Nebraska's Aging and Disability Resource Center Pilot

Year 2 Evaluation Report

HCBS STRATEGIES INCORPORATED

HCBS.INFO

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Acronyms

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

Executive Summary

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

HCBS Strategies was awarded a three-year contract to conduct an evaluation of three ADRC pilot sites that initiated their efforts in July 2016. At the end of 2016, HCBS Strategies produced the Initial Report on these operations. This report evaluates the ADRCs' performance through September 2017. HCBS Strategies will produce one final report at the end of 2018.

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

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

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

The major concern about the ADRC pilot is that it is operating as a separate Area Agency on Aging (AAA) program that overlaps with other AAA programs, notably Information and Assistance (I&A) and Care Management. Because the roles and responsibilities between the ADRC, AAA I&A, and AAA Care Management staff differs across the AAAs, the types of individuals routed to the ADRC differs dramatically. While it was not a requirement of the Request for Grant Proposals (RFGP) for AAAs to integrate the ADRC within their operations, this should occur if the ADRC is to be a successful ongoing initiative.

Some of the support being offered by ADRC staff goes beyond the categories of services included in the original ADRC model. This support appears to fall into two categories: 1) Extensive assistance provided to individuals who are challenging to support; and 2) Assistance provided to individuals who are currently being served by another agency or agencies. The State

should consider revising the model to either accommodate these services or define them as not being part of the ADRC mission.

The analyses of the ADRC data reveal the following:

- The SUA, AAAs/ADRCs, and partner agencies have expanded the number and types of resources that are available in the Information and Referral (I&R) database so that it now includes a substantial number of resources for disability populations other than older adults.
- The ADRCs had 12,198 contacts from 6,329 different individuals from July 1, 2016, the beginning of the pilot period, to September 30, 2017. Of these individuals, 1,805 received basic information, 4,776 received I&R, and 572 received Options Counseling or Enhanced Options Counseling.
- The ADRCs had 895 contacts from 341 different people ages 18-60. There were also a small number of contacts for children and individuals with autism spectrum disorders. Of these individuals, 74 received basic information, 296 received I&R, and 49 received Options Counseling or Enhanced Options Counseling (Note: An individual is counted more than once if they receive more than one type of service, however the total reflects unique individuals).
- ADRC staff appeared to be doing a good job of following up with almost everyone who requested follow-up.
- ADRC staff are developing Action Plans that tend to include a variety of sources of support.
- Individuals receiving I&R and Options Counseling consistently give these services very high ratings.
- While the limited number of OC surveys requires caution in interpreting the data, the results suggest that the ADRCs are preventing or delaying nursing facility use.

The data analyses raised the following concerns:

- The ADRC data only represents a small slice of the information and counseling being provided by the AAAs. Assistance provided under AAA I&A and Care Management make up the bulk of these services.
- Differences in how the AAAs have structured AAA I&A and Care Management and the relationship of the ADRC staff to these programs are likely distorting the data.
- The number of participant surveys was smaller than expected, especially for Options Counseling. This limits the validity of any conclusions.

- Action Plans only contained person-centered goals in a little more than a third of the cases. For most individuals, the goals in these plans just reiterate the services to be provided.

This report also discusses changes necessary to the ADRC initiative to allow it to evolve into a No Wrong Door (NWD) system that is described in the *Nebraska Long Term Care Redesign Plan,* which came out after we completed the Initial Report. While much of the infrastructure developed for the ADRC pilot could serve as a starting point for a NWD system, the ADRC would need to be transformed from a program into a network. This would include integrating AAA and ADRC functions; integrating the work of other entities that serve as access points for publicly-funded LTSS; and developing a sustainability plan that capitalizes on existing funding to minimize the need for additional funding.

Background

NATIONAL ADRC/NWD EFFORTS

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

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

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

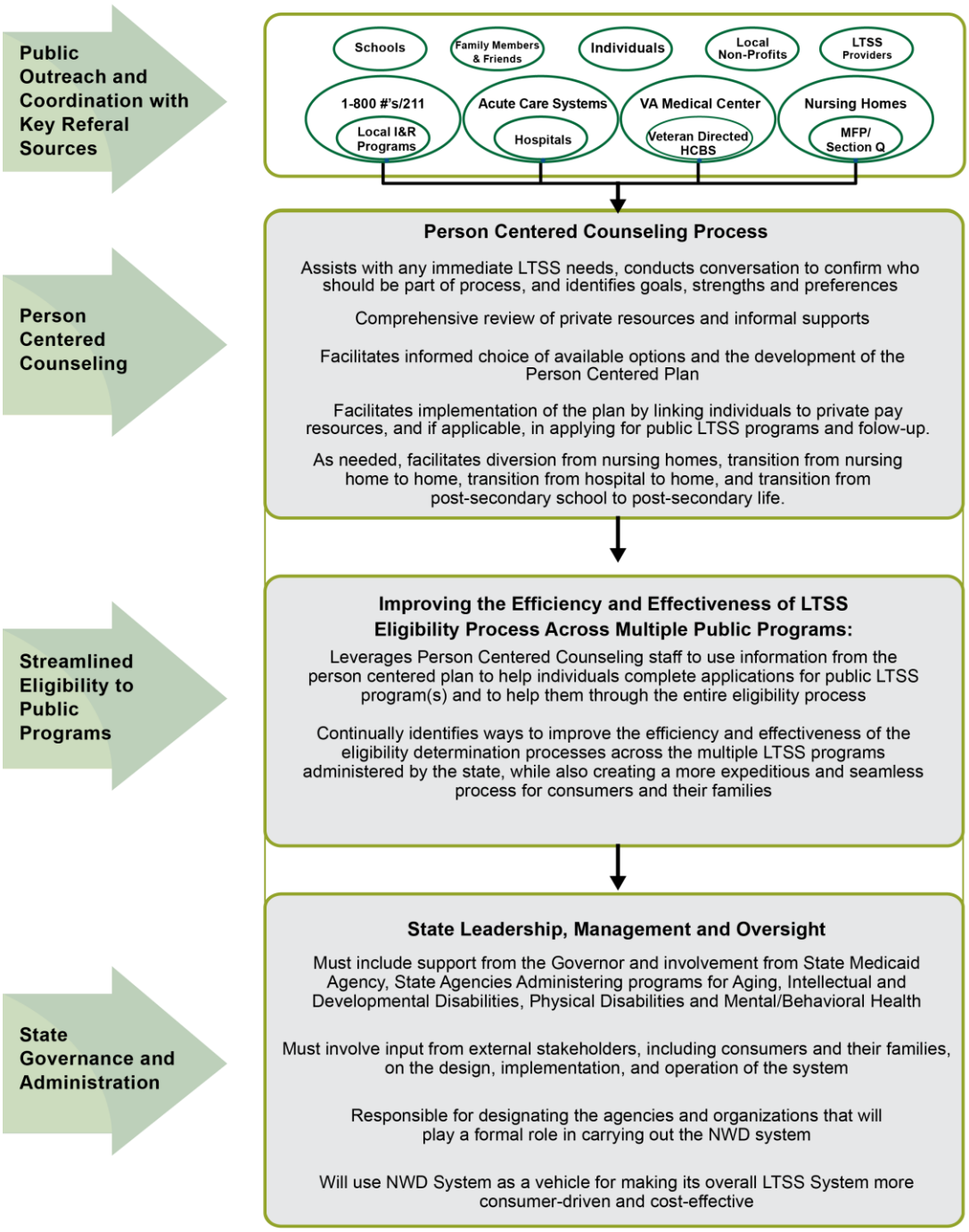
This evolution created challenges because most states had existing entities that provided ADRC-like services to other populations, such as individuals with intellectual and developmental disabilities (IDD). To accommodate this, the federal guidance has shifted to describing a No Wrong Door (NWD) network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

No Wrong Door Schematic

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

BACKGROUND

EXHIBIT 1: FEDERAL NO WRONG DOOR SCHEMATIC



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

BACKGROUND

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

NEBRASKA'S ADRC PILOT EFFORT

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

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

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

(1) Comprehensive information on the full range of available public and private long-term care programs, options, financing, service providers, and resources within a community, including information on the availability of integrated long-term care;
(2) Assistance in accessing and applying for public benefits programs;
(3) Options Counseling;
(4) A convenient point of entry to the range of publicly supported long-term care programs for an eligible individual;
(5) A process for identifying unmet service needs in communities and developing recommendations to respond to those unmet needs;

(6) Facilitation of person-centered transition support to assure that an eligible individual is able to find the services and support that are most appropriate to his or her need;
(7) Mobility management to promote the appropriate use of public transportation services by a person who does not own or is unable to operate an automobile; and
(8) A home care provider registry that will provide a person who needs home care with the names of home care providers and information about his or her rights and responsibilities as a home care consumer.

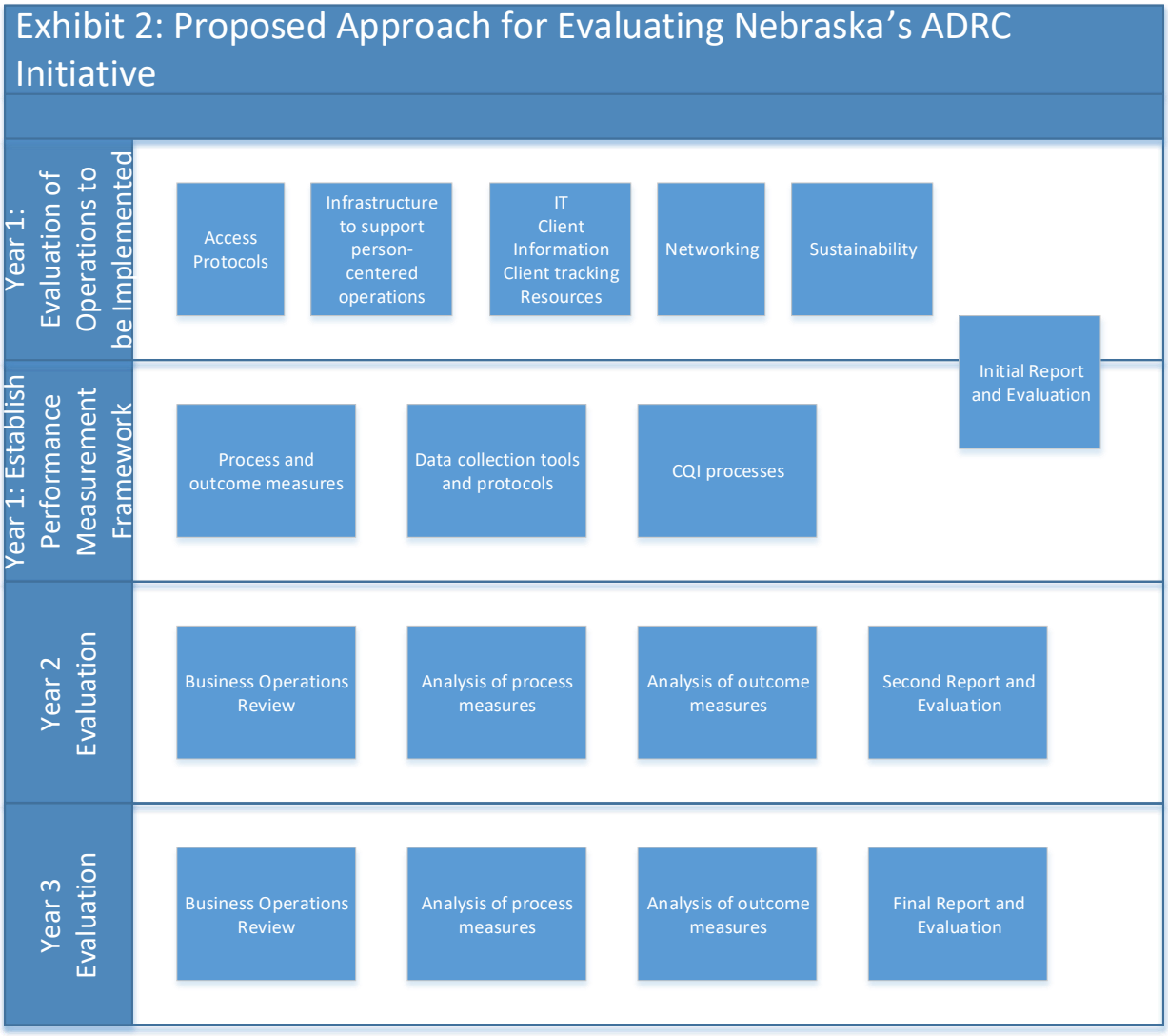
The legislation limited potential pilot sites to Area Agencies on Aging (AAAs). However, the legislation required that these AAAs coordinate with entities that support other populations with disabilities. The legislation does not specify what this coordination should consist of. Instead, it requires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

It is important to note that even if the pilot sites assumed all the functions included in the legislation, the results of the pilot may not address the core question of whether the ADRC can meet all the outcomes for the following reasons:

1. Streamlining and coordinating access functions, including outreach, triage, assessment, and support planning, for all disability populations will require leadership from the State. In Nebraska, a combination of State agencies, local government agencies, and private sector agencies fulfill these functions. They currently operate in silos, separated by disability population (e.g., IDD, older adults, etc.). While the ADRCs can help navigate this web of agencies, State leadership is necessary to truly streamline and coordinate these systems.
2. The legislation did not address if and how the ADRC effort should be integrated with existing AAA access functions (notably Information and Assistance (I&A) and Care Management) and other functions currently being provided by disability partners. If the ADRC effort is meant to build a seamless system, it is necessary to determine where these existing functions fit and how they will need to change to fulfill the goals for the ADRC.
3. Sustainability and cost-effectiveness are important factors that will likely determine whether to continue the ADRC effort, yet the legislation does not explicitly address this. ADRC efforts that have been successful in other states have taken two primary approaches on this issue. One, they have tried to make the business case that the ADRCs save a state money by delaying Medicaid eligibility, especially for expensive institutional services. Two, they have repurposed existing funds and added new sources of funding, such as Medicaid administrative Federal Financial Participation (FFP).

Approach for the Evaluation

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



Business Operations Review

For this report, we built upon the information that we collected as part of the Initial Report. We conducted a site visit in September 2017 in which we traveled to the ADRC sites of each of the three lead agencies and met with staff from all the ADRCs. During these meetings, we addressed the following:

- Review of preliminary ADRC data and Action Plans completed by the ADRC
- Overview of operations from initial phone call to triaging level of need to providing and recording outcomes
- Plans for enhancing operations
- Integration of the ADRC within the broader LTSS system
- Barriers and challenges to operating and building the ADRC
- Vision for next steps in the evolution of the ADRC
- Plans for sustaining and expanding the ADRC

The following exhibits describe the plans for building ADRC operations as of September 2017:

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

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

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Current Standardization	Documentation and Notes
Infrastructure for coordinating across sites	The AAAs have implemented a statewide ADRC Advisory Council and local Advisory Councils. These councils will facilitate collaboration among the AAAs and with other ADRC partners.	Finalized plans	Fully Implemented	Standardized across all AAAs	We reviewed meeting minutes.
Outreach/Marketing	The AAAs have worked with the ADRC Coordinators to develop a formal marketing plan. It is envisioned that this marketing plan will be implemented once the operations of the ADRC are solidified. The AAAs will also be members in statewide and local ADRC Advisory Councils. These councils will help raise awareness of ADRC effort and enhance coordination with other State agencies and disability partners.	Draft plans	Fully Implemented	AAA specific	We reviewed plan and samples of marketing materials.
Linkages to Pathways to LTSS	The AAAs envision that they will continue to improve coordination efforts with health systems and discharge planners statewide to decrease hospital readmission through programs like AIMs. They also envision strengthening the process of responding to individuals who are flagged in Minimum Data Set (MDS) Section Q[1] as wanting to leave a nursing facility. The AAAs are interested in examining how to implement and	Partially imp./plans in flux	Partially imp./plans in flux	AAA specific	Advisory Council Meeting minutes discuss coordination. ADRC staff were able to provide examples during onsite meetings.

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

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Current Standardization	Documentation and Notes
	receive reimbursement for functions carried out by the ADRCs.				
Description of Intake Process	The AAAs envision that the ADRC intake functions will be blended into the AAA intake functions, rather than working in a silo. The coordination team is working to standardize these practices across agencies to the extent possible. There is also a vision of having a standardized tool for collecting initial information about the caller and having intake staff be familiar with the NAPIS[2] data requirements so that this information is captured in an efficient and effective manner.	Finalized plans	Partially imp./plans in flux	Partially standardized across all AAAs	While each of the ADRCs had established intake procedures, in many of the ADRCs, intake for AAA functions is not integrated with the ADRC intake.
Ability to track individuals who contact the AAA/ADRC	The Trilogy system is sufficient for current practices, but an enhanced system to collect a wider range of metrics is desired by both the AAAs and the State. The State envisions implementing an Options Counseling module and developing further reporting capabilities within the Trilogy system. SUA is developing an RFP to procure a system that will better meet their needs. The coordinating team will continue to work with the AAAs to develop the contents of the dashboard and ensure that it is being utilized in a consistent manner.	Draft plans	Partially Implemented	Partially standardized across all AAAs	While intake for the ADRC is standardized and data is being captured in the Trilogy system, AAA I&A is not being captured in this system by most AAAs. In addition, practices for collecting these data appear to differ.

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

BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Current Standardization	Documentation and Notes
Triage: Processes for determine where to route people who contact the AAA/ADRC	The ADRC effort developed standardized guidance regarding how to triage people to other agencies or within the different ADRC offerings (e.g., information and referral (I&R), Options Counseling (OC), Enhanced Options Counseling (EOC)).	Draft plans	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Determination of who will get I&R, Options Counseling, Enhanced Options Counseling or another service	The ADRC effort has developed definitions for who should refer I&R, Options Counseling, and Enhanced Options Counseling. The definitions have been incorporated into ADRC operations.	Draft plans	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Required timeframes	Participant identifying information (name and AAA) must be entered on the Dashboard by the close of business on the day contact was made. All participant information must be entered on the Dashboard within two business days following the contact	Developing plans	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Staff qualifications and training	Each ADRC developed standardized staff qualifications and training for each position that align with the requirements in the Request for Grant Proposals (RFGP).	Developing plans	Fully Implemented	AAA specific	Descriptions of staff qualifications were provided.

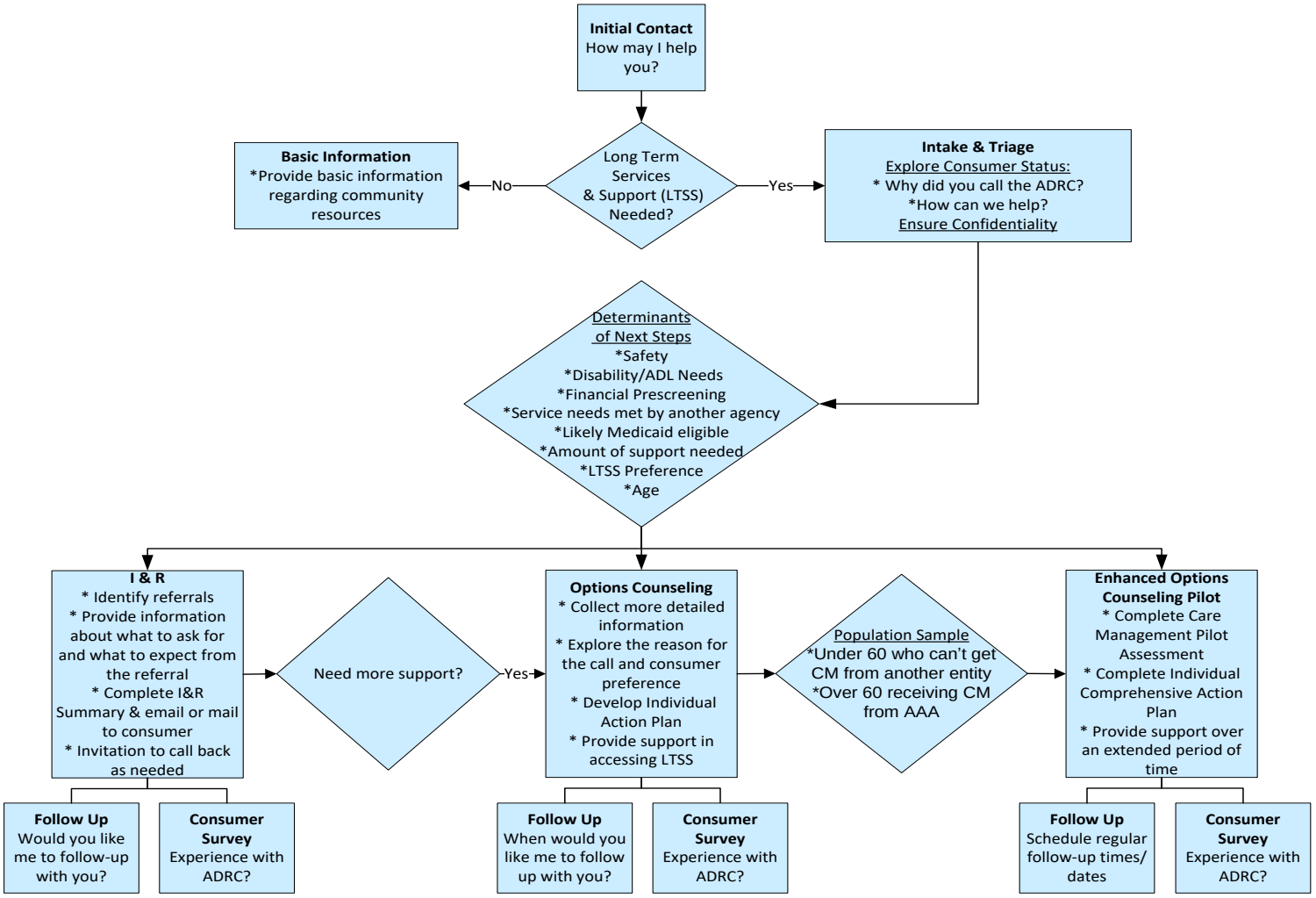
BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Current Standardization	Documentation and Notes
Description of the LTS Options Counseling Process	The vision under the ADRC model is to delineate and define I&R, Options Counseling, and Enhanced Options Counseling to improve clarity about what Options Counseling is and when it should be provided. Training materials and accompanying tools have been developed for each of the options. All options may result a written document that summarizes the outcomes of the process.	Finalized plans	Fully Implemented	AAA specific	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Description of assessment	The pilot sites are using the AAA Care Management assessment as the tool for people who receive Enhanced Options Counseling under the pilot. The AAAs are only collecting high-level assessment categories for Options Counseling and I&R.	Partially imp./plans finalized	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Written plan or other instructions given to clients	The ADRC effort developed standardized template for written plans. Individuals receiving I&R are offered a document that summarizes the referrals, which can be either emailed or mailed to them. Individuals receiving Options Counseling are offered a written plan that identified goals and activities. Enhanced Options Counseling uses a similar format, but includes more comprehensive information.	Finalized plans	Fully Implemented	AAA specific	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring. Very few written plans were created for I&R. Trilogy should develop the ability to upload I&R plans into the system for tracking.

BUSINESS OPERATIONS REVIEW

Business Process	Plans Identified in Initial Report	Status in the initial report	Status as of September 2017	Current Standardization	Documentation and Notes
Required timeframes	The ADRCs have established the following required timelines: • I&R information must be mailed or emailed to participant within three business days of contact. • The Individual Action Plan (IAP) must be mailed or emailed to the participant within five business days of the contact. • For I&R participants, the satisfaction survey is sent within two weeks of the date of service. • For OC participants, the satisfaction survey is sent within two weeks of when the OC case is closed.	Developing plans	Fully Implemented	Standardized across all AAAs	Review of the operations manual and discussions during the onsite reviews demonstrate this is occurring. Unfortunately, the Trilogy system was not capable of tracking these timeframes.
IT (use of NAMIS, Trilogy, and/or other IT)	The ADRCs are using the Dashboard function within the Trilogy system to track calls and clients. Written plans are either be completed using Microsoft Word or fillable PDF templates.	Partially imp./plans in flux	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring.
Approach for updating LTSS resources in the Trilogy system	Several taxonomy categories were added to the database to identify the number of resources in a manner required by the RFGP. The State Unit on Aging (SUA) is producing reports that summarize these resources. The AAAs are using that information to address weaknesses within the database. To standardize processes, the AAAs are considering staff become AIRS-certified, an industry standard for providing quality I&R services.	Finalized plans	Fully Implemented	Standardized across all AAAs	Data in the Trilogy system and discussions during the onsite reviews demonstrate this is occurring. Only one of the ADRCs has obtained AIRS-certification for its staff.

EXHIBIT 4: ADRC PILOT OPERATIONS MODEL



As shown in ***Exhibit 4***, the ADRCs offer four tiers of services:

- **Basic information** is provided to individuals who do not require any referrals or other counseling.
- **Information and Referral (I&R)** is similar to the assistance provided by the AAAs under I&A. The major changes from AAA practices are:
    - This service is available for all individuals with disabilities.
    - Individuals are offered a standardized written referral plan. The referral plan is included in ***Appendix 1***.
    - More data about the individual and the types of referrals are being tracked.
    - People who would benefit from more than just referrals are receiving either Options Counseling or Enhanced Options Counseling. Some of the individuals who currently receive more intensive assistance under AAA I&A may be triaged to Options Counseling.
- **Options Counseling (OC)** is an intermediate service that results in a standardized written plan that identifies the individual's goals and the action steps necessary to meet those goals. The most recent version of the Individual Action Plan (IAP) is included in ***Appendix 1***. This service is available to all populations with disabilities and their caregivers.
- **Enhanced Options Counseling (EOC)** is a more intensive service that is being piloted with a limited number of individuals at two pilot sites (Aging Partners (AP) and South Central Nebraska Area Agency on Aging (SCNAAA)). Many of these individuals would have otherwise received AAA Care Management. For adults ages 60 and over, pilot participants will receive the current Care Management comprehensive assessment. The major change is the use of a standardized written action plan that is similar to, but more comprehensive than, the IAP developed through OC.

EXHIBIT 5: DESCRIPTIONS OF THE ADRC SERVICES

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

BUSINESS OPERATIONS REVIEW

Work Domains	Basic Information	Information & Referral (I&R)	Options Counseling	Enhanced Options Counseling
Number of Contacts	Most typically only one	Contact is typically only one or two contacts over a limited length of time.	Contacts are multiple over a longer period of time (typically no more than 90 days).	Contacts are multiple over a longer period of time (typically more than 90 days).
Nature of Contacts	Telephone	Telephone, email or face-to-face in the ADRC office	Telephone, email, face-to-face in ADRC office or in participant's home	Telephone, email, face-to-face in ADRC office and in participant's home
Assessment	None	Information on Dashboard	Information on Dashboard	Information on Dashboard Comprehensive assessment
Action Planning	None	The 'Information & Referral Summary' is completed and mailed or emailed to the participant.	The 'Individual Action Plan' is completed with the participant face-to-face.	The Individual Comprehensive Action Plan is based on the person-centered planning philosophy and done in conjunction with the participant.
Follow Up	None	Follow-up is not needed or minimal based on participant preference.	Follow-up is ongoing until services and supports are secured by the participant.	Follow-up and monitoring is on-going until participant reaches stabilization with LTSS provided.
Documentation	Dashboard Information: Record AAA and designate as a basic information call	Dashboard information I&R summary Referrals Follow-up notes	Dashboard information Consent to release/receive information forms Individual Action Plan Referrals Follow-up notes	Dashboard information Consent to release/receive information corms Comprehensive assessment Individual Comprehensive Action Plan Referrals Follow-p notes

Enhancement of the Trilogy Network of Care Database

To provide I&R and other services to populations other than older adults, the ADRCs needed to enhance their searchable database, the Trilogy Network of Care (TNoC) database, that catalogues these resources. The current database has been developed using existing resources for the ADRC pilot, however SUA's procurement of an automated system that will better meet their needs will enhance capabilities of the database. During the past year, the State Unit on Aging (SUA), the ADRC Coordinators, ADRC staff, disability partners, and the evaluators worked together on the following enhancements:

- **Categories included in the database were expanded:** This was necessary to add resources that were relevant to other populations with disabilities and to be able to evaluate whether the ADRC effort was allowing individuals to be better informed about a list of resources identified in the evaluation Request for Proposals (RFP).
- **Identify areas in the database to be enhanced:** HCBS Strategies pulled information from the database into a series of tables to classify available resource by: a) resource type (e.g., home delivered meal), b) geographic area covered (by AAA coverage area), c) disability groups covered, and d) whether the resource has been updated in the past year. This report evaluates the degree to which the ADRCs have strengthened the database.

Progress Made Towards Overcoming Challenges to Meeting the ADRC Pilot Vision Identified in the Initial Report

In the Initial Report, we identified the following challenges to implementing the ADRC pilot as originally conceived in the legislation and RFGP:

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

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

We also identified challenges that must be addressed if the ADRC vision is to be successful beyond the pilot in the Initial Report. Because these issues are germane to proposals included in the *Nebraska Long Term Care Redesign Plan*, we have integrated the discussion of these challenges with our analyses about the ability of the ADRC pilot to evolve into the type of NWD system identified in the *Redesign Plan* later in this report.

Strengthening Referrals to Other LTSS Access Points

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

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

The ADRCs have made progress in building relationships with other entities supporting individuals with disabilities, especially at the local level. We identified multiple examples of this in notes from the local and State Advisory Council meetings and our discussions with staff and representatives from the disability partners. These relationships include collaborating on individual cases; presenting at and receiving presentations from partner agencies on available services and supports; and coordinating across referrals. This appears to have resulted in facilitating access to supports who were previously unserved or underserved, especially for individuals who are challenging to serve, such as homeless individuals with mental health needs.

We did not observe progress being made in translating these relationships into ongoing policies and procedures and written agreements as recommended in the Initial Report. Some of the ADRCs identified "turf issues" with other disability agencies as one of the challenges. These issues may be resulting from not clearly delineating the roles of the various agencies supporting people with disabilities.

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

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

In the Initial Report, we identified issues raised by the disability partners and recommended actions to be taken to address these concerns. Based on interviews with ADRC staff and the disability partners, the ADRC initiative has made substantial progress in this area. ***Exhibit 6*** shows the original recommendation followed by the actions taken by the ADRCs to remedy these concerns and any additional recommendations:

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

Recommendation in the Initial Report	Actions taken by the ADRC team	Additional recommendations
The disability partners should be asked to train ADRC staff on working with people with disabilities. The curricula could include topics such as disability etiquette.	Disability partners held several trainings for the ADRC team, including content on disability etiquette.	The ADRC teams should build off this success and develop a set schedule that includes scheduled core topics rather than holding trainings on an ad hoc basis.
The ADRC effort should more clearly delineate the type of input needed from the disability partners that could be addressed at a State level and clarify when representatives from these partners should be included on local Advisory Councils.	Although there is not a document that clearly lays out the roles, the State Advisory Council has focused more on overall program operations, while the local agencies have focused more on cross training with local partners and collaborating on individual cases.	The ADRC should develop a policy that clearly lays out the expectations for both the State and local Advisory Councils.
A stronger effort should be made to include disability partners that represent individuals with mental health issues.	The disability partners noted that this has occurred at the local level. Some of the disability partners expressed concern about mental health representation at the State level. The council roster includes a representative from the Division of Behavioral Health (DBH),	The ADRC team should strengthen the efforts to have mental health representation on the State Advisory Council.

Recommendation in the Initial Report	Actions taken by the ADRC team	Additional recommendations
	however, the disability partners recommended including other individuals outside of DBH.	
The disability partners should be assigned a central role in enhancing the TNoC database. This would include both adding resources targeted to populations with disabilities other than older adults to the database and helping to ensure that the information in the database is accurate and useful.	The disability partners were trained on how to provide resources for the database and provided many recommendations. The number of disability-related resources in the database increased substantially.	None

Ensuring the ADRC Brand Includes All People with Disabilities

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

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

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

However, as shown in the analysis of the data, most of the call volume is going directly to the AAA and the ADRC is not identified unless an individual is routed to the ADRC. This issue is

a component of the larger issue around integration of the ADRC and the AAA which we discuss later.

Potential Changes to the ADRC Model

Our discussions with staff at the pilot sites revealed that some of the support being offered by ADRC staff does not fit well with the categories of services included in the original ADRC model. This support appears to fall into two categories: 1) Extensive assistance provided to individuals who are challenging to support; and 2) Assistance provided to individuals who are currently being served by another agency or agencies.

Extensive assistance provided to individuals who are challenging to support: ADRC staff reported spending a substantial amount of their time assisting individuals who had "fallen through the cracks" and were not being served by other agencies. Examples of the types of individuals receiving this extensive assistance includes 1) people who were homeless with mental health issues and 2) aging individuals with intellectual disabilities who had been supported by a parent who was no longer able to provide the same level of support. In these cases, the challenge is overcoming obstacles, such as a lack of a record that a disability was diagnosed when the individual was a child, with the goal of connecting the person to sustainable supports.

Given that the ADRCs do not have extensive service dollars to pay for supports for these individuals, completing an IAP becomes secondary to trying to establish connections to sustainable supports, such as enrollment in a Medicaid Waiver or identifying family members who are able and willing to provide support.

As the ADRCs enhance their profile, other agencies will be more likely to refer these difficult to serve individuals to the ADRC because of the vision of the ADRC as a place all individuals with disabilities can receive assistance. The more visible the ADRCs become, the more of these individuals the ADRC is likely to receive.

State leadership should look at this issue and first decide if this is a service and population that the ADRCs will serve. If so, ADRCs should develop criteria and tracking mechanisms for this service similar to what they have done for the other ADRC services. If not, they should refine their messaging to the other agencies that make referrals to the ADRCs to minimize the likelihood that the other agencies will make these types of referrals and develop guidance to the ADRC staff regarding what to do when these types of referrals are received.

Assistance provided to individuals who are currently being served by another agency or agencies: ADRC staff also reported instances in which they responded to a request and found that the individual was already being supported by one or more other agencies. These

individuals typically had at least one support plan that was already in place. In these cases, they reported one of the following outcomes:

- The ADRC staff investigated the situation and discovered that there was an adequate plan in place and no further action was needed.
- The ADRC staff worked with staff at the other agency to make a change to the existing plan.
- The ADRC staff worked with staff at multiple agencies to coordinate and integrate plans across these agencies.

These cases do not fit well with the existing ADRC model. The level of involvement and coordination is much more intensive than what should be classified as I&R. However, because developing an IAP could be counterproductive when one or more plan already exists, the ADRC staff typically choose not to develop an Action Plan, which is the defining outcome for Options Counseling.

The State and ADRC leadership should consider adding a separate service that addresses these types of situations. This would include developing criteria and tracking mechanisms for this service.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Performance on Process and Outcome Measures

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

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

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

EXHIBIT 7: PROCESS AND OUTCOME MEASURES

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

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

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

DATA COLLECTION TOOLS

Tools for collecting data include:

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

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

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

FINDINGS

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

Process Measures

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

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

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

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

The SUA, AAAs/ADRCs, and partner agencies have expanded the number and types of resources that are available in the database over the past year. The database now contains 1,619 different agencies that provide statewide or regional coverage. These resources cover 51 programs, services, supports, and other resource taxonomy categories and are searchable across 18 LTSS and other populations.

Exhibits 8-10 provide an overview of the resources available within the database as of September 30, 2017. The identified resources have been updated in the past year and are broken down by AAA service region, including resources for the AAA region not participating in the pilot, West Central Nebraska Area Agency on Aging (WCNAAA). Resources are counted for the AAA region if they either 1) serve the entire State or 2) serve the specific region.

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

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 8: NUMBER OF RESOURCES AVIALABLE BY REGION

Region		Number of Resources in Database
Aging Partners Group	Aging Partners	364
	Blue Rivers	260
	Midland	257
Northeast Nebraska Group	Eastern NE	428
	Northeast NE	429
South Central Nebraska Group	South Central NE	330
	Western NE	259
AAA Not in Pilot, WCNAAA		172
Statewide		119
Total Unduplicated Resources		1,619

Number and Type of Resources by Taxonomy Category

Exhibit 9 summarizes the types of resources included in the database by AAA site, including the AAA not participating in the ADRC pilot, WCNAAA. Cells that are highlighted in yellow indicate that there are no resources in the database for that category in the AAA region.

The most common resources were:

- Assisted Living Facilities (284)
- Congregate Meals/Nutrition Sites (206)
- Nursing Facilities (206)
- Community Clinics (193)
- Leisure Activities/ Recreation (171)
- I&R (161)

Of the 51 taxonomy categories of resources, the database includes at least one resource in all seven of the AAA regions participating in the pilot for 96%. Resources that were not found in all pilot areas were homeless shelters (1 area with no resources) and social development and enrichment activities (4 areas with no resources).

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

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

RFP & Taxonomy Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Category
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
Respite Care	1	1	1	1	1	1	1	1	1
Guardianship Assistance	12	10	11	11	12	12	11	10	26
Caregiver/Care Recipient Support Group	10	5	5	7	6	7	8	5	19
Crisis Intervention	4	4	3	5	4	5	4	2	15
Early Child Education	5	5	5	5	5	5	5	5	5
Special Education	2	2	2	2	2	2	2	2	2
Postsecondary Institutions	1	1	1	1	1	1	1	1	1
Career Counseling	3	3	3	7	4	4	5	3	11
Supported Employment	21	20	19	27	21	30	19	19	43
Vocational Rehabilitation	27	22	29	41	26	37	29	21	85
Utility Assistance	6	7	5	10	5	7	7	5	17
HCBS Waiver Program	1	1	1	1	1	1	1	1	1
Mental Health Support Services	13	6	7	19	9	11	5	4	40
Assisted Living Facilities	53	17	30	70	54	29	22	16	284
Community Clinics	23	24	19	20	63	33	26	1	193
Hospitals	20	11	8	28	30	15	11	1	117
Hospice Care	15	14	4	20	6	16	5	0	76
ICF-IDD	2	7	3	4	2	2	1	1	15
Nursing Facilities	34	20	19	42	44	23	20	11	206
Home/Community Based DD Program	12	7	11	21	9	10	11	6	45
Assistive Technology	7	5	6	12	7	11	7	4	28

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

RFP & Taxonomy Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Category
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
Adult Day Programs	12	3	4	8	9	9	1	1	47
Rehabilitation/ Habilitation Services	10	13	7	20	13	17	8	6	52
Public Assistance Programs	10	9	10	10	10	11	10	9	16
Social Skills Training	8	8	11	16	10	19	10	7	39
Independent Living Skills Instruction	10	7	9	18	7	15	8	6	35
Centers for Independent Living (CIL)	1	1	2	2	1	2	2	0	8
In-home Meal Prep.	9	7	4	10	7	5	3	2	25
Congregate Meals/Nutrition Sites	28	21	13	26	48	25	18	27	206
Food Pantries	14	12	10	11	8	19	9	3	63
Home Delivered Meals	15	24	12	10	39	12	21	20	146
Nutrition Education	7	1	4	4	8	4	2	0	29
Benefits Assistance/Benefits Counseling	30	19	17	22	22	20	21	14	63
Information & Referral (I&R)	72	39	35	44	40	47	63	30	161
LTC Options Counseling	2	2	2	2	2	2	2	1	8
Health/Disability Related Support Groups	10	5	9	9	6	13	11	5	34
Bereavement Support Groups	5	6	6	7	14	7	5	5	20

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

RFP & Taxonomy Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Category
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
Housekeeping Assistance	9	8	6	11	7	6	4	2	31
Personal Care	8	9	3	11	6	7	2	1	32
Home Health Care	28	16	14	62	26	10	7	3	138
Personal Alarm Systems	8	12	8	8	8	5	5	5	18
Homeless Shelter	1	3	2	4	0	2	1	0	14
Housing Authorities	12	12	14	10	28	25	15	1	110
Housing Counseling	15	9	8	6	7	9	7	4	35
Housing Expense Assistance	8	9	4	7	5	5	5	1	37
Low Income/Subsidized Private Rental Housing	12	14	14	16	27	24	3	1	105
General Minor Home Repair Program	2	2	2	4	1	1	2	1	8
Local Transportation	2	3	2	2	2	2	2	2	3
Volunteering Opportunities	18	29	12	23	9	15	16	4	98
Social Development and Enrichment	1	0	0	1	0	2	0	0	4
Leisure Activities/ Recreation	33	21	15	29	41	19	20	21	171

Number and Type of Resources by Target Population

Exhibit 10 show the resources by the 18 population groups within the database. Cells that are highlighted in yellow indicate that there are no resources in the database for that category in the AAA region.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

The database now includes a wide range of resources for all populations with disabilities. There was at least one resource identified for all populations in all of the regions participating in the ADRC pilot.

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

Population Category	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		AAA Not in Pilot	Unduplicated Count by Population
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	West Central NE	
AIDS/HIV	3	4	3	4	3	3	2	2	8
Alzheimer's Disease	22	3	8	26	1	1	4	0	59
Autism Spectrum Disorders	24	22	21	20	18	22	18	18	37
Brain Injuries	22	17	22	24	16	21	19	15	48
Caregivers	20	17	14	15	13	14	16	13	31
Hearing Loss	13	12	11	13	11	13	13	11	20
Holocaust Survivors	2	2	2	3	2	2	2	2	3
IDD	57	53	53	66	50	59	50	42	134
Mental Illness/ Emotional Disabilities	37	27	29	32	27	32	23	20	78
Native American Community	2	1	2	3	2	1	2	1	5
People with Chronic Illness	11	40	7	14	6	33	7	5	85
Physical Disabilities	24	53	20	21	15	46	22	14	113
Speech Impairments	6	7	6	9	6	6	6	6	10
Spinal Cord Injury	18	15	14	19	14	14	14	13	28
Substance Use Disorders	8	5	5	13	7	6	7	4	24
Terminal Illness	18	25	8	27	9	33	7	2	109
Veterans	19	19	19	20	18	19	19	17	29
Visual Impairments	10	9	8	10	9	10	8	8	16

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Summary of the Type of Contacts Received by the ADRC

The ADRCs received 12,198 contacts from 6,329 individuals from July 1, 2016, the beginning of the pilot period, to September 30, 2017. 10,846 were contacts categorized as basic information, I&R, Options Counseling, or Enhanced Options Counseling and 1,359 contacts did not capture the type of contact. 35 contacts had a variation of "Anonymous" as the name and 827 entries did not include a name. Of the 6,329 individuals served, which includes one count each for individuals named "Anonymous" or did not capture a name, 6,309 had the type of contact categorized and included a unique identifying name.

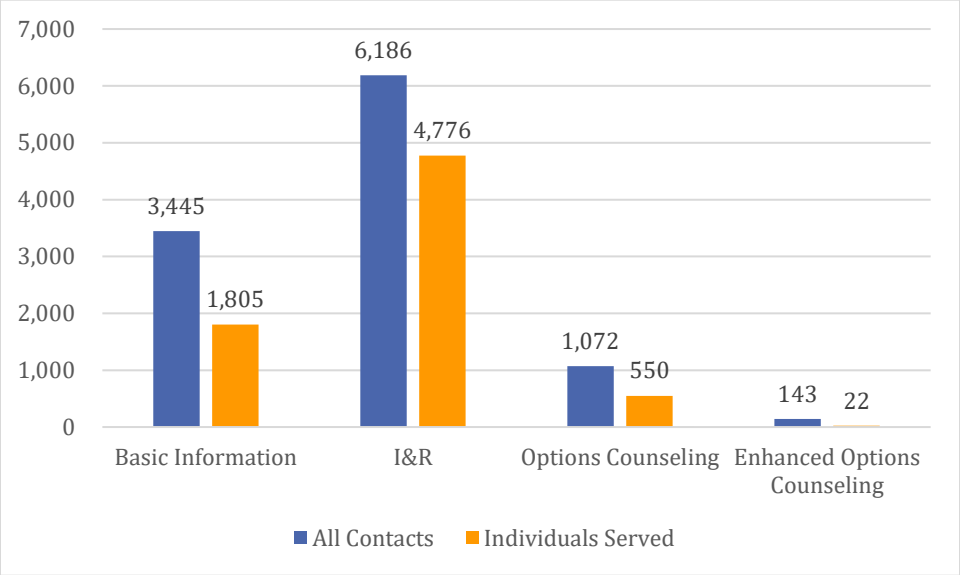
For the remainder of the document, we discuss only contacts that were documented as basic information, I&R, OC, or EOC, and individualized counts only reflect contacts that had a unique name and exclude "Anonymous" and blank named contacts. This results in analyses of 10,846 contacts for 6,309 individuals.

Exhibit 11 summarizes types of contacts documented in the Trilogy Dashboard. Note that an individual may be counted once across each of the contact types, and the individual count of 6,309 reflects overall contacts.

Most ADRC participants (57% of contacts and 76% of unduplicated individuals) were documented as I&R. Options Counseling and Enhanced Options Counseling together accounted for 11% of the total contacts and 9% of unduplicated contacts. During HCBS Strategies' September 2017 site visit, staff reported that there is still confusion around when a contact transitions from basic information to I&R and from I&R to Options Counseling. While this confusion may not impact the participant's experience because staff will provide them with the most appropriate level of service, it almost certainly impacts the accuracy of the reported contacts.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 11: CONTACTS BY ADRC SERVICE TYPE



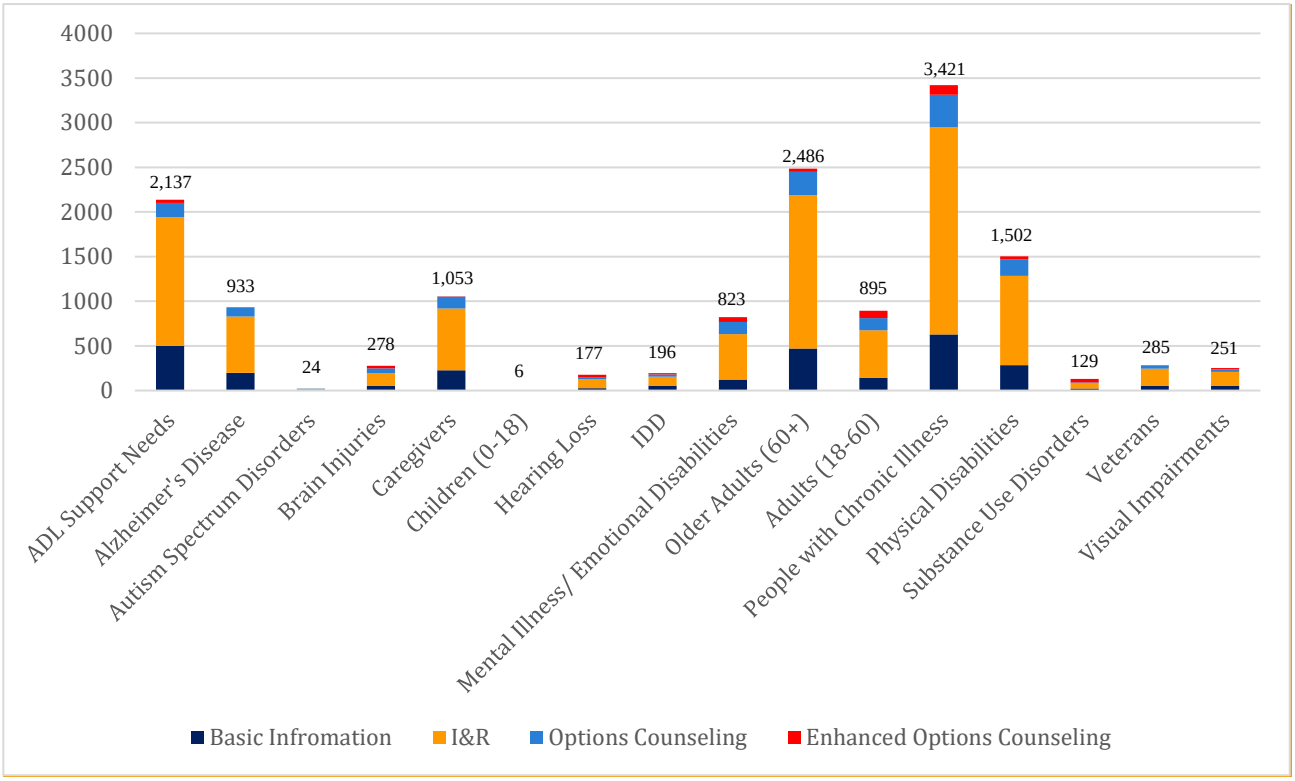
ADRC Contacts Across Populations

Exhibit 12 summarizes contacts by ADRC service type and the target disability populations. Because a participant may be identified as being in more than one population (e.g., many of the adults age 60+ also had chronic illnesses), the totals in this exhibit are larger than those in the previous exhibit.

Although the populations traditionally served by the AAAs accounted for most of the contacts (people with chronic illness (3,421), adults age 60 and over (2,486), individuals with ADL support needs (2,137), individuals with physical disabilities (1,502), and caregivers (1,053)), there were 895 contacts for people age 18-60, and limited contacts with children (6) and individuals with autism spectrum disorders (24).

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 12: CONTACTS BY POPULATION AND ADRC SERVICE TYPE

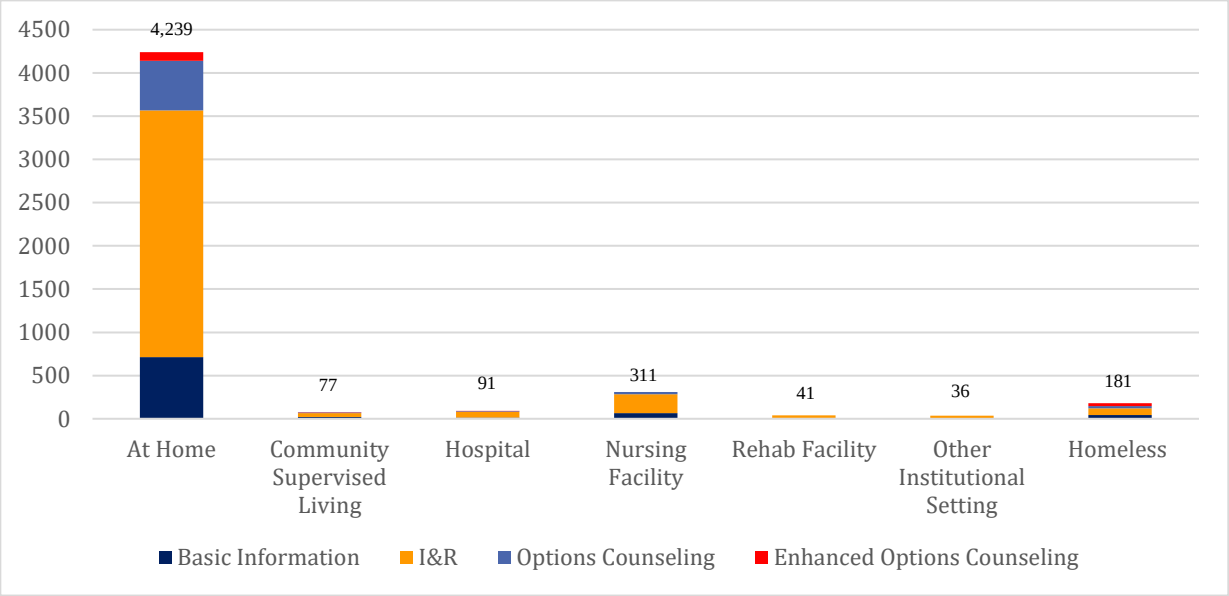


ADRC Contacts Across Settings

85% of the people contacting the ADRC were living at home (see ***Exhibit 13)***. Among the rest of the contacts, nursing facility (6%) and homeless (4%) were the most common settings. The ADRCs were mostly providing I&R to these participants. A notable exception to this is a finding that nearly a quarter of the contacts with homeless individuals were categorized as Enhanced Options Counseling. This is consistent with the discussion with the ADRC staff who indicated that they spend a substantial amount of their time working with difficult to serve populations.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 13: ADRC CONTACTS BY SETTING TYPE



ADRC Contacts by Region

We next examined the data for difference across the ADRCs. ***Exhibit 14*** provides a breakdown of the type of ADRC contacts by AAA region.

In terms of raw numbers, Eastern Nebraska Office on Aging (ENOA) reported the largest number of overall ADRC contacts coded as basic information, I&R, OC, or EOC (4,802), followed by Northeast Nebraska AAA (NENAAA) (1,509).

Consistent with the overall numbers, I&R was the most common service for all the AAAs.

Because some of the regions serve substantially more people than others, we also provide values that are weighted total number of people in each region using Census data. We have color coded these numbers with green representing a larger number of people served, red a lower number, and yellow in the middle. Weighting the numbers by the region's population helps to make the numbers across AAAs to be more comparable.

When looking at these weighted numbers, Midland AAA (MAAA) reported the highest volume of contacts, followed by Northeast and South Central.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 14: ADRC CONTACT BY REGION

Region Category		AAA Pilot Region Population	Basic Information		I&R		Options Counseling		Enhanced Options Counseling		All ADRC Contacts	
			Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	348	8.89	735	18.77	109	2.78	69	1.76	1,261	32.20
	Blue Rivers	73,282	91	12.42	137	18.69	36	4.91	1	0.14	265	36.16
	Midland	130,916	366	27.96	507	38.73	115	8.78	7	0.53	995	76.00
Northeast Nebraska Group	Eastern NE	808,222	1,648	20.39	2,775	34.33	354	4.38	25	0.31	4,802	59.41
	Northeast NE	205,999	462	22.43	848	41.17	189	9.17	10	0.49	1,509	73.25
South Central Nebraska Group	South Central NE	179,660	300	16.70	741	41.24	188	10.46	27	1.50	1,256	69.91
	Western NE	113,081	230	20.34	443	39.18	81	7.16	4	0.35	758	67.03
Pilot Area Total		1,902,778	3,445	18.11	6,186	32.51	1,072	5.63	143	0.75	10,846	57.00

Comparison of ADRC and AAA Contacts Across Services

During the September 2017 site visit, we discussed the contact findings with the AAAs to understand the differences. Most of these differences may be attributed to how the AAAs record AAA I&A activities versus ADRC activities. All the AAAs are recording I&A outside of the Trilogy Dashboard and these numbers are not reflected in ***Exhibit 14***. The AAAs that are performing better tend to be those that lacked specialized I&A staff prior to the ADRC. In these AAAs, a much greater volume of the calls that are coming into the AAA are being routed to the ADRC. In AAAs with designated I&A staff, fewer of these calls are being routed to the ADRCs and recorded in the database.

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

Comparison of ADRC Total Contacts and AAA I&A Contacts

To obtain an overall view of the volume of people being served, we obtained data from the SUA on AAA I&A. ***Exhibit 15*** provides a breakdown of the total ADRC and the AAA I&A contacts.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

The total number of AAA I&A contacts from July 1, 2016 to September 30, 2017 was 72,830, which is just under 7 times higher than the number of ADRC basic information, I&R, OC, and EOC contacts. South Central had the largest overall number of AAA I&A contacts (14,941) and the Aging Office of Western Nebraska (AOWN) had the highest number of contacts per 10,000 residents (1,277).

Across all AAAs participating in the ADRC pilot, there were a total of 72,830 ADRC and AAA contacts. South Central (16,197) and Eastern (15,494) had the largest proportion of total contacts, and Western had the largest number of contacts per 10,000 residents (1,345).

Prior to data clean-up there were wide discrepancies in the reported AAA I&A contact numbers. We discussed the discrepancies with SUA staff and they reported that there appear to be substantial differences in how the AAAs record these numbers. As we noted in the operations review, the AAAs have structured their operations in substantially different ways; this makes apples to apples comparisons challenging.

EXHIBIT 15: AAA I&A AND ADRC CONTACTS BY REGION

Region Category		AAA Pilot Region Population	All ADRC Contacts		AAA I&A Contacts		Total Agency Contacts	
			Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents	Total Contacts	Contacts/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	1,261	32	12,378	316	13,639	348
	Blue Rivers	73,282	265	36	1,135	155	1,400	191
	Midland	130,916	995	76	2,728	208	3,723	284
Northeast Nebraska Group	Eastern NE	808,222	4,802	59	10,692	132	15,494	192
	Northeast NE	205,999	1,509	73	5,664	275	7,173	348
South Central Nebraska Group	South Central NE	179,660	1,256	70	14,941	832	16,197	902
	Western NE	113,081	758	67	14,446	1,277	15,204	1,345
Pilot Area Total		1,902,778	10,846	57	61,984	326	72,830	383

ADRC Options Counseling and AAA Care Management

As we noted in the operational review, the AAAs had different practices for who was routed to AAA Care Management versus to ADRC Options Counseling or Enhanced Options Counseling. To examine the relationship among these services, we created ***Exhibit 16***, which presents

information on both services. Unfortunately, because the ADRCs record Options Counseling in terms of contacts and AAAs record Care Management in terms of hours, we could not combine the numbers.

AAA Care Management is a dramatically larger program than Options Counseling (65,576 hours versus 1,215 contacts for ADRC Options Counseling and Enhanced Options Counseling combined). Generally, when weighted by the population in the region, the volume of Options Counseling and the volume of Care Management appeared to be inverted, with those AAAs that offered more ADRC Options Counseling tending to provide less Care Management. These data must be interpreted cautiously given the discrepancies in how the AAAs triage people to Care Management and Options Counseling; differences in how Care Management dollars are spent; and difference in the AAAs record the data.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 16: ADRC OPTIONS COUNSELING CONTACTS AND AAA CARE MANAGEMENT HOURS BY REGION

Region Category		AAA Pilot Region Population	Options Counseling and Enhanced Options Counseling		Care Management	
			Total Contacts	Contacts/ 10000 Residents	Total Hours	Hours/ 10000 Residents
Aging Partners Group	Aging Partners	391,618	178	5	19,951	509
	Blue Rivers	73,282	37	5	4,146	566
	Midland	130,916	122	9	4,716	360
Northeast Nebraska Group	Eastern NE	808,222	379	5	17,480	216
	Northeast NE	205,999	199	10	10,433	506
South Central Nebraska Group	South Central NE	179,660	215	12	5,349	298
	Western NE	113,081	85	8	5,357	474
Pilot Area Total		1,902,778	1,215	6	67,432	354

Requests for and Timeliness of Follow-Up to ADRC Contacts

As part of each contact, ADRC staff document whether the participant requested that someone from the ADRC follow-up with her or him and the timeframe in which follow-up should occur. ***Exhibit 17*** provides an overview of the number of individuals who requested and received follow-up and whether the follow-up occurred within the timeframe that was identified.

Overall, 23% of individuals who contacted the ADRC requested follow-up. There were substantial differences in the percentage of people requesting follow-up across the AAAs ranging from 3% to 67%. This suggests that the ADRC initiative should enhance training on this issue to create greater consistency.

ADRC staff appeared to be doing a good job of following up with people who requested follow-up. Of all individuals who requested follow-up, 99% received it. All agencies had a follow-up rate of 97% or greater, with six of the seven agencies having a 99 or 100% rate. Staff reported

that follow-up attempts were made unsuccessfully for the remaining individuals that were not able to be contacted.

People generally received follow-up within the timeframe that they requested. Overall, 69% received follow-up within the requested timeframe; 95% received follow-up within seven days of their requested timeframe.

EXHIBIT 17: PEOPLE REQUESTING AND RECEIVING FOLLOW-UP BY REGION

Region Category		Requested Follow-up		Received Follow-up (% of total)		Follow-up Within Requested Timeframe		Follow-up Within 7 Days of Requested Timeframe		Follow-up Within 30 Days of Requested Timeframe	
		# of callers	% of callers	# of callers	% of callers	# of callers	% of callers	# of callers	% of callers	# of callers	% of callers
Aging Partners Group	Aging Partners	427	33%	415	97%	345	83%	414	100%	415	100%
	Blue Rivers	47	18%	47	100%	5	11%	25	53%	39	83%
	Midland	396	40%	393	99%	145	37%	376	96%	393	100%
Northeast Nebraska Group	Eastern NE	137	3%	135	99%	104	77%	129	96%	134	99%
	Northeast NE	1,010	67%	1,007	100%	773	77%	954	95%	987	98%
South Central Nebraska Group	South Central NE	228	18%	227	100%	154	68%	215	95%	225	99%
	Western NE	212	28%	212	100%	156	74%	204	96%	212	100%
Statewide		2,457	23%	2,436	99%	1,682	69%	2,317	95%	2,405	99%

Callers Receiving Information about Consent, Rights, and Eligibility

The original ADRC legislation required that the ADRCs track whether individuals calling the ADRC received information about informed consent and confidentiality of rights and whether they received eligibility counseling and financial prescreening to help them understand their service options. ***Exhibits 18 and 19*** provide a summary of the number of unduplicated individuals who contacted the ADRC and received this information by type of ADRC service, except for basic information. The table excludes basic information because it is very unlikely that individuals would receive this information or counseling if they were calling with a simple question.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Receiving Informed Consent & Confidentiality of Rights Information

Exhibit 18 shows that only 7% of all individuals who contacted the ADRC had documented discussions around informed consent and confidentiality rights. There was substantial variation in these numbers across the sites. Blue Rivers AAA (BRAAA) provided this information to the highest proportion of callers (22%).

EXHIBIT 18: PEOPLE RECEIVING INFORMED CONSENT & CONFIDENTIALITY OF RIGHTS BY REGION

Region		# of I&R Calls Receiving IC & CR	% of I&R Calls Receiving IC & CR	# of OC/EOC Calls Receiving IC & CR	% of OC/EOC Calls Receiving IC & CR	# of I&R & OC/EOC Calls Receiving IC & CR	% of All I&R & OC/EOC Calls Receiving IC & CR
Aging Partners Group	Aging Partners	47	7%	20	33%	64	8%
	Blue Rivers	32	23%	5	17%	37	22%
	Midland	26	6%	16	22%	41	8%
Northeast Nebraska Group	Eastern NE	132	6%	32	13%	156	6%
	Northeast NE	42	6%	18	19%	58	7%
South Central Nebraska Group	South Central NE	72	9%	17	15%	85	10%
	Western NE	20	5%	10	20%	29	6%
Statewide		304	6%	70	12%	349	7%

Receiving Eligibility Counseling and Financial Prescreening during ADRC Contact

Exhibit 19 shows that only 34% of the individuals contacting the ADRC (excluding basic information) had documented eligibility counseling and financial prescreening. This count includes individuals who declined eligibility counseling and those already enrolled in Medicaid.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 19: PEOPLE RECEIVING ELIGIBILITY COUNSELING & FINANCIAL PRESCREENING BY REGION

Region		# of I&R Calls Receiving EC & FP	% of I&R Calls Receiving EC & FP	# of OC/EOC Calls Receiving EC & FP	% of OC/EOC Calls Receiving EC & FP	# of I&R & OC/EOC Calls Receiving EC & FP	% of All I&R & OC/EOC Calls Receiving EC & FP
Aging Partners Group	Aging Partners	347	50%	36	60%	371	49%
	Blue Rivers	60	44%	13	43%	73	44%
	Midland	157	34%	37	51%	189	35%
Northeast Nebraska Group	Eastern NE	666	29%	61	24%	713	28%
	Northeast NE	240	32%	46	49%	280	33%
South Central Nebraska Group	South Central NE	400	52%	47	41%	435	49%
	Western NE	182	43%	28	56%	204	43%
Statewide		1,720	36%	172	30%	1,810	34%

The large variance across sites strongly suggests that this is an area for improvement. We recommend additional training and enhanced monitoring of performance on these items, such as adding to the monthly reports.

Tracking Unmet Need

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

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

Exhibit 20 tabulates unduplicated responses for each unmet need item by the following populations: 1) older adults, 2) individuals with physical disabilities, 3) individuals with IDD, and 4) all other populations and population unknown.

Overall, 8% of the all individuals identified at least one unmet need. LTSS/LTSS Funding was most frequently identified as an unmet need (3.2%) followed by financial benefits (3.1%), other (2.7%), and housing assistance (2.1%).

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 20: UNMET NEEDS BY POPULATION

Unmet Needs Category		Older Adults	Physical Disabilities	IDD	All Other Populations & Unknown	Total
LTSS/ LTSS Funding	Adult Day Services	4	1	1	1	7
	Assistive Technology	0	1	0	0	1
	Care Transitions	0	0	0	0	0
	Home Modifications	11	8	0	1	20
	Homemaker Services	29	15	0	3	47
	LTC/LTSS Funding	45	19	1	14	79
	Mental Health & Substance Use Services	11	1	1	5	18
	Personal Care	32	20	0	6	58
	Respite Care	18	3	1	0	22
All LTSS/LTSS Funding unmet need contacts		130	60	4	8	202
% of population contacts mentioning LTSS/LTSS Funding unmet need		2.7%	8.0%	4.9%	1.2%	3.2%
Housing Assistance	Housing Assistance	49	24	5	36	114
	Utility Assistance	9	5	0	2	16
All Housing Assistance unmet need contacts		58	29	5	38	130
% of population contacts mentioning Housing Assistance unmet need		1.2%	3.9%	6.1%	5.9%	2.1%
Financial & Benefits Assistance	Benefits Assistance	1	2	0	0	3
	Employment	5	4	0	5	14
	Financial Assistance	92	39	2	28	161
	Health Insurance Counseling & Enrollment	4	0	0	6	10

	Prescription Drug Assistance	16	5	0	5	26
All Financial & Benefits Assistance unmet need contacts		111	46	2	35	194
% of population contacts mentioning Financial & Benefits Assistance unmet need		2.3%	6.2%	2.4%	5.5%	3.1%
Other	Caregiving Support	2	1	0	0	3
	Dental Care	9	3	0	0	12
	Elder Abuse/Exploitation	1	1	0	1	3
	Food Assistance	3	2	0	1	6
	Legal Services	2	0	0	0	2
	Transportation	34	14	0	10	58
	Veteran's Assistance	0	0	0	0	0
	Youth Transition Services	1	0	0	0	1
	Other	48	19	1	19	87
All Other unmet need contacts		97	39	1	31	168
% of population contacts mentioning Other unmet need		2.0%	5.2%	1.2%	4.8%	2.7%
Total Number of Unmet Need Contacts		**312**	**129**	**10**	**85**	**536**
Total Percent Total Contacts with Unmet Need		**6%**	**17%**	**12%**	**13%**	**8%**

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

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

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Outcome Measures

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

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

I&R Participant Survey

The I&R Survey is sent to individuals who received I&R through the ADRC. Surveys were first distributed in February 2017.

Exhibit 21 provides a count of the surveys that were received across the regions, the percentage of all surveys attributable to each agency, and the percentage of all I&R contacts that resulted in a completed survey. The ADRCs had proposed to offer to email the survey out to all people receiving I&R and mail a follow-up survey to 10% of those individuals. There were substantial differences in the number of surveys received relative to the number of I&R contacts, ranging from a high of 4% to a low approaching 0%. Western and Blue Rivers each received one survey response.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 21: I&R SURVEY RESPONSES BY REGION

Agency	# Surveys Received	% of Total Surveys Received	Total I&R Contacts	Surveys Received as % of I&R Contacts
Aging Office of Western Nebraska (AOWN)	1	1%	512	0%
Aging Partners (AP)	21	18%	797	3%
Blue Rivers Area Agency on Aging (BRAAA)	1	1%	141	1%
Eastern Nebraska Office on Aging (ENOA)	18	15%	2732	1%
Midland Area Agency on Aging (MAAA)	10	8%	282	4%
Northeast Nebraska Area Agency on Aging (NENAAA)	33	28%	760	4%
South Central Nebraska Area Agency on Aging (SCNAAA)	35	29%	962	4%
Unsure	1	1%		
Total	120	100%	6,186	2%

Exhibit 22 provides a summary of the responses received across the items. Items address the participant's experience with the I&R he or she received and include:

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

Survey responses are provided on a 5 point Likert scale, ranging from strongly disagree (1) to strongly agree (5). All items received an average score of 4.3 or higher, which falls between agree and strongly agree. An agency-specific breakdown of the responses can be found in ***Appendix 3***.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 22: I&R SURVEY ITEM RESPONSE SUMMARY

Response		2A- Better informed about services/ supports	2B- Given obj., accurate, complete info	2C- Referrals were helpful	2D- Clear on who to contact/what to ask
1	Strongly Disagree	4%	3%	4%	3%
2	Disagree	1%	2%	2%	3%
3	Neither Agree nor Disagree	3%	2%	6%	7%
4	Agree	35%	32%	30%	31%
5	Strongly Agree	57%	62%	58%	57%
	# Responses Received	117	117	114	113
	Average Score	4.40	4.46	4.35	4.36

While the relatively small number of surveys completed by some of the sites was problematic (we recommend increasing training and monitoring of the number of surveys received), the surveys suggested that participants believed that the I&R was helpful. 92% of the respondents believe they were better informed about their services and supports. 94% thought they were given objective, accurate and complete information. 88% thought the referrals were helpful, and 88% were clear about who to talk to and what to ask when they were following up on a referral.

Exhibit 23 provides a summary of the individuals who completed the survey across regions. Respondents could select more than one option, for example if the respondent was a family member and legal representative, therefore there were 134 item responses even though 120 surveys were completed.

Of the 120 surveys that were received, 97% provided a response to this item. Over 75% were completed by the person receiving I&R (39%) or a family member (37%). Caregivers comprised 11% of responses, other individuals 7%, and legal representatives and agency representatives each made up 3%.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 23: I&R SURVEY RESPONDENT SUMMARY

Individual Completing the Survey	# Overall Responses	% of Responses
Person plan was made	**52**	39%
Caregiver	**15**	11%
Legal Representative	**4**	3%
Agency Representative	**4**	3%
Family Member	**50**	37%
Other	**9**	7%

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

- *A heavy burden has been lifted off my shoulders - I am so pleased with the kindness and concern I felt I received. Thank you so much for your help. I look forward to working with you and thank you for your kind and caring help.*
- *I'm helping my elderly mother obtain assistance and Erin Davis was extremely patient and helpful pointing me in the right direction. This was uncharted territory for me and I could not have done it without the help of the various people she put me in contact with as well as the information she provided to me.*
- *I was in a crisis and they took a tremendous load off me and I couldn't have done it without them. Please realize that they are valuable to elders in dealing with a very stressful time for them and family members.*
- *This service was a lifeline in the midst of the medical chaos we found ourselves in while my Father was terminally ill this last year. I cannot stress enough how valuable and informative Andrea Cox was. I called countless people and services trying to be a good advocate for my Father in a difficult situation, many of the people I reached were sympathetic and several told me that they hear cases like my Father's all the time but they unfortunately couldn't help me and didn't know what I could do. This service offered support and really put in the effort to help me find those people who could help my Mother and I as we tried to find the best possible care for my Father. After working with Andrea I could see that there are many resources and people out there to help people with elder care, the problem is finding those resources as an individual who has never worked in the health care system or had an elderly family member who is terminally ill.*

  We could not have found the help we did without this service. It is so important to have someone who knows the health care industry and the services available that can help

you navigate a vast and constantly changing health care world, without MAAA I could have been stuck calling any number I could find online for help indefinitely and not been able to get the care my that was needed before he passed.

My Father did pass away in the beginning of January, but thanks to this service it was in a nice facility, with a view to a lake (he was an avid fisherman) surrounded by his family and a staff, and a hospice that truly cared for him and worked to make his life better.

I fear that without MAAA and Andrea, my Father might have fallen through the cracks and not had the care he had in his final days. So many people I talked to before MAAA, said that they hear cases of elderly patients being dumped, and passed off and that they didn't know what to do to help. If even health care workers don't know what to do, how can one family member do it alone. I have heard over and over in the last year that you have to be your own advocate and your family members advocate when they can't, but it is so hard to do that without the right information and resources, that is were someone like MAAA can help fill in the gaps, and get you to the right resources.

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

- *When I called the main number I was able to leave a message, but was not given the name of the person who would call me back, or direct contact information for that person.*
- *Would like to find out more about services out there for people age ranging from 53-65 years of age.*

Options Counseling Participant Survey

The voluntary Options Counseling Participant Survey is distributed to individuals who received OC or EOC from the ADRCs. The survey provides feedback on areas including if the participant was better informed about services and supports; if the referrals they received were helpful; and if the interaction helped them stay out of a nursing facility. Additionally, surveys capture who completed the survey, such as the individual receiving services or a family member, and allow for narrative feedback. Surveys were first distributed in February 2017.

Exhibit 24 provides a summary of the surveys received across the regions. Unfortunately, there were only 15 surveys completed, which is not a large enough sample from which to draw

meaningful conclusions. The ADRCs had proposed to give these surveys to 50% of participants receiving OC and all receiving EOC. Only 1% of people receiving OC or EOC completed a survey. We strongly recommend that the ADRC effort increase its efforts to obtain more complete surveys. Of the 15 OC surveys that were received, Aging Partners (5, 33%) and Northeast (4, 27%) had the highest number of submissions. Blue Rivers and Eastern did not receive a survey response.

EXHIBIT 24: OC SURVEY RESPONSES BY REGION

Agency	# Surveys Received	% of Total Surveys Received	Total OC/EOC Contacts	Surveys Received as % of OC Contacts
Aging Office of Western Nebraska (AOWN)	1	7%	89	1%
Aging Partners (AP)	5	33%	254	2%
Blue Rivers Area Agency on Aging (BRAAA)	0	0%	47	0%
Eastern Nebraska Office on Aging (ENOA)	0	0%	236	0%
Midland Area Agency on Aging (MAAA)	2	13%	127	2%
Northeast Nebraska Area Agency on Aging (NENAAA)	4	27%	196	2%
South Central Nebraska Area Agency on Aging (SCNAAA)	3	20%	266	1%
Unsure	0	0%		
Total	15	100%	1,215	1%

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

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

Survey responses are provided on a 5 point Likert scale, ranging from strongly disagree (1) to strongly agree (5). All items, except for 2E- considered going into a nursing facility, received an average score of 4.4 or higher, which falls between agree and strongly agree. An agency-specific breakdown of the responses can be found in ***Appendix 3***.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 25: OC SURVEY ITEM RESPONSE SUMMARY

Response		2A- Better informed about services/supports	2B- Given obj., accurate, complete info	2C- Actively involved in developing IAP	2D- IAP reflects what is important to me	2E- Considered going into NF before ADRC	2F- IAP will help stay in home or community
1	Strongly Disagree	0%	0%	0%	0%	20%	0%
2	Disagree	0%	0%	0%	0%	13%	0%
3	Neither Agree nor Disagree	0%	7%	0%	7%	40%	13%
4	Agree	40%	40%	47%	40%	13%	33%
5	Strongly Agree	60%	53%	53%	53%	13%	53%
# Responses Received		15	15	15	15	15	15
Average Score		4.6	4.5	4.5	4.5	2.9	4.4

Although the feedback about Options Counseling was overwhelmingly positive (there were no negative responses to any of the items), these results should be interpreted with caution given the extremely small number of surveys.

A core goal of the ADRC is to support individuals with LTSS needs with remaining in the community rather than entering an institution. More than a quarter of the individuals completing the survey agreed that they were considering going into a nursing facility and only a third appeared to have ruled this out as an option. While the limited number of surveys requires caution in interpreting these data, the results suggest that the ADRCs are serving a population at high risk of going into a nursing facility. Given that all of these individuals felt that the ADRC services they had received made it more likely they would remain in their homes, taken together, items 2E and 2F suggest that the ADRCs are preventing or delaying nursing facility use. Again, the extremely small sample sizes prevent us from drawing stronger conclusions.

Exhibit 26 provides a summary of the individuals who completed the OC survey. Respondents could select more than one option, for example if the respondent was a family member and legal representative, therefore there were 17 item responses although there were only 15 completed surveys. Of the 17 total item responses, 88% were completed by the person the plan was made for (29%), caregiver (24%), or a family member (35%). Legal representatives made up the remaining 12%.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 26: OC SURVEY RESPONDENT SUMMARY

Individual Completing the Survey	# Overall Responses	% of Responses
Person plan was made	5	29%
Caregiver	4	24%
Legal Representative	2	12%
Agency Representative	0	0%
Family Member	6	35%
Other	0	0%

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

- *I am so very happy that I was introduced to programs here that have been very helpful to me. I have, before, been struggling to survive for the last seven years. I had gone down probably as far as I could go, on the survival of day to day, without becoming homeless, asking for handouts, or on the street corner. I've been helped by the most friendly, supportive, and helpful people here than I could have ever imagined possible. Thanks & pray to my God, Amen.*
- *This experience was amazing, informative and beneficial. It would have been nearly impossible even make it through the Medicaid process without ADRC. My parents, who are farmers who lost their farm, were well deserving but the process was painful and long. Andrea Cox was with us every step of the way and saved us tons of contacts with the NDHHS. Andrea was knowledgeable and encouraging as obstacle after obstacle arose. This is an extremely important program which needs to be continued as it is life changing.*

Review of Options Counseling Action Plans

To understand the quality of plans that were developed during the OC and EOC processes, we reviewed each Action Plan that was developed between July 1 and September 30, 2017. Prior to July 1, 2017 plans were developed but were not able to be uploaded into the ADRCs' automated system, Trilogy. SUA worked diligently to develop this mechanism, and as of July 1, 2017 plans can be completed on paper and uploaded or entered directly in the system.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Exhibit 27 summarizes the number of IAPs that were completed from July 1 to September 30, 2017. Statewide, 48 plans were completed. Midland had the highest number of plans (14). Blue Rivers did not complete a plan because they had staff turnover during this period.

EXHIBIT 27: NUMBER OF ACTION PLANS COMPLETED PER 10,000 INDIVIDUALS BY REGION FROM JULY 1 TO SEPTEMBER 30, 2017

Pilot Group	Site	AAA Region Pop.	Total Plans
Aging Partners	AP	391,618	10
	BR	73,282	0
	MAAA	130,916	14
NE Nebraska	ENOA	808,222	3
	NENAAA	205,999	4
SC Nebraska	SCNAAA	179,660	9
	AOWN	113,081	8
	Statewide	1,902,778	48

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

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

Exhibit 28 provides an overview of the types of support within each of the plans. ***Exhibit 29*** summarizes the number of goals included in the plans and whether the goals are truly person-centered.

Rows 2-5 of ***Exhibit 28*** display the percent of plans that include at least one goal that identifies each type of support. Plans may include more than one goal, and goals may utilize more than one source of support. For example, if an individual's goal is to attend church, he/she may utilize

support in getting ready for church from both staff paid by Medicaid (government) and family (unpaid) and use a church-sponsored transit van for transportation (unpaid). This goal would include two sources of support, government and unpaid.

Almost half of the plans identified a support source that was funded by a government program. Privately paid supports were identified in 20% of the plans, consumer self-support in 17%, and unpaid supports in 15% of the plans.

Only a quarter of the plans included just one support source. About half included two types of supports. Only one plan included all four sources of support. Northeast had the highest proportion of using 3 or more support sources (100%) across their four plans, and South Central utilized three support sources in 78% of their nine plans.

EXHIBIT 28: ACTION PLAN SOURCES OF SUPPORT BY REGION

Sources of Supports included in Action Plans	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		State Total
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	
Total number of plans	10	0	14	3	4	9	8	48
Government-paid support	63%	0%	48%	50%	31%	36%	62%	47%
Privately paid supports	31%	0%	33%	25%	8%	12%	8%	20%
Unpaid supports	0%	0%	11%	25%	31%	20%	15%	15%
Consumer self-support	6%	0%	7%	0%	31%	32%	15%	17%
1 Support Source	40%	0%	21%	67%	0%	0%	38%	25%
2 Support Sources	60%	0%	64%	33%	0%	22%	63%	48%
3 Support Sources	0%	0%	14%	0%	75%	78%	0%	25%
4 Support Sources	0%	0%	0%	0%	25%	0%	0%	2%

Exhibit 29 summarizes the number goals within a plan and whether the goals were person-centered. While plans may have only one goal for individuals who have very specific and limited needs, a person-centered plan is likely to have more than one goal.

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

EXHIBIT 29: NUMBER OF ACTION PLAN GOALS AND WHETHER GOALS WHERE PERSON-CENTERED BY REGION

Number and Content of Goals in Action Plans	Aging Partners Group			Northeast Nebraska Group		South Central Nebraska Group		State Total
	Aging Partners	Blue Rivers	Midland	Eastern NE	Northeast NE	South Central NE	Western NE	
Total number of plans	10	0	14	3	4	9	8	48
Average # of Goals	2.7	0.0	3.1	2.0	2.5	2.6	2.8	2.2
1 Goal	30%	0%	14%	67%	0%	0%	13%	17%
2 Goals	10%	0%	29%	0%	75%	78%	13%	33%
3+ Goals	60%	0%	57%	33%	25%	22%	75%	50%
Plans only with goals that reiterate services	70%	0%	64%	67%	25%	33%	100%	63%
Plans with goals that reiterate services and have person centered goals	20%	0%	36%	0%	50%	56%	0%	29%
Plans only with person centered goals	10%	0%	0%	33%	25%	11%	0%	8%

Half the plans statewide had three or more goals, with Western (75%) and Aging Partners (60%) having the highest proportion of their plans within this category. Less than one in five plans (17%) had only one goal, with Eastern having the largest proportion of their plans in this category (67%), while 33% had two goals.

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

In the final three rows of ***Exhibit 29***, we classify the plans into the following categories:

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

PERFORMANCE ON PROCESS AND OUTCOME MEASURES

Statewide, close to two-thirds (63%) of plans contained only goals that reiterated services, while 8% contained only person-centered goals. Two agencies, Northeast (75%) and South Central (67%), had a majority of their plans include person centered goals.

As the State continues to provide agencies with person-centered training and staff gain experience with developing person-centered goals, we hope to see a shift in plan contents. Plans should:

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

During the September 2017 HCBS Strategies site visit, we recommended that ADRC staff meet regularly to review Action Plans and the development of person-centered goals. There are several staff who have shown they are knowledgeable around person-centeredness, and collaboration would allow all staff to better understand the process. These reviews could occur within and across agencies. Staff at all agencies said that they felt this would be valuable.

IMPLICATIONS OF THE LONG TERM CARE REDESIGN PLAN

Implications of the *Long Term Care Redesign Plan*

On August 9, 2017, Mercer, in collaboration with the National Association of States United for Aging and Disabilities (NASUAD), released a report entitled *Nebraska Long Term Care Redesign Plan*. This effort was commissioned by the State and included extensive stakeholder input.

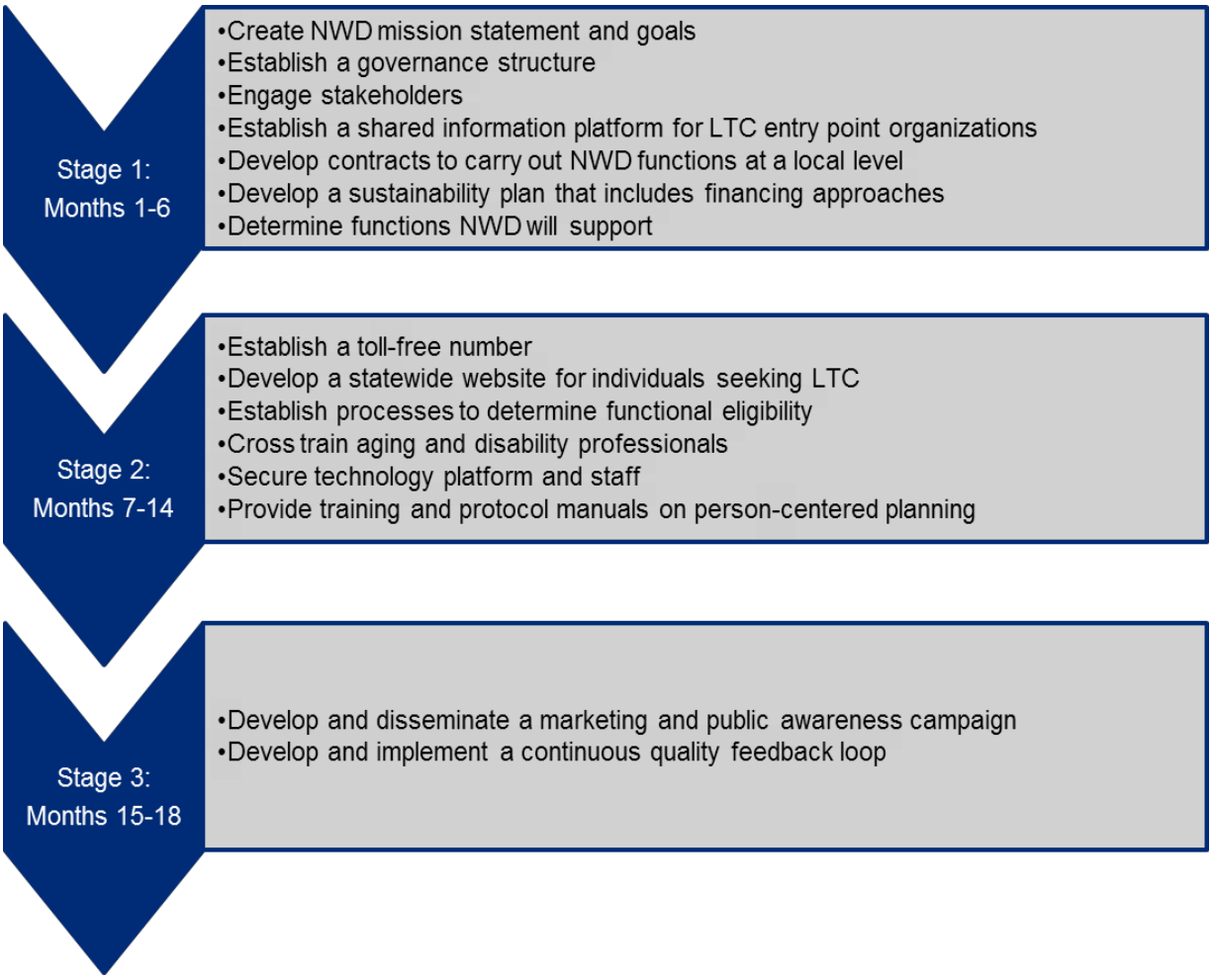
We note that this report uses the term 'Long Term Care' and the acronym 'LTC'. In this report, we use the term 'Long Term Services and Supports' or 'LTSS', which is the language used by the CMS and ACL. These terms are interchangeable.

The Redesign Plan includes a recommendation for Nebraska to develop a NWD system. The report identifies the functions that the NWD system can serve: *"The NWD system can conduct activities such as outreach, referral, assessments, functional and financial eligibility, and even final determinations."*

The report envisions a NWD system in which, "*Key partners in the NWD systems are the state Medicaid agency, state aging and disability divisions, and all social service departments that touch consumers' lives. The NWD system builds on the strengths of the Area Agencies on Aging (AAAs) and the Centers for Independent Living (CILs) by providing a single, more coordinated system of information and access for all consumers seeking LTC both public and privately funded. In Nebraska, the Aging and Disability Resource Center (ADRC) demonstration should play a critical part of the NWD system. This minimizes confusion, enhances consumer choice and supports informed decision making."*

The report includes recommendations for stages and activities for developing the NWD system, which we have included as ***Exhibit 30***.

EXHIBIT 30: STAGES AND ACTIVITIES FOR DEVELOPING THE NWD SYSTEM INCLUDED IN THE LTC REDESIGN REPORT



Source: Nebraska DHHS website http://dhhs.ne.gov/medicaid/Documents/NE-LTC-Redesign-Plan-080917-Final.pdf.

Because the Redesign Plan envisions that the ADRC may evolve into the NWD system, we discuss the steps that will need to be taken to achieve this goal. In addition to discussing the activities included in ***Exhibit 30***, we also identify other issues that will be necessary to develop a NWD system consistent with this vision.

IMPLICATIONS OF THE LONG TERM CARE REDESIGN PLAN

CHALLENGES TO BE ADDRESSED FOR THE ADRC TO TRANSITION FROM A PILOT TO THE NWD SYSTEM DESCRIBED IN THE *MEDICAID LONG TERM CARE REDESIGN PLAN*

The purpose of LB320 was to establish ADRC demonstrations that could help determine the feasibility of establishing a statewide system. The *Long Term Care Redesign Plan* builds upon this vision and clarifies the requirements. The NWD system envisioned in the Redesign Plan is a network that includes all major access points to LTSS rather than a program operated by a single entity.

Exhibit 31 discusses the ability to build off infrastructure developed under the ADRC pilot to fulfill the activities necessary to build a NWD system as described in the *Long Term Care Redesign Plan*. After this exhibit, we discuss additional challenges to be addressed in making this transition.

EXHIBIT 31: ABILITY OF THE ADRC INITIATIVE TO FULFILL THE ACTIVITIES IDENTIFIED IN THE *LTC REDESIGN PLAN*

NWD System Activity in the *LTC Redesign Plan*	Status of the ADRC Initiative in Achieving Goal
Stage 1: Months 1-6	
Create NWD mission statement and goals	The ADRC mission statement and goals could serve as a starting point. However, it should be reexamined considering the expanded requirements.
Establish a governance structure	The ADRC governance structure could be expanded to reflect the more central role to be played by State agencies and agencies that support people with disabilities beyond AAAs.
Engage stakeholders	The State and local Advisory Councils could be expanded to reflect the new requirements. Strategies beyond these councils should be considered.
Establish a shared information platform	This will likely be very challenging given differences across LTSS access points and the amount of effort involved in developing new systems. As an intermediary step, the NWD

NWD System Activity in the *LTC Redesign Plan*	Status of the ADRC Initiative in Achieving Goal
for LTC entry point organizations	system could establish standardized data elements to be incorporated into existing systems and streamlined mechanisms for sharing data across entities.
Develop contracts to carry out NWD functions at the local level	It may be necessary to first identify NWD functions, roles to be played by NWD entities, and financing approaches prior to establishing contracts.
Develop a sustainability plan that includes financing approaches	We discuss the ADRC sustainability below, including how it could be expanded to reflect the NWD vision.
Determine functions NWD will support	This will likely need to be a first step. In addition to LTSS access to functions identified in the Redesign Plan, the NWD could also play a remediation role if the State adopts managed LTSS. In this role, the NWD system could help managed LTSS participants understand what to expect from a managed care organization (MCO) and coach participants who are concerned about the supports that they are receiving.
Stage 2: Months 7-14	
Establish a toll-free number	The ADRC toll-free number could be adapted for this purpose.
Develop a statewide website for individuals seeking LTC	The ADRC website could be adapted for this purpose.
Establish processes to determine functional eligibility	This is not part of the current ADRC functions but could build off the capacity that they are building.

NWD System Activity in the *LTC Redesign Plan*	Status of the ADRC Initiative in Achieving Goal
Cross train aging and disability professionals	The ADRCs have made substantial progress in this area and this could serve as a starting point for the NWD system.
Secure technology platform and staff	The Trilogy system does not appear to be a good solution to meet this requirement. This will likely be a major challenge for building the NWD system, and SUA should examine the ability to coordinate across agencies when procuring a new automation system.
Provide training and protocol manuals on person-centered planning	While the ADRCs have conducted some person-centered training, the training has been limited and done on an ad-hoc basis. This infrastructure will need to be expanded substantially.
Stage 3: Months 15-18	
Develop and disseminate a marketing and public awareness campaign	While the ADRCs have experience developing and implementing a marketing plan, this will likely need to be a more extensive effort.
Develop and implement a continuous quality feedback loop	The ADRC quality improvement components could serve as a starting point. This infrastructure would need to be expanded substantially.

Evolving the ADRC from a Program to a Network

In the Initial Report, we discussed the need for the ADRC to evolve into a NWD network. In that report, we identified "Doors" and steps necessary for this evolution. The *Long Term Care Redesign Plan* also includes those recommendations.

Many of the challenges the ADRC faces could be alleviated by transitioning the pilot into a NWD network:

- Several of the local ADRC staff reported encountering resistance from some other agencies because they felt the AAA was "invading their turf". A NWD initiative could help address this by more clearly identifying the roles and responsibilities of all agencies that are part of the network.
- Disability partners see the ADRC initiative as a AAA program. This has made them less supportive of the program. The disability partners are, for the most part, only advisors to the ADRC. A NWD network initiative could allow these agencies to see themselves as full partners.
- The data being collected by the ADRC initiative only reflects a fraction of the assistance and counseling that is being provided to people with disabilities. As described above, the non-ADRC AAA services are serving more people than the ADRC services. The disability partners, such as the Centers for Independent Living (CILs), also provide substantial amounts of information, and counseling. A NWD network could standardize data collection for this support and show the true reach of these services.
- The ADRC effort has limited ability to streamline access to LTSS. The ADRCs must work within the parameters set by the State (e.g., forms, documentation requirements, funding, access to data systems, etc.). A NWD network initiative would include (and in some cases, be led by) State agencies. This could allow for major changes in access processes that could make the system much more efficient.

In addition to building the infrastructure identified in ***Exhibits 30*** and ***31***, the ADRC initiative will need to address the following challenges to evolve into a NWD system.

- Clarifying the role of the AAAs and the ADRCs
- Diversifying sources of funding

Integrating AAA and ADRC functions

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

Our September 2017 site visit revealed that for most of the AAAs, the ADRC is operating as another AAA program. This is especially problematic for the AAAs that have AAA I&A staff that operate separately from the ADRC staff. In these cases, the AAA I&A staff continue to offer support that overlaps with the Basic Information and I&R (and to a lesser extent Options Counseling) functions offered by the ADRC staff. However, the AAA I&A staff do not use the

ADRC protocols and most agencies are capturing data on these interactions in separate systems using different definitions. For the purposes of reporting, these systems do not communicate with one another and data must be exported and examined using an aggregated mechanism.

A similar problem exists for ADRC Options Counseling and Enhanced Options Counseling and AAA Care Management. Decisions about who is being directed to which service are being driven by AAA-specific policies (e.g., some AAAs require that anyone getting in-home services also get Care Management). As a result, the populations receiving Options Counseling differ substantially across the ADRCs.

If the AAAs are to become part of a NWD system or network, the first step will be to identify all functions the AAA provides (including those that are part of the ADRC pilot) that should be part of this network and integrate them to eliminate redundancies and clarify who should receive what services and supports. This will involve substantial changes to business operations within each individual AAA as well as across the AAAs. This change should include:

- Establishing protocols so that all calls for assistance go through an integrated process that screens and triages individuals to the most appropriate service.
- Overlapping services, such as AAA I&A and ADRC I&R, should be integrated.
- A tiered level of service that has clearly defined criteria should be implemented. The current ADRC services could serve as a starting point, but the following enhancements would be needed:
    - The additional services described earlier in the report should be included if they are adopted as part of the ADRC model.
    - The model should be expanded to include ongoing case management to allow AAA Care Management functions to be folded within the approach

Because most of the AAA funding is related to serving older adults, determining the optimal approach for supporting younger individuals with disabilities (and obtaining the funding for doing so) must also be addressed.

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

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

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

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

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

The following progress has been made over the past year in establishing a sustainability plan.

- The SUA and the ADRC are in the early stages of building infrastructure for Medicaid administrative claiming.
- The SUA has worked with a representative from AARP to develop estimates for providing ADRC services to all populations.
- The ADRCs have included some measures of the degree to which the ADRC services have allowed people to remain in the community. We discuss the results from these measures in the next section.

Because a NWD network will include a variety of agencies beyond the AAAs, the State will need to develop a sustainability plan that includes opportunities for other entities to be able to obtain some of these resources. For example, Medicaid administrative claiming could be expanded to include other disability agencies, such as the CILs.

SUMMARY OF THE RECOMMENDATIONS

Summary of the Recommendations

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

- **Capturing Name and Contact Type for All Contacts-** There were 1,359 contacts that did not include the type of contact (i.e., basic information, I&R, Options Counseling, or Enhanced Options Counseling) and 862 that had the name "Anonymous" or were left blank. These contacts do not contain sufficient data, and therefore were not able to be included in the analyses. ADRC Coordinators and the SUA should work with staff so that all contacts are appropriately captured and can be counted as part of ongoing quality management and the analyses of the effectiveness of the ADRC.
- **Increasing the Number of I&R and OC Surveys-** To increase the number of I&R and OC surveys completed, we recommend increasing sampling, training on when to provide the survey, and monitoring of the number of surveys received.
- **Considering Adding New Service Categories to Address Support that Does Not Fall within an Existing ADRC Service-** We identified two new potential ADRC services: 1) Extensive assistance provided to individuals who are challenging to support and are not receiving assistance from another agency; and 2) Assistance provided to individuals who are currently being served by one or more other agencies. The State and ADRC leadership should consider adding separate services that address these types of situations. This would include developing criteria and tracking mechanisms for these services.
- **Adding the Ability to Capture I&R Plans within Trilogy-** I&R plans are currently being developed by staff using paper forms that are not uploaded or integrated within the Trilogy automated system. The ability to upload and track these plans will be another crucial measure to determine the outcome and effectiveness of I&R interactions.

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

- **Strengthening and Clarifying the Roles of the Advisory Councils-** The State should develop a written policy that more clearly sets expectations for both the State and local Advisory Councils. These policies should help members understand their roles and opportunities to provide feedback. Additionally, disability partners recommended increasing efforts to have mental health representation on the State Advisory Council.

- **Formalizing Partnerships with Community Partners-** While we did see evidence of the ADRC working collaboratively with disability partners, we did not observe progress being made in the Initial Report's recommendation of translating relationships with disability and other community partners into ongoing policies and procedures and written agreements. These written agreements can be policies for cross-training and who and how to refer that are reviewed and agreed upon by all parties impacted. Eventually it would be helpful to have the agreements captured in a contract or Memorandum of Understanding (MoU) or a similar document.

We recommend that the ADRC initiative enhance staff training by:

- **Developing Ongoing Training Curriculum-** Establishing a written training curricula and schedule rather than holding trainings on an ad hoc basis.
- **Continuing the Development of Standardized Training Topics-** Training topics that should receive special focus include:
  - Development of person-centered plans and goals
  - Tracking follow-up in Trilogy
  - How to provide and track discussions around informed consent, confidentiality rights, and eligibility counseling
  - Tracking unmet need in Trilogy

Training could also be enhanced by:

- **Clarifying the Differences Among the Types of ADRC Services-** ADRC Coordinators should help staff better understand when contacts transition from basic information to I&R and from I&R to Options Counseling. Staff identified this as a concern during the September 2017 site visit, and it almost certainly impacted the accuracy of the reported contacts.

- **Supplementing Training with Intra- and Inter-agency Peer Review of Action Plans-** During the September 2017 HCBS Strategies site visit, we recommended that ADRC staff meet regularly to review Action Plans and the development of person-centered goals. These reviews could occur within and across agencies. Staff at all agencies said that they felt this would be valuable.

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

- **Integrating the ADRC and the AAA functions-** This will include clearly establishing the relationship among ADRC I&R, AAA I&A, ADRC Options Counseling, and AAA

Care Management; preventing duplication among these services; and developing a similar level of consistency to the AAA operations as has been developed for the ADRC services.

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

Appendix 1: Current ADRC Tools

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

- I&R Summary Plan
- Individual Action Plan
- Individual Comprehensive Action Plan for EOC
- Options Counseling Satisfaction Survey
- Intake and Referral Satisfaction Survey
- Training Review

ADRC FORMS MANUAL

TABLE OF CONTENTS

ADRC Consumer Rights

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

1. You have the right to receive services without regard to your race, color, sex, national origin, religion or disability.

2. ADRC services are voluntary. You have the right to accept or reject ADRC services.

3. You have the right to have your preferences respected.

4. You have the right to confidentiality. Your information will be kept confidential at all times and you may have access to your information, if desired.

5. You have the right to expect ADRC staff to respect your personal dignity.

6. You have the right to choose from the services available to you.

7. You have the right to choose who provides your services.

8. You have the right to register a complaint or file a grievance without discrimination or reprisal.

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

Purpose: The purpose of the Information and Referral (I&R) Summary Form is to capture information regarding referrals made for persons receiving Information and Referral services. The Options Counselor (OC) completes the form following discussion with the consumer and/or representative. The form provides information for the consumer/representative as they consider their next steps.

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

Instructions for Completion

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

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

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

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

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

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

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

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

Name:_____ **Address:**_____

Date: _____ _____

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

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

Additional Referrals

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

Date

Dear

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

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

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

Closing,
Signature block

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

Purpose: The purpose of the ADRC Individual Action Plan (IAP) is to capture information regarding the goals and preferences of the consumer and/or their representative. Action steps are to be defined to accomplish the goals, along with identifying who will complete the steps, a timeline, and potential funding sources. The Options Counselor (OC) completes the form in collaboration with the consumer and/or representative.

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

Instructions for Completion

Name: Consumer name

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

Background: Provide a brief narrative that describes the consumer's situation and preferences. Document the consumer's answers to the questions:

- **"**What brings me to the ADRC?"
- "What are my preferences?"

Goals: List identified goals for the consumer. Once achieved, mark "Goal Met".

Action Steps: List the agreed-upon action steps to include:

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

Notes: List any notes regarding progress or barriers toward meeting the goal.

Potential Funding: Check the potential source(s) of funding for meeting the goal. If "Other", indicate other potential source.

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

Saving the form upon completion:

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

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

Consumer Name:_____ **Address:**_____

Date of Original Plan:_____ **Date Plan was Updated:**_____

Background/Preferences:

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

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

These are the steps outlined to assist you in meeting the goals as discussed with ADRC staff. If you have questions or want to change your plan, contact:	
Name:_____	**Agency:**_____
Address:_____	**Phone:**_____
	E-mail:_____

Additional Goals

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

Date

Dear

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

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

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

Closing,
Signature block

ADRC Locations

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

Omaha
Eastern Nebraska Office on Aging
402-444-6536

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

Scottsbluff
Aging Office of Western Nebraska
308-635-0851

Lincoln
Aging Partners
402-441-7070

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

Hastings
Midland Area Agency on Aging
402-463-4565

INSTRUCTIONS FOR COMPLETION

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

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

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

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

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

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

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

Part B. My Resources & Challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My Risks	Addressing My Risks

Part E. My Supports

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

If needed, the plan may need to be re-visited and updated more frequently. This should be at times agreed upon by the Options Counselor and consumer and/or legal representative.

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

Part F. My Agreement

I agree to this plan.

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

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

Name:_____ **Address:**_____

Date of Original Plan:_____ **Date of Plan Update(s):**_____

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

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

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

Part B. My Resources & Challenges

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

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

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

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

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

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

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

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

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

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

Part F. My Agreement
I agree to this plan.

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

Date

Dear

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

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

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

Closing,
Signature block

ADRC Locations

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

Omaha
Eastern Nebraska Office on Aging
402-444-6536

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

Scottsbluff
Aging Office of Western Nebraska
308-635-0851

Lincoln
Aging Partners
402-441-7070

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

Hastings
Midland Area Agency on Aging
402-463-4565

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

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

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

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

Basic Information:	0%
Information and Referral:	100% of those receiving an emailed I&R Summary
Information and Referral:	50% of those receiving a mailed I&R Summary
Options Counseling:	50% (every other OC consumer served)
Enhanced Options Counseling:	100%

Process:

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

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

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

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

5. Monthly reports will be generated by Formstack.

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

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

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

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

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

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

Identification of Person Completing this Survey

Please check what applies to you:

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

1.17.17

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

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

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

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

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

Identification of Person Completing this Survey

Please check what applies to you:

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

1.17.17

ADRC Staff Training Review

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

Background Information

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

Training Review

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

Additional Comments:

Return this form to:
lloyafritz@windstream.net

APPENDIX 2: ADRC ADVISORY COUNCIL STRUCTURE AND MEMBERSHIP

Appendix 2: ADRC Advisory Council Structure and Membership

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

ADRC Statewide Advisory Committee

Agency	Representative	E-mail
AARP	Mark Intermill	mintermill@aarp.org
~~Arc of Nebraska~~	~~Mike Chittenden~~	~~mike@arc-nebraska.org~~
Brain Injury Alliance	Peggy Reisher	peggy@biane.org
DD Council	Kristen Larsen	kristen.larsen@nebraska.gov
~~DD Council Consumer Rep~~	~~Dale Johannes~~	~~djohann3@yahoo.com~~
Developmental Disabilities Division	Tony Green	tony.green@nebraska.gov
DHHS-Lifespan Respite/DPFS	Sharon Johnson	sharon.J.Johnson@nebraska.gov
Disability Rights Nebraska	Brad Muerrens	brad@drne.org
Division of Behavioral Health	Jude Dean	jude.dean@nebraska.gov
Early Development Network	Julie Docter/ Laurie Miller	julie.docter@nebraska.gov laurie.miller@nebraska.gov
Easter Seals	Angie Howell	ahowell@ne.easterseals.com
Hotline for Disability Services	Shari Bahensky	shari.bahensky@nebraska.gov
Independence Rising	Irene Britt	ibritt@cilne.org
League of Human Dignity	Mike Schafer Kathy Kay	mschafer@leagueofhumandignity.com kkay@leagueofhumandignity.com
Legislature/NASP	Kate Bolz	bolznasp@gmail.com
Medicaid	Kathy Scheele	kathy.scheele@nebraska.gov
Munroe-Meyer	Mark Smith	msmitha@unmc.edu
NCBVI	Pearl VanZandt/ Deanna Jesse	pearl.vanzandt@nebraska.gov deanna.jesse@nebraska.gov
NCDHH	John Wyvill	john.wyvill@nebraska.gov
PTI	Mike Tufte	mtufte@pti-nebraska.org
Statewide Ind. Living Council	Kathy Hoell	kathy@nesilc.org
VR	Keri Bennett	keri.bennett@nebraska.gov

2.24.17

ADRC Statewide Advisory Committee

AAA Directors	Cheryl Brunz Rod Horsley Connie Cooper Sandi Stevens Randy Jones Zoe Olson Dennis Loose	
SUA Reps	Cynthia Brammeier Doug Bauch Ben Stromberg Amy Hochstetler	

NEBRASKA ADRC: STATEWIDE ADVISORY MEETING

DATE/TIME: SEPTEMBER 27, 2016 1-4 PM

LOCATION: AGING PARTNERS
1005 O STREET
LINCOLN NE

ATTENDEES

SUA	AAA/ADRC REPRESENTATIVES		AGENCY REPRESENTATIVES	PROJECT COORDINATORS
Doug Bauch Amy Hostetler	AOWN (phone) Cheryl Brunz Carol Sinner Mandy Fertig AP Randy Jones Sandy Lutz Gladys Cooper Perian Pattillo BRAA Kathy Erickson Kellie Wiers	ENOA Dennis Loose Mary Ann Eusebio MAAA (phone) Sandi Stevens Andrea Cox NENAA Connie Cooper SCNAAA (phone) Rod Horsley	Mark Smith, UNMC Brad Meurrens, DRN Kathy Hoell, NESILC Kathy Kay, LHD Mike Schafer, LHD Joni Thomas, IR Laurie Miller, DHHS EDN Keri Bennett, VR Tony Green, DHHS DDD Mark Intermill, AARP Peggy Reisher, BIANE Stephanie Crouch, DHHS Medicaid Kate Bolz, NASP/Legislature Jude Dean, DHHS DBH John Wyvill, NCDHH	Mary O'Hare, FOA Lloya Fritz, FOA

BACKGROUND MATERIALS:

- Agenda
- ADRC Overview
- Service Directory Handout
- ADRC Brochure

AGENDA ITEMS

See 9.27.16 Agenda

MEETING MINUTES

TOPIC: COMMITTEE ROLE AND RESPONSIBILITIES
DISCUSSION
1. Committee composition, roles, and responsibilities were discussed. It was recommended that representatives from Adult Protective Services and the Office of Public Guardian be considered for membership.

ACTION STEPS	PERSON RESPONSIBLE	DEADLINE
1. Extend invitation to APS and Office of Public Guardian for committee membership.	Fritz/O'Hare	10.31.16

TOPIC: ADRC OVERVIEW
DISCUSSION
The concerns of a consumer were shared with the committee. Concerns were related to referral information provided when calling into the ADRC and difficulties in accessing the website. Additionally, discussion was held regarding language accommodations for ADRC calls and materials.

ACTION STEPS	PERSON RESPONSIBLE	DEADLINE
1. Follow up on website issue. 2. Training on community resources will be provided to ADRC staff at an initial training session and on an ongoing basis. 3. Take steps to ensure the ADRC materials and services are accessible for those requiring language accommodations.	1. SUA 2. Fritz/O'Hare 3. Fritz/O'Hare	1. 10.7.16 2. 10.19.16 3. 10.31.16

TOPIC: NETWORK OF CARE
DISCUSSION
• It was noted that Autism should be added to the Service Directory Target Populations. • Discussion was held regarding linking to other sites that provide resource listings whenever possible (such as Veterans, Behavioral Health Network of Care, NRRS, Nebraska Transit, etc.) Additionally, information should be cross-referenced whenever possible. • It was noted that it would be beneficial if the Nebraska Transit site included information about wheelchair accessibility. While the ADRC does not control this site, the suggestion will be shared with them. • It was suggested that postings to the Community Calendar page include information about accessibility and accommodations. • It would be beneficial if there could be some type of list-serve or a way to provide notifications when new items are posted or updated. • The disability partner organizations need to be recognized on the ADRC home page. Also, it's important to highlight that the ADRC serves both aging AND disability populations to ensure that people know they're in the right place.

ACTION STEPS	PERSON RESPONSIBLE	DEADLINE
Follow-up will be completed to address the above-referenced items.	SUA	10.31.16

TOPIC: STATISTICS		
DISCUSSION		
Discussion was held regarding the August Statistics and methods of tracking those using ADRC services by population, disability, and/or condition.		
ACTION STEPS	**PERSON RESPONSIBLE**	**DEADLINE**
1. Upgrades to the Dashboard will be completed so data is collected to further define populations using ADRC services. 2. Policies will be designed to ensure collection of disability/condition information.	SUA Fritz & O'Hare	10.31.16

NEXT MEETING INFORMATION:

The next meetings will be as follows, to be held at Aging Partners in Lincoln.

Tuesday, December 6: 1 - 4 pm
Tuesday, March 7: 1 - 4 pm
Tuesday, June 6: 1 - 4 pm

NEBRASKA ADRC: STATEWIDE ADVISORY MEETING

DATE/TIME: DECEMBER 6, 2016 1-4 PM

LOCATION: AGING PARTNERS
1005 O STREET
LINCOLN NE

ATTENDEES

SUA	AAA/ADRC REPRESENTATIVES		AGENCY REPRESENTATIVES	PROJECT COORDINATORS
Doug Bauch Amy Hostetler	AOWN (phone) Cheryl Brunz Mandy Fertig AP Randy Jones Sandy Lutz Perian Pattillo BRAA Kathy Erickson Zoe Olson	NENAA (phone) Connie Cooper Rich Brandow Ashley Saunders SCNAAA (phone) Hayley Jelinek Erin Davis	Brad Meurrens, DRN Kathy Kay, LHD Joni Thomas, IR Laurie Miller, DHHS EDN Keri Bennett, VR Tony Green, DHHS DDD Mark Intermill, AARP Peggy Reisher, BIANE Kathy Scheele, DHHS Medicaid Dan Jenkins, NE Legislature Sharon Johnson, DHHS Lifespan Respite/DPFS Mike Chittenden, Arc of NE Kristen Larsen, DD Council Mike Tufte, PTI (Phone Participants) Jude Dean, DHHS DBH Deanne Jesse, NCBVI	Mary O'Hare, FOA Lloya Fritz, FOA

BACKGROUND MATERIALS:

- Agenda
- October/November Statistics Power Point
- Potential ADRC Training Topics & Resources 12.2.16

MEETING NOTES

TOPIC: ADRC STAFF PERSPECTIVES
DISCUSSION
1. Sandy Lutz, Aging Partners, and Kathy Erickson, Blue Rivers AAA, presented information regarding ADRC work in their areas. Reports included an overview of Local Advisory meetings held and future plans for those groups. A goal for both areas is to continue to expand their membership and to focus on increasing membership of consumer representatives. Initial response to the local teams has been favorable and provides a good forum for networking. 2. Concerns were again noted regarding the involvement of disability partners in the ADRC operations. Specifically, these concerns relate to the 5 partners who have signed MOUs with the ADRC.
ACTION STEPS
1. Project Coordinators will provide Statewide Committee members with a list of individuals and organizations who have been invited to participate in Local Advisory Teams. Upon review, statewide members are encouraged to recommend others who might be invited. 2. Efforts will be made to involve the disability partners at all levels of ADRC operational work. This will include participation in meetings and review of materials such as the Operations Manual, Dashboard Manual, Training Plan, etc.

TOPIC: ADRC MARKETING
DISCUSSION
Zoe Olson of Blue Rivers AAA provided the Committee with an overview of the ADRC marketing plan and materials. Marketing officially began December 1, with the use of radio spots, video, Facebook page, etc. Discussion was held regarding editing materials and printing of brochures. The Regional Developmental Disabilities Planning Councils may be a source of funding for printing brochures.
ACTION STEPS
1. Committee members were asked to provide input on edits to the brochure no later than Dec. 20. Recommendations are to be submitted via email to Project Coordinators. 2. Project Coordinators will send link to radio spots to Committee members.

TOPIC: NETWORK OF CARE
DISCUSSION
1. Amy Hochstetler, DHHS State Unit on Aging, provided an overview of changes made to the Network of Care site. ADRC has reviewed the Service Directory listings for their respective areas and provided feedback on the taxonomies. 2. An Options Counseling module has been identified for possible use on the Network of Care Dashboard.
ACTION STEPS
1. Committee members are asked to identify changes or additions needed to the Service Directory on an ongoing basis. This feedback can be provided directly on the website. 2. The SUA and Project Coordinators will do an initial review of the Options Counseling module on the Network of Care site to determine whether it is something to consider for use.

NEBRASKA ADRC MEETING SUMMARY

TOPIC: ADRC STATISTICS – OCTOBER/NOVEMBER

DISCUSSION

The Committee reviewed the October/November Statistics power point. Discussion was held regarding additional information to be gathered, as well as other possible uses for the data (such as the need for the DD Council and Arc to gather information regarding family providing care for adults with disabilities in their homes). It would also be helpful to know the number of calls coming in from the person or family member vs. agency/NF/hospital representatives.

ACTION STEPS

1. Consider method to further identify age groups (beyond over and under 60).
2. Consider way to gather information about family caregivers of adults with disabilities.
3. Consider way to gather information on consumer/family vs. agency representative calls.

TOPIC: TRAINING COMMITTEE REPORT

DISCUSSION

Kathy Erickson reported on the work of the Training Committee. The October training was very well received and valuable information was provided by many organizations. Another training event is proposed for late February in Kearney. The committee is working to identify and prioritize training topics and resources. The 12.2.16 'Potential ADRC Training Topics & Resources' document was provided for the group to review.

ACTION STEPS

1. Advisory Committee members are asked to review the above-referenced document and submit additional recommendations to the Project Coordinators. Emphasis is to be placed on trainings and/or resources that are already available in the state or web-based resources.
2. Committee members are asked to share training resources on an ongoing basis.

TOPIC: PARTNERSHIP & OUTREACH EFFORTS

DISCUSSION

1. Peggy Reisher of the Brain Injury Alliance shared information about their organization and the work of their Resource Facilitators. This work blends well with the work of the ADRC and provides an opportunity to enhance each other's work.
2. The Center for Rural Affairs has submitted a Letter of Intent for a grant from the Retirement Research Foundation. The letter outlines collaboration with the ADRC.

ACTION STEPS

1. Continue work to collaborate with other entities within the state.
2. Reach out to the Nebraska Children and Families Foundation for potential collaboration with the ADRC.

TOPIC: PROJECT COORDINATORS' UPDATE

DISCUSSION

1. The evaluation from HCBS Strategies, Inc. is in draft form and will be finalized soon.
2. The Quality Assurance Team will begin work after the first of the year. Volunteers for members are needed.
3. The ADRC Operations Manual and Dashboard Manual are under development.

4. Satisfaction Surveys have been drafted.
5. A process for ADRC Consumer Reviews will be implemented in January. This will involve presenting information regarding ADRC contacts and allow for sharing successes, challenges, resources, and strategies.

ACTION STEPS

1. The evaluation report will be shared with the Committee when it is finalized.
2. Disability partners are asked to volunteer for the Quality Assurance Team (see Organizational Structure document for roles/responsibilities).
3. Draft manuals and Satisfaction Survey will be shared with the disability partners for their review and feedback.
4. Disability partners are asked to volunteer for the Consumer Review process.

TOPIC: AGENCY SHARING

DISCUSSION

1. The Arc of Nebraska's Senatorial Dinner will be held on Thursday, February 9.
2. The League of Human Dignity has a Service Coordinator position open.
3. New regulations for the Disabled Persons and Family Support Program are under development.

NEXT MEETING INFORMATION:

The next meetings will be as follows, to be held at Aging Partners in Lincoln.

Tuesday, March 7: 1 - 4 pm
Tuesday, June 6: 1 - 4 pm

NEBRASKA ADRC: STATEWIDE ADVISORY MEETING

DATE/TIME: MARCH 7, 2017 1-4 PM

LOCATION: AGING PARTNERS

1005 O STREET

LINCOLN NE

ATTENDEES

SUA	AAA/ADRC REPRESENTATIVES		AGENCY REPRESENTATIVES	PROJECT COORDINATORS
Doug Bauch Amy Hostetler	AOWN (phone) Mandy Fertig AP Randy Jones Sandy Lutz Perian Pattillo Gladys Cooper BRAA Kathy Erickson Zoe Olson	NENAA (phone) Rich Brandow Ashley Saunders SCNAAA (phone) Hayley Jelinek Erin Davis Midland AAA Sandi Stevens Andrea Cox	Brad Meurrens, DRN Kathy Kay, LHD Laurie Miller, DHHS EDN Keri Bennett, VR (phone) Peggy Reisher, BIANE Sharon Johnson, DHHS Lifespan Respite/DPFS Mike Chittenden, Arc of NE Kristen Larsen, DD Council Deanne Jesse, NCBVI (phone) Mark Smith, Munroe-Meyer Irene Britt, Independence Rising (phone) Angie Howell, Easterseals	Mary O'Hare, FOA Lloya Fritz, FOA

BACKGROUND MATERIALS:

- Agenda
- Performance Measures Power Point
- Operations Manual
- Satisfaction Survey Comments
- Service Directory Handout

MEETING NOTES

TOPIC: OPTIONS COUNSELING
DISCUSSION
1. Consumer Review: Erin Davis of South Central AAA and Andrea Cox of Midlands AAA provided examples of ADRC work they've performed and situations they've encountered. Committee members offered resource suggestions and insight. Members are welcome to participate in monthly Consumer Review calls. These are held the 3rd Tuesday of each month at 10:30 a.m. Central. Call-in information will be provided prior to each meeting. 2. ADRC Service Directory: Amy Hochstetler, DHHS SUA, demonstrated the website and changes made to it. Committee members were encouraged to review the information for their agencies, as well as other statewide resources, and submit edits and additions as appropriate. 3. Operations Manual: Committee members have been provided a copy of the current ADRC Operations Manual and are encouraged to use it as a reference, as needed, for information regarding ADRC policies and procedures.

TOPIC: MARKETING
DISCUSSION
1. Zoe Olson, Blue Rivers AAA, shared recent marketing efforts with the committee. Advertisements have been placed in various publications and will continue to run in newspapers across the state. Efforts will be made to collect ADRC stories that could be used as human interest stories for television or radio. Zoe will develop a blurb regarding the ADRC in pdf or jpeg form that agencies can use in newsletters or other publications. 2. The NE Developmental Disabilities Planning Council has provided funding for printing ADRC brochures. Once printed, committee members may request copies for distribution and use by their agencies.

TOPIC: TRAINING
DISCUSSION
1. Kathy Erickson, Blue Rivers AAA, reported on training activities. This includes: ▪ ADRC staff attending or viewing online webinars/trainings. Upon completion, staff submit a Training Review Form to Project Coordinators. These are compiled and will be used to determine useful topics and resources to be utilized for orientation or ongoing training for ADRC staff. ▪ Disability Etiquette webinar conducted by Mark Smith, Munroe – Meyer and Mike Chittenden, Arc of Nebraska. This session was well received by staff and very much appreciated. ▪ Upcoming quarterly staff training is scheduled for March 21 & 22 in Kearney. 2. Kristen Larsen reminded the group that Regional DD Council funds may be used to assist family members and consumers in attending trainings or conferences. 3. Committee members were encouraged to share information regarding training opportunities as they become aware of them. 4. Committee members also discussed: ▪ The need to identify resources for those who are difficult to serve, including those with co-occurring needs/conditions. Tracking of unmet needs will assist in identifying these issues. Work on these situations begins at the local level, but may need to be bumped up to the state level for complex cases. ▪ The need to work with Managed Care Organizations. ▪ Outreach to DHHS administration.

TOPIC: DASHBOARD

DISCUSSION

Amy Hochstetler, DHHS SUA, demonstrated upcoming changes to the Dashboard to enhance the work of the ADRC. This includes implementation of an Options Counseling Module. These changes are currently being worked on by Trilogy.
The question was raised whether it would be possible and/or beneficial to track the time spent on each consumer call.

TOPIC: QUALITY ASSURANCE

DISCUSSION

1. Mary O'Hare reviewed ADRC data, as outlined in the Performance Measures PowerPoint. The group discussed potential reasons for the low number of callers representing the under 60 disability population. Questions were raised as to how this compares nationally with other ADRCs and how it compares with general statewide population data. Are they not calling because there are other resources available for them? Or, is there a perception that this is not an appropriate resource for them because ADRCs are housed within AAAs?
2. Lloya Fritz reviewed the Satisfaction Survey process and initial results, including comments gathered from surveys. This process was implemented in January, with 29 surveys completed to date. Discussion was held on methods to increase the number of completed surveys. It's important to stress to consumers/callers that results will be used to promote the work of the ADRCs after the pilot ends. Ideas for increasing numbers included asking the survey questions at the completion of the call or adding a place on the website for providing input.
3. The importance of legislative advocacy was discussed. Summer may be an optimal time for this.

TOPIC: AGENCY SHARING

DISCUSSION

1. The Long Term Care Redesign Tour and webinars have been announced and details can be found on the DHHS website.
2. Comments are being taken on DD waiver regulations. Changes to the A&D waiver are in the works.
3. March is Brain Injury Awareness Month and the BI Conference will be held in Kearney March 23 & 24.
4. March is also DD Awareness Month.
5. Proposed changes to the DD system are included in two bills, LB 417 and LB 495.
6. Organizations are encouraged to share information regarding upcoming events with Zoe Olson for posting to the ADRC Facebook page.
7. The Midwest Special Needs Ministry Conference will be held in Lincoln on April 29. Sharon Johnson has additional information regarding this.

NEXT MEETING INFORMATION:

The next meeting will be held on June 27, 2017 from 1- 4 p.m. Location to be determined.

NEBRASKA ADRC: STATEWIDE ADVISORY MEETING

DATE/TIME: JUNE 27, 2017 1- 4 PM

LOCATION: AGING PARTNERS
1005 O STREET
LINCOLN NE

ATTENDEES

SUA	AAA/ADRC REPRESENTATIVES		AGENCY REPRESENTATIVES	PROJECT COORDINATORS
Doug Bauch Amy Hostetler Cynthia Brammeier	AOWN (phone) Cheryl Brunz Mandy Fertig Carol Sinner AP Randy Jones Sandy Lutz Perian Pattillo BRAA Kathy Erickson	NENAA (phone) Rich Brandow Ashley Saunders SCNAAA (phone) Erin Davis ENOA (phone) Mary Ann Eusebio Kieran Anderson Taylor Armstrong	Brad Meurrens, DRN Kathy Kay, LHD Laurie Miller, DHHS EDN Keri Bennett, VR Mark Intermill, AARP Peggy Reisher, BIANE Sharon Johnson, DHHS Lifespan Respite/DPFS Mike Chittenden, Arc of NE Deanne Jesse, NCBVI Shari Bahensky, Hotline for Disability Services Mark Smith, Munroe-Meyer John Wyvill, NCDHH Tessa Humann, Region V Services Angie Howell, Easterseals (phone) Kathy Hoell, SILC (phone)	Mary O'Hare, FOA Lloya Fritz, FOA

BACKGROUND MATERIALS:

- Agenda
- May 2017 Monthly Report
- ADRC Quality Assurance Plan
- ADRC At a Glance
- ADRC Q & A
- LR 142

MEETING NOTES

TOPIC: ADRC COLLABORATIONS
DISCUSSION
1. Kathy Erickson, Blue Rivers AAA, and Tessa Humann, Region V Services, highlighted a partnership that has resulted from Local Advisory Committee connections. Individuals who receive services from Region V are being utilized as providers for in-home services. This gives these individuals opportunities for employment and increases the pool of providers for in-home services.
ACTION STEPS
1. Encourage similar partnerships in other communities. 2. The SUA may wish to highlight this in future DHHS publications.

TOPIC: UNMET NEEDS FOCUS GROUPS
DISCUSSION
Project Coordinators will be attending a Local Advisory Committee meeting in each of the sites over the coming months. One item to be discussed with them is Unmet Needs. While this information is being collected on an individual consumer level on the Dashboard, this focus group activity will gather additional information on a systems level.
ACTION STEPS
1. Project Coordinators will report back to the Statewide Advisory Committee on the results of this activity.

TOPIC: ADRC DATA
DISCUSSION
Data from the May 2017 Monthly Report was reviewed with the group and clarifications were provided. Numbers continue to be consistent.
ACTION STEPS
Continue to gather and analyze data.

TOPIC: TRAINING
DISCUSSION
Kathy Erickson reported on Training activities. ADRC staff continue to access trainings available throughout the state, both in-person and online. All have received or will receive the "Person-Centered Thinking" training. Additionally, trainings are scheduled for all staff on Motivational Interviewing and Trauma Informed Care. The Committee discussed other types of training that may be useful. This includes working with persons who are deaf or heard of hearing and those who are blind. NCDHH and NCBVI offered to provide training, upon request. The Lifespan Respite Provider Training can be accessed at: Answers4families.org/classroom. Training information from the NE Office of Health Disparities & Health Equity may be found at: http://dhhs.ne.gov/publichealth/Pages/healthdisparities_index.aspx Updates were also provided regarding self-advocacy trainings offered through Disability Rights Nebraska (funded by Nebraska VR and in conjunction with Fritz & O'Hare), Munroe-Meyer, and the Arc of Nebraska.

ACTION STEPS

1. Committee members are asked to share training resources on an ongoing basis.
2. Trainings or events may be posted on the Community Calendar at: http://nebraska.networkofcare.org/aging/calendar.aspx

TOPIC: DASHBOARD/OPTIONS COUNSELING MODULE

DISCUSSION

A new module for Options Counseling will be implemented July 1. This is an enhancement to the Dashboard that will expand the ability to attach documents, run reports, and share information between staff. Other tweaks to the dashboard include expanding the list of Unmet Needs to further define these and adding a category of "Friend/Relative/Advocate" to better identify the caller.

ACTION STEPS

1. Staff are being provided with training on the new module and Dashboard changes.

TOPIC: WEBSITE USAGE

DISCUSSION

Use of the Network of Care website continues to rise. HCBS and ADRC staff are completing an exercise to review website listings to identify gaps in resources and/or providers.

ACTION STEPS

1. Advisory Committee members and other stakeholders are encouraged to review and monitor their listings on the website for accuracy. Changes may be submitted directly via the website.

TOPIC: QUALITY ASSURANCE

DISCUSSION

The Quality Assurance Team has identified three goals and corresponding strategies, as outlined on the 'ADRC Quality Assurance Plan' handout.

ACTION STEPS

1. Work will continue to implement the strategies, as identified.

TOPIC: MARKETING

DISCUSSION

Brochures are available for anyone who wishes to have a supply for distribution. The Northeast NE AAA has developed two commercials. They have not yet been finalized, but the drafts may be viewed at:
https://drive.google.com/open?id=0B42WYuh0s44FZ2xISW1CUFcyVnM
http://www.nenaaa.com/

TOPIC: ADRC LEGISLATIVE EFFORTS

DISCUSSION

LR 142 provides for an interim study to review the progress of the ADRC demonstration project and consider the long-term role of ADRCs in Nebraska. A small group will be meeting with Senator Bolz on July 6th to discuss this. Discussion was held regarding where this fits with the Medicaid redesign, which recommends a No Wrong Door system.

TOPIC: AGENCY SHARING

DISCUSSION

Announcements:

- Aging Partners has a Rural Transit program. Call them for more information.
- Follow NE Commission for the Deaf and Hard of Hearing on Facebook for event updates.
- Arc of NE will host the annual Senatorial Dinner on February 8, 2018.
- Two new positions have been added at Munroe-Meyer for Parent Resource Coordinators.
- Brain injury training has been provided through NASP and VR. This will increase the capacity of service providers trained to serve those with brain injury.
- People First conference and NASP/Arc/APSE conference will be held in October
- Brain Injury Alliance is partnering with UNL to hold concussion assessment and management clinic on July 17.
- Disability Pride day at the capitol will be held July 13.
- Lifespan Respite and Caregiver Coalition are hosting Days of Caring, scheduled for:
  Beatrice: July 28
  Columbus: August 2
  North Platte: August 30

NEXT MEETING INFORMATION:

The next meetings will be as follows, to be held at Aging Partners in Lincoln.

Tuesday, October 3: 1 - 4 pm
Thursday, December 14: 1 - 4 pm

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

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

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

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

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

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	5%	0%	0%	10%	7%	3%	0%
2 Disagree	0%	0%	0%	0%	0%	0%	3%	0%
3 Neither Agree nor Disagree	0%	5%	0%	0%	0%	7%	0%	0%
4 Agree	100%	24%	100%	22%	30%	43%	40%	0%
5 Strongly Agree	0%	67%	0%	78%	60%	43%	54%	100%
# Responses Received	1	21	1	18	10	30	35	1
Average Score	4.0	4.5	4.0	4.8	4.3	4.2	4.4	5.0

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

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	5%	0%	0%	10%	7%	0%	0%
2 Disagree	0%	0%	0%	0%	0%	0%	6%	0%
3 Neither Agree nor Disagree	0%	0%	0%	0%	0%	3%	3%	0%
4 Agree	0%	19%	100%	17%	20%	50%	31%	100%
5 Strongly Agree	100%	76%	0%	83%	70%	40%	60%	0%
# Responses Received	1	21	1	18	10	30	35	1
Average Score	5.0	4.6	4.0	4.8	4.4	4.2	4.5	4.0

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

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

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	5%	0%	0%	10%	11%	0%	0%
2 Disagree	0%	0%	0%	0%	0%	0%	6%	0%
3 Neither Agree nor Disagree	0%	5%	0%	12%	10%	7%	3%	0%
4 Agree	0%	24%	100%	12%	40%	39%	29%	100%
5 Strongly Agree	100%	67%	0%	76%	40%	43%	63%	0%
# Responses Received	1	21	1	17	10	28	35	1
Average Score	5.0	4.5	4.0	4.6	4.0	4.0	4.5	4.0

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

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	5%	0%	0%	10%	4%	0%	0%
2 Disagree	0%	10%	0%	0%	0%	0%	3%	0%
3 Neither Agree nor Disagree	0%	0%	0%	12%	10%	7%	9%	0%
4 Agree	0%	19%	100%	12%	30%	41%	37%	100%
5 Strongly Agree	100%	67%	0%	76%	50%	48%	51%	0%
# Responses Received	1	21	1	17	10	27	35	1
Average Score	5.0	4.3	4.0	4.6	4.1	4.3	4.4	4.0

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

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

EXHIBIT 5- OC ITEM 2A RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure

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

1	Strongly Disagree	0%	0%			0%	0%	0%	
2	Disagree	0%	0%			0%	0%	0%	
3	Neither Agree nor Disagree	0%	0%			0%	0%	0%	
4	Agree	0%	40%			0%	75%	33%	
5	Strongly Agree	100%	60%			100%	25%	67%	
	# Responses Received	1	5	0	0	2	4	3	0
	Average Score	5.0	4.6			5.0	4.3	4.7	

EXHIBIT 6- OC ITEM 2B RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	0%			0%	0%	0%	
2 Disagree	0%	0%			0%	0%	0%	
3 Neither Agree nor Disagree	0%	0%			0%	25%	0%	
4 Agree	0%	40%			0%	75%	33%	
5 Strongly Agree	100%	60%			100%	0%	67%	
# Responses Received	1	5	0	0	2	4	3	0
Average Score	5.0	4.6			5.0	3.8	4.7	

EXHIBIT 7- OC ITEM 2C RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	0%			0%	0%	0%	
2 Disagree	0%	0%			0%	0%	0%	
3 Neither Agree nor Disagree	0%	0%			0%	0%	0%	
4 Agree	0%	40%			0%	100%	33%	
5 Strongly Agree	100%	60%			100%	0%	67%	
# Responses Received	1	5	0	0	2	4	3	0
Average Score	5.0	4.6			5.0	4.0	4.7	

EXHIBIT 8- OC ITEM 2D RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	0%			0%	0%	0%	

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

2 Disagree	0%	0%			0%	0%	0%	
3 Neither Agree nor Disagree	0%	20%			0%	0%	0%	
4 Agree	0%	20%			0%	100%	33%	
5 Strongly Agree	100%	60%			100%	0%	67%	
# Responses Received	1	5	0	0	2	4	3	0
Average Score	5.0	4.4			5.0	4.0	4.7	

EXHIBIT 9- OC ITEM 2E RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	40%			0%	0%	33%	
2 Disagree	0%	0%			0%	25%	33%	
3 Neither Agree nor Disagree	100%	20%			100%	25%	33%	
4 Agree	0%	0%			0%	50%	0%	
5 Strongly Agree	0%	40%			0%	0%	0%	
# Responses Received	1	5	0	0	2	4	3	0
Average Score	3.0	3.0			3.0	3.3	2.0	

EXHIBIT 10- OC ITEM 2F RESPONSE SUMMARY BY REGION

Response	AOWN	AP	BRAAA	ENOA	MAAA	NENAAA	SCNAAA	Unsure
1 Strongly Disagree	0%	0%			0%	0%	0%	
2 Disagree	0%	0%			0%	0%	0%	
3 Neither Agree nor Disagree	0%	20%			0%	0%	33%	
4 Agree	0%	20%			0%	100%	0%	
5 Strongly Agree	100%	60%			100%	0%	67%	
# Responses Received	1	5	0	0	2	4	3	0
Average Score	5.0	4.4			5.0	4.0	4.3	