐ Family Member
- ☐ Caregiver
- ☐ Agency Representative
- ☐ Other: (note)

1.17.17

ADRC Staff Training Review

Please provide a review of the recent training in which you participated. This information will assist the ADRC Training Committee in planning orientation training for new ADRC staff, as well as assembling valuable continuing education training opportunities for existing staff. **Thank you!**

Background Information

1. Your Name:
2. Training Title:
3. Training Sponsor:
4. Presenter:
5. If online, provide website link:
6. Date you attended or viewed the training:
7. Brief description of the topics covered.

Training Review

Please rate the following statements.	Disagree	Neutral	Agree
1. The training had relevance for ADRC staff.			
2. The information was presented in a clear and understandable manner.			
3. The presenter was credible in his/her field.			
4. The training would be of value as orientation for new ADRC staff.			
5. The training would be of value as continuing education for existing ADRC staff.			

Additional Comments:

Return this form to:
lloyafritz@windstream.net

AUGUST 29, 2017

ADRC Nebraska

Operations Manual

Aging & Disability Resource Center (ADRC) Nebraska Pilot Operations Manual

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1 Introduction to ADRC Nebraska Operations Manual

This manual is a resource for ADRC staff working in the ADRC Nebraska pilot locations. It is intended to be:

- An orientation tool for new ADRC staff;
- An ongoing source of direction for ADRC staff; and
- A means to ensure consistent ADRC services across the ADRC pilot sites.

The manual will be reviewed and updated throughout the life of the pilot (June, 2018) to ensure that it is current, accurate and reflective of the practices of the ADRC Nebraska.

1.1 Contact Information

Questions regarding the ADRC Nebraska Operations Manual should be directed to Fritz & O'Hare Associates, ADRC Pilot Coordinators:

- Lloya Fritz: lloyafritz@windstream.net
- Mary O'Hare: maryohare7@gmail.com

1.2 Best Practice

Throughout the manual, "Best Practice" recommendations are included in text boxes.

2 Program Description

The ADRC Nebraska Demonstration Project was established by the Nebraska Legislature in 2015 under LB 320. The purpose is to evaluate the feasibility of establishing resource centers statewide to provide information about long term services and supports (LTSS) available in the home and community for older Nebraskans, persons with disabilities, family caregivers, and persons who request information or assistance on behalf of others. The goal is to assist eligible individuals to access the most appropriate public and private resources to meet their LTSS needs.

The ADRC pilot serves as a feasibility study to determine how a program on an expanded scale might work in practice. The outcome of the pilot will provide the Nebraska Legislature information and data to determine the future of further state funding. The pilot operates through June 30, 2018.

Responsibility for the ADRC pilot was assigned to the State Unit on Aging of the Division of Medicaid and Long Term Care within the Nebraska Department of Health and Human Services (DHHS). Three Area Agencies on Aging were selected as lead agencies through a DHHS request for proposal process. In total, seven Area Agencies on Aging serve as ADRC pilot sites. Lead agencies and pilot sites include:

a. Northeast Nebraska Area Agency on Aging, Lead Agency: Norfolk
    - Eastern Nebraska Office on Aging: Omaha
b. South Central Nebraska Area Agency on Aging, Lead Agency: Kearney
    - Aging Office of Western Nebraska: Scottsbluff

c. Aging Partners, Lead Agency: Lincoln
    - Blue Rivers Area Agency on Aging: Beatrice
    - Midland Area Agency on Aging: Hastings

2.1 ADRC Mission Statement

The mission of the ADRC is to support seniors, persons with disabilities, their families and caregivers by providing useful information, assistance, and education on community services and LTSS options, while at all times respecting the rights, dignity and preferences of the individual.

2.2 ADRC Target Population

LB 320 defines an eligible individual as a person who has lost, never acquired, or has one or more conditions that affect his or her ability to perform basic activities of daily living that are necessary to live independently. More specifically, the target population includes:

- Older adults-defined as 60 and over;
- Persons of any age with disabilities such as physical, developmental, mental health, and substance use disorder; and
- Family members, caregivers, advocates and providers for these groups.

2.3 ADRC Goals

ADRCs are designed to serve as highly visible and trusted places available in communities across the state where people of all ages, incomes, and disabilities can get information and counseling on the full range of LTSS options. The overall goal is to enhance the existing infrastructure at the local level to increase consumer access to information and services for LTSS in a comprehensive, flexible, and cost effective manner.

- **Goal 1.** Aging Nebraskans and Nebraskans with disabilities, regardless of their income, health condition and long-term care needs, access Long Term Services & supports (LTSS).
- **Goal 2.** ADRC participants' LTSS needs which cannot be met within a timely manner, or at all, are identified.

2.4 ADRC Services

A major focus of the ADRC pilot is to assure collaboration among the different public and private agencies involved in assisting older adults, individuals with disabilities, and those who support them in obtaining information and access to needed services. The three primary services to be provided, as designated in LB 320, are:

- Information and Referral (I&R);
- Options Counseling; and
- Identification of unmet service needs in communities.

In addition, ADRC staff are available to provide basic information to the public regarding local services and supports for persons who are aging or have a disability.

The ADRC pilot is a long-term systems change initiative aimed at improving and streamlining access to information, assistance and LTSS. ADRC sites are engaged in strategic partnerships at the local level. This includes developing working relationships with local health and human services agencies, service providers and other private partners to facilitate LTSS referrals. These partnerships include a range of agencies and organizations such as:

- State & Local Advocacy Organizations
- LTSS Providers (e.g., behavioral health providers, intellectual/developmental disability providers, centers for independent living, home health agencies, nursing facilities)
- State Agencies including: Department of Health and Human Services, Department of Education, Commission for the Deaf & Hard of Hearing, Commission for the Blind & Visually Impaired
- Housing Authorities
- City/County Social Services
- Critical pathway providers (e.g., hospital discharge planners, physicians, pharmacies)
- Educational programs

2.5 ADRC Evaluation

HCBS Strategies, Inc. serves as the independent evaluator for the ADRC pilot. The State Unit on Aging (SUA) works in partnership with HCBS Strategies, Inc. in the development and completion of the evaluation. Evaluation results will be compiled into reports for the Nebraska Legislature throughout the life of the project. This information, along with other sources of information and feedback, will be utilized by the Legislature as it evaluates the feasibility of establishing statewide ADRCs.

2.6 Methods to Contact the ADRC

ADRC Nebraska pilot sites may be reached by calling the toll-free number: 1-844-843-6364. The caller will be directed to the ADRC in their locale. Interested parties may also call the ADRC directly or visit an ADRC office. ADRC phone numbers and locations are listed on the website for each AAA, as well as on the ADRC website. A list of these numbers, websites and locations is included in Attachment A.

The ADRC Nebraska website is located at: http://adrcnebraska.org. The website provides a guide to Nebraska resources designed to assist individuals in need of LTSS.

3 ADRC Organizational Structure

The ADRC Pilot Project Organizational Chart (Attachment B) displays the interworking of the ADRC pilot project.

3.1 Overview

The SUA contracts with Northeast Nebraska Area Agency on Agencies on Aging, Aging Partners, and South Central Nebraska Area Agency on Aging for development and delivery of ADRC services. Additional ADRC pilot sites include Eastern Nebraska Office on Aging, Aging Office of Western Nebraska, Blue Rivers Area Agency on Aging, and Midland Area Agency on Aging. In total, there are seven pilot sites covering the entire state.

The following disability advocacy and provider organizations, under a signed agreement with the Nebraska Association of Area Agencies on Aging (NE4A), provide technical assistance, as requested:

- Arc of Nebraska
- Disability Rights Nebraska
- Independence Rising
- League of Human Dignity
- UNMC Munroe-Meyer Institute

Per signed agreement, technical assistance shall mean:

- Participation in the statewide marketing plan promoting the ADRC through individual organization communication channels
- Assuring accuracy of ADRC website through review and provision of corrections and updates
- Participation as advisors in semi-annual meetings
- Proactive engagement, collaboration, and participation in the development of ADRC state plan
- Participation in the hiring of options counselors and the coordination specialist
- Provision of training information for staff members, as needed and appropriate
- Participation in broad stakeholders meetings

The Nebraska Association of Area Agencies on Aging (NE4A) contracts with Fritz and O'Hare Associates as the Statewide Project Coordinators for the ADRC pilot.

The SUA contracts with HCBS Strategies, Inc. for evaluation services.

3.2 ADRC Pilot Statewide Advisory Committee

The ADRC Pilot Statewide Advisory Committee is coordinated by the ADRC Project Coordinators and meets quarterly. Meeting minutes are documented and distributed to

all committee members, AAA Directors, ADRC staff, SUA staff, and Project Evaluators within ten days of the meeting.

The purpose of the ADRC Pilot Statewide Advisory Committee is to provide on-going advice and support to the ADRC Pilot Project. The responsibilities of the ADRC Pilot Statewide Advisory Committee are to:

- Provide input and feedback to the ADRC pilot as a whole and the ADRC pilot work teams through discussions at meetings, review of documents, and participation in relevant work teams;
- Assist in promoting the use of ADRC pilot resources and services to constituents and the public; and
- Inform respective consumer population of ADRC activities and share consumer input with the ADRC Pilot Statewide Advisory Committee.

3.3 Local Advisory Committees

Local Advisory Committees are established by local ADRC staff. Local ADRC staff are responsible for all meeting logistics, agenda development, and meeting facilitation. Meeting notes are documented and distributed to Local Advisory Committee members, ADRC Project Coordinators, and SUA Representatives within ten days of the meeting.

The purpose of the Local Advisory Committees is to coordinate local efforts in delivery of ADRC services. The responsibilities of the Local Advisory Committees are to:

- Coordinate delivery of local ADRC services with local aging and disability partners;
- Share information regarding the ADRC pilot with local aging and disability partners;
- Troubleshoot difficult situations;
- Share local resources; and
- Provide feedback to the ADRC Pilot Statewide Advisory Committee.

Invited members include representatives from the following groups/organizations:

- Local aging and disability partners providing LTSS services, both public and private;
- AAA Representatives;
- ADRC Staff; and
- Consumers.

In some cases, the Local Advisory Committee may be an extension of an already existing aging/disability committee. Meeting schedules are determined by local teams.

3.4 ADRC Pilot Work Teams

The Project Coordinators organize and lead the ADRC Pilot Work Teams. Teams meet on an as needed basis. Meeting notes are documented and distributed to team members. Work products of the ADRC Pilot Work Teams are sent to the AAA Directors for review and approval. There shall be, at a minimum, four ADRC Pilot Work Teams:

Training Team

Purpose: Provide recommendations and work on strategies to ensure ADRC staff is adequately trained to perform the duties related to the ADRC Pilot.

Responsibilities:

- Recommend initial and on-going training for ADRC staff;
- Develop a sustainable method to share relevant statewide aging and disability training opportunities; and
- Present training plans to the ADRC Statewide Advisory Committee for input and feedback.

Quality Assurance Team

Purpose: To assist in the development and study of unmet service needs and development of a Quality Assurance (QA) plan.

Responsibilities:

- Develop/implement a process for identifying and examining unmet needs;
- Develop/implement a statewide QA plan and identify strategies for improvement; and
- Present findings to the ADRC Statewide Advisory Committee for feedback and input.

Options Counseling Team

Purpose: To develop, review, and revise protocols/policies as needed to ensure successful delivery of ADRC services.

Responsibilities:

- Develop protocols, policies for the delivery of ADRC services, including workflow, assessments, person-centered plans, follow-up, and documentation;
- Review and revise protocols/policies, as needed;
- Troubleshoot issues with program implementation, as needed;
- Gather feedback on the Dashboard usability and data collected and recommend changes, as needed; and
- Develop standardized reports for use at the state and local level.

Network of Care Team

Purpose: To further develop and maintain information on the Network of Care website; revise and update the Service Directory.

Responsibilities:

- Develop information on statewide and local public and private LTSS resources available on ADRC website;
- Ensure accuracy of resource information posted; and
- Conduct outreach to organizations to post and utilize information on the ADRC website.

3.5 Work Team Subcommittees

The ADRC Pilot Statewide Advisory Committee, ADRC Local Advisory Committees, and ADRC Work Teams may form subcommittees designed to study relevant issues and/or develop draft work products, as needed. Each subcommittee is responsible to report findings to the relevant committee or work team and document meeting notes.

4 ADRC Staff

ADRC staff are employed by their respective ADRC pilot site. Staff positions are funded through state designated funds. ADRC Project Coordinators are under contract with the Nebraska Association of Area Agencies on Aging (NE4A) and paid through state designated funds.

4.1 Staffing Plan

Executive Directors: The ADRC site Executive Directors have lead responsibility for ADRC operations, staff performance, supervision and the quality of ADRC services. The Directors have authority over budget development, policies, and personnel. They report to the State Unit on Aging Administrator and are responsible for keeping their respective governing boards informed and receiving advice and direction on ADRC matters. Directors are instrumental in operationalizing the ADRC's vision with ADRC staff and its governing board.

Duties of the Executive Directors related to the ADRC include:

- Ensuring the ADRC meets its obligations under its contract with the State of Nebraska; and
- Managing ADRC service demand and service availability to meet the needs of older adults and persons with disabilities.

ADRC Project Coordinators: This is a contract position between Fritz & O'Hare Associates and NE4A to develop, coordinate and assist in evaluation of the pilot project. This position is responsible for identifying statewide aging and disability resources and potential partners. The Coordinators are the statewide liaison with aging and disability partners, the State Unit on Aging, and the NE4A. The Coordinators coordinate ADRC

staff training and meetings, as well as develop policies, oversee the pilot project work plan, and assist the evaluation team.

Qualifications: Two or more years' experience in disability or aging fields, and/or two or more years' experience in State government in related field, and two or more years working in an ADRC and/or bachelors of social work or related field.

Options Counselor Supervisors: Options Counselor Supervisors provide direct supervision to Options Counselors and report to the AAA Executive Director. Their work includes working cooperatively with the ADRC Project Coordinators in the development of ADRC policies, procedures, reports, etc.

Options Counselor: Options Counselors provide needs assessments, counseling and referrals, preliminary care planning, and short-term tracking based on consumer needs, preferences and situational context for aging adults and persons with disabilities in need of LTSS.

Options Counselors work with consumers, family members, and others with regard to their needs and preference for LTSS. This includes providing information, referral, and education on accessing LTSS. Options Counselors assess preferences and needs and provide information on options related to a consumer's preferences for long-term needs, including both publicly and privately funded. LTSS preferences and needs may include living at home with services such as habilitation, respite, service coordination, care management, transportation, housekeeping, meal delivery or preparation, medication monitoring, assistive technology, home accessibility, employment supports, etc. Other options may include out of home services. Services may be provided and funded by a variety of sources, including Nebraska's Medicaid Waiver programs, other state/federal programs, private insurance, or private pay.

Additionally, Options Counselors may: assist a consumer in applying for Medicaid; make a referral to Senior Health Insurance Information Program (SHIIP); assist in applying for other state and local benefits; or refer to other disability-related services such as developmental disability services, local advocacy agencies, mental health services, substance use disorder services, assistive technology, or services for persons who are deaf and hard of hearing or have visual impairments.

Qualifications:

- Two to four years of college or equivalent experience
- Three to five years of experience working with seniors and/or people with disabilities

4.2 Staff Coverage

Each ADRC location can be accessed through a single point of entry. ADRC sites have a local phone number as well as a toll-free number. The office hours are from 8:00 a.m. to 4:30 p.m. Monday through Friday. ADRC callers after hours hear a recorded message stating the office is closed, information on ADRC office hours, and steps for leaving a message. ADRC staff respond to initial inquiries and requests for information and assistance within one business day. In the event of an extended absence of an Options Counselor, ADRC sites will arrange for adequate coverage.

4.3 New Employee Orientation

Each staff member assigned to the ADRC will have an orientation to the daily operating policies and procedures within that particular ADRC site, including introduction to coworkers, orientation to the IT systems, daily workflow, as well as orientation to related departments located at the site.

Each staff member will have an orientation to the ADRC to include:

- Review of the ADRC Operations Manual
- Instruction on use of the Dashboard
- Instruction on the use of the Network of Care public website
- Instruction on the use of the phone system

4.4 Training Policy

Following is the plan for ongoing training for ADRC staff. The training plan operates on a quarterly cycle that will repeat throughout the life of the pilot.

Month 1: ADRC staff choose an online training or webinar to view related to their work. As staff become aware of training resources, these should be shared with Project Coordinators for inclusion in a resource listing. After viewing the training, staff complete the Training Review form (see Forms Manual) and submit to Project Coordinators. Project Coordinators will compile these reviews and share with staff, the Training Team, the Statewide Advisory Committee, SUA, and others, as applicable.

Month 2: A customized webinar for ADRC Nebraska will be developed and presented for ADRC staff and others, as applicable.

Month 3: A two-day training and ADRC staff meeting will be held at a central location, utilizing presenters for topics identified by the Training Team.

Ongoing: ADRC staff will attend local or statewide trainings as available and applicable. Upon completion of the training, staff will complete the

Training Review form and submit to Project Coordinators. Project Coordinators will compile these reviews and share with staff, the Training Team, the Statewide Advisory Committee, SUA, and others, as applicable.

4.5 Conflict of Interest Policy

ADRC staff shall avoid situations that create a conflict of interest.

- A conflict of interest is present whenever a person or entity involved in a relationship with a consumer has a personal interest in the situation or has the potential to benefit by a particular decision, outcome, or expenditure related to the relationship. The interest or benefit may be real, perceived, or possible. The benefit may be positive or negative.
- Staff should consult with their supervisor to determine if a conflict of interest exists.
- Whenever competing interests are identified, action must be taken to limit, mitigate, or eliminate the conflict. That action will be developed and implemented dependent upon the specific situation encountered, most usually through the use of an alternate staff person.
- When a conflict of interest is identified, at a minimum, the consumer should be made aware of the potential of a conflict of interest and included in decisions to either minimize or eliminate the potential of a conflict.

The following can help prevent a conflict of interest from taking place:

- No employee will use their position for personal or financial gain of themselves, their family, or another person.
- No employee shall solicit or accept for themselves, their family, or another person any gift, campaign contribution, gratuity, favor, service, promise of future employment, loans, entertainment or other things of monetary value from the person who has or is seeking services through the ADRC.
- ADRC staff should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.
- ADRC staff should not engage in dual or multiple relationships with consumers or former consumers (examples include, but are not limited to, business relationships or transactions, personal relationships, etc.) or in which there is real or potential harm to the consumer.
- When ADRC staff provide services to two or more people who have a relationship with each other, staff must clearly identify who is to be considered the “consumer” and the role and the nature and professional obligation to the various individuals who are receiving services.
- Staff shall inform consumers of all LTSS options within their community. If referred to a service provided by the AAA, the consumer is to be informed that service is a part of the AAA.

4.6 Reporting Requirements

ADRC staff are required to provide documentation regarding a variety of activities including, but not limited to:

- Dashboard Information: Caller Information, Consumer Information, Referrals, Finish Call, Options Counseling Module (as appropriate)
- ADRC Information & Referral Summary
- ADRC Individual Action Plan
- Care Management Comprehensive Assessment
- ADRC Individual Comprehensive Action Plan (Enhanced Options Counseling)
- Monthly operational reports regarding activities, accomplishments, and concerns
- Review of on-line and non-ADRC training events

5 Confidentiality

All information disclosed between ADRC staff and the consumer shall remain confidential. ADRC staff will utilize their AAA procedures for obtaining/releasing confidential information. Consumers will not be asked to disclose more personal information than necessary to make a referral, conduct an intake, or assist with an application. All information obtained during an interview will be deemed confidential.

5.1 Consumer Rights

Consumers receiving Options Counseling, and Enhanced Options Counseling must be informed of the following consumer rights during the initial contact.

1. You have the right to receive services without regard to your race, color, sex, national origin, religion or disability.
2. ADRC services are voluntary. You have the right to accept or reject ADRC services.
3. You have the right to have your preferences respected.
4. You have the right to confidentiality. Your information will be kept confidential at all times and you may have access to your information, if desired.
5. You have the right to expect ADRC staff to respect your personal dignity.
6. You have the right to choose from the services available to you.
7. You have the right to choose who provides your services.
8. You have the right to register a complaint or file a grievance without discrimination or reprisal.

Consumer Rights-Conversational Example
I'd like to briefly review your rights related to ADRC services. These services are offered to all Nebraskans and you have a right to accept or decline them at any time. We will respect your preferences and personal dignity, including keeping your information confidential. You can choose the services you receive and choose who provides them. You may file a complaint or grievance regarding ADRC services at any time. If you'd like a written copy of your rights, let me know and I will provide them for you.

6 Information Technology

All ADRC staff are required to utilize the Dashboard to enter consumer information. Specific instructions for the Dashboard are located in the ADRC Dashboard Manual.

- Each contact must be logged on the Dashboard.
- Consumer identifying information (name and AAA) must be entered on the Dashboard by the close of business on the day contact was made.
- All other consumer information must be entered on the Dashboard within two business days following the contact.
- In the absence of ADRC staff, each individual site determines staff coverage procedures.

7 ADRC Services

ADRC services consist of:

- Basic Information
- Information & Referral (I&R)
- Options Counseling
- Enhanced Options Counseling

A work flow chart graphically depicting the delivery of ADRC services is included in Attachment C and is described below. A table with a description of the ADRC services is included in Attachment D.

7.1 Eligible Individual

LB 320 defines an eligible individual for ADRC services as:

> "a person who has lost, never acquired, or has one or more conditions that affect his or her ability to perform basic activities of daily living that are necessary to live independently."

Eligible individuals are referred to as consumers. ADRC services are conducted with the consumer and/or legal representative and others as invited by the consumer or legal representative.

7.2 Initial Contact

Initial contact may be initiated by a consumer, consumer's caregiver, friend or relative or an agency representative calling on behalf of a consumer. During the initial contact, ADRC staff determines if the consumer in question is potentially in need of LTSS or simply needs basic information regarding community resources.

At all times, ADRC staff strive to:
• Ensure the consumer/caller experiences a welcoming atmosphere and is satisfied with the interaction. • Use telephone or interpersonal skills (professional greeting, warm tone of voice, courteous and appropriate language) and interviewing techniques using active listening skills over the phone or in-person to build rapport, with an unhurried attitude.

7.3 Basic Information

If the consumer requests only community resource or provider basic information such as location, business hours, or phone numbers, ADRC staff provides the information requested. The contact is logged on the Dashboard as 'Basic Information' and ADRC staff's pilot site (AAA) noted. The individual's name may or may not be collected. Basic Information requests are typically handled via phone conversation.

7.4 Intake & Triage

During Intake and Triage, ADRC staff determine if the consumer is eligible for the ADRC program. This is accomplished by asking the following questions:

- "Do you or the individual you are calling about have a disability?"
- "What is the nature of the disability?"
- "Do you or the individual you are calling about have difficulties with activities of daily living such as walking, dressing, bathing, hygiene, eating, transferring in and out of a bed or chair, toileting?"

The consumer's <u>self-reported condition</u> (or that reported by the caller) must be recorded on the Dashboard to verify eligibility for the ADRC program. Some consumers will have more than one disability and all conditions that apply must be noted. If "Other", the condition is noted in the Notes section.

If the consumer has a disability or difficulty with ADLs, ADRC staff then seek as much information as possible regarding the consumer's concerns, preferences, current situation, and needs and asks how they can help. At a minimum, ADRC staff determine the following:

- Is the consumer experiencing an immediate crisis or safety issue?
- What is the age of the consumer?
- What is the consumer's basic income and asset status (financial pre-screening)?
- Are service needs currently being met by another agency?
- Is the consumer likely to be Medicaid eligible?
- What amount and type of support seems to be needed?
- What are the consumer's preferences for LTSS?

Consumer information is logged on the Dashboard Caller and Consumer Information screens at this time. From this interview, ADRC staff documents the consumer's preferences, strengths and needs. Specific instructions regarding Dashboard entries are addressed in the ADRC Dashboard Manual.

ADRC staff determine the consumer's need for either Information & Referral or Options Counseling. ADRC staff may at first believe the consumer needs only I&R, but later recognize that Options Counseling is more appropriate. If the consumer requires Options Counseling, ADRC staff enter information, as appropriate, on the Dashboard Options Counseling module.

Protection and Safety

If there is reason to believe the consumer's immediate safety is threatened, call 911.

If there is reason to believe the consumer has been abused, neglected or exploited:

Call the 24-hour Adult Protective Services (APS) and Child Protective Services (CPS) toll-free hotline at:
1-800-652-1999

OR, call local law enforcement.

7.5 Information & Referral (I&R)

I&R is designed for consumers who desire information about LTSS and need assistance with referrals. They may be potentially eligible for LTSS, may already be receiving Medicaid or services through another LTSS program, or may be receiving no services.

I&R consists of providing information and assistance on a wide range of community resources; informing and educating consumers, families, advocates, and professionals about LTSS options; and assisting in connecting to programs and services, including public and privately funded options. ADRC staff serve as trusted sources of information regarding publicly funded programs and promote the use of home and community-based LTSS based on consumer preference. Consumers receiving I&R explore their options and may follow up with suggested LTSS referrals independent of ADRC staff. I&R may be offered in person or via phone conversation.

Essential I&R Service Components

- Information: ADRC staff provide information to a consumer in response to a direct request concerning LTSS. Information provided may range from simply describing a variety of LTSS options to detailed information about eligibility and referral processes.

- Referral: Based on consumer or caller preference, ADRC staff may perform any or all of the following referral activities:
  - Explore consumer needs and preferences
  - Identify potential community-based resources and service systems, utilizing the ADRC Network of Care website and other resources
  - Provide information on how to contact community-based resources and service systems
  - Assist consumers for whom services are unavailable by locating alternative resources
  - Provide a warm transfer to a community-based provider or service system to directly connect the consumer or caller to the provider or system representative
  - Provide referral information regarding privately funded LTSS

- I&R Summary Form: ADRC staff offer to complete an I&R Summary Form, print referrals from the Dashboard or provide other available printed material that captures information regarding suggested referral sources, along with additional information that may assist the consumer when contacting the organization. If the consumer wishes to receive referral information, it is mailed or emailed to them within three business days of the contact. The I&R Summary Form, along with instructions on completing the form and a sample cover letter, is located in the ADRC Forms Manual.

- Follow Up: ADRC staff offer to call the consumer at an agreed upon time to perform a follow-up inquiry. Consumers are encouraged to contact ADRC staff at any time if they have further questions or concerns. All follow up agreements are documented on the Dashboard. All attempts to follow-up with consumers must be documented, whether successful or not. If unsuccessful, ADRC staff document why the contact was unsuccessful such as consumer unavailable, wrong phone number, or consumer requested a call back later. After three unsuccessful contact attempts, the consumer is discontinued from the ADRC program and status is documented in follow-up notes.

7.6 Options Counseling (OC)

Options Counseling is a natural extension of the I&R process. Options Counseling is a decision-support process whereby consumers are assisted to evaluate and weigh their LTSS options. It is designed for consumers who have little knowledge about their LTSS options and limited capability in pursuing LTSS independently. They most likely have not received LTSS services in the past and find themselves at a loss of where to turn for help. ADRC staff work with them to explore their LTSS options (both publicly and privately funded) and provide hands-on assistance in applying and securing LTSS services. Services are most typically provided in a face-to-face setting, such as an ADRC office or the consumer's home.

To be effective in providing this service, it is important to fully understand each individual's strengths, preferences, and needs. This service is focused on consumer education and is often provided when an individual is planning for or experiencing a life change. Indicators for the need for Options Counseling may include those who are:

- Seeking information and/or decision support about LTSS options
- Demonstrating a change in ability to meet needs independently at home
- Requesting assistance with planning, whether short or long term
- Requesting someone to "talk to" about what they or a loved one needs/wants
- Not Medicaid eligible and seeking information on long-term options and costs
- Medicaid eligible and requiring additional supports
- Seeking information on how to apply for Medicaid
- Needing considerable time and assistance in sorting out their LTSS options
- Asking more questions with every referral given
- Unsure of their wants and needs

Essential Service Components

- Rights & Disclosures: ADRC staff must:
    - Inform consumers of their rights, obtain verbal agreement that they understand their rights, and offer to email or mail them a copy of their rights (see 5.1). ADRC staff must indicate on the Dashboard that they have informed the consumer of their rights.
    - If confidential information is to be provided to or received from a source outside of the ADRC, follow AAA procedures in procuring a signed consent.

- Consumer Information Gathering: Based on consumer preference, ADRC staff perform any or all of the following:
    - Collect additional information regarding the consumer's status and preferences; including information from past or current providers, caregivers, relatives, friends, etc.
    - Gather sufficient information from the consumer to accurately identify and clarify the consumer's strengths, needs, and preferences.
    - Explore consumer needs beyond the presenting problem.
    - Check in with the consumer and summarize their request.

- Individual Action Plan (IAP): The IAP Form, along with instructions on completing the form and a sample cover letter, is located in the ADRC Forms Manual. An IAP is also available on the Dashboard Options Counseling Module. The Options Counselor develops an effective consumer-driven plan with the consumer, using either the IAP Form or the Dashboard Options Counseling Module version, which can be printed. The IAP is mailed or emailed to the consumer within **five business days** of the contact.

- Assisting Consumer with Acquiring LTSS Services: Based on consumer preference, ADRC staff perform any or all of the following:
  - Utilize system knowledge, assisted by the use of the ADRC Nebraska website and other Nebraska resources, to identify, evaluate, and recommend potential programs and services.
  - Provide LTSS options and help consumer to prioritize options.
  - Provide specifics on eligibility and the process to apply for public and private LTSS.
  - Assist the consumer in communicating with LTSS agencies and applying for LTSS of their choice.

- Follow-Up: Based on consumer preference, ADRC staff perform any or all of the following:
  - Assist in connecting with a resource if consumer is unable to do so independently or requests assistance.
  - Provide advocacy throughout the process of selecting and applying for services and supports.
  - Review the IAP with the consumer to ensure all goals are met or to revise goals, as needed.
  - Follow-up with consumers at agreed upon dates/times/locations.

Consumers are encouraged to contact ADRC staff at any time if they have further questions or concerns. All follow up agreements are documented on the Dashboard. All attempts to follow-up with consumers must be documented, whether successful or not. If unsuccessful, ADRC staff document why the contact was unsuccessful such as consumer unavailable, wrong phone number, consumer requested a call back later. After three unsuccessful contact attempts, the consumer is discontinued from the ADRC program and status is documented in follow-up notes.

7.7 Enhanced Options Counseling Pilot

An Enhanced Options Counseling Pilot will be conducted in two ADRC pilot sites: Aging Partners and South Central Nebraska Area Agency on Aging. The pilot is designed for a sample in each site consisting of:

- Four (4) consumers under 60 with disabilities who are not currently eligible for care/case management from any other LTSS program; and
- Four (4) consumers over sixty referred to an AAA Care Management program.

The pilot is period is January 1, 2017 through June 30, 2018.

Essential Service Components

- Comprehensive Assessment: Care Managers or ADRC staff conduct a comprehensive assessment with the consumer in addition to recording information on the Dashboard. The comprehensive assessment utilized will be the standardized long-term care assessment currently in use by AAA Care Management programs.

- Individual Comprehensive Action Plan (ICP): The ICP is based on the person-centered planning philosophy and reflects the services and supports that are important **for** the consumer to meet the needs identified through the Care Management Assessment as well as what is important **to** the consumer with regard to preferences for the delivery of such services and supports. The ICP is to be completed after the Care Management Assessment has been administered. Documentation must be written in first person language to paint the picture of telling their story in their own words. Others may be involved in developing the plan, such as a legal representative, as desired by the consumer.

- Care Management: Within the pilot sites for Enhanced Options Counseling, Care management will be provided by either ADRC or AAA Care Management staff and be delivered according to the most current version of Care Management Title 15 NAC 2 Regulations. It is delivered on a one-on-one basis most typically in the consumer's home. Care Management activities include:
  - Conducting the comprehensive assessment;
  - Developing the ICP;
  - Assisting with referrals/applications to LTSS programs;
  - Coordinating services among providers; and
  - Providing follow-up and reassessment as needed.

Person-Centered Planning Philosophy
Person-centered planning is a discovery process used to search out what is truly important to and about a person and what capacities and skills that individual possesses. It is values-based with the knowledge that each and every individual has unique capacities and skills. It focuses on a positive vision for the future of the person based on his or her strengths, personality, preferences, and capacities for acquiring new skills and abilities. It focuses on what a person can do versus what a person cannot do.

7.8 Unmet Needs

Unmet needs are any type of public or private service, which aids the consumer to remain in the community of their choice and is not available to them. Consumers may have one or more unmet needs. Unmet needs may be due to a multitude of issues including: financial ineligibility, lack of personal funds, no service within the community

in which the consumer lives, service doesn't exist, waiting lists for services, etc. The collection of unmet needs will assist service systems to potentially address them in the future. The collection and evaluation of unmet needs is an ADRC pilot service which must be provided. ADRC staff are required to document consumer unmet needs on the Dashboard.

8 Accommodations

ADRC sites are committed to ensuring services and information are made available to all consumers and their representatives. Accommodations may be necessary to fulfill this commitment.

8.1 Language Accommodations

Language accommodations may be necessary for consumers and representatives, including those with limited English proficiency and individuals who may have physical, hearing, speech, visual, or cognitive impairments, which require special accommodations.

- For non-English speaking or limited English speaking consumers, services such as Language Line or interpreters shall be arranged with advanced notice.
- ADRC documents distributed to the public shall be made available in Spanish.
- Sign language interpreters shall be made available with advance notice for all ADRC services.

8.2 Hearing Accommodations

Individuals who are deaf, hard of hearing, or have a speech impairment may utilize a Video Relay Service (VRS) or Teletype (TTY) device to assist in communicating over the phone.

The TTY uses a free relay service, required of each state. The relay service is accessed by dialing 7-1-1. If an ADRC receives a call from a TTY device, the relay service will receive the caller's responses, and speak for them to the ADRC staff. In turn, the relay service will relay the ADRC staff's responses to the caller. If an ADRC staff member needs to call a person who is deaf, hard of hearing, or has a speech impairment and that person has a video TTY device, they may dial 7-1-1 before the phone number they are trying to reach.

The Video Relay Service allows persons who are deaf or hard-of-hearing to communicate through the telephone system with hearing persons. The VRS caller, using a television or a computer with a video camera device and a broadband (high speed) Internet connection, contacts a VRS qualified sign language interpreter. They communicate with each other in sign language through a video link. The interpreter then places a telephone call to the party the user wishes to call. The interpreter relays the conversation back and forth between the parties -- in sign language with the VRS user,

and by voice with the called party. No typing or text is involved. A voice telephone user can also initiate a VRS call by calling a VRS center, usually through a toll-free number. For more information or to contact the Nebraska Commission for the Deaf and Hard of Hearing with questions, go to: https://ncdhh.nebraska.gov

9 Outreach & Marketing

ADRC pilot sites are required to develop and implement an ongoing program of marketing, outreach, and public education to make their services known to members of the target populations, including people who are isolated or otherwise hard to reach, and to community agencies and services providers in its service area. It is understood that all ADRC pilot sites will participate in the marketing plan. All publications or resources will use the approved ADRC Nebraska logo. ADRCs should also coordinate with other sites to minimize duplication and be most cost effective. The following are best practice ideas and examples of what to include in such a program.

Outreach & Marketing Best Practice

General Principles

- Have a clear, simple message, be consistent, & use a variety of marketing methods.
- Use more than one method at a time. Keep it up. Try continuous marketing in several venues.
- Try new things & repeat successful efforts that increase call volume.
- Word-of-mouth is very important, and takes time to build.

Marketing to Medical Community

- Visit and introduce yourself and your services to physicians, nurses, emergency room staff, first responders, hospital discharge planners, social workers, home health care agencies, home and community-based service providers, etc.
- Provide information packets to each provider so they know how to reach ADRCs.
- Routinely revisit to restock materials, as well as continue to build relationships.

Internal Marketing

- Educate and involve people who work for and with the ADRC on a regular basis.
- Make sure people in all departments of your agency know about the ADRC, what it is, and what services are available.
- Provide training to receptionists and all front desk staff so they understand the ADRC, the services provided, and the protocols for accessing ADRC staff.
- Encourage ADRC staff to become actively involved in community organizations.

Presentations to Community Groups

Presenting to existing groups generally works better than hosting your own presentations. Be available when the groups meet. This may include, but is not limited to:

  - Consumer groups
  - Service providers
  - Chamber of Commerce
  - Health and wellness fairs
  - Employee assistance and other employer-sponsored programs
  - Religious organizations
  - High school counselors and special education staff
  - Village councils and other local boards
  - Police departments, fire departments, and EMS

- Train volunteer drivers and other transportation providers about the ADRC.
- Train home-delivered meal providers. Encourage them to provide information about the ADRC to people who are new to their services.

All ADRC staff should remember that they are “selling” the services of the ADRC in their conversations with others, both in the office and in the community. All ADRC staff should have the opportunity at least once annually to represent the ADRC at a presentation, health expo, support group, media interview, or other “marketing” event.

10 Local Partnerships

The ADRC program is a long-term care systems change initiative aimed at improving and streamlining access to information, assistance and LTSS. ADRC sites must form strategic partnerships at the local level. This may include developing working

relationships with local health and human service agencies, service providers, and other private partners. These partnerships should include a range of agencies and organizations such as:

- Centers for Independent Living
- Aging and Disability Service Providers
- Employment
- Housing
- Transportation
- County Social Services
- Advocacy Groups
- LTSS Providers (e.g., home health agencies, nursing facilities)
- Critical pathway providers (e.g., hospital discharge planners, physicians, pharmacies)
- Universities where students actively seek opportunities in the community to volunteer and engage in service learning activities

11 Quality Assurance

ADRC services are designed to impact consumers and their families, as well as communities and systems. Following are principles to guide the ADRC Quality Assurance process:

- Consumers and families served by the ADRC are more satisfied with their lives, able to remain in their homes and communities, become more independent, and have control over their lives.
- Communities benefit from the ADRC through cooperative efforts to build services, provide education, and link people to services.
- ADRC staff works with systems partners to achieve the right fit for each consumer based on the consumer's preference.

11.1 Consumer Satisfaction Surveys

Consumer Satisfaction Surveys are designed to gather feedback on the experience of participants who have interacted with an ADRC. The Satisfaction Survey forms, along with instructions for use, are located in the ADRC Forms Manual.

Based upon the following sampling process, the Options Counselor asks the consumer and/or representative if they will agree to complete a Satisfaction Survey. Completion is optional. If declined, the OC documents this in the Notes section of the Dashboard.

Sampling is completed as follows:

- Basic Information: 0%
- Information and Referral: 100% of those receiving emailed I&R Summary
- Information and Referral: 50% of those receiving mailed I&R Summary

- Options Counseling: 100%
- Enhanced Options Counseling: 100%

As per consumer preference, the survey is sent by mail (with a stamped, self-addressed envelope) or via email with a link to an automated survey. For I&R consumers, the survey is sent within two weeks of the date of service. For those receiving Options Counseling, it is sent within two weeks of when the OC case is closed.

Returned surveys are entered into the automated survey system on a monthly basis. A sampling of completed surveys may be reviewed as part of the Quality Assurance process to ensure consistency and accuracy of entries.

Consumer Satisfaction Best Practices

- ADRC services provide guidance, meaning that each step is explained clearly; the consumer receives help navigating the system; they feel their needs are important and that staff go "above and beyond" to help them.
- ADRC services are accessible, referring to: hours of operation; parking; a welcoming environment; privacy in talking with ADRC staff; limited waiting time; convenient locations; accessibility to services; responsiveness of staff; and ease in finding contact information.
- ADRC services support decision making, meaning that consumers are connected with the services they need; receive help exploring choices available; receive help weighing pros and cons of each choice; and feel their personal circumstances are taken into account.
- ADRC services are customized, meaning a consumer's special circumstances are addressed; their opinions are considered before recommending services; they receive help in making decisions and with paperwork; and needs of their family are considered.

11.2 Quality Assurance Plan

The Quality Assurance (QA) Team will develop strategies to improve ADRC services based on a review of the Performance Measures. Reviews will occur at QA meetings held on a monthly basis.

11.3 Complaint & Grievance Policies

The ADRC is committed to the provision of high quality services delivered in a manner that insures that the rights of consumers are protected. Consumers of the ADRC have the right to file a complaint/grievance if they are not satisfied with the service they receive. Each ADRC site has internal processes for a grievance procedure. The following is a guideline for ADRC staff to follow in the event of consumer concern or complaint.

Informal Process: Consumers should be encouraged to discuss concerns regarding ADRC services informally with the staff person involved and their supervisor. They may include a personal advocate if they wish. A “concern” means a complaint, disagreement or dispute which a consumer or a person on behalf of a consumer may have with ADRC services or staff that the consumer chooses to resolve through the informal resolution process.

Formal Process: Formal complaints or grievances must be in writing. The complaint or grievance must clearly describe the concern, the time and place of the incident, those involved, names of witnesses (if any), and the relief the consumer is seeking. The complaint must be signed and dated by the consumer. The consumer may have a personal advocate or staff person assist them in completing the formal complaint report. Consumers will be provided the appropriate grievance/compliant form from their respective ADRC site.

11.4 Consumer Review

The purpose of the ADRC Consumer Review is to provide opportunities for ADRC staff and disability partners to assist each other in locating community-based resources for individuals requesting assistance from an ADRC. The review process facilitates learning about different populations, their needs, and resources available throughout the state as well as an opportunity to consistently deliver ADRC services.

Participant Roles:

- ADRC staff from each of the pilot sites choose and present information regarding consumer calls or referrals they’ve received.
- Disability partners and ADRC staff provide input on potential resources and strategies regarding the situation presented.
- ADRC Project Coordinators set up the review schedule and facilitate the conference call.

Frequency: Consumer Reviews occur on the 3rd Tuesday of each month. ADRC pilot sites will be asked to present information regarding a consumer situation every other month. In addition, requests may be made for additional reviews of difficult situations.

Format: The following information is provided by the ADRC staff presenting the Consumer Review. To protect confidentiality, individual names or other identifying information are not to be mentioned during the call.

- Demographic information including age, gender, ethnicity
- Disability
- Description of current living situation and assistance provided within the home, if any
- Consumer strengths, needs, and preferences

- Informal and formal services and supports
- Needed/requested services and supports
- Challenges and successes

Once the above information is presented, conference call participants discuss potential resources and strategies.

Follow-Up: The ADRC staff presenting the Consumer Review provides an update at the next Consumer Review meeting noting progress or lack of progress. If necessary, the consumer case is reviewed again by the entire group until an acceptable resolution is reached.

12 Definitions

Individual Action Plan (IAP): A written, time limited plan developed by the consumer and the ADRC staff outlining future work and/or the steps necessary to achieve goals or obtain long term services and supports that have been identified during the process.

Aging and Disability Resource Center (ADRC): ADRCs are designed to serve as highly visible and trusted places available in communities across the state where people of all ages, incomes, and disabilities can get information and counseling on the full range of Long Term Service and Support (LTSS) options. The overall goal is to enhance the existing infrastructure at the local level to increase consumer access to information and services for LTSS and supports in a comprehensive, flexible, and cost effective manner.

Activities of Daily Living (ADL): Activities that are regularly necessary for personal care. These activities include: transfers in and out of a bed or chair, toileting, walking, dressing, bathing, hygiene, and eating.

Advocacy: Advocating or representing the upholding of rights for individuals or specific groups of individuals.

Assessment: To evaluate the consumers' needs, beginning with the initial communication (e.g., telephone call, e-mail, or walk-in).

Basic Information: Service where the consumer, representative, or agency professional requests only community resource or provider basic information such as location, business hours, or phone numbers. Typically, this is provided via phone.

Business Days: Monday through Friday, not including weekends or holidays.

Caregiver: An individual, such as a spouse, partner, family member, or friend who attends to the needs of another individual. Activities can be relatively undemanding, such as driving the individual to an appointment or the activities can be highly demanding, such as bathing, dressing, and feeding the individual.

Comprehensive Assessment: A more in-depth assessment provided for consumers receiving Enhanced Options Counseling

Consumer: Any individual 60 years of age or older or an individual with a disability of any age who has lost, never acquired, or has one or more conditions that affect his or her ability to perform basic activities of daily living necessary to live independently.

Eligibility Determination: The process of evaluating the financial or programmatic parameters an individual must meet in order to receive services.

Dashboard: The mandated electronic system in which ADRC sites are required to enter consumer data utilized for local and state-level reports and management information.

Enhanced Options Counseling: A service provided under a limited pilot area (Aging Partners and South Central AAA) for consumers under 60 with disabilities not currently eligible for care/case management under any other LTSS program and consumers over 60 referred to a AAA Care Management program. This service offers more extensive services and supports than the Options Counseling service.

Follow Up: A contact with the consumer or designated representative to evaluate the usefulness of services and any barriers to achieving his or her goal, to determine if the identified goals were met, or to determine next steps.

Grievance: A complaint or formal objection about the way services are provided.

Information & Referral (I&R): Information provided to individuals who have contacted the ADRC site with a specific question or need regarding available services and/or referral to other agencies.

Informed Choice: The process of choosing from options based on accurate information and knowledge.

Instrumental Activities of Daily Living Skills (IADLS): Activities necessary for independent living including: meal preparation, shopping, medication management, housework, laundry, appointment management, money management, access resources, transportation and telephone.

Intake: The process of collecting and documenting basic demographic data and initial eligibility screening for services.

Legal Representative: A person who oversees the legal affairs of another. This includes a court appointed guardian of a minor or a person determined incompetent.

Long Term Services & Supports (LTSS): As defined by the Centers for Medicare and Medicaid (CMS), LTSS refers to services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice. This may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Low-Income: Income at or below the Federal Poverty Level (FPL).

Marketing/Outreach: Activities related to ensuring that all potential users of LTSS and their families are aware of public and private long-term support options, as well as to promote awareness of the ADRC, especially among underserved and hard-to-serve population.

Medicare: A federal program that pays for certain health care expenses for people aged 65 or older, persons with end stage renal disease and some younger persons with disabilities. Enrolled individuals must pay deductibles and co-payments, but much of their medical costs are covered by the program. Medicare is less comprehensive than some other health care programs, but it is one source of post-retirement health care.

Medicaid: The State and Federal Government program that pays for certain health services and nursing home care for older people with low incomes and limited assets. In most states, Medicaid also pays for some long-term care services at home and in the community. Who is eligible and what services are covered vary from state to state. Most often, eligibility is based on income and personal resources.

Network of Care: The online system for the ADRC, including the Dashboard for recording and tracking consumer information and a Service Directory that provides a comprehensive database of state and local programs and services.

Options Counseling: Person-centered approach to helping individuals gain an understanding of the benefits and limitations of LTSS options, and the knowledge to access these resources in order to empower them to make choices that reflect their unique needs, values, and circumstances.

Person-Centered Planning (PCP): The process to develop an individualized support plan driven by an individual's own preferences, strengths and personal goals, as well as directed by the consumer and/or their representative.

Private Pay Consumers: Includes consumers who are able to pay for some services and/or are ineligible for public programs. Consumers with a range of incomes fall under this definition, including the following: eligible for public programs but able to pay for some services on a sliding scale or reduced fee basis; not eligible for public programs and unable to purchase services; not eligible for public programs but able to pay for some services on a sliding scale or reduced fee basis; and not eligible for public programs and able to purchase services at market value.

Quality Assurance: System for evaluating the delivery of services to consumers.

Representative: An individual who is chosen to assist or to act on behalf of an individual seeking ADRC services in making decisions regarding LTSS. This may be an informal designation, as opposed to a court-appointed legal representative.

State Unit on Aging (SUA): State unit designated to administer the ADRC Pilot Project. This agency is housed within the Nebraska Health and Human Services Medicaid and Long Term Care Division.

Unmet Need: Any type of public or private service, which aids the consumer to remain in the community of their choice and is not available to them. Consumers may have one or more unmet needs.

Attachment A. ADRC Contact Information

✓ **ADRC TOLL-FREE**: 1-844-843-636

✓ **BEATRICE**:

Blue Rivers Area Agency on Aging
103 Eastside Blvd.
Beatrice NE 68310
402-223-1376 888-317-9417 (toll free)
http://www.braaa.org

✓ **HASTINGS**:

Midland Area Agency on Aging
2727 West 2nd Street, Suite 440
Hastings NE 68901
402-463-4565 800-955-9714 (toll free)
http://www.midlandareaagencyonaging.org

✓ **KEARNEY**:

South Central Nebraska Area Agency on Aging
620 East 25th Street, Suite 12
Kearney NE 68847
308-234-1851 800-658-4320 (toll free)
http://www.agingkearney.org

✓ **LINCOLN**:

Aging Partners
1005 O Street
Lincoln NE 68508
402-441-7070 800-247-0938 (toll free)
https://lincoln.ne.gov/city/mayor/aging

✓ **NORFOLK**:

Northeast Nebraska Area Agency on Aging
119 West Norfolk Avenue
Norfolk NE 68701
402-370-3454 800-672-8368 (toll free)
http://www.nenaaa.com

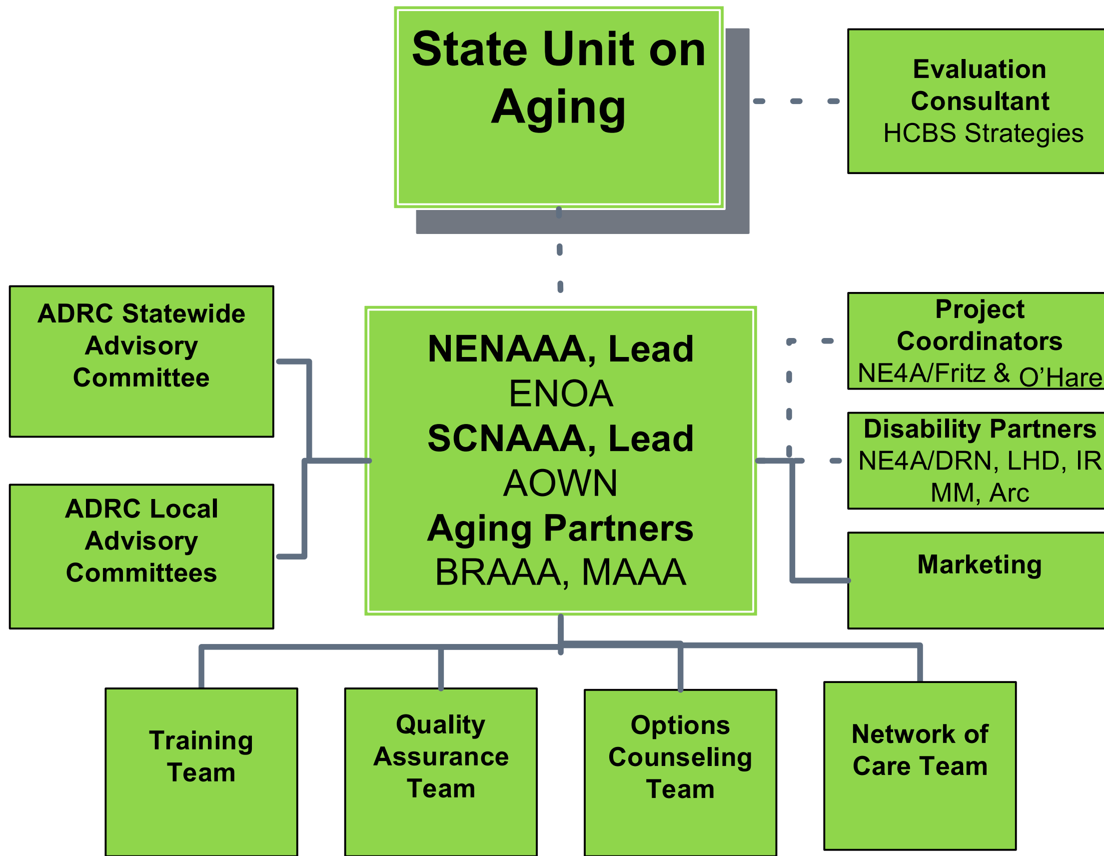
✓ **OMAHA**:

Eastern Nebraska Office on Aging
4780 S. 131st St
Omaha NE 68137
402-444-6536 888-554-2711 (toll free)
http://enoa.org

✓ **SCOTTSBLUFF**:

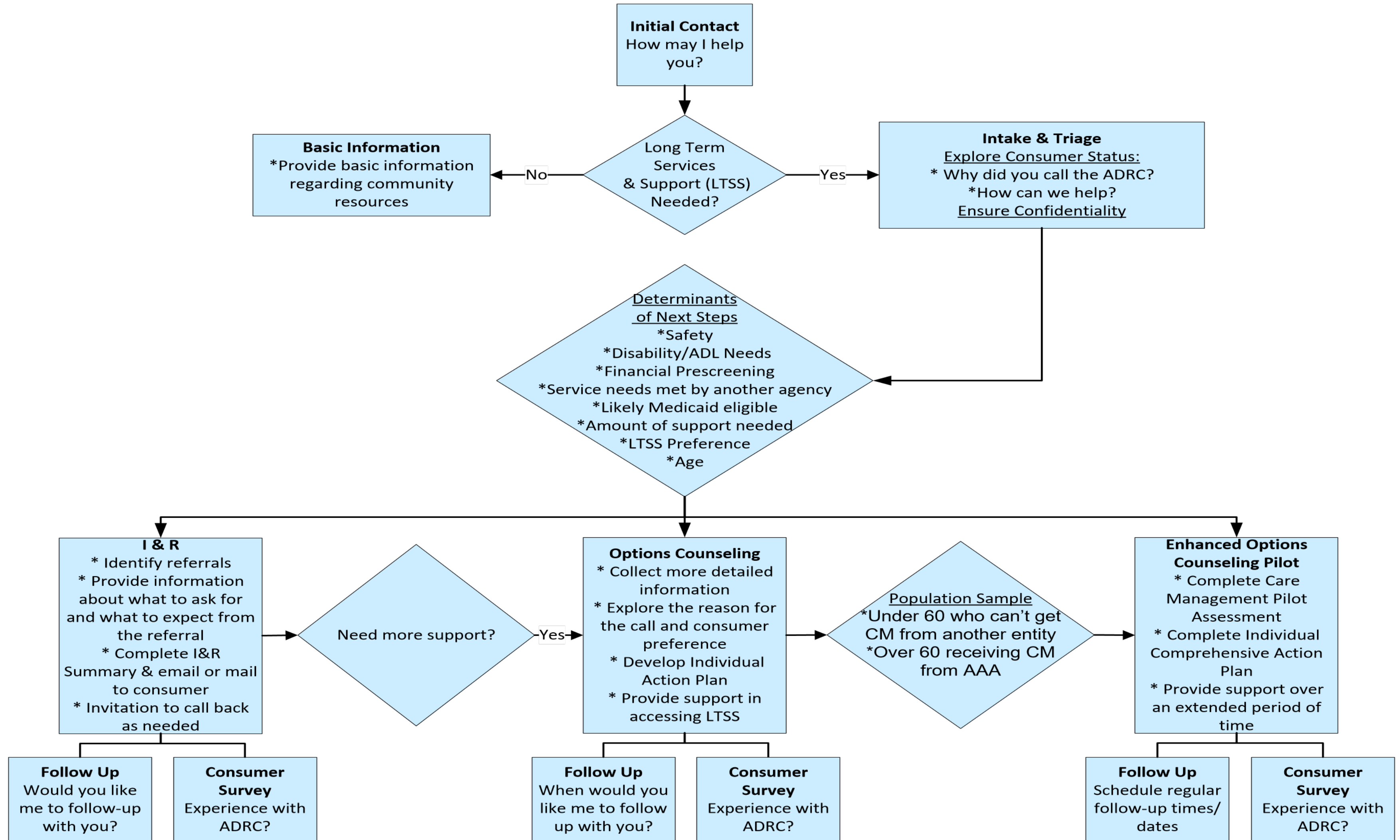
Aging Office of Western Nebraska
1517 Broadway, Suite 122
Scottsbluff NE 69361
308-635-0851 800-682-5140 (toll free)
http://www.aown.org

Attachment B. ADRC Pilot Organizational Chart



Abbreviations
NENAAA: Northeast Nebraska Area Agency on Aging
ENOA: Eastern Nebraska Office on Aging
SCAAA: South Central Nebraska Area Agency on Aging
AOWN: Aging Office of Western Nebraska
BRAAA: Blue Rivers Area Agency on Aging
MAAA: Midland Area Agency on Aging
NE4A: Nebraska Association of Area Agencies on Aging
DRN: Disability Rights Nebraska
LHD: League of Human Dignity
MM: Munroe Meyer
Arc: Arc of Nebraska
IR: Independence Rising

Attachment C. ADRC Work Flow Chart



Attachment D. ADRC Services

Work Domains	Basic Information	Information & Referral (I&R)	Options Counseling	Enhanced Options Counseling
Consumer Status	Consumer does not present as wanting anything more than specific information.	Consumer may be potentially eligible for LTSS; already be receiving Medicaid or services through another LTSS program; or receiving no services.	Consumer has little knowledge about their LTSS options and limited capability or interest in pursuing LTSS independently. They most likely have not received LTSS services in the past and find themselves at a loss of where to turn for help.	Consumers under 60 with disabilities who are not currently eligible for care/case management from any other LTSS program. Consumers over 60 referred to an AAA Care Management program.
Information Requests	Consumer requests only community resource or provider basic information such as location, business hours, or phone numbers.	Consumer seeks information about LTSS. Information provided may range from simply describing a variety of LTSS options to detailed information about eligibility and referral processes.	Consumers seek extensive information and/or decision support about LTSS options including: how to plan for the future; information about Medicaid and other LTSS eligibility, application, options, and costs; and assistance determining their wants and needs.	Consumers seek extensive information and/or decision support about LTSS options including: how to plan for the future; information about Medicaid and other LTSS eligibility, application, options, and costs; and assistance determining their wants and needs.

Work Domains	Basic Information	Information & Referral (I&R)	Options Counseling	Enhanced Options Counseling
Consumer Assistance	Information is most commonly provided over the telephone.	Consumer indicates preference for no or minimal assistance with contacting community resources and/or pursuing potential benefits.	Consumer indicates preference or demonstrates the need for hands-on assistance with contacting community resources and/or pursing potential benefits. ADRC services are provided on a face-to-face basis and home visits are common.	Consumer demonstrates the need for assistance to further explore preferences and LTSS needs. Consumer is in need of hands-on assistance in following through with referrals to LTSS and following up with selection of LTSS providers. ADRC services are provided on a face-to-face basis and home visits may be required to monitor service provision.
Number of Contacts	Most typically only one	Contact is typically only one or two contacts over a limited length of time.	Contacts are multiple over a longer period of time (typically no more than 90 days).	Contacts are multiple over a longer period of time (typically more than 90 days).
Nature of Contacts	Telephone	Telephone, email or face-to-face in the ADRC office	Telephone, email, face-to-face in ADRC office or in consumer's home	Telephone, email, face-to-face in ADRC office or in consumer's home
Assessment	None	Information on Dashboard	Information on Dashboard	Information on Dashboard Comprehensive Assessment

Work Domains	Basic Information	Information & Referral (I&R)	Options Counseling	Enhanced Options Counseling
Action Planning	None	The 'Information & Referral Summary' is completed and mailed or emailed to the consumer, if requested.	The 'Individual Action Plan' is completed with the consumer face-to-face.	The 'Individual Comprehensive Action Plan' is based on the person-centered planning philosophy and done in conjunction with the consumer.
Follow Up		Follow-up is not needed or minimal based on consumer preference.	Follow-up is ongoing until services and supports are secured by the consumer.	Follow-up and monitoring is ongoing until consumer reaches stabilization with LTSS provided.
Documenta-tion	Dashboard Information: Record AAA and designate as a Basic Information Call	• Dashboard Information • I&R Summary • Referrals • Follow Up Notes	• Dashboard Information • Consent Forms • Individual Action Plan • Referrals • Follow Up Notes	• Dashboard Information • Consent Forms • Care Management Comprehensive Assessment • Individual Comprehensive Action Plan • Referrals • Follow Up Notes

APPENDIX 2: ADRC ADVISORY COUNCIL STRUCTURE AND MEMBERSHIP

Appendix 2: ADRC Advisory Council Structure and Membership

This Appendix provides membership, attendees, and structure of the Statewide Advisory Council.

ADRC Statewide Advisory Committee

Agency	Representative	E-mail
AARP	Jina Ragland	jragland@aarp.org
Arc of Nebraska	Edison McDonald	edison@arc-nebraska.org
Brain Injury Alliance	Peggy Reisher	peggy@biane.org
DD Council	Kristen Larsen	kristen.larsen@nebraska.gov
Developmental Disabilities Division	Tony Green	tony.green@nebraska.gov
DHHS-Lifespan Respite/DPFS	Sharon Johnson	sharon.J.Johnson@nebraska.gov
Disability Rights Nebraska	Brad Muerrens	brad@drne.org
Division of Behavioral Health	Jude Dean	jude.dean@nebraska.gov
Early Development Network	Julie Docter/ Laurie Miller	laurie.miller@nebraska.gov
Easter Seals	Angie Howell	ahowell@ne.easterseals.com
Independence Rising	Irene Britt	ibritt@cilne.org
League of Human Dignity	Mike Schafer Kathy Kay	mschafer@leagueofhumandignity.com kkay@leagueofhumandignity.com
Legislature/NASP	Kate Bolz	bolznasp@gmail.com
Medicaid	Kathy Scheele Karen Houseman	kathy.scheele@nebraska.gov karen.houseman@nebraska.gov
Munroe-Meyer	Mark Smith	msmitha@unmc.edu
NCBVI	Larry Roos	Larry.roos@nebraska.gov
NCDHH	John Wyvill	john.wyvill@nebraska.gov
PTI	Nina Baker	nbaker@pti-nebraska.org
Statewide Ind. Living Council	Kathy Hoell	kathy@nesilc.org
VR	Keri Bennett	keri.bennett@nebraska.gov
AAA Directors	Cheryl Brunz Rod Horsley Connie Cooper Casey Muzik	

8.8.18

	Randy Jones Zoe Olson Dennis Loose	
SUA Reps	Cynthia Brammeier Doug Bauch Amy Hochstetler	

APPENDIX 3: REGIONAL ANALYSIS OF THE I&R AND OC PARTICIPANT SURVEYS

Appendix 3: Regional Analysis of the I&R and OC Participant Surveys

Appendix 3 Exhibits 1-4 provide a regional analysis of the following items from the I&R Participant survey:

- 2A- I am better informed about options for services and supports
- 2B- I was given objective, accurate, and complete information
- 2C- The referral(s) were helpful
- 2D- I was clear on how to contact the referral(s) and what to ask for

EXHIBIT 1- I&R ITEM 2A RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%	0%	0%	6%	0%	0%
2 Disagree	0%	0%	12%	0%	2%	3%	0%
3 Neither Agree nor Disagree	0%	0%	12%	0%	2%	0%	0%
4 Agree	0%	0%	41%	50%	50%	30%	27%
5 Strongly Agree	0%	100%	35%	50%	39%	67%	73%
# Responses Received	0	11	1	17	12	82	33
Average Score	0	4.7	5.0	4.0	4.5	4.1	4.6

EXHIBIT 2- I&R ITEM 2B RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree		0%	0%	0%	0%	6%	0%
2 Disagree		0%	0%	12%	0%	2%	0%
3 Neither Agree nor Disagree		0%	0%	6%	0%	2%	3%
4 Agree		27%	0%	47%	42%	46%	24%
5 Strongly Agree		73%	100%	35%	58%	43%	73%
# Responses Received	0	11	1	17	12	82	33
Average Score	0	4.7	5.0	4.1	4.6	4.2	4.7

EXHIBIT 3- I&R ITEM 2C RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA

APPENDIX 3: REGIONAL ANALYSIS OF THE I&R AND OC PARTICIPANT SURVEYS

1 Strongly Disagree		0%	0%	6%	0%	5%	0%
2 Disagree		0%	0%	12%	0%	3%	3%
3 Neither Agree nor Disagree		0%	0%	12%	25%	5%	9%
4 Agree		18%	0%	29%	0%	52%	15%
5 Strongly Agree		82%	100%	41%	75%	35%	73%
# Responses Received	0	11	1	17	4	77	33
Average Score	0	4.8	5.0	3.9	4.5	4.1	4.6

EXHIBIT 4- I&R ITEM 2D RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree		0%	0%	0%	0%	6%	3%
2 Disagree		0%	0%	7%	0%	3%	0%
3 Neither Agree nor Disagree		0%	0%	7%	33%	8%	3%
4 Agree		18%	0%	53%	0%	45%	27%
5 Strongly Agree		82%	100%	33%	67%	38%	67%
# Responses Received	0	11	1	15	3	77	33
Average Score	0	4.8	5.0	4.1	4.3	4.1	4.5

Appendix 3 Exhibits 5-10 provide a regional analysis of the following items from the OC Participant survey:

- 2A- I am better informed about options for services and supports
- 2B- I was given objective, accurate, and complete information
- 2C- I was actively involved in developing my Individual Action Plan (IAP)
- 2D- My IAP reflects what is important to me
- 2E- Before I contacted the ADRC I was considering going into a nursing facility or other institution as an option
- 2F- My IAP will help me stay in my home or community setting

EXHIBIT 5- OC ITEM 2A RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%		0%		0%	0%
2 Disagree	0%	0%		0%		0%	0%
3 Neither Agree nor Disagree	0%	0%		0%		0%	0%
4 Agree	0%	0%		0%		57%	0%

APPENDIX 3: REGIONAL ANALYSIS OF THE I&R AND OC PARTICIPANT SURVEYS

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
5 Strongly Agree	100%	100%		100%		43%	100%
# Responses Received	2	3	0	1	0	7	2
Average Score	5.0	5.0		5.0		4.4	5.0

EXHIBIT 6- OC ITEM 2B RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%		0%		0%	0%
2 Disagree	0%	0%		0%		0%	0%
3 Neither Agree nor Disagree	0%	0%		0%		0%	0%
4 Agree	0%	33%		0%		71%	0%
5 Strongly Agree	100%	67%		100%		29%	100%
# Responses Received	2	3	0	1	0	7	2
Average Score	5.0	4.7		5.0		4.3	5.0

EXHIBIT 7- OC ITEM 2C RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%		0%		0%	0%
2 Disagree	0%	0%		0%		0%	0%
3 Neither Agree nor Disagree	0%	0%		0%		17%	0%
4 Agree	0%	33%		0%		67%	0%
5 Strongly Agree	100%	67%		100%		17%	100%
# Responses Received	2	3	0	1	0	6	2
Average Score	5.0	4.7		5.0		4.0	5.0

EXHIBIT 8- OC ITEM 2D RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%		0%		0%	0%
2 Disagree	0%	0%		0%		0%	0%
3 Neither Agree nor Disagree	0%	0%		0%		20%	0%
4 Agree	0%	33%		0%		60%	0%
5 Strongly Agree	100%	67%		100%		20%	100%

APPENDIX 3: REGIONAL ANALYSIS OF THE I&R AND OC PARTICIPANT SURVEYS

# Responses Received	2	3	0	1	0	5	2
Average Score	5.0	4.7		5.0		4.0	5.0

EXHIBIT 9- OC ITEM 2E RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%		0%		20%	50%
2 Disagree	0%	33%		0%		0%	0%
3 Neither Agree nor Disagree	50%	0%		0%		60%	50%
4 Agree	0%	0%		0%		20%	0%
5 Strongly Agree	50%	67%		100%		0%	0%
# Responses Received	2	3	0	1	0	5	2
Average Score	4.0	4.0		5.0		2.8	2.0

EXHIBIT 10- OC ITEM 2F RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA
1 Strongly Disagree	0%	0%		0%		0%	0%
2 Disagree	0%	0%		0%		20%	0%
3 Neither Agree nor Disagree	0%	0%		0%		40%	50%
4 Agree	0%	33%		0%		20%	0%
5 Strongly Agree	100%	67%		100%		20%	50%
# Responses Received	2	3	0	1	0	5	2
Average Score	5.0	4.7		5.0		3.4	4.0

APPENDIX 4: ADRC ACTION PLANS

Appendix 4: ADRC Action Plans

ADRC Action Plan: Draft 10/1/18

Nebraska Aging and Disability Resource Center (ADRC) Mission: The mission of the NE ADRC is to support seniors, persons with disabilities, their families and caregivers by proving useful information, assistance, and education on community services and long-term care services and support options while at all times respecting the rights, dignity and preferences of the individual.

Nebraska ADRC Target Population: Eligible individual means a person "who has lost, never acquired, or has one or more conditions that affect his or her ability to perform basic activities of daily living that are necessary to live independently." (LB 793)

ADRC Partnerships: The Nebraska Association of Area Agencies on Aging (NE4A) of which Aging Office of Western Nebraska, Aging Partners, Eastern Nebraska Office on Aging, Blue Rivers Area Agency on Aging, Northeastern Nebraska Area Agency on Aging, South Central Nebraska Area Agency on Aging, and Midland Area Agency on Aging are members has established partnerships with the following organizations (ADRC Disability Partners) serving individuals with congenital and acquired disabilities:

- Munroe-Meyer Institute at UNMC
- Nebraska VR
- Disability Rights Nebraska
- League of Human Dignity
- Easterseals Nebraska
- Brain Injury Alliance of Nebraska
- Arc of Nebraska

Additionally, NE4A contracts with Fritz & O'Hare Associates to serve as ADRC Project Coordinators.

Overview

The Nebraska ADRC Action Plan is designed to advance the NE ADRC pilot created in 2016 legislation (LB320) to permanent status, as promulgated in 2018 legislation (LB 793). The experience, lessons learned, work teams, procedure documentation (ADRC Operations Manual, ADRC Dashboard Manual, ADRC Forms Manual) and agency-specific protocols developed during the NE ADRC pilot project will be built upon to further develop the NE ADRC.

Of utmost importance is the LB 793 requirement to "establish a partnership with one or more lead organizations that specialize in serving persons with congenital and acquired disabilities." To that end, the NE4A has established a partnership with the agencies (ADRC Disability Partners) listed above.

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An ADRC Leadership Team (AAAs, Disability Partners, Project Coordinators) are jointly developing this NE ADRC Action Plan and what follows is the work accomplished as of October 2018. The Leadership Team will continue to refine and revise the Action Plan in upcoming months and begin work on goals/actions steps as soon as possible.

Definitions

- ADRC: "A community-based entity established to provide information about long-term care services and support and to facilitate access to options counseling to assist eligible individuals and their representatives in identifying the most appropriate services to meet their long-term care needs." (LB 793)
- ADRC Leadership Team: AAA Directors, Disability Partners, Project Coordinators
- ADRC Statewide Advisory Committee: Committee established to provide on-going advice and support to the ADRC; membership inclusive of state agencies, advocacy organizations, AAA Directors, and disability partners
- Community Resources/Services: Resources and services available at the local level
- Dashboard: Software program administered by the State Unit on Aging (SUA) used to record consumer information and ADRC service delivery
- Disability Partners: Agencies who have signed on as ADRC partners-Disability Rights Nebraska, Easterseals Nebraska, Munroe Meyer Institute, Brain Injury Alliance, Nebraska VR, League of Human Dignity, Arc of Nebraska
- Local providers: providers of aging and disability services at the local level
- Options Counseling: "A service that assists an eligible individual in need of long-term care and his or her representatives to make informed choices about the services and settings which best meet his or her long-term care needs and that uses uniform data and information collection and encourages the widest possible use of community-based options to allow an eligible individual to live as independently as possible in the setting of his or her choice." (LB 793)

Abbreviations

- AAA: Area Agency on Aging
- ADRC: Aging and Disability Resource Center
- I&R: Information & Referral
- NE4A: Nebraska Association of Area Agencies on Aging
- SUA: State Unit on Aging

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ADRC Action Plan: Draft 10/1/18

ADRC Goals

Goal 1: Consistent language that clearly identifies AAAs and Disability Partners as part of the ADRC is developed and documented.
Estimated Completion Date: 2/1/19

Goal 2: An ADRC model integrating Disability Partners into the delivery of ADRC services (Information & Referral, Options Counseling-currently being delivered solely by AAA) is created.
Estimated Completion Date: 4/1/19

Goal 3: ADRC Statewide Advisory Committee continues to provide advice and support on ADRC operations and outcomes.
Estimated Completion Date: 5/1/19

Goal 4: Current outreach plans and efforts for educating consumers, caregivers, state and local providers, and advocacy organizations on ADRC services are built upon to include Disability Partners.
Estimated Completion Date: 7/1/19

Goal 5: The ADRC online resource listing is accurate and up-to-date.
Estimated Completion Date: 7/1/19

Goal 6: Disability Partner & AAA staff providing ADRC services are trained in the consistent and uniform delivery of ADRC services.
Estimated Completion Date: 9/1/19

Goal 7. The ADRC is financially stable, including pursing Medicaid administrative claiming.
Estimated Completion Date: 9/1/19

Goal 8: Disability Partners perform ADRC functions and/or services as identified in their individualized contracts with NE4A.
Estimated Completion Date: 10/1/19

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Goal 9: Individuals are seamlessly and confidentially referred to local providers and community resources/services through Disability Partners & AAAs.

Estimated Completion Date: 10/1/19

Goal 10. All calls coming to AAAs route through a unified process.

Estimated Completion Date: 10/1/19

Goal 11. ADRC service documentation (on the dashboard, I&R Plans, and Action Plans) is complete, accurate, and timely.

Estimated Completion Date: 10/1/19

Goal 12: ADRC materials are accessible to all individuals in alternate formats and languages.

Estimated Completion Date: 11/1/19

Goal 13: Referral sources such as hospital discharge planners and nursing home social workers utilize ADRC services to assist consumers. Estimated Completion Date: 1/1/20

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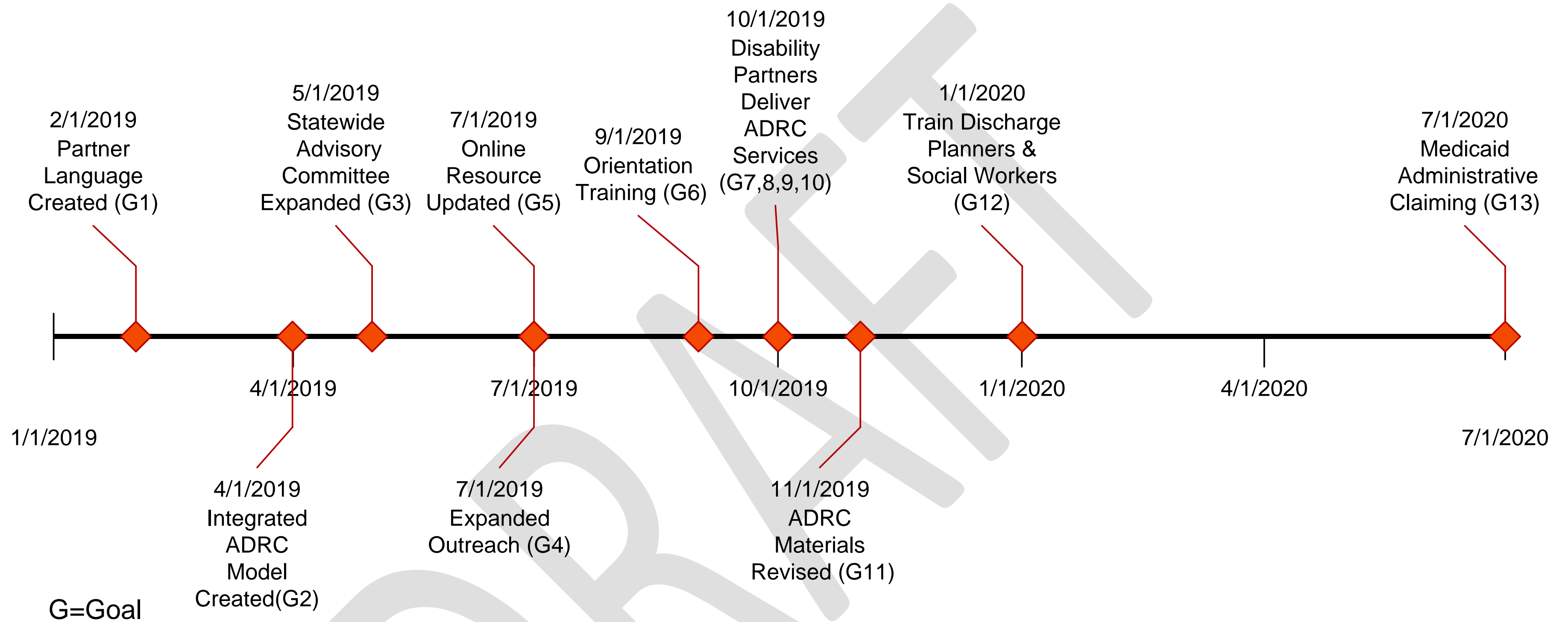
ADRC Milestones & Timeline

Figure 1 ADRC Milestones & Timelines



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Goal 1: Consistent language that clearly identifies AAAs and Disability Partners as part of the ADRC is developed and documented. Estimated Completion Date: 2/1/19

Action Steps	Lead	Timeline	Obstacles	State Guidance Needed
Develop Language Reflecting ADRC Partners				
1.1 Explore ADRC language other states are using when referring to AAAs and Disability Partners	ADRC Leadership Team	1/1/19		
1.2 Discuss the language as it relates to the incorporation of Disability Partners into the delivery of ADRC services	ADRC Leadership Team	2/1/19		
1.3 Adopt language	ADRC Leadership Team	2/1/19		
Document Language				
1.4 Document language and include in ADRC Operations Manual	ADRC Project Coordinators	7/1/19		

Goal 2. An ADRC model integrating Disability Partners into the delivery of ADRC services (Information & Referral, Options Counseling- currently being delivered solely by AAA) is created.

Estimated Completion Date: 4/1/19

Action Steps	Lead	Timeline	Obstacles	State Guidance Needed
Research Other States				
2.1 Research other states to identify how agencies delivering disability services and aging services are integrated in the delivery of ADRC services.	ADRC Leadership Team	1/1/19		
2.2 Discuss results with ADRC Leadership Team.	ADRC Leadership Team	1/1/19		
2.3 Develop model integrating the delivery of ADRC Services with AAA & Disability Partners	ADRC Leadership Team	3/1/19		
2.4 Present model to SUA	ADRC Leadership Team	4/1/19		X
Document Model				
2.5 Document developed model in the ADRC Operations Manual	ADRC Project Coordinators	7/1/19		

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Goal 3: ADRC Statewide Advisory Committee continues to provide advice and support on ADRC operations and outcomes.

Estimated Completion Date: 5/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Recruit Consumers for ADRC Statewide Advisory Committee Membership				
3.1 Develop list of potential consumer representatives	ADRC Leadership Team	2/1/19		
3.2 Contact potential consumer representatives	Project Coordinators	3/1/19		
3.3 Inservice consumer representatives	Project Coordinators	5/1/19		
Determine New Meeting Schedule/Location				
3.4 Discuss current quarterly meeting schedule & decide upon meeting schedule going forward	ADRC Leadership Team	2/1/19		
3.5 Discuss potential meeting locations & decide upon location going forward	ADRC Leadership Team	2/1/19	Meeting Room Costs	

Goal 4: Current outreach plans and efforts for educating consumers, caregivers, state and local providers, and advocacy organizations on ADRC services are built upon to include Disability Partners.

Estimated Completion Date: 7/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Form ADRC Outreach Team				
4.1 Develop Charter for Outreach Team	ADRC Leadership Team	3/1/19		
4.2 Seek membership for Outreach Team including representatives from SUA, Statewide Advisory Committee, Disability Partners, Consumers, AAAs	Project Coordinators	4/1/19		X
Implement Outreach Team According to Charter				
4.3 Build upon Outreach Plan to include state and local events such as presentations at conferences, meetings and distribution of printed materials and website postings	ADRC Outreach Team	5/1/19		
4.4 Develop printed material and distribute at state and local level	ADRC Outreach Team	6/1/19	Limited funding	
4.5 Implement Outreach Plan	ADRC Outreach Team	7/1/19		

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Action Steps	Lead	Timeline	Obstacles	State Support Needed
4.6 Track outreach events & report to ADRC Leadership Team	Project Coordinators	7/1/19		

Goal 5: The ADRC online resource listing is accurate and up-to-date.

Estimated Completion Date: 7/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Review Online Resource Listing				
5.1 Develop protocol for reviewing online resource listing	Quality Assurance Team	3/19		
5.2 Implement protocol for reviewing online resource listing	AAAs & Disability Partners	4/19		
5.3 Monitor online resource listing reviews	Quality Assurance Team	Ongoing		
5.4 Submit changes to SUA	AAAs & Disability Partners	Ongoing		
Document Protocol				
5.5 Document protocol in existing Operations Manual		7/19		

Goal 6: Disability Partner & AAA staff providing ADRC services are trained in the consistent and uniform delivery of ADRC services.

Estimated Completion Date: 9/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Increase Membership to Current ADRC Training Team				
6.1 Seek representatives from SUA & Disability Partners to join the existing ADRC Training Team	Project Coordinators	3/1/19		X
Develop Orientation Training Plan				
6.2 Establish core competencies for staff delivering ADRC services	ADRC Training Team	4/1/19		
6.3 Review current orientation training opportunities being provided at agency level	ADRC Training Team	4/1/19		

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Action Steps	Lead	Timeline	Obstacles	State Support Needed
6.4 Research additional training opportunities	ADRC Training Team	5/1/19		
6.5 Develop ADRC orientation training requirements	ADRC Training Team	6/1/19		
6.6 Train Staff as Needed	Project Coordinators	9/1/19		
6.7 Document orientation requirements in existing ADRC Operations Manual	ADRC Training Team	7/1/19		

Goal 7: Disability Partners perform ADRC functions and/or services as identified in their individualized contracts with NE4A.

Estimated Completion Date: 10/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Determine Core Functions/Services to be Completed by Disability Partners				
7.1 Discuss core functions (training, Quality Assurance, Consumer Review, I&R Database, Outreach, etc.) each individual Disability Partner will perform	ADRC Leadership Team	3/1/19		
7.2 Discuss ADRC services (I&R & OC) each Disability Partner will perform	ADRC Leadership Team	3/1/19		
7.3 Discuss Disability Partners' service delivery and core function role with SUA	ADRC Leadership Team	3/1/19		X
Establish Protocols-Cross-Referrals, Documentation, Work Flow				
7.4 Develop protocols for cross-referrals between Disability Partners delivering ADRC services & AAAs	ADRC Leadership Team	7/1/19		
7.5 Develop protocols for documentation (Dashboard & forms) requirements for Disability Partners delivering ADRC services	ADRC Leadership Team	7/1/19		
7.6 Develop service delivery work flow incorporating Disability Partners into the current ADRC work flow	ADRC Leadership Team	7/1/19		
Determine Funding Scale				
7.7 Determine Payment Scale for Service Delivery by Disability Partners	NE4A & Disability Partners	8/1/19		
Train Staff				

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Action Steps	Lead	Timeline	Obstacles	State Support Needed
7.8 Train Disability Partner and AAA staff on work flow and protocols	Project Coordinators	9/1/19		
7.9 Train Disability Partner staff on ADRC delivery of services & documentation requirements (Dashboard & forms)	Project Coordinators	9/1/19		X
7.10 Provide Disability Partners with training on ADRC functions (Quality Assurance, Consumer Review, I&R Database, Outreach, etc.) so they can fulfill their roles in participating more fully in the ADRC	Project Coordinators	9/1/19		
Documentation				
7.11 Revise existing ADRC Operations manual to reflect changes to work flow		10/1/19		
Service Delivery				
7.12 Disability Partners begin delivering ADRC services and functions	Disability Partners	10/1/19		

Goal 8: Individuals are seamlessly and confidentially referred to local providers and community resources/services through Disability Partners & AAAs.

Estimated Completion Date: 10/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Revise Referral Protocols & Confidentiality Practices as Needed-AAAs				
8.1 Strengthen existing protocols for referrals to local providers and community resources	AAAs	3/1/19		
8.2 Review confidentiality practices	AAAs	3/1/19		
8.3 Revise protocols & practices as needed	AAAs	5/1/19		
Revise Referral Protocols & Confidentiality Practices to Include ADRC Referrals as Needed-Disability Partners				
8.4 Strengthen existing protocols for referrals to local providers and community resources	Disability Partners	5/1/19		
8.5 Review confidentiality practices	Disability Partners	5/1/19		
8.6 Revise protocols & practices as needed	Disability Partners	7/1/19		

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Action Steps	Lead	Timeline	Obstacles	State Support Needed
Establish MOUs with Local Providers & Community Resources/Services Providers As Needed				
8.7 Identify common referral sources	AAAs & Disability Partners	5/1/19		
8.8 Meet with common referral sources to determine if formal agreement is necessary	AAAs & Disability Partners	6/1/19		
8.9 Develop formal agreement, if needed	AAAs & Disability Partners	10/1/19		

Goal 9. All calls coming to AAAs route through a unified process.

Estimated Completion Date: 10/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Develop Unified Process for Taking all Calls-AAAs				
9.1 Create a work flow chart for incoming calls with written explanation	AAAs	3/1/19		
9.2 Train all staff on work flow chart	AAAs	5/1/19		
Develop/Implement Screening Protocol for I&R, Options Counseling & Care Management Based on SUA Taxonomy-AAAs				
9.3 Research other states' screening tools	Quality Assurance Team	5/1/19		
9.4 Research AAA current practice	Quality Assurance Team	5/1/19		
9.5 Review SUA taxonomy & guidance	Quality Assurance Team	5/1/19		X
9.6 Develop screening tool	Quality Assurance Team	7/1/19		
9.7 Train staff on screening tool	AAAs	9/1/19		
9.8 Document in ADRC Operations Manual and Forms Manual	Project Coordinators	10/1/19		
Develop/Implement Protocol for Transferring Calls from AAAs to Disability Partners				
9.9 Review case scenarios to determine which calls to route to Disability Partners	ADRC Leadership Team	7/1/19		

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Action Steps	Lead	Timeline	Obstacles	State Support Needed
9.10 Discuss specialty areas of Disability Partners	ADRC Leadership Team	7/1/19		
9.11 Determine which calls will be transferred to which Disability Partners	ADRC Leadership Team	7/1/19		
9.12 Develop protocols on transferring calls	Quality Assurance Team	8/1/19		
9.13 Train staff on protocols	AAAs & Disability Partners	9/1/19		
9.14 Implement transferring calls to Disability Partners	AAAs & Disability Partners	10/1/19		
9.15 Document protocols in ADRC Operations Manual	Project Coordinators	10/1/19		

Goal 10. ADRC service documentation (on the dashboard, I&R Plans, and Action Plans) is complete, accurate, and timely.

Estimated Completion Date: 10/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Develop workable internal process to monitor service documentation (Dashboard & Action Plans)-AAAs				
10.1 Review how service is currently internally monitored & revise as needed	AAAs	5/1/19		
10.2 Discuss with SUA what additional Dashboard reports are available to assist in Dashboard monitoring	AAAs	5/1/19		
10.3 Document monitoring process	AAAs	7/1/19		
Develop workable internal practices for collection and monitoring of ADRC service documentation-Disability Partners				
10.4 Train Disability Partner staff on Operations, Dashboard & Forms Manuals	Project Coordinators SUA	9/1/19		X
10.5 Develop internal monitoring process for service documentation	Disability Partners	9/1/19		
10.6 Discuss with SUA what Dashboard reports are available to assist in Dashboard monitoring	Disability Partners	9/1/19		X
10.7 Document monitoring process	Disability Partners	10/1/19		
Review Action Plans for Person-Centered Planning, Completeness, Appropriateness of Service				

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Action Steps	Lead	Timeline	Obstacles	State Support Needed
10.8 Continue review of Action Plans and include Action Plans created by Disability Partners	Quality Assurance Team	Ongoing		
10.9 Provide feedback to ADRC staff on Action Plans	Quality Assurance Team	Ongoing		

Goal 11: ADRC materials are accessible to all individuals in alternate formats and languages.

Estimated Completion Date: 11/1/19

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Establish Standards for ADRC Materials				
11.1 State defines and develops specific standards for ADRC materials (i.e. different languages, accessible to visually and hearing impaired)	SUA	7/19		X
Develop ADRC Materials				
11.2 ADRC materials are developed in different languages	SUA	11/1/19	Funding	X
11.3 ADRC materials are developed in accessible formats	SUA	11/1/19	Funding	X

Goal 12: Referral sources such as hospital discharge planners and nursing home social workers utilize ADRC services to assist consumers.

Estimated Completion Date: 1/1/20

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Train Hospital Discharge Planners & Nursing Home Social Workers on ADRC Services				
12.1 Develop a work group with members from AAAs, Disability Partners, hospital discharge planners & nursing home social workers	ADRC Leadership Team	9/1/19		
12.2 Develop training options	Work Group	11/1/19		
12.3 Provide training to discharge planners and social workers in local areas	AAAs & Disability Partners	1/1/20		

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Goal 13. The ADRC is financially stable, including pursing Medicaid administrative claiming.

Estimated Completion Date: 7/1/20

Action Steps	Lead	Timeline	Obstacles	State Support Needed
Develop SUA Infrastructure				
13.1 Hire contractor for technical assistance	SUA	4/1/19		X
13.2 Hire internal position-Federal Aid Administrator	SUA	4/1/19		X
13.3 Hire Business Analyst for Reporting	SUA	4/1/19		X
13.4 Obtain CMS Approval	SUA	1/1/20		X
Develop AAA Infrastructure				
13.5 Meet with MLTC staff on FFP process	AAAs	2/1/20		X
13.6 Train AAA staff on FFP	AAAs	3/1/20		
13.7 Submit information on FFP to MLTC staff	AAAs	4/1/20		X
Develop Disability Partners Infrastructure				
13.8 Meet with MLTC staff on FFP process	Disability Partners	5/1/20		X
13.9 Train Disability Partner staff on FFP	Disability Partners	6/1/20		
13.10 Submit FFP to MLTC Staff	Disability Partners	7/1/20		X
Seek Other Funding Opportunities				
7.10 Research potential funding opportunities	ADRC Leadership & SUA	Ongoing	Limited resources	
7.11 Pursue other funding opportunities as appropriate	ADRC Leadership & SUA	Ongoing	Limited funding available; Limited resources to write grants	

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