



Aging and Disability Resource Centers (ADRCs):

Federal and State Efforts to Guide Consumers
Through the Long-Term Services and Supports Maze

BACKGROUND
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OVERVIEW — Since 2003, the U.S. Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) have made a series of grants to states to develop Aging and Disability Resource Centers (ADRCs). The ADRC program's purpose is to help people of all ages, disabilities, and income levels more easily access long-term services and supports through single points of entry, make more efficient use of care options, and maximize the services available. Almost \$111 million in joint AoA-CMS funding has been devoted to the ADRC initiative since its inception in fiscal year 2003. As of October 2010, 325 ADRC sites are in operation in 45 states and territories. Wide variation among ADRCs exists, and the AoA is calling for more standardization. This publication provides background on the evolution of ADRCs, their functions and implementation, grants to states, and state and federal evaluation efforts. It also points to selected issues in continuing ADRC implementation.

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Accessing long-term services and supports (LTSS)¹ has been described by researchers and bloggers alike as wandering through a maze.² Even to those knowledgeable about caring for the elderly and younger people with disabilities, the LTSS “system” appears to be a labyrinth of complicated services, programs, funding streams, and eligibility requirements. Indeed, Robert Kane, a noted gerontologist and physician in the field of LTSS policy, decried an unfriendly and difficult-to-manage system when his mother needed care.³ A recent survey of home and community-based services opinion leaders strongly supported development of ways to help people with disabilities through the maze of services and supports.⁴ To those unfamiliar with aging or disability services and who need help for themselves or their family members, accessing LTSS can be confusing, difficult, and frustrating. Most people, even those who have financial resources to pay for care themselves, do not know where to get help or may not know how to access preferred services.

Understanding the different eligibility and program coverage requirements for the myriad array of institutional and home and community-based services and benefits is daunting. For example, Medicaid is the major federal financing source for LTSS, but coverage differs widely among and within states; the program’s eligibility criteria are highly complex and services are limited to those who meet strict income and assets tests. LTSS providers range from brick-and-mortar institutions like nursing homes to the organizations and individuals who deliver a wide variety of home and community-based services, each of which has different eligibility and coverage criteria. Moreover, an uneven distribution of services in communities and across states presents access barriers to people with disabilities and their family caregivers, even to those who can afford to pay out-of-pocket. Many believe that more should be done to increase knowledge and planning about care alternatives and available programs and benefits on the part of consumers who cannot cope with the complexity of LTSS. These issues become especially salient when

Long-Term Services and Supports

The term “long-term services and supports” (LTSS) refers to a broad range of supportive services needed by people who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition. A person’s need for LTSS is generally measured, irrespective of age and diagnosis, by functional status, that is, his or her inability to perform basic activities necessary to live independently, and by the need for assistance from another person to carry out these activities. People of all ages may need LTSS: the elderly with physical disabilities or cognitive impairments, such as Alzheimer’s disease; adults under age 65 with inherited or acquired disabling conditions; and children born with disabling conditions. Services may be provided in one’s home and/or community, for example, through home care and adult day care programs; in residential settings, such as assisted living facilities or board and care homes; or in institutions, such as nursing homes. The intensity and cost of services vary widely, depending on an individual’s functional and health status, the severity of his or her disabilities, and the location in which services are provided. (For more information, see Carol V. O’Shaughnessy, “National Spending for Long-Term Services and Supports (LTSS),” National Health Policy Forum, The Basics, April 30, 2010; available at www.nhpf.org/library/details.cfm/2783.)

people are facing a crisis, such as being discharged from a hospital and needing help transitioning to home or to a care facility or living at home but finding they are no longer able to fully care for themselves. People who live in nursing or rehabilitation facilities and want to transition home with supportive care face particularly difficult challenges navigating access to community services.

National spending on LTSS is significant. In 2008, spending on LTSS was over \$191 billion, almost 10 percent of all U.S. personal health care spending, with the Medicaid program paying for almost two-thirds.⁵ Given the enormous costs, policymakers have sought ways to coordinate LTSS and provide better outcomes for consumers, providers, and payers. A key U.S. Supreme Court decision, *Olmstead v. L.C.*, laid the groundwork for these efforts.

In 1999, the *Olmstead* decision affirmed a state’s obligation to serve individuals with disabilities in the most integrated setting appropriate to their needs; it also held that unjustified isolation of people with disabilities violates the Americans with Disabilities Act. The Bush administration, through its New Freedom Initiative (NFI)⁶ and the Obama administration, through its Community Living Initiative (CLI),⁷ have taken numerous steps to implement the intent of the *Olmstead* decision. The NFI included support for Real Choice Systems Change (RCSC) grants, whose purpose was to help states develop the necessary regulatory, administrative, program,

and funding infrastructure to enable individuals of all ages with a disability or impairment to live in the most integrated community setting suited to their needs and to have meaningful choices about their living arrangements. The CLI has a similar aim and includes interagency partnerships; civil rights enforcement activities; regulatory, research, and technical assistance efforts; and grants to states.⁸ Both the NFI and the CLI initiatives have included implementation of Aging and Disability Resource Centers (ADRCs) as a way to assure that people with disabilities have streamlined access to LTSS of their choice.

SINGLE POINTS OF ENTRY/NO WRONG DOOR: HELPING CONSUMERS THROUGH THE MAZE

For many years, aging and disability services researchers and practitioners have discussed the need to develop methods to improve access to and coordination of care for people who need LTSS. Beginning in the 1980s, a few state aging and Medicaid agencies implemented ways to streamline access for public LTSS programs through a “single point of entry” (SPE) and to help consumers access services through a “no wrong door” approach. SPE programs are intended to provide consumers smooth access to LTSS through one agency or organization which sorts out the range of care alternatives and helps people make decisions about the best and most feasible care alternative. A no wrong door system assists people in need to connect with desired services, regardless of the agency through which they try to gain access. (In this paper, the single point of entry and the no wrong door approaches to easing access to services are subsumed under the term “SPE.”) Functions performed by SPEs include information and assistance, referral, initial screening for services, assessment of a consumer’s functional needs and services, development of care plans, authorization of funding for services, monitoring of care, and periodic consumer reassessments.⁹ These functions may be carried out by social workers, nurses, a multidisciplinary team, and other staff trained to conduct such activities, in collaboration with and at the direction of the consumer.

Along with a few other states, Washington, Oregon, and Wisconsin pioneered the concept of coordinated access points for LTSS for publicly funded programs. Among LTSS practitioners, these three states are often referred to as models for other states to emulate because of their emphasis on offering consumer choice, coordinating access to services, streamlining both financial and functional eligibility determinations for public programs, and using automated assessment tools to determine program eligibility and care plans. In Washington, regional offices of the state’s Aging and Disability Services Administration (ADSA) conduct consumer assessments for all Medicaid LTSS (both institutional and home and community-based), perform functional eligibility determinations, and develop care plans. Staff who conduct Medicaid financial eligibility determinations are co-located with the regional ADSA staff in order to expedite eligibility determination. Washington uses a single automated system to assess functional, health, and cognitive status; determine eligibility for services; develop a care plan; and determine hours of home care services that

Chronology of ADRC Development

1999—*Olmstead v. L.C.* Supreme Court decision required states to administer services, programs, and activities to appropriately meet the needs of people with disabilities in the most integrated setting.

2001—President Bush announced the New Freedom Initiative as part of a nationwide effort to remove barriers to community living for people with disabilities.

FY 2001—Real Choice Systems Change (RCSC) Grants for Community Living initiated by the Department of Health and Human Services (HHS) to help states modify their long-term services and supports systems to promote home and community-based services.

FY 2003—First federal grants made to 12 states for ADRC development under RCSC initiative; funding continues through FY 2010 (see Table 2, page 17).

2003—ADRC Resource Center Technical Assistance Exchange established (www.adrc-tae.org).

2006—Older Americans Act legislation added requirement that the Administration on Aging establish ADRCs in all states.

2009—President Obama announced the Year of Community Living and HHS announced the Community Living Initiative that includes ADRCs.

2010—P.L. 111-149, the Patient Protection and Affordable Care Act appropriated \$10 million for ADRCs for each of FYs 2010 through 2014.

may be authorized.¹⁰ In Oregon, the state Division of Seniors and People with Disabilities contracts with area agencies on aging or county offices to determine eligibility for LTSS, develop care plans, and perform on-going case management for Medicaid and state-funded LTSS.¹¹ Wisconsin's ADRCs were initiated with state funds and served

as a model for an effort by the U.S. Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) to help states develop ADRCs. The state's ADRCs are considered "information stations," where individuals can obtain accurate, unbiased information regarding LTSS and connections to services. Wisconsin ADRCs employ informa-

An increasing number of states have restructured the organization of their LTSS systems to improve consumer access through SPEs, but wide variation in functions performed and populations served exists.

tion and assistance specialists, options counselors, and benefit specialists, as well as staff who perform consumer assessments for Family Care, its capitated Medicaid- and state-funded LTSS program for adults with physical, mental, or cognitive disabilities. Wisconsin's 35 ADRCs operate nearly statewide.¹²

Over the last decade, an increasing number of states have restructured the organization of their LTSS systems to improve consumer access through SPEs, but wide variation in functions performed and populations served exists.¹³ The concept of the SPE, designed and implemented in a limited number of states, has been translated into a national program that began with joint AoA-CMS funding to states under the RCSC grants in fiscal year (FY) 2001.¹⁴ ADRC grants were one of many types of grants funded under the RCSC initiative and part of a wider AoA-CMS partnership to improve the delivery of supportive services to vulnerable populations.¹⁵ Agencies that serve both the aging and disability communities have been incorporated into the ADRC design.

In 2006, Congress formally recognized the ADRC program in amendments to the Older Americans Act (P.L. 109-365). The legislation requires the AoA to implement ADRCs in all states. As envisioned by the Older Americans Act amendments, the AoA, and CMS, ADRCs are intended to be visible and trusted sources to help people of all ages, disabilities, and income levels access information and assistance on the full range of LTSS. ADRCs are tasked with providing personalized counseling to assist individuals and their families with care choices; developing a single and integrated approach to LTSS intake, assessment, and eligibility determination; and serving

as convenient entry points for all public and private LTSS programs (see text box on ADRC provisions in the Older Americans Act).

Some observers consider the ADRC legislative provisions one component of efforts to “modernize” the Older Americans Act’s aging services programs to prepare them to better respond to the needs of a growing elderly population and move forward with greater emphasis on standardizing and improving consumer access to LTSS. While information, referral, outreach, and access assistance for many community services have long been considered core services for the aging services network, the 2006 law requires all states to develop an integrated and coordinated approach to help people access LTSS that thus far has existed in only a limited number of states.

Joint AoA and CMS funding for wider adoption of ADRCs by states began in earnest in FY 2003 and has continued through FY 2010. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended) appropriated \$10 million for each of FY 2010 through FY 2014 to continue and expand state ADRC implementation. In addition to funding states, the AoA also provides support to a national Technical Assistance Exchange that provides a forum for state and community stakeholders on ADRCs and other LTSS programs.¹⁶ In September, the AoA awarded FY 2010 ADRC funding appropriated by PPACA to 42 states and the District of Columbia (see section on funding, below).¹⁷

ADRC Provisions in the Older Americans Act

Section 102(4) of the Older Americans Act defines an ADRC as an entity established by the state as part of the state long-term care system to provide a coordinated approach that provides consumers with:

- Comprehensive information on the full range of available public and private long-term care programs, options, service providers, and resources within a community, including information on the availability of integrated long-term care
- Personal counseling to assist in assessing their long-term care needs, and developing and implementing a plan for long-term care to meet their specific needs and circumstances
- Access to the range of publicly supported long-term care programs for which they may be eligible, by serving as a convenient point of entry for such programs

Section 202 (a)(8) requires the Administration on Aging to implement Aging and Disability Resource Centers in all states to perform the following functions:

- Serve as visible and trusted sources of information on the full range of long-term care options, including both institutional and home and community-based care, which are available in the community
- Provide personalized and consumer-friendly assistance to empower individuals to make informed decisions about their care options
- Provide coordinated and streamlined access to all publicly supported long-term care options so that consumers can obtain the care they need through a single intake, assessment, and eligibility determination process
- Help individuals to plan ahead for their future long-term care needs
- Assist [in coordination with the State Health Insurance Program (SHIP)] Medicare beneficiaries and prospective beneficiaries understand and access prescription drug and preventative health benefits under the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Source: Adapted from Older Americans Act of 1965, as amended.

ADRC FUNCTIONS AND CRITERIA

The AoA and CMS have defined five key functions to be carried out by ADRCs: information and referral/awareness (I&R/A); options counseling (OC); streamlined eligibility determination for public programs and streamlined access to services; person-centered transition support; and quality assurance and continuous improvement (see text box, next page).¹⁸ Most of these functions are carried out by information specialists, nurses or social workers, a multidisciplinary team, or other trained staff.

Not all ADRCs perform all aspects of these functions. As a way to assess whether ADRCs are carrying out each of the five functions, the AoA and CMS have defined and published criteria for “fully functioning” ADRCs. The fully functioning criteria reflect the AoA’s and CMS’ vision of a totally integrated system for people of all ages, income levels, and types of disabilities. The criteria, while intended to be goals for all ADRCs, are quite extensive and their implementation is dependent on an adequate funding base as well as state and local leadership. ADRCs are to use these criteria to measure their implementation progress in each of the five functions. The six criteria are shown in the Appendix (see page 27).¹⁹

Not all ADRCs perform all aspects of the five key functions defined by the AoA and CMS.

As of September 2010, the AoA reports that over 80 percent of states and territories implementing ADRCs have achieved more than half of the measurable outcomes associated with the six ADRC fully functional criteria; almost 30 percent have achieved more than three-quarters of the measurable outcomes. While no state or territory has achieved fully functional status statewide, the AoA reports that many states have achieved integration and coordination of services across historically fragmented systems and have improved access to information and choice about LTSS for consumers. Many ADRCs need to focus on implementing performance tracking and continuous quality improvement initiatives, instituting standards and protocols for options counseling (a focus of one of the AoA’s 2010 grant initiatives, see discussion below), and serving individuals who can pay privately for both information and options counseling.²⁰

The Five Key Functions of ADRCs

Information and Referral/Awareness (I&R/A)—Aging and Disability Resource Centers (ADRCs) are to promote awareness of the various long-term services and supports (LTSS) options as well as information individuals can use to plan ahead for their care. They are to focus I&R/A on underserved, hard-to-reach populations who rely on public programs for care, as well as those who pay for their care without public support. ADRCs are to have the capacity to link consumers with needed services and supports, both publicly and privately supported, through appropriate referrals to other agencies and organizations. They are expected to partner with State Health Insurance Assistance Programs to assist people with information on Medicare and other insurance issues.

Options Counseling (OC)—The main function of options counselors is to help consumers and their caregivers assess their needs, understand the full range of LTSS options available, and evaluate how these options relate to their circumstances. Counselors are also to assist consumers with making informed decisions about appropriate services, financed through their own resources or through the help of public and private programs. Options counselors are to provide one-on-one assistance and help consumers develop service plans and arrange for the delivery of services and supports, including the hiring and supervision of direct care workers.

Streamlined Eligibility Determination for Public Programs and Streamlined Access to Services—ADRCs are to serve as single points of entry (SPEs) to all publicly financed LTSS, including Medicaid, the Older Americans Act, and other federal and state programs and services. To be an SPE, an ADRC is expected to develop an integrated and coordinated approach to carrying out the following functions: consumer intake and screening, assessment of individual needs, development of service/care plans, eligibility determination (for both functional and financial eligibility) for public programs, and assurance that people receive the services for which they are eligible.

Person-Centered Transition Support—ADRCs are to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening programs for nursing home facilities and hospital discharge planning programs. The purpose of having ADRCs involved in care transition activities is to help people avoid unnecessary placement in nursing facilities or other institutions or readmission to hospitals and to provide for continuity of care through the transition process. ADRCs are to work with consumers and their caregivers by strengthening the connection between health and LTSS providers.

Quality Assurance and Continuous Improvement—In order to ensure that public and private investments are producing measurable results, ADRCs are expected to develop and implement measurable goals and indicators related to their visibility in the community, helping consumers access services, and efficiency and effectiveness. ADRCs are expected to use electronic information systems to track consumers, services, performance, and costs and to continuously evaluate and improve their operations. This activity can include linkages with other data systems, such as Medicaid information systems and electronic health records, and involve formal processes to get feedback from consumers and families.

Source: Administration on Aging, "Implementing the Affordable Care Act: Making it Easier for Individuals to Navigate Their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access," available at www.aoa.gov/aoaroot/Grants/Funding/docs/2010/AoA_CMS_Affordable_Care_Act_June_2010.pdf; and ADRC TAE, "Fully Functioning Aging and Disability Resource Centers, June 2010, available at www.adrc-tae.org/tiki-download_file.php?fileId=29618.

ADRC MODELS, ORGANIZATIONAL PLACEMENT, STATEWIDE FUNCTIONING, AND STAFFING PATTERNS

States have developed two types of ADRC models. The first is an integrated/centralized system in which all the services consumers need are offered by one agency (the single point of entry approach).

About three-quarters of the ADRCs across the country include an area agency on aging as one of their operating agencies.

A consumer can call or walk into the agency and receive assistance from the agency's staff. The second is the coordinated/decentralized model (the no wrong door approach), in which multiple organizations located in various locations in a service area cooperate to provide all ADRC functions. Coordination among the various agencies makes "one-stop shopping" for services possible. The coordinated/decentralized model relies on standardized consumer intake tools and assessment procedures, formal referral protocols, and electronic data sharing systems. Some organizations may use hybrids of the integrated/centralized and coordinated/decentralized model; for example, they might use one approach for aging services and another approach for services to younger people with disabilities.²¹

Organizationally, most states have placed ADRCs in area agencies on aging. Some have designated centers for independent living (CILs) to carry out ADRC functions. Area agencies on aging are focused on broad planning and advocacy activities for older people within their planning and services areas, fund providers to deliver a range of home and community-based services, and directly provide other services, including information and referral and outreach.²² CILs, authorized under the Rehabilitation Act of 1973, are organizations that provide an array of independent living services, including core services of information and referral, independent living skills training, peer counseling, and individual and systems advocacy. They are designed and operated within a local community by individuals with disabilities.²³ The inclusion of both area agencies on aging and CILs into the ADRC program design is aimed at improving access to LTSS for people of all ages and disabilities.

About three-quarters of the ADRCs across the country include an area agency on aging as one of their operating agencies. In many coordinated/decentralized ADRCs, both an area agency on aging and a CIL that serve the same geographic area partner to carry out ADRC

functions for older people and for younger people with disabilities, respectively. The balance of ADRCs are located in state or county offices or other human services agencies.

Regardless of the model used, administrative partnerships and cooperation among the various LTSS programs and providers are critical to ADRC success. Key ADRC state partners are the state Medicaid and disability and aging agencies and the State Health Insurance Assistance Programs. Community partners are area agencies on aging (when the ADRC is not located in the area agency on aging), CILs, public and private aging and disability service providers, hospital discharge planners, physicians and physician groups, adult protective service providers, and state/county Medicaid programs. Partnerships may entail a range of activities, including written cross-agency agreements and referral protocols, co-location of staff, joint funding, cross-agency staff training, compatible information technology systems, shared I&R/A systems, shared client data, and joint marketing and outreach activities.²⁴ ADRCs are also required to develop advisory roles for consumers and their families.

A key partner for ADRCs is the state Medicaid agency, which is generally responsible for determining consumers' financial eligibility for Medicaid.

A key partner for ADRCs is the state Medicaid agency, which is generally responsible for determining consumers' financial eligibility for Medicaid. ADRCs can play an important role in facilitating the eligibility determination process. Reportedly, 76 percent of ADRCs have Medicaid applications available online, and 35 percent have decision-making tools available to consumers. Over three-quarters can track the eligibility status of applicants as they move through the system.²⁵

According to the AoA, as of October 2010, about one-third of states and territories that operate ADRCs had statewide systems.²⁶ Whether ADRC functions are considered statewide depends upon the criteria used to judge statewideness. According to the AoA's Technical Assistance Exchange, about 11 states have ADRC offices in all areas of the state that consumers can walk into to receive LTSS information. Four states have developed statewide call centers for consumer assistance.²⁷ Twenty-nine states maintain publicly accessible databases of information and resources across the state and, as of May 2010, 13 states were developing similar statewide capacity.²⁸ While some of the ADRC functions, such as I&R/A, can be carried out through call centers and websites, most ADRC functions require face-to-face

contact between consumers, their families, and ADRC staff in order to be successfully implemented.

Most ADRC program staff are case workers, information and referral and assistance specialists, nurse case workers, and benefits counselors. Data supplied by 217 program sites indicate that average ADRC staffing consists of almost 21 full-time equivalent staff (see Table 1).²⁹

TABLE 1
ADRC Staffing Averages by Job Category

Staff Position	Average Number of FTEs*	Percent of 217 Program Sites Reporting FTEs
Any	20.8	100.0
I&R/A [†] Specialists	3.9	95.5
Nurse Case Workers/ Options Counselors	1.1	26.0
Case Workers/ Options Counselors	4.9	45.0
Benefits Counselors	1.5	57.5
Financial Eligibility Workers	0.6	8.0
Training and Outreach Staff	0.6	33.0
IT/MIS [‡] Staff	0.4	35.5
Management	3.0	81.0
Administrative Support Staff	2.1	68.0
Consultants	0.2	7.5
Other	4.0	33.0

* Full-time equivalent staff

[†] Information, referral and awareness

[‡] Information technology/management information system

Source: Aging and Disability Resource Center Technical Assistance Exchange, Aging and Disability Resource Center Semi-Annual Outcomes Report, draft, Spring 2010, unpublished data, email communication with author, November 8, 2010.

INCREMENTAL UPTAKE AND IMPLEMENTATION OF ADRC FUNCTIONS

Initial federal grants were made to 12 states in FY 2003, and additional states received grants in succeeding years. During subsequent grant cycles, selected states that had received prior-year funding have been eligible for special focus funding. The initial grants allowed some states to pilot ADRCs to carry out basic functions in one or more parts of each state, with the intent that additional federal grants and complementary state funding would enable all states to push out ADRC operations statewide and that over time all ADRCs would become fully functioning in all aspects of operations. As of October 2010, 325 ADRCs are in operation in 45 states and territories. Nine states and territories have ADRC programs in development.³⁰

Variations in Implementation

The variations in funding cycles and availability of grant funds have resulted in different patterns of implementation of the ADRC functions. This is exemplified in two of the five ADRC functions: options counseling (OC) and person-centered transition support. Also, ADRCs differ in the extent to which they serve people of all income groups.

Options Counseling—The AoA has recognized that implementation of the OC function varies within and across states; the resulting lack of uniformity necessitates more standardization. According to the AoA, consumers in one area of a state might be receiving different levels, types, and quality of OC. Qualifications criteria and training requirements for counselors vary among programs. In some states, counseling is provided by staff with advanced degrees in social work or nursing, in others by those with less training or experience.³¹

Another issue identified is the overlap between I&R/A, OC, and streamlined eligibility determination for public programs. OC is focused on understanding the needs of consumers and providing them information to help them understand their LTSS options and to develop plans on how they wish to have their needs addressed. Many ADRCs view OC as an extension of the ADRC I&R/A function and offer it to anyone who calls, but some reserve OC for consumers

who undergo a full assessment for nursing facility admission or for public home and community-based services.

In the state grant solicitation for FY 2010 funds, the AoA indicated that funds were to be used to help states develop and implement a comprehensive set of standards to improve and strengthen the OC function. States receiving grant funds will be expected to standardize policies and procedures related to OC, invest in staff training, and implement client tracking procedures to assess OC in their states. Funds are ultimately intended to produce a set of minimum national standards that will guide the AoA to improve OC operations in ADRCs nationwide. Standards will guide states in determining which consumers will be offered OC and under what circumstances; they will also cover staffing requirements, define core competencies, and establish training and recommended staffing ratios. States will be required to develop state-specific standard operating procedures for ADRC OC functions within six months of the AoA awards and to implement the standards by the end of the first year of the FY 2010 grant awards. Nineteen states and the District of Columbia received funds under this grant award.³²

Transition Support—Another area of variation among ADRCs is the extent to which they are involved in person-centered transition support (in the past referred to as person-centered hospital discharge planning).³³ At the inception of ADRCs in 2003, grants were to be used for creating formal linkages between and among the major pathways to LTSS, including having ADRC staff work with hospital discharge planners, physician offices, and nursing homes to link consumers with various community agencies and organizations that serve the ADRC target populations.³⁴ In subsequent years, CMS awarded dedicated funds to selected states to be used specifically to improve hospital discharge planning processes as part of the overall ADRC transitional care function. In FYs 2008 and 2009, CMS awarded 11 states almost \$13 million to develop hospital discharge planning processes that place greater emphasis on involving consumers and their families in post-discharge care plans. Grantee efforts have included development of discharge planning checklists, hospital staff training webinars, electronic referral, application and patient tracking systems, and use of transition coaches to follow up with individuals once they have been discharged.³⁵ The CMS hospital discharge planning grants to states generally allowed states to define what activities they would conduct based on state and local needs.³⁶

AoA grant guidelines for FY 2009 ADRC funds encouraged prospective grantees to strengthen ADRC coordination with hospital discharge planning programs and physician practices to help Medicare beneficiaries or individuals with chronic conditions avoid unnecessary hospital readmission by improving care transitions. Grantees were also encouraged to partner with federally supported care transition programs, such as those operated by CMS through Quality Improvement Organizations (QIOs), and to use other evidence-based care transitions interventions designed to increase linkages with physicians.³⁷ Through the CMS QIO Program ninth statement of work,³⁸ QIOs in 14 states are demonstrating care transitions projects efforts. In eight states, service areas of QIOs intersect with the ADRC service areas; in these areas ADRCs are to serve as key community partners to QIOs to connect individuals to home and community-based long-term care services and to options counseling or care management staff.³⁹

In its FY 2010 grant announcement, the AoA became more directive in its guidance by specifying that state recipients must use evidence-based care transition models. The AoA indicated that four evidence-based models meet its standards: the Care Transitions Intervention,⁴⁰ the Transitional Care Model,⁴¹ Guided Care,⁴² and Geriatric Resources for Assessment and Care of Elders.⁴³ While states may propose other models, they must be based on the results of randomized controlled trials. Sixteen states received funds under this 2010 announcement, and each state will implement one of six care transition models (the four mentioned, the Better Outcomes for Older adults through Safe Transitions [BOOST] model,⁴⁴ and the Bridge Program).⁴⁵

According to the ADRC Technical Assistance Exchange, as of May 2010, 49 ADRC sites in 40 states are either actively involved in or are in the planning stages of care transition activities. Those sites actually involved in care transitions activities use varying interventions.

The recent call by the AoA for OC and care transitions standardization across these two ADRC key functions should result in more uniformity for the limited number of states that receive FY 2010 funding. However, implementation of fully functional ADRCs in all states may occur incrementally over time, depending on available resources and level of commitment from state and local leaders.

Serving People Not Eligible for Public Programs—Another variation among ADRCs is the extent to which they assist people who do not rely on public LTSS programs. As noted above, people of all income levels

Helping families with higher incomes identify their LTSS options is one of the key ways that ADRCs can help individuals avoid unnecessary institutionalization and avoid spending down their resources to the point of becoming Medicaid-eligible.

have challenges navigating the LTSS system and could benefit from the information, referral, and options counseling services that ADRCs provide. Helping families with higher incomes identify their LTSS options is one of the key ways that ADRCs can help individuals avoid unnecessary institutionalization and avoid spending down their resources to the point of becoming Medicaid-eligible.

Targeting individuals and families with higher incomes is a relatively new priority for many of the partner organizations within an ADRC system, in particular area agencies on aging and CILs, and others that have traditionally focused on serving low-income older people and younger adults with disabilities. Means-testing and imposition of fees for Older Americans Act services (for example nutrition and supportive services) and CILs are prohibited by law.

While people with higher income levels cannot be turned away from services provided by area agencies on aging and CILs, most of these agencies are not staffed to provide services to these groups. Relatively few area agencies serve consumers who can afford to pay for the full costs of services. According to a survey by the National Association of Area Agencies on Aging, in 2008, about 28 percent of area agencies provided services to private-pay consumers; but an almost equal proportion did not plan to do so. In recent years, some area agencies have made progress in serving as SPEs for private-pay consumers for at least some services: in 2008, almost half of area agencies surveyed indicated that they served as an SPE for private-pay clients, compared to a little over one-third in 2007.⁴⁶

Because ADRCs have been funded by AoA and CMS discretionary grants, they are not restricted to serving people who have the greatest economic need. They are not bound by Older Americans Act prohibitions on means testing and fees, unless Title III funds are used. Some ADRCs are reportedly making progress on serving consumers with higher income levels. According to the ADRC Technical Assistance Exchange, over half of ADRC grantees report that they are actively targeting private-pay consumers. Almost half of projects that are able to track client income level have reported that about 30 percent of their clients are not low-income.

Area agencies that have been designated as ADRCs may have to make changes in their organizational culture to reach out to private-pay consumers who have not been the primary focus of their service programs. Also, use of specialized staff training, and social marketing tools may be necessary to serve this population.⁴⁷

FUNDING

From FY 2003 to FY 2010, the AoA and CMS have devoted almost \$111 million in discretionary grant funds to the ADRC initiative. Of total federal support, about 65 percent was from the AoA's Older Americans Act fund and 35 percent was from CMS's RCSC grant funds and other CMS funding (see Table 2).

TABLE 2 | Federal Funding for ADRC State Grants, FY 2003–FY 2010
(in millions of dollars)

Fiscal Year	No. of States Funded	AoA*	CMS†	Total	Funding Source/ Authorizing Legislation
2003	12	\$9.688	\$4.911	\$14.599	AoA Title IV funding and CMS Real Choice System Change grants
2004	12‡	\$7.936	\$4.485	\$12.421	AoA Title IV funding and CMS Real Choice System Change grants
2005	19§	\$8.922	\$6.164	\$15.086	AoA Title IV funding and CMS Real Choice System Change grants
2006 & 2007	None	0	0	0	
2008	11 (CMS)	0	\$12.976	\$12.976	CMS Person-Centered Hospital Discharge Planning grants and CMS Real Choice System Change grants
2009	49¶ (AoA)	\$22.367	0	\$22.367	AoA Title II and Title IV funding
2010	43§	\$23.132	\$9.986	\$33.118	Patient Protection and Affordable Care Act, Money Follows the Person Rebalancing Demonstration, and AoA Title II and Title IV funding
Total Funding All Years		\$72.045	\$38.522	\$110.567	

* Administration on Aging

† Centers for Medicare & Medicaid Services

‡ Includes Northern Marianas.

§ Includes District of Columbia.

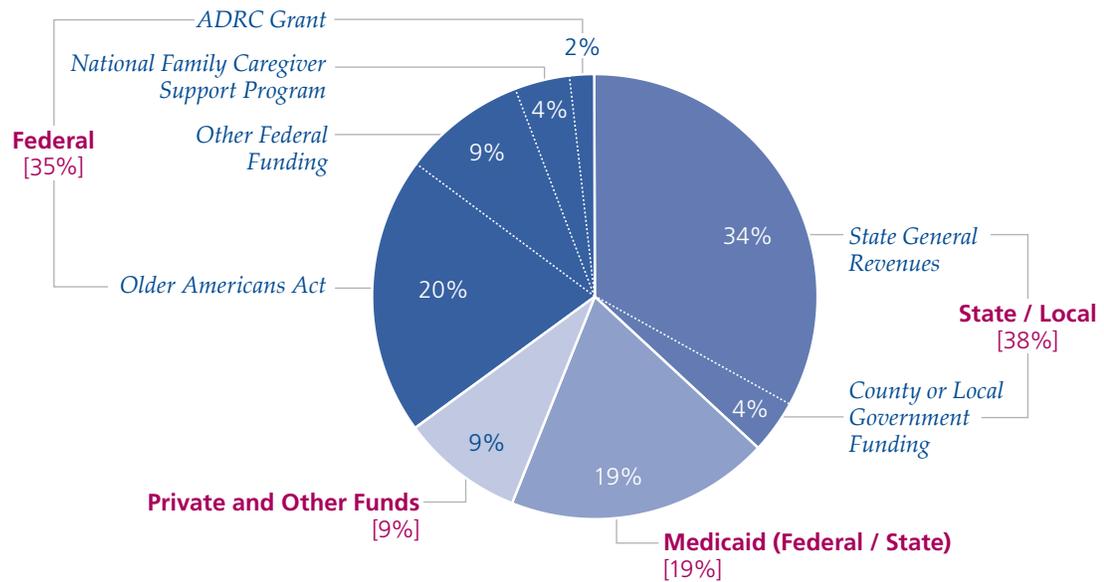
¶ Includes District of Columbia, Puerto Rico, and Guam.

Note: AoA did not fund ADRC grants in 2008. CMS reported funding for 2008 and 2009 combined.

Source: AoA, email communication with author, October 8, 2010.

AoA and CMS grant funding is intended to build upon the infrastructure of existing agencies that may already have responsibilities for information, referral, outreach, and access services. As shown in Figure 1, ADRC federal discretionary grants represent only 2 percent of funds for agencies that are implementing ADRC functions. The rest is from Older Americans Act formula grant funds and Medicaid funds, with fairly substantial support from state and local sources.

FIGURE 1 | Sources of ADRC Funding



Note: Due to rounding, percentages do not add up to 100 percent.
 (n = 107 program sites; average budget = \$2.0 million)

Source: Extracted from charts in *Aging and Disability Resource Center Technical Assistance Exchange, Aging and Disability Resource Center Semi-Annual Outcomes Report, draft, April 1, 2009-September 30, 2009, unpublished data, email communication with author, November 8, 2010.*

STATE AND FEDERAL EVALUATION OF ADRCs/SPEs

Future ADRC development will be affected by evaluation of the state initiatives. Some states have evaluated their programs, and a federal evaluation is planned.

State Evaluation Efforts

A few states have undertaken evaluation studies of their SPE systems. Some evaluations have studied consumer satisfaction as well as effectiveness of systems that ease consumer access. High levels of consumer satisfaction were found in analysis of ADRC operations in Wisconsin,⁴⁸ Michigan, New Hampshire, Vermont, and Georgia. Satisfaction measures included services received, ease of access, and staff responsiveness to unique individual needs and preferences, among other things.⁴⁹

An analysis in Wisconsin found that its ADRCs had developed policies and procedures that are aligned with generally accepted practices to support consumer access. It also pointed to some selected best practices, such as co-locating staff who perform functional and financial assessment of consumers needing LTSS, using methods to assure quality in the LTSS screening process, and processing applications for services within the 30-day required time frame.⁵⁰

Supporters of ADRCs indicate that they offer opportunities for greater cost efficiencies in delivering LTSS, for example, by streamlining consumer assessment and eligibility determinations and helping consumers access home and community-based alternatives to institutional services. Thus far, with the exception of limited state evaluation efforts, little attention has been given to the impact of ADRCs on cost-effectiveness. A state-mandated evaluation of the Michigan ADRC program, called Long-Term Care Connections (LTCC), conducted by Health Management Associates is considered the most rigorous review of impact on LTSS costs to date.⁵¹ The evaluation looked at changes in spending trends that might be correlated with the activities of the LTCC pilots. Although the study did not find cost savings as a result of the program, the researchers noted that cost data at the time of the evaluation were incomplete. They were cautiously optimistic that future savings could be achieved for two reasons: First, the study found that LTCCs improved the accuracy of level-of-care determinations for consumers applying for Medicaid nursing facility care; consequently, fewer people met the required minimum level-of-care threshold for Medicaid-funded nursing home care and were not admitted. Second, the LTCCs were found to be successful in helping people transition from nursing homes to the community with non-Medicaid services. The report indicated that, if these trends continued, there would be fewer individuals using Medicaid-funded nursing home care, leading to lower Medicaid

costs. The evaluators concluded that, going forward, “the LTCCs can be expected to generate sufficient savings in long term care costs to fully support their operations. The net result is not only a (small) cost savings to the state budget but also a better continuum of care for elderly and disabled individuals that need some degree of long term care supports and services.” Pinpointing direct cost savings attributable to ADRCs may be difficult. But as the Michigan evaluation showed, it is possible to compare areas of the state with and without ADRCs, controlling for a host of other factors, to determine the impact on costs.

Federal Evaluation Efforts

During the next several years, the AoA will partner with the Department of Health and Human Services’ Office of the Assistant Secretary of Planning and Evaluation and the Agency for Health Care Research and Quality to conduct an evaluation of ADRCs. The evaluation will be conducted in five to seven states, using a quasi-experimental design, and will sample communities that have ADRCs and those that do not. The goals of the evaluation are to understand the broad experiences of people who access LTSS and the community and program characteristics that facilitate access. The evaluation is expected to cost about \$2.2 million over the three-year period.⁵² A contract for the design implementation was awarded to IMPAQ International in September 2010.

A federal evaluation will face a number of challenges. Because of the wide variation among ADRCs nationwide, measurement may be difficult. However, impact on consumer satisfaction and access to care may be assessed by comparing consumer experiences in areas of a state with and without ADRCs, holding comparable levels of services and program funding constant. Also, because ADRC functions are relatively complex, involving multilayered levels of state and community administrative partnerships and coordination, any potential cost savings that ADRCs could achieve may have to be assessed within the context of broader state policies, programs, and funding streams. ADRCs are part of existing state and local infrastructures that often come with their own efficiencies or inefficiencies; therefore, it may be difficult to assess ADRC effects in isolation from a number of external factors.

GOING FORWARD: ADRCs AND LTSS SYSTEMS CHANGE

In creating the national ADRC program, the AoA and CMS set forth a vision that seeks to translate an uncoordinated LTSS “system” with inherent complexities to one that seeks to unravel the complexities for consumers. Taming the LTSS system might be considered by some to be a Sisyphean challenge. Moving from the original version of the program, pilot projects in a small number of states, to fully functional ADRCs in all states will take time and an undefined level of investment. ADRCs are charged with implementing a multifaceted agenda with limited resources. The \$111 million in federal AoA and CMS resources devoted to the effort through FY 2010 is extremely modest. ADRC FY 2010 appropriations of \$10 million represent less than \$1 for each person receiving LTSS and less than one-third of 1 percent of total Medicaid home and community-based services spending for FY 2009.

Evaluations that have been completed so far have pointed to some ADRC success in helping consumers. The Wisconsin evaluation described ADRCs as a way to “provide a voice for those who would otherwise ‘fall through the cracks’ or who may be too ill, or too proud to call attention to” their care needs.⁵³ Helping consumers navigate through LTSS and improve choice of services are laudable goals and have been on the agenda of LTSS policymakers for decades. But the amount of funding available for the nationwide federal ADRC initiative may be insufficient to accomplish these goals across all states. Also, some policymakers may want to challenge ADRCs to achieve some positive impact on saving avoidable LTSS costs and reducing unnecessary hospital readmission rates as well as to ease consumer access. Federal policymakers serious about sustaining momentum on these objectives may find that a multipronged strategy is necessary. Such an approach would include robust institutional diversion and transition programs, constraints on the nursing home supply and reimbursement, greater availability of home and community-based services to move people from waiting lists, and increased supply of the direct care workforce, among other things. A number of states initiated SPEs without the benefit of new federal funds, and policymakers may want to consider intensive state technical assistance efforts to showcase how these states achieved access improvement absent federal support. However, most states are facing intense fiscal constraints

ADRCs are charged with implementing a multifaceted agenda with limited resources.

and may be unlikely to invest a substantial amount of their funds in ADRC functions without the benefit of federal support.

The AoA and CMS have been fairly specific about ADRC functions, have articulated the vision in many venues, and have supported multiple technical assistance conferences and an extensive Technical Assistance Exchange effort to help states implement the vision. Even with these efforts, there appear to be wide variation in how ADRCs are implemented within and across states and differences in capacities among ADRCs. Variation is expected and capacities are affected by state and local commitment, resources, and infrastructure differences; however, the AoA's recent directives to states calling for more standardization and use of evidence-based criteria in implementation of two of the ADRC functions should bring about more uniformity among some aspects of the projects in the future. Some observers may also push for increased standardization in all of the ADRC functions. The level of success in bringing about standardization will in part depend upon the availability of sustained funding as well as state and local commitment.

As the national ADRC initiative unfolds in coming years, policy-makers may consider some of the following questions.

- Thus far, relatively limited data are available on the impact ADRCs have had on consumers and the LTSS system. The planned federal evaluation is expected to produce some information on ADRC effectiveness. What findings from the ADRC evaluation will be most important to guide policy on future funding?
- What level of resources, staffing, and training will it take to fully implement the ADRC vision and objectives? What level and combination of federal, state, and local resources will be needed to have statewide, fully functional ADRCs in all states?
- How will outcomes be assessed? Can ADRCs improve consumer access and coordination of LTSS systems? Will it be sufficient to achieve high consumer satisfaction and outcomes, even if cost-effectiveness is difficult to demonstrate? What factors external to ADRC implementation will affect cost-effectiveness?
- ADRCs are tasked with helping people plan ahead for their LTSS needs before they need care and assisting health care and community providers to reduce preventable hospital readmissions. What impact will ADRCs have on this objective?

- ADRCs are intended to improve consumer access, but are not funded to provide home and community-based services. Can the information ADRCs provide about unmet services needs in their communities be used to better target new investments in the home and community-based services system?
- ADRCs are required to serve people of all ages and income and disability levels. Traditionally, these groups have been served by different agencies, with different federal authorizing legislation and funding streams, making coordination and streamlined access difficult. Many ADRCs are reported to have successfully negotiated cross-agency partnerships. What federal, state, and local initiatives can be taken to help states facilitate such partnerships in the future?

ENDNOTES

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APPENDIX: Selected Criteria for Fully Functioning ADRCs, as Defined by the Administration on Aging and the Centers for Medicare & Medicaid Services*

Program Component: Information and Referral / Awareness (I&R/A)

Definition and Purpose

ADRCs are to (i) serve as a highly visible and trusted place where people of all ages, disabilities, and income levels can turn to for objective information on the full range of long-term services and supports (LTSS) options and (ii) promote awareness of the various LTSS options that are available in the community (especially among underserved, hard-to-

reach, and private-paying populations) as well as options individuals can use to plan ahead for their care. ADRCs should have the capacity to link consumers with needed services and supports, both public and private, through appropriate referrals to other agencies and organizations.

Selected Criteria/Metric to Assess Performance

Outreach and Marketing

- ADRCs have a proven outreach and marketing plan focused on establishing operating partners. ADRCs are to actively market to and serve private-pay consumers, in addition to those who require public assistance.

Information and Referral

- ADRCs use systematic processes across all operating partners to provide I&R/A, using the same comprehensive resource database about the range of LTSS resources in the ADRC service area.
- ADRCs consistently conduct follow-up with individuals receiving I&R/A to determine whether more assistance is needed.

Program Component: Options Counseling and Assistance

Definition and Purpose

The options counseling and assistance function is defined by the ADRC's ability to provide counseling and decision support, including one-on-one assistance, to consumers and their family members and/or caregivers. The main purpose of this function is to help consumers assess and understand their needs and to assist them in making informed decisions about appropriate LTSS choices, as well as their Medicare options, in the context of their personal needs, preferences, values, and individual circumstances.

Options counseling and assistance may also entail helping consumers to develop service plans and arranging for the delivery of services and supports, including helping individuals to hire and supervise their direct care workers. Individuals and families who receive options counseling should be in a better position to make service and support choices that optimally meet their needs and preferences and be able to make better use of their own personal and financial resources in the short term and over time.

Selected Criteria/Metric to Assess Performance

- Standards and protocols are in place that define what options counseling entails and who will be offered options counseling. At a minimum, options counselors will serve any consumer who requests assistance and those who go through a comprehensive assessment process.
- ADRCs have the capability, through a single or multiple operating partner(s), to provide objective, accurate and comprehensive LTSS counseling to consumers with different types of disabilities and families of all income levels.
- All ADRC operating partners that serve as entry points for consumers use standard intake and screening instruments.
- Options counseling sessions are conducted by staff trained

and qualified to provide objective, person-centered assistance to consumers in the process of making decisions, as evidenced by certification, minimum qualifications, and/or training/cross-training practices.

- ADRCs provide intensive support to individuals in short-term crisis situations until LTSS arrangements have been made.
- ADRCs consistently conduct follow-up to individuals receiving options counseling to determine the outcome and any need for more assistance.
- ADRCs provide individuals and families with assistance in planning for future LTSS needs directly or contractually by staff who possess specific skills related to needs planning and financial counseling.

* These criteria were developed to assist states in measuring their progress toward developing fully functioning SPEs and ADRCs. As illustrated elsewhere in this paper, not all ADRCs perform all aspects of these criteria.

Program Component: Streamlined Eligibility Determination for Public Programs

Definition and Purpose

LTSS are funded by a variety of different government programs administered by a wide array of federal, state, and local agencies, each with its own eligibility rules, procedures, and paperwork requirements. The streamlined eligibility determinations for the public programs component of an ADRC is defined by its ability to serve as a single point of entry to all publicly funded LTSS, including those funded by Medicaid, the Older Americans Act, and other state and federal programs and services. This requires ADRCs to have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to performing the following administrative functions for all public programs (including both home and community-based services programs and institution-based programs):

- Consumer intake
- Screening
- Assessing an individual's needs
- Developing service/care plans
- Determining programmatic and financial eligibility
- Ensuring that people receive the services for which they are eligible

The goal is to create a process that is both administratively efficient and seamless for consumers, regardless of which program they are eligible for or the types of services they receive.

Selected Criteria/Metric to Assess Performance

Intake and Screening

- ADRCs have a standardized process for helping consumers access all publicly funded LTSS programs available in the state.
- In multiple entry point systems, the intake and screening process is coordinated and standardized so that consumers experience the same process wherever they enter the system.

Financial and Functional Eligibility Processes

- Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by ADRCs, so consumers experience it all as one process.
- ADRCs use uniform criteria to assess risk of institutional placement in order to target support to individuals at high risk.
- Staff located on-site within ADRCs conduct level-of-care assessments that are used for determining functional/clinical eligibility, or ADRCs have a formal process in place for seamlessly referring consumers to the agency that conducts level-of-care assessments.
- ADRC staff assist consumers as needed with initial pro-

cessing functions (for example, taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews).

- Staff located on-site (co-located from or delegated by the single state Medicaid agency) within ADRCs can determine financial eligibility, or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers.

Tracking Eligibility Status

- ADRCs are able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination.
- ADRCs are routinely informed of consumers who are determined ineligible for public LTSS programs or services and conduct follow-up with those individuals.

In localities where waiting lists for public LTSS programs or services exist, ADRCs are routinely informed of consumers who are on waiting lists and conduct follow-up with those individuals.

Program Component: Person-Centered Transition Support

Definition and Purpose

The person-centered transitions component is defined by an ADRC's ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made, usually

in a time of crisis, that often determine whether a person ends up in a nursing home or is transitioned back to his or her own home.

ADRCs can play a pivotal role in these transitions to ensure that people end up in the settings, often their own homes, that best meet their individual needs and preferences. ADRC staff can be present at these critical points to provide individuals and their families with the information they

Definition and Purpose *(continued)*

need to make informed decisions about their service and support options and to help them to quickly arrange for the care and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a

nursing home. They can also break the cycle of readmission to the hospital that often occurs when a chronically impaired individual is discharged to the community without needed social services and supports.

Selected Criteria/Metric to Assess Performance

ADRCs have formal agreements with local critical pathway providers, such as hospitals, physician's offices, nursing homes, and intermediate care facilities for people with intellectual or developmental disabilities. These agreements include:

- An established process for identifying individuals and their caregivers who may need transition support services

- Protocols for referring individuals to the ADRC for transition support and other services
- Regular training for facility administrators and discharge planners about the ADRC

ADRCs work with the state Medicaid agency to become local contact agencies to provide transitions services for institutionalized individuals who indicate they wish to return to the community.

Program Component: Consumer Populations, Partnerships, and Stakeholder Involvement**Definition and Purpose**

Many ADRCs started out serving older adults and one other target population, such as adults with physical disabilities, intellectual or developmental disabilities, or mental illness. ADRCs are intended to work towards the goal of serving persons with disabilities of all ages and types.

To be truly person-centered, ADRCs must meaningfully involve stakeholders, including consumers, in planning, implementation, and quality assurance activities.

In order to function efficiently and serve as the single entry point for the full array of LTSS programs in the state, ADRCs must have the documented support and active participation of the single state agency on aging, the single state Medicaid agency, and the state

agency or agencies serving the target populations(s) of people with disabilities. ADRCs should also establish strong partnerships with state health insurance assistance programs, adult protective services, benefit outreach and enrollment centers, and other programs instrumental to ADRC activities. Examples of other important programs and partners to cultivate include area agencies on aging, centers for independent living, Alzheimer's disease programs, developmental disabilities councils, information and referral 2-1-1 programs, long-term care ombudsman programs, housing agencies, transportation authorities, state mental health planning councils, one-stop employment center, and other community-based organizations.

Selected Criteria/Metric to Assess Performance**Consumer Populations**

- ADRCs serve individuals with all types of disabilities, either through a single operating organization or through close coordination with multiple operating partners.
- ADRC staff demonstrate competencies relating to serving people of all ages and types of disabilities and their families.
- Formal mechanisms for involving consumers on state/local ADRC advisory boards or governing committee and in planning, implementation and evaluation activities are in place.

Medicaid

- ADRCs have formal partnership agreements at the local level (or at the state level if applicable across all sites) with Medicaid agency(ies) that describe explicitly the role of each partner in the eligibility determination process and information-sharing policies.
- ADRC staff are involved as partners or key advisors in

other state LTSS system reform initiatives (for example, Money Follows the Person).

Aging and Disability Partners

- In multiple entry point systems, ADRCs have formal service standards, protocols for information sharing, and cross-training across all operating partners.
- In single entry point systems, strong collaboration, including formal agreements, exists at the state and local levels between critical aging and disability agencies and service organizations.

Stakeholders

- If the state health insurance assistance program, adult protective services, and local 2-1-1 programs are operated by entities separate from ADRCs, there is a memorandum of understanding or interagency agreement establishing, at a minimum, a protocol for mutual referrals between the ADRC and these three programs.
- Evidence of strong collaboration with other programs and services instrumental to ADRC activities exists.

Program Component: Quality Assurance and Continuous Improvement

Definition and Purpose

Quality assurance and continuous improvement is a part of every ADRC system to ensure adherence to the highest standard of service, as well as to ensure that public and private investments in ADRCs are producing measurable results.

ADRCs should be using electronic information systems to track their customers, services, performance, and costs and to continuously evaluate and improve on the results of the ADRC services that are provided to individual consumers and their families, as well as to other organizations in the community. These systems can include linkages with other

data systems, such as Medicaid information systems and electronic health records.

The quality assurance and continuous improvement component of an ADRC should also involve formal processes for getting input and feedback from consumers and their families on the ADRC's operations and ongoing development. Every ADRC should have measurable performance goals and indicators related to its visibility, trust, ease of access, consumer responsiveness, efficiency, and effectiveness.

Selected Criteria/Metric to Assess Performance

Staffing

- ADRCs have adequate capacity to assist consumers in a timely manner with LTSS requests and referrals, including referrals from critical pathway providers.
- In multiple entry points systems, ADRCs have one overall coordinator or manager with sufficient authority to maintain quality processes across agencies.

Information Technology/Management Information Systems

- ADRC operating organizations use management information systems that support all program functions.
- ADRCs have established an efficient process for sharing resource and client information electronically across operating partners and with external entities, as needed, from intake to service delivery.

Continuous Improvement

- ADRCs have a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered such as consumer satisfaction evaluations.
- ADRCs inform consumers of complaint and grievance policies and have the ability to track and address complaints and grievances.

Performance Tracking

- ADRCs routinely track service delivery and consumer outcomes and can demonstrate:
 - That the ADRC serves people in different age groups and income levels and with different types of disabilities in proportions that reflect their relative representation in the community
 - That options counseling provided enables people to make informed, cost-effective decisions about LTSS.
 - The number of individuals diverted from nursing home/institutional settings
 - The number of individuals successfully transitioning from institutional settings (that is, the number of people assisted through formal coordinated transitions programs)
- States operating ADRCs evaluate their overall impact in the following areas:
 - Reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services
 - Impact on the use of home and community-based services as opposed to institutional services
 - Documentation of the cost impact to public programs, including Medicaid

Source: Aging and Disability Resource Center Technical Assistance Exchange, "Fully Functioning Criteria for Single Entry Point Systems and ADRCs." June 3, 2010; available at www.adrc-tae.org/tiki-index.php?page=Guidelines. Selected components of each criterion/metric have been abbreviated, and slight wording changes from the original document have been made for incorporation in this Forum publication.