



Successful ADRC Partnership Planning Phases

This document is an informal outline of a typical ADRC Partnership Planning process. The ADRC Advisory Committee has requested a list of outcomes that can help local partners track their planning progress toward ADRC designation. This is an optional resource and is not intended to be a complete list of required actions. This outline is brief with only a few guidance tips that seem necessary for clarity. Three important points to keep in mind:

- Each outcome listed here represents hours of discussion and planning work.
- Forming a partnership and streamlining local LTSS systems is not a paper exercise.
- The ultimate and overarching purpose for all this work is to improve consumers' access to information and services.

ADRC Policy Information

State and federal policy resources are listed at the end of this document. The federal Administration for Community Living (ACL), the Centers for Medicare and Medicaid Services (CMS) and the Veterans Administration have provided policy guidance for building No Wrong Door systems and specifically for implementing an Aging and Disability Resource Center (ADRC). ADRC policy has been evolving as ADRC best practices have been collected and published. The California Department of Aging, along with the California Health and Human Services Agency, established state ADRC Designation Criteria based on emerging federal policy that supports a consumer's right to be informed of and receive Long Term Services and Supports (LTSS) in the most integrated community setting possible. Aligning California ADRC policy with federal is intended to maximize any potential for federal financing from a variety of funding streams that have embraced No Wrong Door models. Federal policy has clarified that an ADRC partnership a brand of the No Wrong Door Model. In California, stakeholders support a slight variation in the name due to California's size and diversity. In California, the title is Aging and Disability Resource *Connection*.

Time Frames for Planning an ADRC Partnership

State and federal guidance does not require local ADRC partners to adhere to a specific time frame for planning activities. ADRC partnership planning is an iterative process with each local group establishing its own timeline and priorities for streamlining local LTSS systems. The sequence of local planning events also varies. Local partnerships do not have to adhere to the order presented here.

Citations that appear in parentheses (x.x) refer to California's ADRC Designation Criteria by numbered reference. Until the ADRC Designation Criteria document is published online, you may email a request to pjacosta@yahoo.com or robin.jordan@aging.ca.gov

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State Support for Local ADRC Partnerships

Emerging ADRC Partnerships: Local organizations are invited to submit a Letter of Introduction at any time to let the California Department of Aging know about work on a local ADRC partnership. Emerging ADRC partnerships receive general ADRC information updates, can attend a monthly technical assistance roundtable via teleconference and may request technical assistance at any time. Submit Letter of Introduction and/or inquiries to either robin.jordan@aging.ca.gov or pjacosta@yahoo.com

The Department supports local ADRC initiatives, as resources allow, by:

- Attending local ADRC Advisory Committee meetings upon invitation and when possible
- Providing technical assistance
- Reviewing and commenting on related documents
- Providing scheduled presentations on ADRC core elements
- Reviewing ADRC Designation Applications on a flow basis
- Coordinating and communicating with other state agencies on shared ADRC interests; Departments of Health Care Services, Rehabilitation, Developmental Disabilities, Mental Health, Veterans Affairs, Social Services and others.



Phase 1 – Foundation Period Outcomes

ADRC Partnership Advisory (AC) Committee (5.3 and 6.1)¹

- Vision and Goals/Mission Statement
- Date(s) and agenda for orientation sessions covering the ADRC AC Role and Functions
- Advisory Committee Member List
- List of Consumers on the ADRC AC (*at least 20% of AC membership*)
- List of Front Line Staff of LTSS organizations as AC members
- Calendar/Frequency of AC Meetings
- A growing list (parking lot) of questions and topics for future discussion and fact-finding

¹ Citations indicate specific California ADRC Designation Criteria addressed in the planning process.



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Core ADRC Partner Agreement(s) (5.1)

- Draft Agreement (or Memorandum of Understanding (MOU)) between at minimum, an Area Agency on Aging (AAA) and an Independent Living Center (ILC) as Core ADRC Partners (*Additional partners are allowed.*)

Guidance: *In the case of AAA or ILC refusal, either the AAA or the ILC may be substituted as a core partner; but not both. Alternate or additional core partners could be County Operated Health System (COHS), local government entity, In-Home Supportive Services (IHSS) public authority, 211, regional center, county mental health, or veterans' organization. Federal policy encourages at minimum, an AAA and ILC partnership model.*

- Document a First Right of AAA or ILC Refusal (if applicable) early in the process to avoid miscommunications.

Guidance: *Core partners must be not-for-profit organizations due to the conflict-free nature of Person Centered Options Counseling and the overall principle of informing consumers of comprehensive LTSS options. Extended partners may be for-profit or not-for-profit organizations. The reasoning behind core ADRC partner (not-for-profit) requirement is due to fact that some LTSS providers are members of highly competitive, profit-making industries. Core partners, as leaders of the partnership, can ensure consumers are not receiving limited provider and other information solely based on a profit-making motive.*

Extended ADRC Partners So Far (5.1)

- List of Potential Extended Partners
- Names of Extended Partners represented on the AC

Guidance: *Extended Partners at this phase should include both facility and community LTSS and at least one managed care plan.*

Opportunities for Discussion Across ADRC Partner Organizations (5.1, 3.0, 6.2)

- Meeting dates, orientation, seminars or other events that include information sharing and ADRC planning across Core and Extended ADRC Partners
- Growing lists (and/or parking lots) of discussion topics and technical issues to address in the short and long term.

Guidance: *Unique technical issues will emerge in each local area. Discussions focus primarily on LTSS consumers from a broad, community wide perspective; consumers of any age, any disability type, any income/source with each organization sharing it's*

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perspective and expertise. Helpful discussions also include the resources and challenges of the local system overall. A neutral facilitator can be helpful in some situations.



Phase 2 – Development Period Outcomes

In Phase 2, partners explore some topics in greater depth and often make refinements to work done in Phase 1. In Phase 2, partners develop the four core ADRC services and plan for specific system improvements.

LTSS System Environmental Scan *(by partners and/or Advisory Committee)*

- LTSS consumer demographics *(from a broad, community wide perspective and often available from existing provider reports, area plans and other data)*
- Lists of network strengths, challenges and gaps *(What works; what doesn't; What we have; what we don't have, for example)*
- Lists of obstacles for consumer access to information and services (3.0)
- Recommendations for a revised ADRC Vision/Mission *(if applicable)* (3.0)
- Inventory list of intake/screening/assessment systems across partners to explore duplication and find efficiencies

Guidance: *Intake, application and/or assessment of need can be the first “door” to the LTSS system for some consumers. They often have questions beyond the scope of a single organization’s function or service type; a perfect opportunity to discover what other questions or service needs they have and how they can receive comprehensive and trusted information about LTSS options.*

Recommended Extended Partners – Early Engagement

Guidance: *While there are other important extended partners, the following organizations are recommended for early engagement in partnership discussions. These organizations have constituencies in common with AAA and ILCs and most LTSS providers.*

- Veterans’ Organization and/or Regional Office
- HICAP
- LTC Ombudsman
- County Medi-Cal Eligibility Experts
- County IHSS Leadership



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- Facility Partners (Nursing Facility and Hospital(s))
- Managed Care Plan(s)
- Home Health Agency/Hospice
- Regional Center(s)
- County Mental Health

ADRC CORE SERVICES

Guidance: *There are four core ADRC service types. Building a partnership is often an exercise of connecting with organizations already engaged in these types of services. Any partner (core or extended) organization delivering a core ADRC service should eventually be party to a signed written agreement with core ADRC partners.*

FOUR CORE SERVICES

Information and Assistance/Referral (1.0 through 1.4)

- List of expanded and/or shared LTSS Service provider database(s)

Guidance: *At minimum, any consumer (any age, disability type and income level/source) should have facilitated access to broader LTSS provider database(s) in order to make informed decisions without having to visit and call each individual LTSS provider organization.*

- List of I&A/R and intake organizations that provide LTSS consumer information
- New or existing procedures for “warm” telephone transfers (*keeping the consumer on the line while transferring the call to another party*)
- Lists or compilations of quality and consumer satisfaction strategies used -by partners
- Lists or compilations of strategies used by partners to Identify urgent need (Red Flags)
- Discussions across partners and mutually agreed to procedures to engage protective services and emergency responder partners in specific types of situations.
- Lists of consumer demographic datasets that can be used for planning ADRC core services (No name or SS) For example, request type, referrals to Options Counseling, length of certain call types, etc.
- Discussions about proactive and comprehensive I&A/R; who does it, where does it happen, what improvements are needed, etc.
- Follow-up procedures to assess quality and make improvements in the service



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Person Centered Options Counseling (2.1)

- List of organizations and staff providing Person Centered Options Counseling

Guidance: *Options Counseling should be available to consumers of any age, any income level/source and disability type. Person Centered Options Counseling is receiving state and federal policy attention. Updates will be provided to existing and emerging ADRC partnerships as more information becomes available and considerations will be discussed with individual ADRC Designation applicants due to the training component of this core service. Pending more information, these are the development discussions that are typically needed:*

- Training Dates and Curricula for Options Counselors
- **Counselor Training Placeholder:** *Pending more information about access to skills training sessions. Meanwhile, partnerships can pursue Community Transitions Intervention (CTI) a coaching model of decision support, Motivational Interviewing or other person centered interviewing skills training. There may be a cost. Consult with veteran ADRC partnerships for possible train-the-trainer or alternatives.*
- **Service Standards Placeholder** –*More information will be shared as information becomes available. Meanwhile, you may request the existing Options Counseling Standards resource document and federal technical resources for general guidance. Documents are being considered for updates but historical materials may be helpful.*
- Shared consumer profiles/situations adopted by call centers and ADRC partners that “trigger” referrals to OC
- Orientation presentation dates and methods for informing extended LTSS organizations/partners on the availability of Options Counseling
- Specified procedures, content and privacy standards for OC as a futures planning service (optional) (*Futures planning is more general, available to anyone and the need for services is often in the future. Not all organizations choose to offer this type of service and it is not required.*)
- Follow-up procedures to assess quality and make improvements in the service

Short Term Service Coordination/Streamlined Access to Public Programs (2.2 and 3.0)

- List of partner organizations that provide case management of any type and specifically short term and urgently needed service coordination, including expedited access to public programs
- Locally defined risk identifiers (Red Flags) that result in an expedited response to a consumer with urgent needs.



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Guidance: *Red Flags discussed and agreed to by partners are helpful in identifying consumers at risk for health and safety; for example, callers expressing suspected abuse, hunger, or loss of shelter.*

- Discussions and lists of approaches used by partners for discussions with the decision maker (consumer self) and legally identified surrogate decision makers. This includes partner discussions about privacy and person centered interview methods and skills needed.
- Referral tools (procedures, forms, and specially trained staff) that expedite services in urgent situations across partner organizations.
- Shared procedures for reporting suspected abuse to protective agencies.
- Procedures for streamlined access to Medi-Cal eligibility, as needed (3.0, 3.4)
- Follow-up procedures to assess quality and make improvements in the service

Person Centered Transition Assistance (4.0)

- List of partner organizations that provide Transition Assistance: hospital-to-home and nursing facility-to-home
- List of nursing facility and hospital partners, so far
- Signed agreements with participating hospitals and nursing facilities, so far
- Description/plan for providing training for Transition Coaches
- Agreement(s) with local organizations that are designated by the state to be California Community Transition (CCT) and Minimum Dataset (MDS) 3.0 responders to consumers who request to transition to a community setting
- Agreements with managed care plan(s) for transition services (especially in Medi-Cal/Medi-Cal and/or LTSS integrated managed care counties)
- Agreement(s) and/or resources used for urgently needed Affordable Housing and Transportation services
- Follow-up procedures to assess quality and make improvements in the service

Shared Written Protocols for ADRC Core Services

Guidance: *Any organization delivering a core ADRC service should be party to a signed written agreement with core ADRC partners.*

Each protocol describes shared priorities and improvements across partner organizations. Protocols are not descriptions of the way each organization does their work currently but rather describes how partners will work together in new ways. Protocols describe how partners will work together to create a streamlined access to information and services for consumers of any

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age, any disability type or income level/source. Each protocol describes “how is the system different by working together?” Consult the new ADRC Shared Protocol resource document.

New Resource about ADRC Shared Protocols

A new technical guidance document has been developed to assist with developing the four shared ADRC Core Service Protocols that become part of the ADRC Designation Application. This new resource document includes information about the content of each written protocol. Until the document is available online, you may request it by sending an email to pjacosta@yahoo.com

ADRC Marketing Plan for All Ages, Income Levels/Source and Disability Types (1.1)

- Discussions and plans for marketing and branding the ADRC; including Outreach Methods, Materials & Timeframes for informing the public of the availability of comprehensive, consistent and trustworthy LTSS information and services via the ADRC partnership
- Samples of how the ADRC Logo will be used

Guidance: Use of the state ADRC logo is strongly recommended so that consumers moving from one area to another have a recognizable and trusted source of information anywhere in the state. Request logo clip art from CDA. Discuss with partners how it can be used along with any other locally familiar logo.

I/T/MIS Supports (6.4)

- Environmental scan of I/T and MIS Resources used by ADRC partners
- Plans and/or list of priorities for broadening and sharing Information databases
- Recommendations for sharing (non-identifiable) consumer demographics for planning purposes
- List of online resources to be utilized to assist information and service delivery
- Methods for performance tracking and trending the four core ADRC services using data resources (for example, hospital re-admission rates for Transition Services or numbers of referrals to Options Counseling)

Quality Improvement Plans and Methods (6.0)

- List of technical expert presenters/training sessions discussions
- Priorities list for LTSS system changes; short term and longer term
- Priority list of future goals

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- More cross training among ADRC Core and Extended Partners
- Sustainability Plan (6.1)

Guidance: *Discussions on sustainability should include planning for participation in Medi-Cal, Medicare, Veterans' services funding, private insurance, providing contracted services to managed health plans in the local area or other new financing arrangements that help to sustain ADRC core services.*

- Methods for collecting and trending data from organizations delivering the four ADRC core services

Compiling the ADRC Designation Application

- Letter of Intent to CDA with application date target
- Consultation with partners for application development, discussion and critical input
- Draft written protocol for each of the four ADRC core services
- Completed ADRC Application for Designation Package
- Technical Assistance from the State and/or peer review (optional)

Guidance: *The ADRC Designation Application package lists required content and describes steps in the review process. The ADRC Application package is in revision. Please submit a request for the updated application package to pjacosta@yahoo.com or robin.jordan@aging.ca.gov*

Note: Completion of the outcomes listed here signifies the general readiness of the local ADRC partnership to submit an application to the State for ADRC designation. The outline above is a simple roadmap and is not a list of all the ADRC principles and requirements. Consult the list of policy resources at the end of this document for more guidance.

California ADRC Model Integrity

California Department of Aging State Review and Oversight

- Conducts the State ADRC application review process
- Convenes an ADRC designation application review panel made up of state agency partners; Department of Health Care Services, CalVet and the Department of Rehabilitation
- Executes one agreement between CDA and all the Core Partners (*one master agreement between state and local entities*)



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- Promotes the ADRC model among state agency partners with the purpose of supporting local partners and their outreach to other LTSS system players
- Provides technical assistance to existing and emerging local ADRC partners

ADRC Technical Assistance Available

Existing and emerging ADRC partnerships are invited to request technical assistance at any time. Technical assistance can include review of draft documents, consultation about planning strategies, problem solving and learning about practices used by other ADRC partnerships. Request technical assistance via email to pjacosta@yahoo.com

ADRC POLICY REFERENCES

State and federal policy and best practices for ADRC partnerships and No Wrong Door systems are evolving as more states gain experience with increasing community based alternatives to institutional long term care.

Request these documents via email (pjacosta@yahoo.com) until they are available online:

1. California State ADRC Designation Criteria
2. California ADRC Designation Application and Instructions
3. California Options Counseling Standards (*historical document until new guidance is available*)
4. ADRC Core Services Shared Protocol Technical Guidance (*new*)
5. Use of the State ADRC Logo (*new*)

These resources are available on the internet or are included below:

1. ACL Components of a Fully Functional ADRC
 2. ACL No Wrong Door Elements (download or view at <http://www.acl.gov/Programs/CIP/OCASD/ADRC/index.aspx>)
 3. CMS Goals of a Balanced Medicaid System
 4. CMS Definition of Person Centered Planning
 5. ACL Option Counseling Elements
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Core Components and Criteria of a Fully Functional Aging and Disability Resource Center (ADRC)

At-A-Glance

Updated March 2012

Information, Referral and Awareness (I&R/A)

- Formal Marketing Plan for All Ages, Income Levels, Disability Types
- Marketing to and Serving Private Paying Populations
- Systematic I&R Processes Provided Across all Operating Organizations
- Follow-Up on I&R Services
- Online Comprehensive Resource Database, Public and Searchable

Options Counseling and Assistance

- Formal Standards and Protocols Guiding Delivery to All Income Levels and Disabilities
- Short-term Support in Crisis/Urgent Situations (Preventing Institutionalization)
- Follow-Up on Options Counseling Services
- Futures Planning for Long Term Service and Support (LTSS) Needs

Streamlined Eligibility Determination for Public Programs

- Coordinated/Integrated Process for Financial and Functional Eligibility
- Standardized Intake and Screening Across all Operating Organizations
- Uniform Criteria to Assess Risk of Institutionalization
- Functional Eligibility Determined On-Site or Through Seamless Referral Process
- Personalized Assistance in Financial Application Completion
- Financial Eligibility Determined On-Site or Through Electronic Exchange
- Applicants Tracked through Determination Process; Follow-up with Ineligible Individuals

Person-Centered Transition Support

- Formal Agreements with Critical Pathway Providers and Protocols for Providing Transitions Support, Referral Processes, and Staff Training
- Local Contact Agency Designation (MDS 3.0 Section Q)

Consumer Populations, Partnerships and Stakeholder Involvement

- Staff with Capacity and Training to Serve All Ages and Disability Types
- Consumer Involvement in Program Design, Operation, and Quality Improvement
- Formal Partnership Agreements, Protocols, or Contracts with:
 - Critical Aging and Disability Organizations
 - Medicaid
 - State Health Insurance Assistance Program (SHIP), Adult Protective Services (APS), and 2-1-1
 - Veteran's Administration (VA) Medical Center(s)

Quality Assurance and Continuous Improvement

- Formal Sustainability Plan with Diverse Funding Sources



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Core Components and Criteria of a Fully Functional Aging and Disability Resource Center (ADRC)

At-A-Glance

Updated March 2012

- Adequate Staffing and Management
- Continuous Quality Improvement Plan and Procedures in Effect
- IT/MIS Supports All Program Functions
- Routine State Level Performance Tracking
- Routine Local Level Performance Tracking

Centers for Medicare & Medicaid Services (CMS) - Goals of a Balanced Medicaid Funded Delivery System

The goal of the Medicaid balancing initiatives is to create a person-driven, long-term support system that offers people with disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life. A balanced system is:

- **Person-driven:** The system gives people choice over where and with whom they live, control over the services they get and who they get services from, the chance to work and earn money, the option to include friends, and supports to help them participate in community life.
- **Inclusive:** The system encourages people to live where they want to live, with access to a full array of community services and supports.
- **Effective & Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners, and includes personal accountability and planning for long-term care needs, including greater use of private funding sources.
- **Sustainable & Efficient:** The system efficiently coordinates and manages a package of paid services appropriate for the beneficiary, paid for by the right entity.
- **Coordinated & Transparent:** The system coordinates services from various funding streams to provide a seamless package of supports, and uses health information technology to effectively provide transparent information to consumers, providers and payers.
- **Culturally Competent:** The system provides user-friendly, culturally-appropriate, accessible information and services.

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CMS Person-Centered Planning Definition

The Centers for Medicare and Medicaid Services (CMS) released a working definition of Person-centered Planning, as of January 2014.

“Person-centered planning is a process, directed by the family or the individual with long term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person centered planning process. The process includes:

- Participants freely chosen by the family or individual who are able to serve as important contributors.
- The family or participants in the person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting.
- The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff.
- The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care.”

– CMS, January 2014

Administration for Community Living Options Counseling Standards *(excerpt)*

June 2012

Options Counseling includes the following steps:

- A personal interview to discover strengths, values, and preferences of the individual and the utilization of screenings for public programs,
- A facilitated decision support process which explores resources and service options and supports the individual in weighing pros and cons,
- Action steps toward a goal or a long term support plan and assistance in applying for and accessing support options when requested, and
- Quality assurance and follow-up to ensure supports and decisions are working for the individual. Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization.