Dakota at Home

Program Evaluation Report

Division of Fiscal and Program Analysis

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South Dakota Legislature

Legislative Research Council

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CONTENTS

Executive Summary

Overview

The cost of long-term services and supports in South Dakota and nationwide continues to grow each year. A direct path to reduced spending is unclear; however, the state has implemented strategies and approaches to help curb spending. One approach is the use of Aging and Disability Resource Centers not only to reduce spending, but to provide clear, streamlined services to consumers in the complex world of long-term services and supports. South Dakota's Aging and Disability Resource Center (ADRC), Dakota at Home, is administered by the South Dakota Department of Human Services (DHS), Division of Long-Term Services and Supports (LTSS). Dakota at Home is South Dakota's "one-stop shop" for individuals seeking information about or assistance with obtaining long-term services and supports for themselves, their loved ones, or their patients.

This program evaluation examines ADRC national best practices and standards and how those best practices and standards compare to the functions carried out by Dakota at Home. Applying the best practices and standards to Dakota at Home, this evaluation gauges areas in which Dakota at Home meets or does not meet those established best practices and standards.

Findings

The evaluation identifies the following five findings:

1. The Department of Human Services does not track or report costs specifically for the Dakota at Home program;
2. The Department of Human Services does not use Medicaid Administrative Federal Financial Participation (FFP) for Dakota at Home/ADRC, which provides a 50% federal match rate for eligible ADRC services and activities;
3. The Department of Human Services is utilizing outdated policies and procedures and does not have a formalized training plan in place for Dakota at Home staff;
4. The Department of Human Services does not utilize surveys to gauge consumer satisfaction with Dakota at Home services; and
5. The Department of Human Services has limited access to the data collected by their Dakota at Home IT system.

Conclusion

Dakota at Home aligns with many areas of established best practices but not with others. The Department of Human Services should focus on identifying Dakota at Home program costs and finding additional funding opportunities that could reduce general fund expenditures. In addition, the Department of Human Services should ensure Dakota at Home staff are provided adequate training and certifications to provide high quality services to South Dakotans. Consumers of Dakota at Home services must be given opportunities to provide feedback on service delivery. Finally, to ensure Dakota at Home performs at its highest potential, access to and analysis of program data should be made a top priority.

Introduction

"Long-Term services and supports (LTSS) refers to a broad range of supportive services needed by people who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition."[1] Aging and Disability Resource Centers (ADRCs) were designed to help citizens navigate the long-term care system. The cost of long-term services and supports in South Dakota and nationwide has been rapidly increasing for years. South Dakota alone expended over $337 million on Medicaid long-term services and supports in federal fiscal year 2016, while the federal government and states together spent $167 billion on Medicaid long-term services and supports during that same time.[2] A path to reduced spending is unclear, but both federal and state agencies have adopted strategies and best practices to curtail rising costs and increase program efficiencies. One strategy includes using Aging and Disability Resource Centers not only to reduce spending, but to provide clear, streamlined services to consumers in the complex world of long-term services and supports.

South Dakota's ADRC, Dakota at Home, is administered by the South Dakota Department of Human Services (DHS), Division of Long Term Services and Supports. Dakota at Home is South Dakota's repository of LTSS information and, in many instances, may be the first point of contact for consumers and healthcare providers inquiring about available long-term services and supports for themselves, their loved ones, or their patients. As South Dakota's population ages and more individuals need access to long-term services, it is critically important that Dakota at Home is accessible and the services it provides are well-known to all South Dakotans. It is also imperative that Dakota at Home provides accurate and timely information about services available in local communities, as well as statewide, for elderly individuals and individuals with disabilities.

Dakota at Home is the primary contact for key resources to ensure South Dakotans are informed about their long-term care options when planning for their own needs or the needs of their loved ones. The role of Dakota at Home is increasingly important to ensure that those needs are met in the least restrictive setting possible. This importance was emphasized when the U.S. Department of Justice found that South Dakota was not informing individuals of the options to receive services in their home. In May 2016, the Civil Rights Division of the U.S. Department of Justice found that South Dakota was non-compliant with Title II of the Americans with Disabilities Act by requiring thousands of individuals with disabilities to receive care in nursing facilities rather than in their homes or communities. In the Department of Justice's official report, *United States Investigation, Pursuant to the Americans with Disabilities Act, of South Dakota's Use of Nursing Facilities to Serve Individuals with Disabilities*, the report found "South Dakota's system of care requires thousands of people with disabilities to live in segregated nursing facilities . . . despite their preference to remain in their own homes and communities . . .. And many have never been informed by the State that they could be receiving care while living in their own homes."[3]

[1] O'Shaughnessy, Carol V. *Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze.* Washington, DC: National Health Forum, 2010.
[2] Eiken, Steve, Kate Sredl, Brian Burwell, and Angie Amos. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* IAP Medicaid Innovation Accelerator Program, IBM Watson Health, 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.
[3] U.S. Department of Justice, Civil Rights Division. *United States Investigation, Pursuant to the Americans with Disabilities Act, of South Dakota's Use of Nursing Facilities to Serve Individuals with Disabilities.* Vanita Gupta to Governor Dennis Daugaard, May 2, 2016. https://www.ada.gov/olmstead/documents/south_dakota_lof.pdf.

Purpose and Scope

The Executive Board of the State Legislature, in accordance with South Dakota Codified Law 2-9-4, directed the South Dakota Legislative Research Council's Division of Fiscal and Program Analysis to evaluate the Dakota at Home program.

The evaluation was guided by the following research questions:

1. Does Dakota at Home align with best practices and standards for aging and disability resource centers for assisting clients through options counseling, benefits counseling, referral, and planning for future needs?
2. Does Dakota at Home align with best practices and standards for aging and disability resource centers for assisting clients to access services through eligibility screening, programmatic eligibility determination, and availability of services?
3. Does Dakota at Home effectively reach target audiences to promote awareness of the program?

The program evaluators collected and analyzed data from numerous sources including:

- Interviews with Department of Human Services staff;
- Interview with Secretaries of the Departments of Social Services, Health, and Human Services;
- Interviews with the Administration for Community Living staff;
- Review of Division of Long Term Services and Supports policies and procedures for Dakota at Home;
- Analysis of Dakota at Home data, including operational, financial, and consumer survey results;
- Literature review; and
- Research on law, policy, and practices related to Aging and Disability Resource Centers.

Background

ADRC History and Legal Framework

In 2003, the United States Administration on Aging and Centers for Medicare and Medicaid Services (CMS) awarded ADRC grants to 12 states to create single-points of entry for individuals seeking long-term services and supports.[4] These "one-stop shops" are commonly referred to as the "No Wrong Door" (NWD) approach and aging and disability resource centers.

In 2006, the reauthorization of the Older Americans Act provided that the Secretary of the Administration on Aging shall “implement in all States Aging and Disability Resource Centers” to be a trusted source for long-term care options; provide personalized assistance so consumers can make decisions about care options; provide coordinated, single-point access to all long-term care options; help consumers plan for future long-term care needs; and assist consumers with understanding and accessing prescriptions and preventative benefits.[5]

In 2009, the Veterans Health Administration (VHA) entered into formal agreements with ADRCs to deliver the Veterans-Directed Home and Community Based Services program.[6] In 2010, the Patient Protection and

[4] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* *https://www.acl.gov/index.php/about-acl/reports-congress-and-president*.

[5] Older Americans Act Amendments of 2006, Pub. L. No. 109-365; 120 Stat. 2522 (2006). https://www.gpo.gov/fdsys/pkg/PLAW-109publ365/pdf/PLAW-109publ365.pdf

[6] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.

Affordable Care Act provided funding to expand state Aging and Disability Resource Centers by appropriating 10 million dollars per year for federal fiscal years 2010 through 2014.[7]

ADRCs have grown substantially since the 12 states were awarded grants in 2003. There are now 525 ADRC sites in 53 states and territories.[8] South Dakota has a single statewide ADRC called Dakota at Home.

Dakota at Home History

During the 2006 Legislative Session, House Bill 1156 passed with overwhelming support (one no vote) to require the Department of Social Services (DSS) conduct a comprehensive study to examine long-term care for senior citizens. More specifically, the Act required DSS to "examine long-term care financing, including long-term care insurance; costs of providing long-term care; alternative approaches to providing long-term care; barriers to the provision of quality long-term care services; programs and techniques employed in other states for providing long-term care; and other issues appropriate to the study of the continuum of care."[9]

Following the passage of House Bill 1156, DSS contracted with Abt Associates, Inc. to conduct the required study and develop the final report. The report was submitted to the South Dakota Legislature and Governor in November 2007. Of the eight recommendations, one was directly related to Aging and Disability Resource Centers. The study recommended South Dakota "explore options to develop 'One-Stop Shops' that provide information, assessment and referral to appropriate services."[10]

In 2011, the South Dakota Department of Social Services, Division of Adult Services and Aging launched the Aging and Disability Resource Connections. In South Dakota's 2013-2017 State Plan on Aging, DSS reported, "The implementation of South Dakota's Aging and Disability Resource Connections (ADRC) was the driving force of systems-change in the State Unit on Aging. Two workgroups, a local ADRC workgroup in the Sioux Falls pilot area and a statewide ADRC workgroup, convened for the purpose of obtaining both consumer and provider input relative to the availability and delivery of services. Protocols were piloted with changes and adjustments made according to the results. Input from consumers and providers proved valuable in modifying processes and protocols to provide positive outcomes to consumers. Between November 2009 and December 2011, the local ADRC workgroups each met quarterly to review and discuss progress towards goals."[11]

ADRC call centers were initially located in five areas (Rapid City, Pierre, Watertown, Mitchell, and Sioux Falls), which were directly connected to Adult Services and Aging local office locations. Each call center had its own unique toll-free telephone number.

In 2015, the Department of Social Services again contracted with Abt Associates, Inc. to conduct an updated study and prepare an updated report. The 2015 update reported that DSS had started a task force on long term care services and supports in South Dakota, which recommended, and DSS implemented, a "No Wrong Door" Aging and Disability Resource Center. In addition, the 2015 update found South Dakota "must clearly maintain its focus on rebalancing the long-term services and supports systems (LTSS), through: Continuing to utilize options counseling through the ADRC to educate consumers and families about community-based care alternatives, in attempts to reduce nursing home admissions . . .." Similar to the 2016 report from the

[7] Patient Protection and Affordable Care Act, Pub. L. No. 111-148; 124 Stat. 119 (2010). https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[8] Administration for Community Living, National Study of Aging and Disability Resource Centers. *Process and Outcome Study Report,* by Barretto, Tina, Dr. Rekha Varghese, Sarah Pedersen, Dr. Leanne Clark-Shirley, Dr. Sandeep Shetty, Dr. Manan Roy, Sharanjit Toor, Michael Siers, Dr. Rosanna Bertrand, Luisa Buatti. Report HHSP233201000692G. Columbia, MD, 2014. https://www.acl.gov/sites/default/files/programs/2017-02/ADRCs-final-study-report.pdf.

[9] HB 1156, 81st Legislative Assembly (SD 2006), *An Act to require a study of the continuum of care needs for senior citizens.* https://sdlegislature.gov/sessions/2006/bills/HB1156enr.pdf.

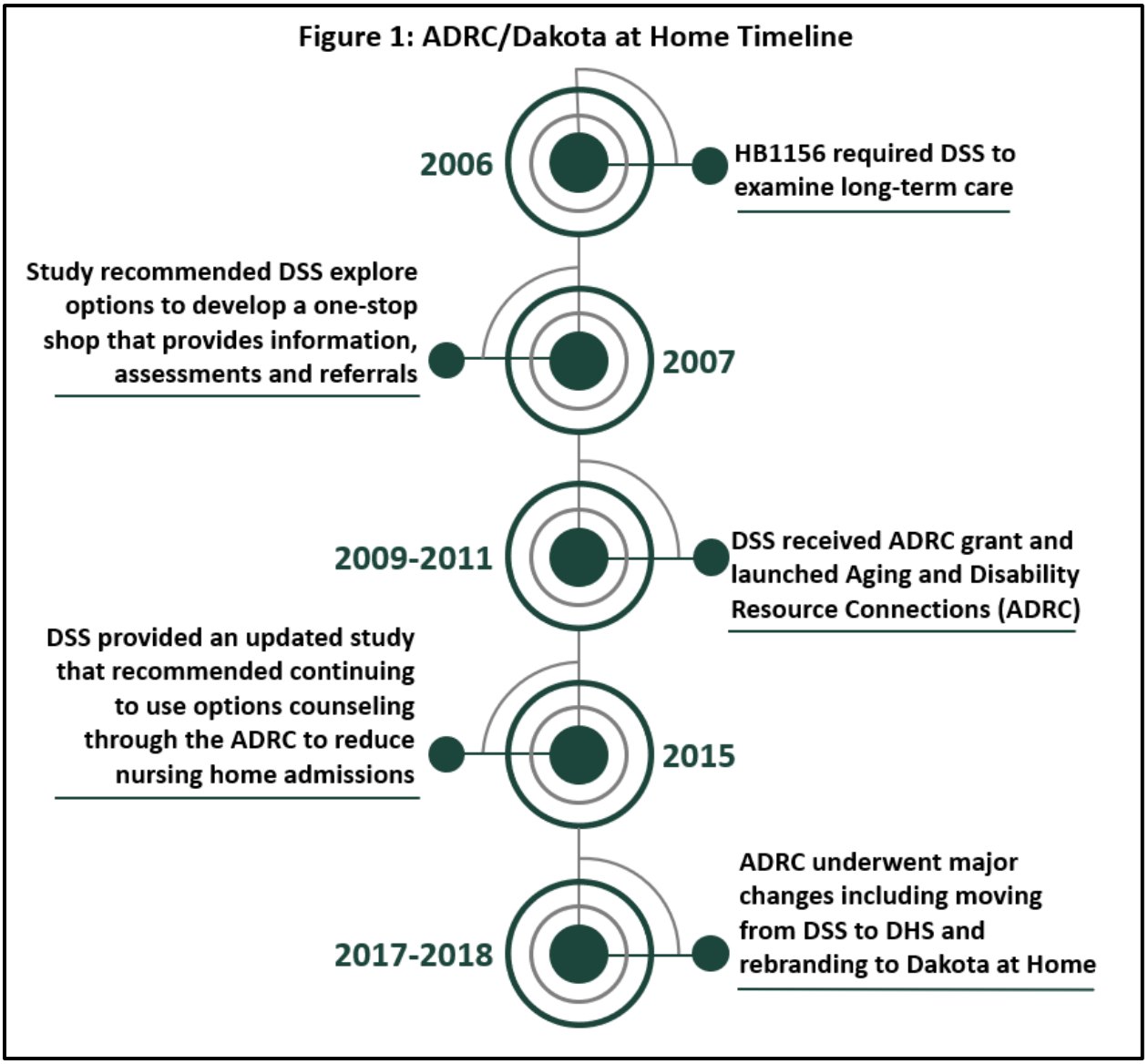
[10] South Dakota Department of Social Services. *Final Report Evaluation of Long-Term Care Options for South Dakota*, prepared by Abt Associates, Inc. Cambridge, MA, 2007. https://ltcpartnership.sd.gov/docs/Final%20Report%20SD%20LTC%2012-07-07%20.pdf.

[11] South Dakota Department of Social Services. *South Dakota State Plan on Aging, October 1, 2013 – September 30, 2017, 2013.* https://dhs.sd.gov/LTSS/docs/stateplan.pdf.

U.S. Department of Justice, the 2015 Abt updated report emphasized the importance of ensuring consumers receive care in the least restrictive setting possible.

In January 2017, via executive order, the DSS Division of Adult Services and Aging was renamed the Division of Long-Term Services and Supports, and in April 2017, the Division of Long-Term Services and Supports transitioned from DSS to DHS. Likewise, the ADRC also underwent major changes. After entering into a contract with a consultant, Insight Marketing Design, Inc., in June 2017, the Aging and Disability Resource Connections was rebranded as Dakota at Home. Subsequently, in February 2018, DHS launched a public awareness campaign for Dakota at Home. The job duties of certain DHS staff were realigned to promote specialization in ADRC services. The five unique telephone numbers for the five locations were replaced by one statewide toll-free phone number to increase ease of access for consumers.

Figure 1: ADRC/Dakota at Home Timeline



ADRC Best Practices and Standards

National Best Practices and Standards

The United States Department of Health and Human Services, Administration for Community Living (ACL) oversees Aging and Disability Resource Centers. ACL confirmed that the Aging and Disability Resource Center's *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012* is the criteria that should be used when assessing South Dakota's Dakota at Home program.[12] Through guidance from this document and additional research, overarching themes emerged to identify five standards or best practices for ADRCs:

1. Streamlined Access to Long-Term Services and Supports;
2. Personalized Counseling and Planning;
3. Public Outreach and Marketing;
4. Stakeholder Involvement; and
5. Quality Assurance and Continuous Improvement.

It is important to note that one agency alone cannot carry-out every aspect of a No Wrong Door/ADRC system. Fully functioning ADRCs require collaboration across multiple state and federal agencies, private stakeholders, and consumers. According to the report, "[t]he governance and administration of a NWD system involves a collaborative effort among multiple state agencies, since no one state agency has the authority or expertise to carry out all the functions involved in a NWD system as envisioned by ACL, CMS and VHA. The NWD system is a critical component of any well-developed, person-centered state LTSS system. Its governing body is responsible for coordinating the on-going development, implementation, financing, evaluation and continual improvement of the state's NWD system. It includes representatives from the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and the state authorities administering mental health services."[13]

Standard 1: Streamlined Access to Long-Term Services and Supports

Aging and Disability Resource Centers are designed to serve the public as a one-stop shop for long-term services and supports. The ability to contact one entity to receive information and referrals; assistance such as individualized counseling and planning; and other needed services is integral to the No Wrong Door/ADRC service delivery model. ADRCs provide:

- Access to information;
- Referrals to available resources;
- A public resource directory; and
- Additional assistance such as options counseling and assessments.

Aging and disability resource centers should be designed to have streamlined policies and processes in place to ensure all individuals receive consistent and appropriate assistance and follow-up to ensure their needs are met. The No Wrong Door service delivery model provides for "streamlined access to public LTSS programs [and] includes all the processes and requirements associated with conducting formal assessments and/or determining an individual's eligibility that are required by any of the state administered programs that provide LTSS to any of the NWD system populations. All these public access processes and requirements must be part of, and integrated into, the state's NWD system's streamlined access function, so states can use their NWD system as a vehicle for optimally coordinating and

[12] Phone call with Administration for Community Living staff, September 21, 2018.
[13] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.

integrating these processes to make them more efficient and effective, and more seamless and responsive for consumers."[14]

ADRCs also provide resource directories, which serve as a repository of information and resources that are accessible to the public and act as a single source of information about long-term services and supports in an area. The resource directory should contain valid and up-to-date information, include or exclude resources through a standard set of policies, and be easily accessible and understandable to the public, including individuals with disabilities.[15] The database of information should provide a single, streamlined point of access for information when consumers are searching for available services in their local community or statewide.

Standard 2: Personalized Counseling and Planning

Options counseling is person-centered assistance to individuals and others the individual includes to assist them in making informed decisions, develop action plans to arrange services and supports, and use resources more efficiently and effectively. A person-centered system recognizes that every individual is unique, and the system can respond flexibly to individual needs and preferences. A person-centered counseling process includes personal conversations, screening and assessment tools, and goal setting to determine the most appropriate services and supports for each individual.

The Administration for Community Living's National Study of Aging and Disability Resource Centers, found most ADRCs provide options counseling, and many utilize a standardized tool to provide options counseling. Additionally, most conduct initial screenings for Medicaid eligibility and use standard needs assessment procedures.[16] When used appropriately, options counseling is an important mechanism for diverting consumers away from an institutional setting to a home or community-based setting. To ensure options counseling is provided in an accurate and comprehensive manner, ADRCs must have policies in place, use standards for intakes and screenings, and have well-trained and certified staff. After options counseling is provided, ADRCs must follow-up with individuals to determine if the needs have been met or additional assistance is needed.[17]

Recommended criteria for a fully functioning ADRC regarding personalized options planning/counseling include:

- Standards and protocols defining options counseling and the individuals who will be offered the service;
- Objective, accurate, and comprehensive long-term support options counseling provided to individuals at all income levels and with all types of disabilities;
- All ADRC operating organizations that serve as entry points for individuals use standard intake and screening instruments;
- Options counseling sessions conducted by staff who are trained and qualified to provide objective, person-centered assistance and decision support to individuals, evidenced by certification, minimum qualifications, or training/cross-training practices;
- Intensive support provided to individuals in short-term crisis situations until long-term support arrangements are made;

[14] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.

[15] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*. https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

[16] Administration for Community Living, National Study of Aging and Disability Resource Centers. *Process and Outcome Study Report,* by Barretto, Tina, Dr. Rekha Varghese, Sarah Pedersen, Dr. Leanne Clark-Shirley, Dr. Sandeep Shetty, Dr. Manan Roy, Sharanjit Toor, Michael Siers, Dr. Rosanna Bertrand, Luisa Buatti. Report HHSP233201000692G. Columbia, MD, 2014. https://www.acl.gov/sites/default/files/programs/2017-02/ADRCs-final-study-report.pdf.

[17] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

- Consistently conducting follow-up with individuals receiving options counseling to determine the outcome and whether any other assistance is needed; and
- Providing individuals and families assistance with planning for future long-term support and service needs by staff that possesses specific skills related to LTSS needs planning and financial counseling.

Standard 3: Public Outreach and Marketing

The public must be aware of the ADRC program to ensure it is utilized to its full capacity. ADRCs should be designed "to be a visible source of individualized counseling and help with accessing LTSS, the NWD system must proactively engage in public education to promote broad public awareness of the resources that are available. The goal is for citizens in each state to know where they can turn to for unbiased and trusted help in understanding and accessing the LTSS options that are available in their communities."[18]

ADRCs should have a clear outreach and marketing plan. According to the U.S. Department of Health and Human Services Aging and Disability Resource Technical Assistance Exchange, "the outreach and marketing plan includes:

1. Consideration of all the populations they serve including different age groups, people with different types of disabilities, culturally diverse groups, underserved and unserved populations, individuals at risk of nursing home placement, family caregivers and professionals;
2. A strategy to assess the effectiveness of the outreach and marketing activities; and
3. A feedback loop to modify activities as needed."[19]

Using these three objectives, an ADRC should be a recognizable program for individuals seeking information and resources related to long-term services and supports.

Standard 4: Stakeholder Involvement

According to the Criteria of Fully Functioning Aging and Disability Resource Centers, "[T]o be truly person-centered, ADRCs must meaningfully involve stakeholders and individuals they serve in planning, implementation and quality assurance/quality improvement activities."[20] Many ADRCs were implemented with a focus on serving older adults and one other target population, such as adults with physical disabilities, intellectual or developmental disabilities, or mental illness. ADRCs should strive toward serving persons with all types of disabilities regardless of age.

To function efficiently and serve as the single-entry point for the full array of long-term service and support programs, ADRCs must have the documented support and active participation of the Single State Agency on Aging, the state Medicaid agency, and the state agency serving people with disabilities. ADRCs should be operated by or establish strong local partnerships with area agencies on aging, centers for independent living, and other community-based organizations instrumental to ADRC activities such as Departments of Veterans Affairs, adult protective services, information and referral/2-1-1 programs, benefit outreach and enrollment centers, employment centers, vocational rehabilitation,

[18] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.

[19] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

[20] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

developmental disabilities councils, long-term care ombudsman programs, Alzheimer's disease programs, housing agencies, and transportation authorities.[21]

Including leadership from critical pathways (hospital administrators, geriatricians, etc.) on the ADRC advisory board can aid in developing a strong care transition and diversion program. These programs require strong partnerships with the providers that will be involved, such as hospitals and nursing facilities. These relationships take time to develop and should result in formalized memorandums of understanding and referral protocols.

Recommended criteria for a fully functioning ADRC regarding stakeholder involvement include:

Consumer Populations

- Serve individuals with all types of disabilities;
- Staff demonstrate competencies relating to serving people of all ages and types of disabilities and their families, including people with dementia, and people of different cultures and ethnicities; and
- Formal mechanisms for involving consumers on ADRC advisory boards, and in planning, implementation, and evaluation activities.

Medicaid

- Formal partnership agreements with the state Medicaid agency that describe explicitly the role of each partner in the eligibility determination process and information sharing policies; and
- Staff involved as partners or key advisors in other state long-term support and service system reform initiatives.

Other Partners and Stakeholders

- Memorandum of understanding or interagency agreement establishing a protocol for mutual referrals between the ADRC and the State Health Insurance Assistance Program, Adult Protective Services, and 2-1-1 programs;
- A formal agreement with the Veterans Health Administration outlining a protocol for linking veterans with needed long-term services and supports and making mutual referrals; and
- Evidence of strong collaboration with other programs and services instrumental to ADRC activities.

Standard 5: Quality Assurance and Continuous Improvement

Aging and Disability Resource Centers must effectively and efficiently meet the public's needs by:

- Operating under a pre-determined plan to identify a service delivery model, program outcomes, staffing availability and adequacy, and funding amounts and sources;
- Gathering and analyzing consumer satisfaction data;
- Setting clear outcomes and performance measures; and
- Using a fully functioning and robust information technology (IT) system.

ADRCs must have an adequate number of staff to meet the needs of consumers in an efficient manner. Inadequate staffing levels could impede consumers' ability to access the services and supports they need in a timely manner.[22]

[21] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

[22] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

As part of quality assurance, consumer satisfaction should be systematically gathered and analyzed to ensure consumers, providers, and all other individuals receive the information, referrals, and assessments they need. "The NWD system's Continuous Quality Improvement process involves getting input and feedback from the many different customers who use or interact with the NWD system, including individuals and their families, system partners, advocates, providers and professionals in the health and LTSS systems, on the responsiveness of the NWD system to their varying needs."[23]

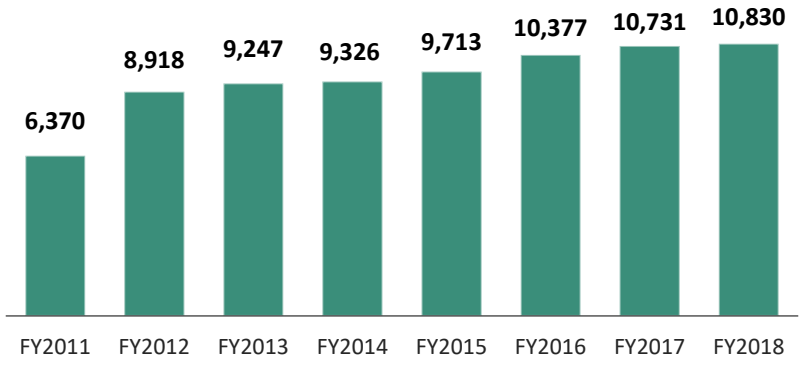
The agency administering the ADRC must establish outcome and performance indicators to monitor the quality of services provided and to ensure continuous program improvement. Data should be collected and analyzed to inform programming cost, consumer satisfaction, and individual outcomes.[24]

A fully functioning IT system must be in place to ensure accurate and timely data is made available to policy makers. A robust IT system enables the sharing of information between key stakeholders. As ACL points out in the 2015 Report to Congress, "NWD systems also include a robust Management Information System (MIS) that builds on and leverages existing state MIS systems, which is essential for a state to be able to effectively gather and manage information from the many entities that will be carrying out NWD system functions, as well as from individual consumers who use the NWD system."[25]

Dakota at Home's Alignment with Best Practices and Standards

In South Dakota's 2017-2021 State Plan on Aging, the ADRC and the services it offers are described as, "the single point of entry for older adults, adults with disabilities, caregivers, family members and friends to learn about the long term services and supports available in the state. Through the ADRC, individuals can access both public and nonpublic services and supports that are available as well as plan for the future. By accessing these long term services and supports, individuals can continue to live at home and in the community as long as possible, and as an alternative to moving into facility-based care . . .. [T]he State Unit on Aging strengthened the capacity of the Aging and Disability Resource Connections (ADRC) by offering Options Planning as a free service, offering information and decision support to all individuals, regardless of age, disability, or income."[26] As Figure 2 shows, Dakota at Home has seen an increase in individuals served year-over-year.

Figure 2: Dakota at Home Annual Contacts



Dakota at Home has seen an increase of 70% in annual contacts from FY2011 to FY2018.

[23] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.

[24] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf

[25] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.

[26] South Dakota Department of Human Services, Division of Long Term Services and Supports. *South Dakota State Plan on Aging, October 1, 2017 – September 30, 2021*. https://dhs.sd.gov/LTSS/docs/1%20South%20Dakota%202017-2021%20State%20Plan%20on%20Aging3.pdf.

South Dakota's ADRC, Dakota at Home, has undergone significant changes over the past two years, including moving from the Department of Social Services to the Department of Human Services and rebranding and relaunching the ADRC as Dakota at Home. During interviews, DHS staff informed the evaluation team there are still many planned changes including additional staff training and certification, an updated IT system, additional performance measures, and additional use of data collection and reporting.[27]

To determine Dakota at Home's alignment with best practices and standards, the evaluation team developed a checklist, provided in Appendix A, of fully functional criteria in accordance with the Aging and Disability Resource Center's *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012.*[28] Dakota at Home's alignment with those standards are addressed in the following sections.

Standard 1: Streamlined Access to Long-Term Services and Supports

Although DHS recently changed the Dakota at Home service delivery model, the department has not updated the policies and procedures for Dakota at Home to reflect those changes. DHS is currently using processes dating back to September 2014. Some new processes are in place, but they are limited in scope and provide only partial guidance to staff. DHS staff confirmed there are no updated written processes or scripts in place and the 2014 processes need to be updated to adhere to current practices.[29]

DHS does not systematically follow-up, either by personal contact or through a systematic survey method, with individuals who contact Dakota at Home to determine if their needs were met. If the individual receives only information or a referral, there is typically no follow-up with that individual. If the individual is identified as potentially eligible for LTSS services, the individual is referred to an LTSS case manager and follow-up is completed at that time.[30]

Dakota at Home provides a resource directory, which is accessible to the public, searchable, and may be accessible to individuals with disabilities. A review of the public resource directory identified the following concerns, which may impact the accessibility of the directory for certain individuals:

1. Fonts: the font size buttons do not work properly. The small font and medium font buttons deliver the same results. The large font button increases the font size of the website menu buttons and title; however, the font size of the body of the text and map do not increase. This issue may impede individuals with disabilities from accessing the information.
2. Search: the "Search Learn About" or "Learning Library" search option provides results that are not related to the intended result of the search function. For example, when searching the term "food" many irrelevant and unrelated results were returned. This issue may impede all individuals from utilizing the search function for its designed purpose.

Despite these concerns, the resource directory appears to be complete, is searchable by county, and formal inclusion and exclusion policies are in place for including providers in the directory in alignment with identified best practices.

[27] Interview with Department of Human Services staff, September 6, 2018 and September 27, 2018.
[28] Aging and Disability Resource Center Technical Assistance Exchange. *Criteria of Fully Functioning Aging and Disability Resource Centers March 2012*.https://www.colorado.gov/pacific/sites/default/files/No%20Wrong%20Door%20%20Federal%20Administration%20on%20Aging%20ADRC%20Fully%20Functioning%20Criteria%20March%202012.pdf
[29] Interview with Department of Human Services staff, September 6, 2018.
[30] Interview with Department of Human Services staff, September 6, 2018.

Standard 2: Personalized Counseling and Planning

The evaluation found Dakota at Home in compliance with most of the best practices relating to personalized counseling and planning. Dakota at Home deviated from the best practices and standards outlined in Appendix A in making consumer financial eligibility determinations, helping consumers to submit completed applications to the state Medicaid agency, and tracking an individual's eligibility status following application. Although Dakota at Home does not carry out these best practices "in house" the program has agreements with the appropriate state entities to ensure consumers needing these services are provided a proper referral to obtain them.

Foundational to providing personalized counseling and planning that aligns with best practices is to include standard intake systems and high-quality screening tools. Information obtained through the Dakota at Home intake process is comprehensive, objective, and includes the full range of available services. A coordinated management information system of consumer information, the Social Assistance Management System (SAMS) provides the ability to track individuals from point of initial contact through an ongoing record of subsequent contacts. When an individual, family member, or another entity contacts Dakota at Home, intake information is entered into SAMS and integrated into the consumer case management database. DHS staff utilize SAMS to record calls, complete intake screenings, complete assessments, enter journal notes on each call or contact, schedule follow-up activities, and receive prompts to complete scheduled activities including follow-up. DHS indicates that SAMS has limitations and they have entered into a cost-effective contract with a known vendor to develop and implement an improved system.[31]

SD Choices is a standardized intake screening developed using national standards that includes algorithms applied to questions in the areas of communication, cognition, behavior, medication, health status, activities of daily living, instrumental activities of daily living, living arrangement, and basic financial information.[32] Standardized results help determine the level of service need and whether further assessment is necessary.

The award of an options counseling grant from the Administration for Community Living in 2012 enhanced South Dakota's efforts to offer options planning as a service to individuals regardless of age, income, or disability who contact the ADRC seeking free, unbiased, objective information on long-term services and supports. DHS staff conduct a personal interview with individuals to help identify the type of assistance needed. Assistance is provided to make informed decisions, access long-term services and supports, and to plan for future long-term care needs through a verbal or written plan.

Through the provision of options planning, individuals receive access to in-home services that can prevent, delay, or avoid unnecessary placement in a nursing facility or readmission to a hospital. “Critical Pathways” providers and partners, i.e., hospitals, nursing facilities, assisted living providers, perform an important role in identifying and intervening with individuals at risk of institutional placement. The ADRC provides information on available services to both the individual and facility to best meet individual needs and preferences at these critical decision points.

The Options Planning Critical Pathways Workgroup developed the options planning hospital discharge referral protocols to assist individuals in learning about available in-home services and supports to assist in reducing hospital readmissions, emergency room repeat visits, and preventing premature placement into nursing facilities. Presentations on options planning are provided to critical pathway partners, i.e., hospitals, healthcare associations, in-home provider agencies, and nursing homes.[33]

[31] Interview with Department of Human Services staff, September 27, 2018.
[32] South Dakota Department of Social Services. *Development of ADRCs in South Dakota and South Dakota ADRC Options Counseling Program* by Petersen, Debra D. Pierre, SD. December 29, 2014.
[33] South Dakota Department of Social Services. *Development of ADRCs in South Dakota and South Dakota ADRC Options Counseling Program* by Petersen, Debra D. Pierre, SD. December 29, 2014.

Standard 3: Public Outreach and Marketing

Figure 3: Dakota at Home Marketing Image

The Department of Human Services recently entered into a contract with Insight Marketing Design of Sioux Falls, South Dakota, to overhaul Dakota at Home's outreach and marketing design. Figure 3 illustrates one of the characters incorporated into Dakota at Home's new marketing campaign.[34] Insight staff held meetings with the DHS' Division of Long Term Services Supports staff members to determine a new name for the ADRC, which would reflect the services provided. Insight explored a unique spokesperson that would be an easily recognizable character and designed a logo. Focus groups were conducted in three community locations (Rapid City, Aberdeen, and Watertown) and surveys were sent to hundreds of caregivers across the state. Dakota at Home's public outreach and marketing strategies are aligned with the three marketing objectives:

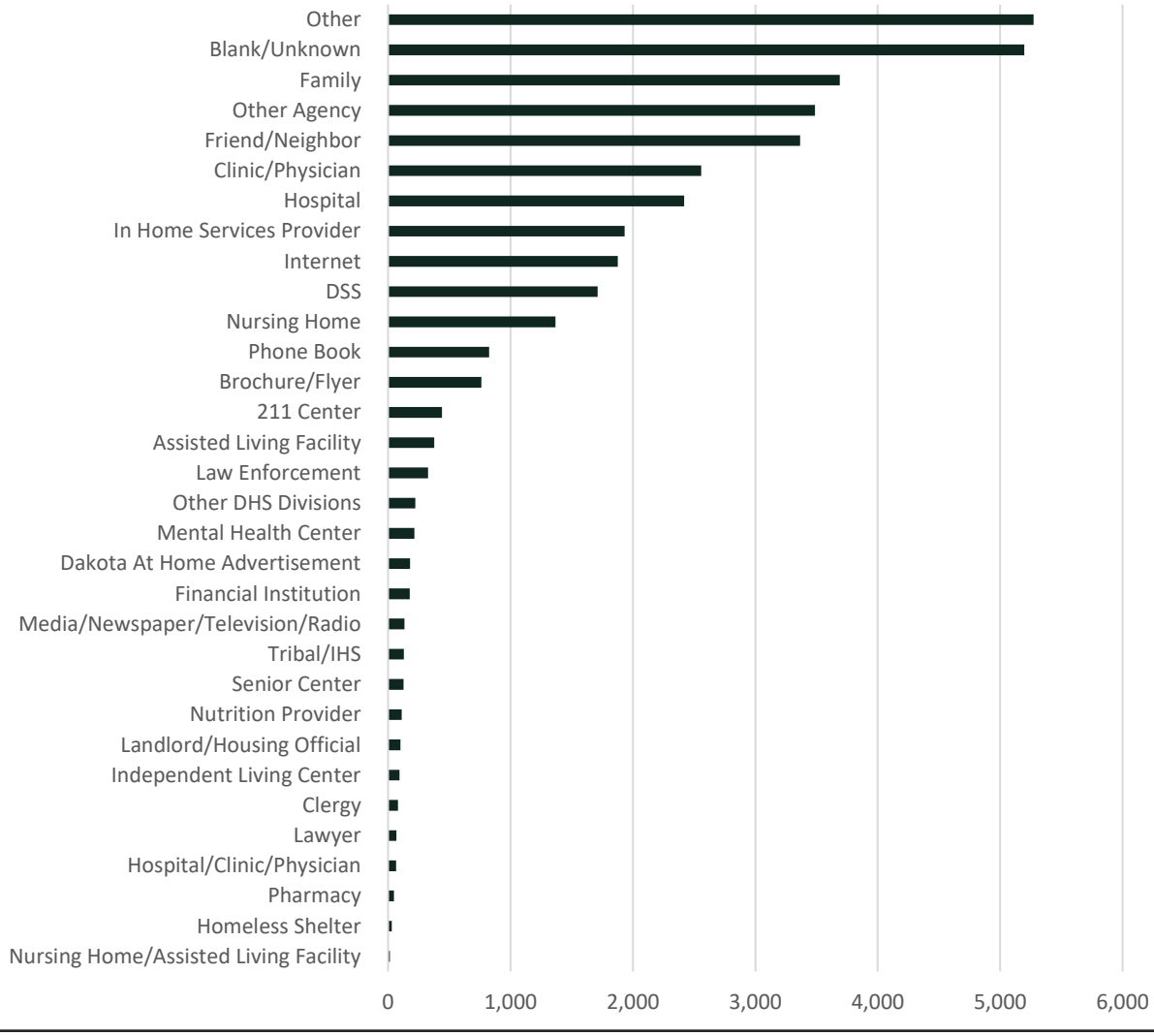
1. **Consideration of all populations they serve including different age groups, people with different types of disabilities, culturally diverse groups, underserved and unserved populations, individuals at risk of nursing home placement, family caregivers, and professionals**.
   Insight Marketing Design undertook extensive research to better understand the needs of the target audience for ADRCs. This research was done to ensure communication efforts would resonate with the target audience and provide answers to real-world problems. One of the main assets that Insight Marketing Design developed was an Aging and Disability Advisory Council which provided guidance to Insight Marketing Design regarding the target population.[35] The individuals that made up the council represented industry leaders and concerned parties from across South Dakota.[36] This statewide advisory council met on a regular basis to provide insights and information about the ADRC target markets and service usage. The council also used as an additional focus group for provider feedback on marketing materials.
2. **A strategy to assess the effectiveness of the outreach and marketing activities.**
   Insight Marketing Design provides monthly reports to DHS regarding marketing activities and outreach. These reports have not been used by DHS to make any changes to the marketing approach.[37]No additional tools have been implemented to gauge whether the marketing plan and outreach have been effective
3. **A feedback loop to modify activities as needed.**
   Insight Marketing Design provides monthly reports regarding marketing activities, milestones, and other potential opportunities. Insight works closely and collaboratively with the Department of Human Services to:
   - Discuss and define the goals and objectives of the campaign;
   - Listen to suggestions or concerns from staff;
   - Provide written reports after meetings and phone calls;
   - Provide project estimates and timelines to be presented and approved by the client before proceeding to any next step;

[34] Insight Marketing Design, "Dakota at Home Cartoon", https://dakotaathome.org/, 2017
[35] Insight Marketing Design, "Caregivers Survey Online Research Results" (State of South Dakota Department of Social Services Division of Adult Services and Aging, 2017), pg.8-11
[36] Insight Marketing Design, "Request for Proposal #890" (State of South Dakota Department of Social Services Division of Adult Services and Aging, 2017), pg.3
[37] Interview with Department of Human Services staff, September 27, 2018.

- Present creative concepts with rationale to communicate the strategy behind the concepts;
- Present media plans, along with flowcharts and budgets; and
- Launch the campaign upon approval of concepts and media plans.[38]

While Dakota at Home has taken essential steps to provide a public outreach and marketing campaign that reaches the target audience, the assessment tools at their disposal have not been fully utilized to make potential changes to the marketing plan or materials. Figure 4 shows how new callers learned of South Dakota's ADRC/Dakota at Home based on information provided during call intake.

Figure 4: ADRC/Dakota at Home New Caller Referral Source



[38] Insight Marketing Design, "Request for Proposal #890" (State of South Dakota Department of Social Services Division of Adult Services and Aging, 2017), pg.3

Standard 4: Stakeholder Involvement

The Department of Social Services and the Department of Human Services have consistently used task forces and workgroups to engage stakeholders in developing and refining Dakota at Home. A South Dakota ADRC Statewide Five-Year Plan submitted to the Administration on Aging in October 2011 included a goal of developing state and local advisory stakeholder workgroups to guide implementation, including development of formal linkages between publicly funded systems of long-term care services and to leverage state and local resources to contribute to ADRC development.[39]

An ADRC State Workgroup was formed to guide planning, development, and implementation of the five ADRC call centers. The group reviewed each step and provided valuable information and feedback on the establishment of the ADRC model. Membership consisted of a variety of partner representatives including the South Dakota Association of Healthcare Organizations, the South Dakota Health Care Association, in-home and home health providers, adult day centers, nutrition sites, 2-1-1 Call Center, hospitals, nursing facilities, the South Dakota Advisory Council on Aging, County Human Services, AARP, Alzheimer's Association, South Dakota Coalition of Citizens with Disabilities, Center for Independent Living, DSS (Divisions of Adult Services and Aging and Economic Assistance), and DHS (Division of Rehabilitation Services).[40]

A second workgroup, the ADRC Options Planning Critical Pathways Workgroup, was formed in December 2012 and met regularly until October 2013. Workgroup members included personnel from Sanford Health, Avera Health, nursing facilities, in-home service providers, the South Dakota Association of Healthcare Organizations, and LTSS staff. Workgroup members were instrumental in rebranding "Options Counseling" to "Options Planning," development of the options planning hospital discharge referral protocols, brochure, plan of action tool, and a decision-making tool.[41]

Core partners are the state agency partners that provide long-term services and supports funded through state and federal dollars. The role of core partners consists of working with Dakota at Home to share information on state and federally funded services including intake, assessment, eligibility requirements, etc. DHS has also identified critical pathway partners, such as hospitals and nursing facilities, that provide long-term services and supports, and community aging and disability partners who work closely with ADRC staff through reciprocal referring of people in need of services.[42] Regular communication methods exist with all partners to facilitate identification of issues and resolution of problems as well as general information sharing. Meetings are held in direct relation to issues identified by either party, followed by discussion towards a resolution.

Despite the engagement of these partners in Dakota at Home, the Department of Human Services did not provide evidence of formal agreements with these stakeholders. A fully functioning ADRC should have formal agreements with local critical pathway providers, such as hospitals, physicians' offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and intermediate care facilities, that include: an established process for identifying individuals and their caregivers, protocols for referring individuals to the ADRC for support and other services, and regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations.

When asked about formal partnerships with stakeholders, DHS pointed to oversight from the State Advisory Council on Aging, a body appointed by the Governor in accordance with the Older Americans

[39] South Dakota Department of Social Services. *State of South Dakota ADRC Statewide Five Year Plan.* by Petersen, Debra D. Pierre, SD. October 2011.
[40] South Dakota Department of Social Services. *Development of ADRCs in South Dakota and South Dakota ADRC Options Counseling Program* by Petersen, Debra D. Pierre, SD. December 29, 2014.
[41] South Dakota Department of Social Services. *Development of ADRCs in South Dakota and South Dakota ADRC Options Counseling Program* by Petersen, Debra D. Pierre, SD. December 29, 2014.
[42] South Dakota Department of Social Services. *State of South Dakota ADRC Statewide Five Year Plan.* by Petersen, Debra D. Pierre, SD. October 2011.

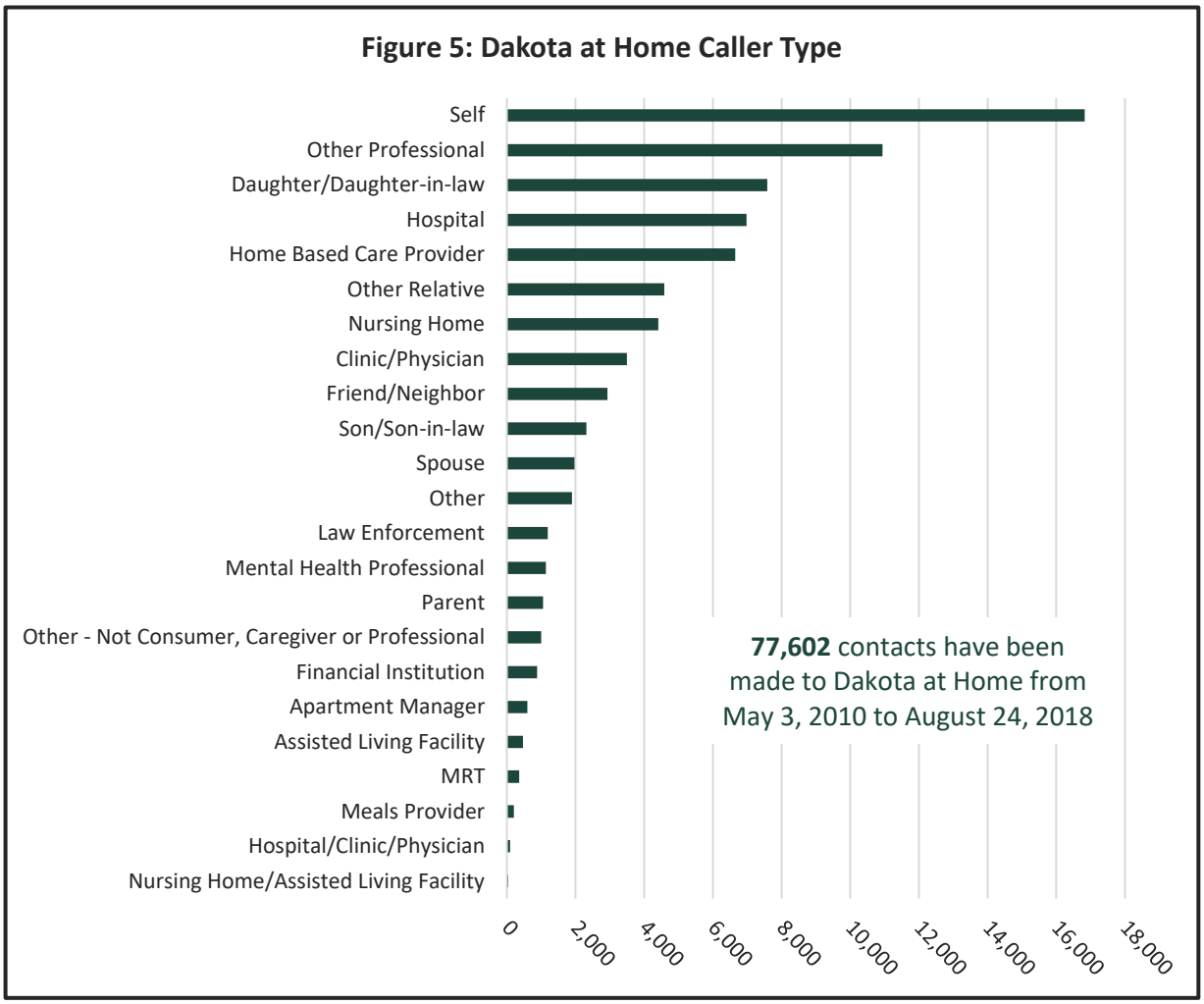
Act of 1965 to ensure representation of older South Dakotans regarding administrative and social concerns. This council has responsibilities other than the ADRC and does not include representation from Dakota at Home consumers of all ages and disabilities. Establishment of an advisory council dedicated exclusively to Dakota at Home could strengthen relationships with these partners and lead to better consumer referral outcomes.

Standard 5: Quality Assurance and Continuous Improvement

Dakota at Home recently increased staff assigned to the program and asserts there are now adequate staff to meet the needs of consumers.[43] Currently, there are four Intake Specialists and one Supervisor dedicated to the program. DHS has hired two additional Intake Specialist as of August 2018. DHS ascertained that four Intake Specialist were unable to adequately manage the volume of contacts made to Dakota at Home. The two additional full-time staff already existed within the DHS full-time equivalent (FTE) allocation and will soon be transferring to the new assignment.

The Department of Human Services does not systematically gauge consumer satisfaction with Dakota at Home services. DHS implemented an online survey option in May 2018 when the Dakota at Home website was launched. In a review of the data provided by DHS, only four consumer satisfaction surveys were completed between May and August. DHS staff indicate that consumers are not routinely informed of the survey option.[44] DHS staff also indicate that a phone survey is forthcoming, but there

Figure 5: Dakota at Home Caller Type



[43] Interview with Department of Human Services staff, September 27, 2018.
[44] Interview with Department of Human Services staff, September 6, 2018.

is no timeline for the phone survey's implementation. No other surveys have been conducted to gauge consumer satisfaction with Dakota at Home or previously for the ADRC. With 77,602 contacts since its inception from a variety of consumers, as outlined in Figure 5, Dakota at Home should gauge consumer satisfaction to measure and improve service delivery.

DHS is aligned with best practices by utilizing a 5-Year State Plan on Aging and a 5-Year Department Strategic Plan identifying objectives and outcomes for the Dakota at Home program. DHS has two performance measures outlined in the Department's Strategic Plan:

1. Increase the number of contacts to Dakota at Home, South Dakota's Aging and Disability Resource Center (ADRC) to 14,000 by Federal Fiscal Year (FFY) end 2020; and
2. Ensure a 95% satisfaction rate for customers who make contact to Dakota at Home, South Dakota's Aging and Disability Resource Center (ADRC), by Federal Fiscal Year (FFY) end 2020.[45]

DHS outlined the following strategies related to the ADRC in the State Plan on Aging:

1. Rebrand the ADRC and create a public awareness campaign to improve public education and awareness of available long term services and supports;
2. Expand ADRC partner collaboration;
3. Promote the ADRC Call Centers as the single point of entry for all aging and disability services at the state and local level;
    a. Engage with local and state community partners to promote the ADRC as the single point of entry to access person-centered long term services and supports in South Dakota;
    b. Promote the ADRC Resource Directory as an access point for information on available long term services and supports, providers and resources;
4. Increase utilization of ADRC Resource Directory;
5. Increase in calls received by the ADRC Call Center; and
6. In collaboration with the ADRC, implement consumer surveys for key programs and services.[46]

Dakota at Home's IT system presents challenges for accessing and reporting data. DHS staff reported the IT system allows for input of multiple data points for each individual consumer, and reports for an individual consumer are easily accessible. However, staff also reported that, although data is collected, it is not accessible or reportable at an aggregate level. Because of IT system reporting limitations, DHS does not have access to complete or timely information, which may prevent policy makers from utilizing data to make informed decisions about the program and its services. DHS is currently under a procurement contract for a new IT system and reports that implementation will occur gradually over the next two years. [47]

[45] South Dakota Department of Human Services Strategic Plan 2016-2020. https://dhs.sd.gov/strategicplan.aspx.
[46] South Dakota Department of Human Services, Division of Long Term Services and Supports. *South Dakota State Plan on Aging, October 1, 2017 – September 30, 2021*. https://dhs.sd.gov/LTSS/docs/1%20South%20Dakota%202017-2021%20State%20Plan%20on%20Aging3.pdf.
[47] Interview with Department of Human Services staff, September 6, 2018 and September 27, 2018.

Cost/Financial Oversight

Costs for Dakota at Home could not be estimated. Since the inception of Dakota at Home, DHS has not tracked personal services or operating expenses specifically for the program.

DHS reported expenditures for a 2009 Aging and Disability (ADRC) Grant and an award amount for a 2012 ADRC Options Counseling Grant.

- September 2009: Aging Disability Resource Center Grant from the Centers for Medicare and Medicaid Services Administration on Aging.
  - Amount: $970,187
  - Duration: Four Years
  - Purpose: Develop an ADRC in South Dakota.
  - Goals: 1.) Develop an ADRC in Sioux Falls, within twelve months. 2.) Develop a plan to implement ADRCs across South Dakota within three years.

Aging and Disability Resource Center Grant	
Federal Fiscal Year	Total Expenditure
2010	97,319.73
2011	217,188.38
2012	429,064.70
2013	226,614.19
Total	**$970,187.00**

- September 2012: ADRC Options Counseling Grant from the Administration for Community Living
  - Amount: $163,938 Federal Funds; $45,577 Non-Federal Cash
  - Duration: One Year
  - Purpose: Strengthen the capacity of ADRC through development of an Options Counseling Program

Another trackable expense that DHS provided is a contract for Insight Marketing Design for the marketing and rebranding efforts associated with Dakota at Home.

- June 2017: DHS awarded a contract to Insight Marketing Design
  - Amount:
    - 50% General Funds: $159,990
    - 50% Federal Funds: $159,990
    - Total Funds: $319,980
  - Duration: June 1, 2017 through May 31, 2019
  - Purpose: Rebrand Dakota at Home and create associated marketing materials

DHS could attribute no other costs to Dakota at Home.

Findings and Recommendations

Finding 1: The Department of Human Services does not track or report costs specifically for the Dakota at Home program.

DHS does not track and report expenditures specifically for the Dakota at Home program. DHS combines all costs associated with Dakota at Home into the agency's field staff budget. Without a specific budget center assigned to Dakota at Home, it is impossible to ascertain the cost of the program. Without this information, it is difficult to gauge the cost-effectiveness of Dakota at Home relative to other ADRCs, the number of consumers served, services provided, and so on.

Finding One
DHS does not track and report costs specifically for the Dakota at Home program.

Recommendation 1: The Department of Human Services should assign a budget center specific to Dakota at Home.

DHS should assign a specific budget center for Dakota at Home. With its own budget center, DHS and any other external entity could identify which personal services and operating expenses are associated specifically with Dakota at Home. In addition, a separate budget center allows for tracking and reporting of the fund sources for Dakota at Home.

Finding 2: The Department of Human Services does not utilize Medicaid Administrative Federal Financial Participation (FFP) for Dakota at Home/ADRC, which provides a 50% federal match rate for eligible ADRC services and activities.

Finding Two
DHS does not utilize Medicaid Administrative FFP for Dakota at Home services and activities.

Medicaid Federal Financial Participation (FFP) provides matching dollars under Title XIX of the Social Security Act, 42 U.S.C. §1903(a)(7), to cover activities that contribute to the proper and efficient administration of the Medicaid program. Under 42 C.F.R. § 433.15(b)(7), the Secretary has the authority to approve the 50% administrative match rate for activities "necessary for the proper and efficient administration of the State plan."[48]

Many ADRC activities may be eligible for Medicaid administrative FFP. "Federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan, when those activities are performed either directly by the state Medicaid agency or through contract or interagency agreement by another entity."[49]

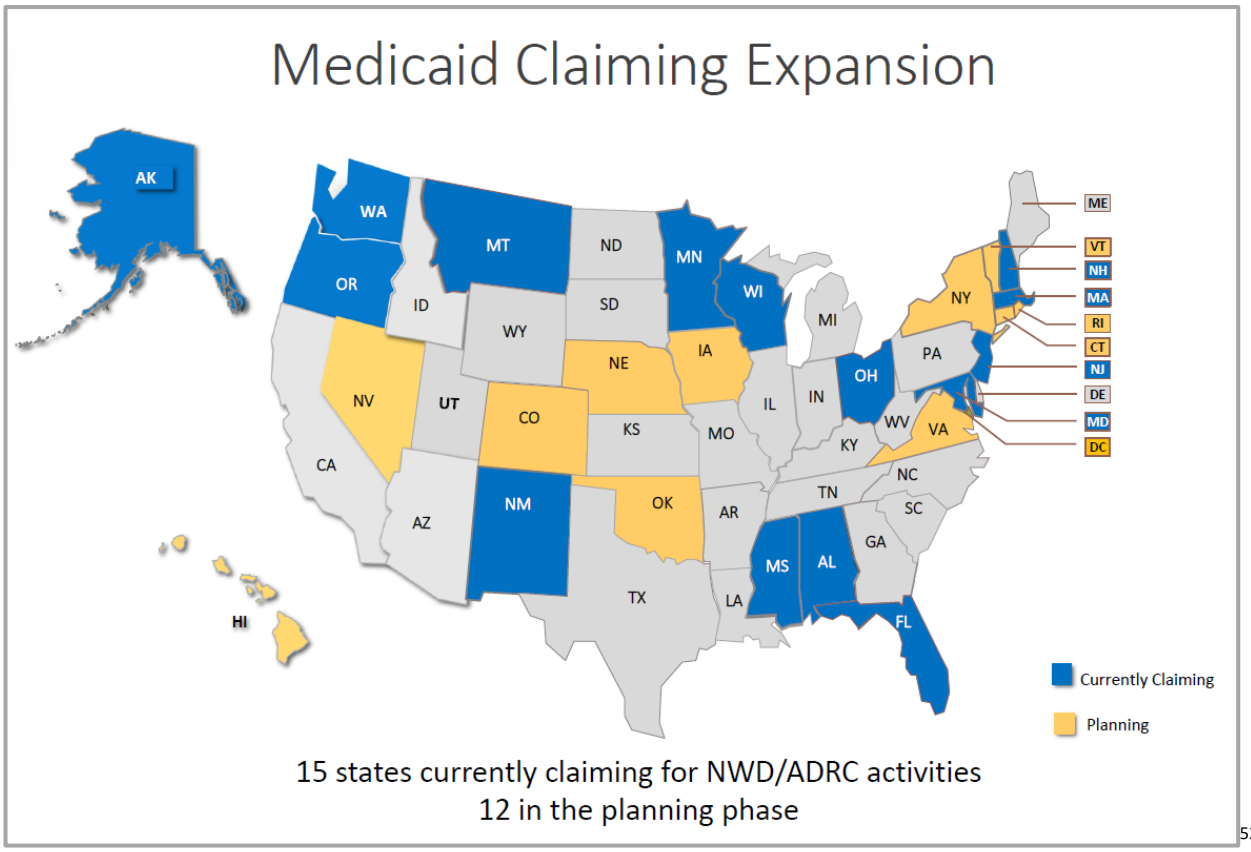
ADRC activities that may be eligible for the Medicaid administrative FFP include:

1. Medicaid outreach, such as public outreach and referrals to access or enroll in Medicaid;
2. Referral, coordination, and monitoring of Medicaid services, such as person-centered counseling related to enrollment in or accessing Medicaid;

[48] Code of Federal Regulation, title 42 (2018): Part 433.15 Rates of FFP for administration. https://www.ecfr.gov/cgi-bin/text-idx?SID=5cccd6d8803615269bf68443445410ed&mc=true&node=pt42.4.433&rgn=div5#se42.4.433_115
[49] No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance. https://www.medicaid.gov/medicaid/finance/downloads/no-wrong-door-guidance.pdf.

3. Facilitating Medicaid eligibility, such as streamlined eligibility for public programs as it relates to Medicaid; and
4. Medicaid administrative functions, which may include training staff to help consumers apply for supports and services, provider outreach, program planning, quality improvement, and information technology development undertaken by the Medicaid agency or authorized through interagency agreement.[50]

ACL states the ability to utilize Medicaid Administrative FFP for NWD-type functions has been in place since the late 1990s. Fifteen states currently claim FFP for No Wrong Door/ADRC activities and an additional 12 states are in the planning process. ACL also indicates that most states claim between $500,000 - $2,000,000 per year, with Wisconsin as an outlier claiming approximately $30 million per year. Annually, $45 million in Medicaid administrative FFP supports NWD system activities. [51]



[52]

DHS staff indicate that during discussions with Navigant Consulting, with whom the division contracted to complete a division-wide evaluation of operations and performance, the consultants suggested approximately 30% of costs may be eligible for the Medicaid administrative FFP. This estimate was based on a review of one quarter of cost allocation reports in another area of DHS. Therefore, DHS indicates that, to determine the actual potential for the match for Dakota at Home activities, additional work must be

[50] No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance. https://www.medicaid.gov/medicaid/finance/downloads/no-wrong-door-guidance.pdf. http://www.n4aconference.org/2017/local/uploads/files/Diversifying Funding Streams for ADRCs Medicaid Claiming.pdf
[51] Email correspondence with Administration for Community Living, U.S. Department of Health and Human Services, October 15, 2018.
[52] Christina Neill Bowen, Ami Patel, Steve Lutzky, Lisa Morley, Sara Tribe Clark, "NWD System Medicaid Claiming," PowerPoint presentation, 2018 HCBS Conference, August 29, 2018.

completed.[53] Neither the Department of Human Services nor Legislative Research Council staff may estimate the potential state general fund savings for South Dakota because, as indicated in Finding 1, DHS does not track Dakota at Home expenditures specifically for the program. Additionally, neither DHS nor LRC staff may estimate the cost of Dakota at Home personal services or operating expenditures to develop or apply methodology to estimate potential state general fund savings related to the Medicaid administrative FFP.

Recommendation 2: The Department of Human Services should work with the Department of Social Services, the state's Medicaid agency, to establish an agreement to submit claims for the Dakota at Home/ADRC Medicaid administrative activities.

Although an estimate of program costs could not be derived, based on the average from other states, there will be state general fund savings for the State of South Dakota if the Medicaid administrative FFP is implemented. DHS and DSS should immediately begin the initial planning stage to implement the Medicaid administrative FFP for Dakota at Home activities.

The Centers for Medicare and Medicaid Services (CMS) and the Administration for Community Living released guidance for states, *No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance*, which is available on CMS' public website.[54] In addition, the Administration for Community Living (ACL) recently released the *NWD System Medicaid Administrative Claiming Workbook.*[55] The workbook provides step-by-step guidance and specific tools to help states implement Medicaid Administrative FFP. ACL is also available to provide technical assistance to state agencies.[56] DHS and DSS should utilize the official guidance and technical assistance offered from both CMS and ACL.

Finding 3: The Department of Human Services is utilizing outdated policies and procedures and does not have a formalized training plan in place for Dakota at Home staff.

Finding Three
DHS is utilizing outdated policies and procedures and does not have a formalized staff training plan in place.

Dakota at Home has recently undergone significant changes in service delivery; however, DHS has not updated the policies and procedures to reflect any changes. Currently, Dakota at Home staff rely on outdated policies and procedures with limited guidance for staff.

In addition, there is no formalized training plan in place for Dakota at Home staff. To ensure all South Dakotans are receiving consistent and accurate information and referrals, access to the services they need, and accurate and timely information about services that allow them to be served in the least restrictive setting possible, Dakota at Home staff must receive appropriate and adequate training and certifications.

Recommendation 3: The Department of Human Services should update its policies and procedures and pursue additional training for Dakota at Home staff.

DHS should update the policies and procedures for Dakota at Home. Accurate and comprehensive policies and procedures are critical to ensure the consistent delivery of quality services.

[53] Email correspondence with Department of Human Services, October 3, 2018.

[54] No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance. https://www.medicaid.gov/medicaid/finance/downloads/no-wrong-door-guidance.pdf.

[55] NWD System Medicaid Administrative Claiming Workbook. https://nwd.acl.gov/pdf/NWD%20System%20Medicaid%20Administrative%20Claiming%20Workbook%2012-7-17.pdf.

[56] Email correspondence with Administration for Community Living, U.S. Department of Health and Human Services, October 3, 2018.

DHS should pursue additional trainings and certifications for Dakota at Home staff. Two training and certification options identified during the program evaluation include:

1. Person-Centered Counseling Training Program

The Administration for Community Living developed and piloted a national training program, the Person-Centered Counseling Training Program. The program is available online and offers six courses focused on:

1. Introduction to No Wrong Door;
2. Person-Centered Thinking and Practice;
3. Person-Centered Planning and Implementation;
4. Who We Serve;
5. Person-Centered Access to Long Term Services and Supports; and
6. Protection and Advocacy.[57]

Although this program is not required by ACL, it provides a model for the type of training program that ACL would like to see implemented.[58]

2. Alliance of Information and Referral Systems (AIRS) Certification

DHS informed the evaluation team that Dakota at Home Intake Specialists and the Supervisor will receive the Alliance of Information & Referral Systems (AIRS) CIRS-A/D certification.[59] The CIRS-A/D certification is a certification for Information and Referral Specialists who work with individuals and providers in the aging and disabilities area.

The training and certifications are merely two examples that may benefit Dakota at Home staff. As the experts and providers of long-term services and supports, DHS should immediately develop a comprehensive training and certification program for Dakota at Home staff.

Finding 4: The Department of Human Services does not utilize surveys to gauge consumer satisfaction with Dakota at Home services.

Finding Four
DHS does not gauge consumer satisfaction for Dakota at Home services.

The Department of Human Services does not systematically gauge consumer satisfaction for the Dakota at Home program. DHS currently offers an online survey to consumers; however, since implementation in May 2018, only four surveys have been completed. Further, DHS staff indicate that consumers are not currently informed of the online survey. DHS plans to implement a telephone survey for individuals who contact Dakota at Home via telephone, but the department has not established a timeline to implement the telephone survey.[60]

Recommendation 4: The Department of Human Services should conduct a comprehensive survey to gauge consumer satisfaction regarding the services provided by Dakota at Home and utilize those results to enhance service delivery.

ADRC best practices advise systematically collecting and analyzing consumer satisfaction data to ensure ADRC consumers, providers, and all other individuals receive any information, referrals, and assessments they need. "The NWD system's Continuous Quality Improvement process involves getting input and feedback from the many different customers who use or interact with the NWD system, including

[57] https://nwd.acl.gov/personcenteredcounseling.html
[58] Email correspondence with Administration for Community Living, U.S. Department of Health and Human Services, October 3, 2018.
[59] Email correspondence with Department of Human Services staff, August 28, 2018.
[60] Interview with Department of Human Services staff, September 6, 2018.

individuals and their families, system partners, advocates, providers and professionals in the health and LTSS systems, on the responsiveness of the NWD system to their varying needs."[61] DHS should implement policies and procedures to more frequently conduct follow-ups with Dakota at Home consumers and should conduct a comprehensive survey of consumer and stakeholder satisfaction.

Finding 5: The Department of Human Services has limited access to the data collected by their Dakota at Home IT system.

The Department of Human Services has limited access to Dakota at Home data, which limits their ability to analyze the data they collect to make informed decisions about programming, performance, and consumer outcomes. Although data is recorded for individual consumers, data reporting limitations are especially evident when trying to analyze consumer data at an aggregate level. Without full utilization of the data, the department cannot determine whether Dakota at Home is producing measurable results.

Finding Five
DHS has limited access to data collected by their Dakota at Home IT system.

Recommendation 5: The Department of Human Services should work with their IT system vendor to obtain better access to their data.

DHS reports they are currently in the process of procuring a new IT system, but the new system will not be fully functional for about two years.[62] During this time, the Department should work with their current IT vendor to obtain more comprehensive access to the data and to establish protocols for standardized or customizable reports. Once accessible, this data can be utilized by the department to inform programming, performance, and consumer outcomes.

Report Limitations

Two report limitations have been identified through the course of the program evaluation.

1. Limited access to or lack of data from primary sources.
   - Department of Human Services staff were unable to provide certain data that was requested due to IT system limitations, including an inability to capture the data or the inability to access the data in a usable format. This lack of access to primary source data hindered LRC staff's ability to conduct an independent analysis on requested datasets.

2. Inability to shadow Dakota at Home staff during the intake process.
   - LRC staff were not allowed to shadow Dakota at Home staff. DHS cited the confidential nature of information obtained during calls as the reason that LRC staff were denied requests to conduct shadowing or "on-site" visits of the Dakota at Home call center.[63]

[61] Department of Health and Human Services, Administration on Aging, Administration for Community Living. *FY 2015 Report to Congress: Older Americans Act.* https://www.acl.gov/index.php/about-acl/reports-congress-and-president.
[62] Interview with Department of Human Services staff, September 27, 2018.
[63] Email correspondence and interviews with Department of Human Services staff, September 17, 2018 and September 27, 2018, respectively.

Appendix A

Dakota at Home Alignment with Aging and Disability Resource Center (ADRC) Best Practices and Standards

Standard 1: Streamlined Access to Long-Term Services & Supports	Fully Functional	Partially Functional	Not Functional
Dakota at Home has a systematic process in place for information, referral, and/or assistance.		●	
Dakota at Home follows-up with individuals to ensure needs are met or determine if they need additional assistance.		●	
All Dakota at Home staff use the same resource directory.	●		
Dakota at Home has a system in place for ensuring the resource directory is accurate and up-to-date.	●		
Dakota at Home has exclusion and inclusion policies in place for the resource directory.	●		
The resource directory accessible to the public, user friendly, searchable, and accessible to individuals with disabilities.		●	

Standard 2: Personalized Counseling and Planning	Fully Functional	Partially Functional	Not Functional
Dakota at Home has policies and procedures in place to define options counseling and determine who will be offered options counseling.		●	
The policies and procedures that are in place are based on national options counseling standards.			●
Dakota at Home provides objective, accurate and comprehensive options counseling to individuals of all income levels and individuals with all types of disabilities.	●		
All Dakota at Home staff use standard intake and screening tools.	●		
Dakota at Home staff are trained and qualified to conduct options counseling.	●		
Dakota at Home provides short-term supports until long-term arrangements can be made for individuals in crisis.	●		
Dakota at Home provides LTSS needs planning and financial counseling to individuals when planning for LTSS.		●	
Dakota at Home has processes in place for helping individuals access all publicly-funded LTSS programs.		●	
Dakota at Home uses a set of criteria to identify risk for institutional placement to target high-risk individuals.[64]		●	
Dakota at Home staff conduct level of care assessments that are used for functional eligibility.	●		

[64] Dakota at Home does not have a set of criteria in place for all callers; however, Dakota at Home staff sometimes utilize the SD CHOICES intake screen to identify individuals at risk for institutional placement.

Dakota at Home staff assist individuals with completing the application for financial eligibility.	●		
Dakota at Home staff make financial eligibility determinations.[65]			●
Dakota at Home staff submit completed applications to the Medicaid Agency on behalf of the consumer.			●
Dakota at Home staff track the individual's financial eligibility status.[66]			●
Dakota at Home staff are informed when an individual is not financially eligible for LTSS.[67]		◍	

Standard 3: Public Outreach and Marketing	**Fully Functional**	**Partially Functional**	**Not Functional**
Dakota at Home has a marketing plan in place.	●		
The marketing plan takes into consideration all populations, including age, disability, cultural background, etc.	●		
Dakota at Home assesses the effectiveness of outreach and marketing activities.	●		
Dakota at Home receives and utilizes feedback to modify marketing activities.		◍	
Dakota at Home markets to and provides services to both private pay and those on public assistance.	●		

Standard 4: Stakeholder Involvement	**Fully Functional**	**Partially Functional**	**Not Functional**
Dakota at Home has formal agreements in place with stakeholders.[68]		◍	
If formal agreements exist, they include a process for identifying individuals and their caregivers who need transitions services; a process for referring individuals to Dakota at Home; and regular training for facility administrators and discharge planners about Dakota at Home and the processes that are in place.[69]		◍	
Dakota at Home serves individuals with all types of disabilities.	●		
Dakota at Home staff are competent to work with individuals of all ages and individuals with all types of disabilities.	●		
There is a formal process in place for involving consumers on state advisory boards and workgroups.[70]		◍	

[65] Financial eligibility determinations for Medicaid funded programs are made by the Department of Social Services (DSS). A memorandum of understanding is in place between DHS and DSS. DHS reports that non-Medicaid program eligibility determinations are made by DHS staff.
[66] DHS reports that eligibility status is tracked; however, the LRC evaluation team was not able to verify this due to limited access to data and being denied the opportunity to shadow, as described in the limitations section.
[67] DSS notifies DHS of requests for fair hearings and pending hearing decisions, as outlined in the memorandum of understanding.
[68] Dakota at Home specifically does not have formal agreements in place with stakeholders; however, the Department of Human Services has formal agreements in place such as a memorandum of understanding with DSS and informal agreements with other stakeholders.
[69] The Department of Human Services has a Hospital Discharge Referral Protocol document, but formal agreements do not exist.
[70] There are multiple advisory boards and workgroups in place; however, only the Advisory Council on Aging has formal processes in place.

There is a formal agreement with Medicaid to define each partners role in the eligibility determination process.	●		
There is a formal agreement in place with Medicaid for information sharing.	●		
There are formal agreements in place with other LTSS agencies, aging and disability agencies, etc.[71]		◐	
There are formal processes/agreements in place for referrals to State Health Insurance Assistance Program, Adult Protective Services and 2-1-1 programs.[72]		◐	
There are formal agreements in place with a VA Medical Center to provide Veteran-Directed Home and Community Based Services (HCBS) or some sort of agreement to link Veterans with LTSS.[73]	●		

Standard 5: Quality Assurance and Continuous Improvement	**Fully Functional**	**Partially Functional**	**Not Functional**
Dakota at Home operates in accordance with a written 5-year plan.	●		
The 5-year plan includes how Dakota at Home Services will be sustained through a diverse set of public and private funding sources.			●
Dakota at Home has adequate staff to assist individuals in a timely manner.	●		
Dakota at Home's IT system supports all program functions.		◐	
Dakota at Home has an established and efficient process for sharing consumer information electronically across LTSS organizations and external entities.			●
Dakota at Home has a plan in place to monitor program quality.		◐	
Dakota at Home has a process in place to ensure continuous program improvement.		◐	
Dakota at Home uses data, such as consumer satisfaction surveys to monitor quality and improvement.			●
Dakota at Home tracks and addresses complaints/concerns from consumers. A formal process is in place for responding.		◐	
Dakota at Home routinely tracks service delivery and individual outcomes.		◐	
Dakota at Home demonstrates that individuals served in terms of age, types of disabilities, income levels are relatively representative of the community.			●
Dakota at Home demonstrates that options counseling helps consumers make informed decisions and cost-effective decisions about LTSS.[74]			●

[71] The Department of Human Services lists multiple partnerships in the 2017-2021 South Dakota State Plan on Aging; however, there are not formal agreements in place.
[72] Senior Health Information and Insurance Education (SHIINE) and Adult Protective Services are administered by DHS, Division of Long Term Services and Supports and the Department states that referrals take place; however, there are no formal processes in place.
[73] The Department of Human Services reports that Dakota at Home does not have any agreements in place with VA, but the Department does have a partnership with the VA on a lifespan respite grant.
[74] Email Correspondence with Department of Human Services, October 11, 2018.

Dakota at Home tracks and can demonstrate the number of individuals diverted from nursing homes/institutionalized settings.[75]			●
Dakota at Home tracks and can demonstrate the number of individuals transitioning from institutional settings.	●		
Dakota at Home evaluates its impact in reducing the average time from first contact to eligibility determination (both functional and financial) for publicly funding HCBS.			●
Dakota at Home evaluates its impact on the use of HCBS versus institutional services.			●
Dakota at Home evaluates its cost impact to public programs including Medicaid.			●

[75] The Department of Human Services does not track diversion statistics for Dakota at Home; however, the Department does track some data on diversion statistics related to individuals eligible for and receiving LTSS services.

MEMORANDUM TO:	**2018 Members of the Executive Board: Senator Brock Greenfield, Chair and Representative Mark Mickelson, Vice Chair**
FROM:	**Gloria Pearson, Secretary, Department of Human Services**
SUBJECT:	**DHS Dakota at Home Program Evaluation Response**
DATE:	**November 2, 2018**

The Department of Human Services appreciates the opportunity to respond to the Dakota at Home Program Evaluation Report by LRC first received on October 26, 2018. The Division of Adult Services and Aging was moved over to DHS on April 12, 2017 as the result of a reorganization by Governor Daugaard. The budget moved from the Department of Social Services to the Department of Human Services with the new fiscal year FY2018. This reorganization created the Division of Long Term Services and Supports (LTSS) in the Department of Human Services. The purpose of the LTSS reorganization is to create a more integrated approach to long term services and supports delivery in SD. People with physical or other disabilities who needed state assistance with long term services received them from the Department of Human Services. People with aging related disabilities received assistance from the Department of Social Services. Combining these services in one Department helps ensure that people can best access long term services in their homes and communities, regardless of why they need the services or what type of disability they have.

LTSS serves as the State Unit on Aging for the Older Americans Act (OAA) administered by the Administration for Community Living (ACL), administering funding, reporting to ACL and meeting the State Plan on Aging requirements. OAA Title III funding includes the Nutrition Program providing nutritionally balanced meals through over 200 meal sites; Supportive Services Program providing adult day services, legal assistance, and community transportation; and Caregiver Supports which provides respite or other support for caregivers.

LTSS administers the Medicaid 1915 (c) HOPE Waiver which supports home and community-based, person-centered services that divert participants from institutional settings. In addition, LTSS administers the Medicaid State Plan Personal Care Optional Service Program that provides homemaker services, personal care services and nursing to eligible adults who are aged, blind or disabled.

Other programs include In Home Services providing supports to eligible individuals on a sliding scale fee basis; Adult Protective Services for vulnerable, elderly adults; Ombudsman services providing advocacy for residents of nursing facilities and assisted living centers; and Medicaid supported hospice services.

Dakota at Home is the name and identity used for the information and referral call center free to all individuals who are aging or who have a disability to support options planning and research on services available. Dakota at Home provides the single point of contact for all people with disabilities to be able to connect to the right services and information they need.

“Dakota at Home” and the other Aging and Disability Resource Center (ADRC) functions in South Dakota were evaluated by the Administration for Community Living in 2012 and were found to be “meeting criteria” for 20 of 30 assessment points, “partially meeting criteria” for 7 of 30 points, and “needing improvement” for 3 of 30 assessment points. The Criteria of Fully Functioning Aging and Disability Resource Centers (ADRC) and our most recent evaluation (2012) are attached for reference. The ADRC Technical Assistance Exchange was the entity supported by the Administration for Community Living (ACL) to provide support and functional assessment of ADRCs developed around the country through ACL funding.

Findings and Recommendations:

Finding 1: The Department of Human Services does not track or report costs specifically for the Dakota at Home program.

Recommendation 1: The Department of Human Services should assign a budget center specific to Dakota at Home.

DHS Response to Finding 1: Expenditures are not tracked specifically to Dakota at Home because it is funded by many funding sources which must be tracked and reported individually in accordance with the Department of Human Services cost allocation plan. Dakota at Home is the brand name for the process by which the department provides a single point of contact to make it easier for people wanting information and/or referral to any of the department's disability programs and services. Costs are divided among the various funding sources by cost allocation of staff time. The DHS disagrees with the recommendation to create a budget center specifically for Dakota at Home.

Finding 2: The Department of Human Services does not utilize Medicaid Administrative Federal Financial Participation (FFP) for Dakota at Home/ADRC, which provides a 50% federal match rate for eligible ADRC services and activities.

Recommendation 2: The Department of Human Services should work with the Department of Social Services, the state's Medicaid agency, to establish an agreement to submit claims for the Dakota at Home/ADRC Medicaid administrative activities.

DHS Response to Finding 2: The Department of Human Services agrees that this may be an opportunity and plans to evaluate the possibilities utilizing the guidance documentation provided by the Administration for Community Living (ACL) and the Centers for Medicare and Medicaid Services (CMS). We recently learned of this option while working with an outside consultant.

Dakota at Home is currently utilizing federal funding sources: Medicaid Title XIX, Social Services Block Grant Title XX, Older Americans Act Title III which includes the following: III-B Supportive Services, Title III-C Nutrition Services, Title III-D Preventive Health Services (Community Support), and Title III-E Family Caregiver Support. Each funding source has a match rate that must be considered to analyze and determine if it would be beneficial for the Department to utilize Medicaid Administrative Federal Financial Participation (FFP) for Dakota at Home/ADRC.

Employees assigned to intake calls already charge their time based on everyone they serve in the intake process. This process begins with a request for information for services available. The specific funding type that the requests relate to include both Medicaid programs and non-Medicaid programs. Costs are allocated through the Department of Human Services cost allocation plan approved by the Federal Department of Health and Human Services. The breakdown below shows the amount of general and federal funding utilized specific to the staff assigned to work on Dakota At Home during SFY 2018.

SFY2018:

General	$73,593
Federal	$112,745
TOTAL	**$186,338**

Finding 3: The Department of Human Services is utilizing outdated policies and procedures and does not have formalized training plan in place for Dakota at Home staff.

Recommendation 3: The Department of Human Services should update its policies and procedures and pursue additional training for Dakota at Home staff.

DHS Response to Finding 3: Policies are in place. The Department of Human Services acknowledges the policies need updating to reflect the new structure of the intake staff and the unified telephone number; however, the basic processes remain relevant. Creation of the current Intake Specialist positions required individuals filling these positions to have at least one year of experience as an LTSS Specialist prior to becoming an Intake Specialist for Dakota at Home. Each LTSS Specialist, including Dakota at Home Intake Specialists have a training plan developed by their supervisor upon their start date. Dakota at Home intake staff were also provided specific training on Intake processes prior to the launch of the updated intake structure on May 10, 2018. Training

was provided by both expert consultants from Navigant Consulting and from Program Specialists within the LTSS, specific to intake roles. Silent call monitoring is utilized by the Dakota at Home Supervisor to identify potential training issues or opportunities for improvement. A call monitoring form is completed for these monitoring events to document training needs, identify opportunities, and as an on-going quality assurance tool for each Intake Specialist.

Training has been provided in all divisions to become a person-centered organization. All DHS staff understand and implement person centered practices daily. The supervisory and executive level staff within DHS work together to eliminate silos. By engaging with Support Development Associates in a multi-year effort to "Become a Person-Centered Organization", South Dakota Department of Human Services is the first state agency - in SD and nationwide - to take on the process of becoming a Person-Centered Organization through the Learning Community for Person-Centered practices.

Finding 4: The Department of Human Services does not utilize surveys to gauge consumer satisfaction with Dakota at Home services.

Recommendation 4: The Department of Human Services should conduct a comprehensive survey to gauge consumer satisfaction regarding the services provided by Dakota at Home and utilize those results to enhance service delivery.

DHS Response to Finding 4: A telephone survey is under contract and in the development phase for the Dakota at Home program. System research, requirements, and design have been underway since July 2018. The projected timeline for installation and testing is November 5 – 9 and is expected to move to production by November 15, 2018. The survey uses an Interactive Voice Response (IVR) system. Prior to speaking to a customer service representative, callers are invited to stay on the line to provide feedback via voice responses or keypad buttons. After speaking with Dakota at Home staff, callers are automatically transferred to the survey to provide feedback which helps DHS inform policy and improve services. Monthly reports will provide call results by question, agent detail, and a monthly scorecard.

Dakota at Home has a prominent link to an online customer satisfaction survey on the webpage just below the phone number that will connect services and information seekers to program staff. As of October 2018, 10 surveys have been completed. The Department of Human Services social media (Facebook and Twitter) are being used to promote the online survey monthly. The low number of online surveys is consistent with the mode of contact to Dakota at Home; the majority of contacts to Dakota at Home are telephone calls.

Finding 5: The Department of Human Services has limited access to the data collected by their Dakota at Home IT system.

Recommendation 5: The Department of Human Services should work with their IT system vendor to obtain better access to their data.

The Department of Human Services Response to Finding 5: Division staff, including Intake Specialists, have access to all data collected by the Dakota at Home Information Technology system. Data and information on individuals is readily available and searchable. The limitation of the system is in creating reports that are de-identified with protected consumer information for evaluation by an outside entity. The barrier to the request to provide years of data to the evaluation team was created by the manual process necessary to de-identify the information in the short turn-around period required by the evaluation process. The Department of Human Services is in the midst of implementing a new case management system which will allow enhanced reporting capabilities and is being built with specific request for reporting capabilities consistent with standard monitoring for Aging and Disability Resource Center reporting.

Report Limitations #1 – Much of the requested data could be produced but could not be de-identified to protect the consumer's confidentiality without significant manual intervention that was time prohibitive to the review period.

Report Limitations #2 – LTSS explored several options with our Legal Department to be able to provide a meaningful shadowing experience to the LRC. One option that we felt would protect consumer confidentiality as well as provide a meaningful experience for LRC, was to record incoming calls, request permission from the caller to share a recording of the live call with the LRC and then forward a sampling of recorded calls to LRC for review. Any callers declining this request would have their call recording deleted. The Dakota at Home Intake Supervisor worked with BIT staff to set up a record function on the Dakota at Home Call Software. This record function was set up by BIT and available on 10/19/18. Due to time constraints, this option was not in place soon enough to be utilized prior to the end of the program review period. LTSS did offer to put together some case studies, where narratives of the calls could be de-identified and provided as well as the outcomes of the call, assessment results, referrals made, service authorizations, etc. Case studies were never requested as an alternative to live shadowing.

Appendix A

The Department of Human Services understands the challenges presented in assessing the Aging and Disability Resource Center (ADRC) in South Dakota as it is unique in it's design. In most states the ADRC is a stand-alone entity, created in addition to existing state government agencies. In South Dakota, due in part to the rural nature of our state and limited resources, but more due to the desire to create an integrated system, the ADRC is a part of everyday business with the designated State Unit on Aging, Long Term Services and Supports (formerly Adult Services and Aging). Dakota at Home represents the identity of the ADRC, the front door so to speak. If one is to fully evaluate the ADRC functions, the actions of the entire Division must be considered along with the intake and referral actions of the call center staff which were evaluated as Dakota at Home by the team.

South Dakota's ADRC was last evaluated in 2012 by the Administration for Community Living and was found to be "meeting criteria" for 20 of 30 assessment points, "partially meeting criteria" for 7 of 30 points, and "needing improvement" for 3 of 30 assessment points. This report references using the Criteria of Fully Functioning Aging and Disability Resource Centers from March 2012 as the criteria (page 6), but it is noted that the criteria have been modified in this evaluation.

Standard 2: Personalized Counseling and Planning

Standard 2 #12 - Dakota at Home make Financial Eligibility determinations "Not Functional". **The Department of Human Services Response**: Dakota at Home Intake staff do make determinations for non-Medicaid Services. Medicaid eligibility is referred to the Department of Social Services as the Medicaid agency – this should reflect at least partially functional.

Standard 2 # 13 - Dakota at Home staff submit completed applications to the Medicaid Agency on behalf of the consumer "Not Functional". **The Department of Human Services Response**: LTSS staff do assist with completion of Medicaid applications and will submit the application to the Medicaid agency if requested. Most often consumers complete this process themselves since the application requires the consumer signature. This should reflect fully functional or at least partially functional.

Standard 2 # 14 Dakota at Home staff track the individual's financial eligibility status "Not Functional". **The Department of Human Services Response**: Individual's financial eligibility status is documented in the consumer record in SAMS and in the SD Choices Intake Screen. Additionally, for State funded services, an individuals' financial eligibility is documented on the Income and Resources Form that is completed annually or as the consumers' financial status changes. This should reflect at least partially functional.

Standard 5: Quality Assurance and Continuous Improvement

Standard 5 - #2. The plan includes how Dakota at Home Services will be sustained through a diverse set of public and private funding sources "Not Functional". **The Department of Human Services Response**: Dakota at Home is the brand name for the process by which the department provides a single point of contact to make it easier for people wanting information and/or referral to any of the department's disability programs and services. Costs are divided among the various funding sources by cost allocation of staff time. This process has been in

place since the advent of the ADRC in South Dakota. This should reflect fully functional. (The ADRC has been sustained for approximately 10 years).

Standard 5 - #5. Dakota at Home has an established and efficient process for sharing resource and consumer information electronically across organizations and external entities "Not Functional". **The Department of Human Services Response:** LTSS staff share resource and client information electronically across ADRC operating organizations and with external entities, as needed, from intake to service delivery. This should reflect at least partially functional.

Standard 5 - #8: Dakota at Home uses data, such as consumer satisfaction surveys to monitor quality and improvement "Not Functional". **Department of Human Services Response:** As previously state in finding 4, a telephone survey is under contract and in the development phase for the Dakota at Home program. System research, requirements, and design have been underway since July 2018. The projected timeline for installation and testing is November 5 – 9 and is expected to move to production by November 15, 2018. The survey uses an Interactive Voice Response (IVR) system. Prior to speaking to a customer service representative, callers are invited to stay on the line to provide feedback via voice responses or keypad buttons. After speaking with Dakota at Home staff, callers are automatically transferred to the survey to provide feedback to provide to help The Department of Human Services inform policy and improve services. Monthly reports will provide call results by question, agent detail, and a monthly scorecard. Dakota at Home has a prominent link to an online customer satisfaction survey on the program's main page just below the phone number that will connect services and information seekers to program staff. As of October 2018, 10 surveys have been completed. The Department of Human Services social media (Facebook and Twitter) are being used to promote the online survey monthly. The low number of online surveys is consistent with the mode of contact to Dakota at Home; the majority of contacts to Dakota at Home are telephone calls. This should reflect at least partially functional.

Standard 5 - #11 Dakota at Home tracks and can demonstrate that individuals served in terms of age, types of disabilities, income levels are relatively representative of the community "Not Functional". **The Department of Human Services Response:** Dakota at Home does record information on individuals age, type of disability and income as part of the collected information. Although this has not historically been reported; it could be. This should reflect at least partially functional.

Standard 5 - #12 Dakota at Home tracks and can demonstrate that options counseling helps consumers make informed decisions and cost-effective decisions about LTSS "Not Functional". **The Department of Human Services Response:** Dakota at home records ADRC outcomes for each call. Although this data has not been historically reported, it is collected. This should reflect as least partially functional.

Standard 5 - #13 Dakota at Home tracks and can demonstrate the number of individuals diverted from nursing home/institutional settings "Not functional". **The Department of Human Services Response:** Division staff have tracked diversion efforts and statistics as a function of an internal workgroup since 2016. Dakota at Home and the Division of Long Term Services and Supports are integrally connected, and it is difficult to accurately evaluate Dakota at Home without considering the actions of the division. This should reflect as least partially functional.

Standard 5 - #15. Dakota at Home evaluates its impact in reducing the average time from first contact to eligibility determination (both functional and financial) for publicly funded HCBS "Not Functional". **The Department of Human Services Response**: All the data necessary to determine the average time from first contact to eligibility is documented within the IT system and timeliness is monitored to make sure all eligibility reviews are done within required guidelines as a part of routine operations. Dakota at Home and the Division of Long Term Services and Supports are integrally connected, and it is difficult to accurately evaluate Dakota at Home without considering the efforts of the Division as a whole. This should reflect as least partially functional.

Standard 5 - #16. Dakota at Home evaluates its impact on the use of HCBS versus institutional services "Not functional". **The Department of Human Services response:** The use of HCBS versus institutional services is a metric identified and tracked both through an LTSS workgroup that was initiated in 2017 and the Department of Human Services Strategic plan. Dakota at Home and the Division of Long Term Services and Supports are integrally connected, and it is difficult to accurately evaluate Dakota at Home without considering the efforts of the Division as a whole. This should reflect fully functional.

Standard 5 - #17. Dakota at Home evaluates its cost impact to public programs including Medicaid “Not functional”. **The Department of Human Services Response**. The Department of Human Services monitors budget expenditures by program, including Medicaid funded programs, tracking expenditures and eligible participants. Dakota at Home and the Division of Long Term Services and Supports are integrally connected, and it is difficult to accurately evaluate Dakota at Home without considering the efforts of the Division as a whole. This should reflect fully functional.

Aging & Disability ResourceCenter
TECHNICAL ASSISTANCE EXCHANGE

Criteria of Fully Functioning Aging and Disability Resource Centers

March 2012

These criteria were developed to assist states and stakeholders to measure and assess state progress toward developing fully functioning Aging and Disability Resource Centers (ADRCs), sometimes referred to as "single entry point" or "no wrong door" systems for long term services and supports. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. The term "ADRC" in this document may be interpreted to represent one organization in each community, a network of operating organizations or operating partners in each community, or a combination of state level and local level organizations operating in partnership to serve the entire state. Metrics that should be interpreted or applied differently to different types of ADRC models are noted.

If there is one a single organization designated as the ADRC and serving as the single entry point in a designated area, that one organization must provide or contract with others to provide all the ADRC functions for all populations. If there are multiple organizations designated as ADRC operating partners providing multiple entry points in a designated area, each organization does not necessarily need to perform every function for all populations. It is the combination of the organizations' highly coordinated efforts which results in a fully-functional ADRC.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
Information, Referral and Awareness	The *Information, Referral and Awareness* function of an ADRC is defined by the ADRC's ability to serve as a highly visible and trusted place where people of all ages, disabilities and income levels know they can turn for objective and unbiased information on the full range of long-term service and support options. It is also defined by its ability to promote awareness of the various options that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to plan ahead for their long-term needs. Finally, ADRCs should have the capacity to link individuals with needed services and supports – both public and private - through appropriate referrals to other agencies and organizations.	<u>Outreach and Marketing</u> • ADRC has a proven outreach and marketing plan focused on establishing operating organizations as highly visible and trusted places where people can turn for the full range of long-term support options as well as raising awareness in the community about long term service and support options. The outreach and marketing plan includes: 1. Consideration of all the populations they serve including different age groups, people with different types of disabilities, culturally diverse groups, underserved and unserved populations, individuals at risk of nursing home placement, family caregivers and professionals; 2. A strategy to assess the effectiveness of the outreach and marketing activities; and 3. A feedback loop to modify activities as needed. • <u>ADRC actively markets to and serves private pay individuals in</u>

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
		addition to those that require public assistance. Information and Referral • ADRC uses systematic processes across all operating organizations to provide information and referral/ assistance. • ADRC consistently conducts follow-up with individuals receiving I&R/A to determine whether more assistance is needed. • Whether the ADRC has single or multiple operating organizations in the service area, all organizations use the same comprehensive resource database with information about the range of long term supports and resources in the service area and: 1. A system is in place for updating and ensuring the accuracy of the information provided; 2. Resources in the database conform to established inclusion/exclusion policies; these policies specifically address inclusion of resources and providers for private paying individuals and families; and 3. The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities.
Options Counseling	The Options Counseling function is defined by the ADRC's ability to provide person-centered one-on-one assistance and decision support to individuals and others they may wish to include in the process such as family members and/or caregivers/support persons. The main purpose of Options Counseling is to help individuals understand and assess their situation, assist them in making informed decisions about long-term service and support choices in the context	Options Counseling • Standards and protocols are in place that define what options counseling entails and who will be offered options counseling based on draft national Options Counseling standards. At a minimum, this will include any individual who requests it and individuals who go through a comprehensive assessment. Options Counseling should be incorporated into all state and local rebalancing efforts, systems integration activities, transition supports activities, and participant-directed programs.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	of their preferences, strengths, and values. Options Counseling also entails working with individuals to develop action plans and, if requested, arranging for the delivery of services and supports, including hiring and supervising their own direct service workers. Individuals and families who receive options counseling should be able to make service and support choices that optimally meet their needs and preferences, and use their own personal and financial resources more efficiently and more effectively.	• ADRC has the capability, through one or multiple operating organizations, to provide objective, accurate and comprehensive long term support options counseling to individuals of all income levels and with all types of disabilities. • All ADRC operating organizations that serve as entry points for individuals use standard intake and screening instruments. • Options counseling sessions are conducted by staff trained and qualified to provide objective, person-centered assistance and decision support to individuals, as evidenced by certification, minimum qualifications and/or training/cross-training practices. • ADRC provides intensive support to individuals in short-term crisis situations until long term support arrangements have been made. • ADRC consistently conducts follow-up with individuals receiving options counseling to determine the outcome and whether more assistance is needed. • ADRC provides individuals and families with assistance in planning for future long term support and service needs directly or contractually by staff that possess specific skills related to LTSS needs planning and financial counseling.
Streamlined Eligibility Determination for Public Programs	Long-term services and supports are funded by a variety of different government programs administered by a wide array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. The Streamlined Eligibility Determinations for Public Programs component of an ADRC is defined by its ability to serve as a single point of entry/no wrong door, to all publicly funded long-term supports, including those funded by Medicaid, the Older Americans Act (OAA), the	<u>Intake and Screening</u> • ADRC has a standardized process for helping individuals access all publicly-funded long term services and supports programs available in the state. • In multiple entry point systems, the intake and screening process is coordinated and standardized across operating organizations and key partners so that individuals experience the same process wherever they enter the system. <u>Financial and Functional Eligibility Processes</u>

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	Rehabilitation Services Act, and other state and federal programs and services. This requires ADRCs to have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to performing the following administrative functions for all public programs (including both home and community-based services programs and institutional-based programs): • consumer intake • screening • assessing an individual's needs • determining programmatic, functional/clinical and financial eligibility • developing service/care plans • ensuring that people receive the services for which they are eligible The goal is to create a process that is both administratively efficient and seamless for individuals regardless of which program they end of being eligible for or the types of services they receive.	• Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by the ADRC, so individuals experience it all as one process. • ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk. • Staff located on-site within the ADRC conduct level of care assessments that are used for determining functional/clinical eligibility, or ADRC has a formal process in place (e.g. MOUs, written protocols) for seamlessly referring individuals to the agency that conducts level of care assessments. • ADRC staff assist individuals as needed with initial steps in completing the application (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews). • Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of applicants. <u>Tracking Eligibility Status</u> • ADRC is able to track individuals' eligibility status throughout the process of eligibility determination and redetermination. • ADRC is routinely informed of individuals who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals to provide further options counseling. • In localities where waiting lists for public LTC programs or services exist, the ADRC is routinely informed of individuals who

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
		are on the waiting list and conducts follow-up with those individuals.
Person-Centered Transition Support	The Person-Centered Transitions component is defined by an ADRC's ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person ends up in a nursing home or is transitioned back to their own home. The ADRC can play a pivotal role in these transitions to ensure that people understand their options and receive long term services and supports in the setting that best meet their individual needs and preferences, which is often in their own homes. ADRC staff can be present at these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and to help them quickly arrange for the supports and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a nursing home or other institution. They can also break the cycle of readmission to the hospital that often occurs when an individual with chronic illness is discharged to the community	• ADRC has formal agreements with local critical pathway providers such as hospitals, physician's offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and ICFs-MR that include: (1) An established process for identifying individuals and their caregivers who may need transition support services; (2) Protocols for referring individuals to the ADRC for transition support and other services; and (3) Regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations. • ADRC works with the State Medicaid Agency to serve as Local Contact Agencies (LCAs) to provide transition services for institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	without the social services and supports they need.	
Consumer Populations, Partnerships and Stakeholder Involvement	Many ADRCs started out serving older adults and one other target population, such as adults with physical disabilities, intellectual or developmental disabilities, or mental illness. ADRCs should work toward the goal of serving persons with all types of disabilities regardless of age. To be truly person-centered, ADRCs must meaningfully involve stakeholders and individuals they serve in planning, implementation and quality assurance/quality improvement activities. In order to function efficiently and serve as the single entry point / no wrong door for the full array of long term service and support programs in the state, ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving people with disabilities. Examples of other important state partnerships could include the State Health Insurance Assistance Program (SHIP), Brain Injury Associations, and the State Mental Health Planning Councils. ADRCs should be operated by or establish strong local partnerships with Area Agencies on Aging, Centers for Independent Living, and other community-based organizations instrumental to ADRC activities such as Departments of Veterans Affairs, Adult Protective Services, Information and Referral/2-	<u>Consumer Populations</u> • ADRC serves individuals with all types of disabilities, either through a single operating organization or through close coordination with multiple operating organizations. • ADRC staff demonstrates competencies relating to serving people of all ages and types of disabilities and their families, including people with dementia and people of different cultures and ethnicities. • There are formal mechanisms for involving consumers on state/local ADRC advisory boards or governing committee and in planning, implementation and evaluation activities. <u>Medicaid</u> • ADRC has formal partnership agreements at the local level (or at the state level if applicable across all sites) with Medicaid agency(ies) that describe explicitly the role of each partner in the eligibility determination process and information sharing policies. • ADRC staff are involved as partners or key advisors in other state long term support and service system reform initiatives (e.g. Money Follows the Person initiatives) <u>Aging and Disability Partners</u> • In multiple entry point systems, the ADRC has formal service standards, protocols for information sharing, and cross-training across all ADRC operating organizations. • In single entry point systems, there is strong collaboration, including formal agreements, at the state and local levels between the ADRC and all other critical aging and disability agencies and service organizations serving the same area that

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	1-1 programs, Benefit Outreach and Enrollment Centers, One Stop Employment Centers, Vocational Rehabilitation, Developmental Disabilities Councils, Long-Term Care Ombudsman programs, Alzheimer's disease programs, housing agencies, and transportation authorities.	are not ADRC operating organizations. <u>Other Partners and Stakeholders</u> • State Health Insurance Assistance Program (SHIP), Adult Protective Services, and 2-1-1 programs are operated by the ADRC, or there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals between the ADRC and these three programs. • ADRC operating organizations (e.g., AAA or SUA) have a Provider Agreement with a VA Medical Center to provide Veteran-Directed HCBS or there is a formal agreement at the state or local level between the ADRC and VA system outlining a protocol for linking Veterans with needed long term services and supports and making mutual referrals. • There is evidence of strong collaboration with other programs and services instrumental to ADRC activities.
Quality Assurance and Continuous Improvement	Quality Assurance and Continuous Improvement are a part of every ADRC system to ensure services are available, are of high quality and meet the needs of individuals, and are sustained statewide. They ensure that services adhere to the highest standard, as well as ensure the public and private investments in ADRCs are producing measurable results. ADRCs should be using electronic information systems to track their customers, services, performance and costs, and to continuously evaluate and improve on the results of the ADRC services that are provided to individuals and their families, as well as to other organizations in the community. This may include linkages with other data systems, such	<u>Sustainability</u> • State operates in accordance with a formal written plan (e.g., the ADRC 5-Year Plan) that details how ADRC services will be made available statewide and sustained through a diverse set of public and private funding sources. <u>Management and Staffing</u> • In multiple entry points systems, the ADRC has one overall coordinator or manager with sufficient authority to maintain quality processes across operating organizations. • ADRC has adequate staff capacity to assist individuals in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. <u>IT/MIS</u> • ADRC operating organizations use management information

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
	as Medicaid information systems and electronic health records. The Quality Assurance and Continuous Improvement component of an ADRC should also involve formal processes for getting input and feedback from individuals and their families on the ADRC's operations, services used, and on-going development. Every ADRC should have measurable performance goals and indicators related to its visibility, trust, ease of access, responsiveness, efficiency and effectiveness.	systems that support all program functions. • ADRC has established an efficient process for sharing resource and client information electronically across ADRC operating organizations and with external entities, as needed, from intake to service delivery. <u>Continuous Improvement</u> • ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered such as consumer satisfaction evaluations and surveys. • ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. <u>Performance Tracking</u> • At the local or programmatic level, ADRC routinely tracks service delivery and individual outcomes and can demonstrate: 1. That the ADRC serves people in different age groups, with different types of disabilities and income levels in proportions that reflect their relative representation in the community; 2. That options counseling provided enables people to make informed, cost-effective decisions about long-term services and supports; 3. The number of individuals diverted from nursing home/institutional settings; and 4. The number of individuals successfully transitioning from institutional settings (i.e. number of people assisted through formal coordinated or evidence-

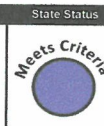
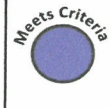
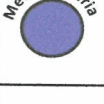
Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
		based transitions programs). • States evaluate their ADRCs' overall impact in the following areas: 1. Reduction in the average time from first contact to eligibility determination (both functional/clinical and financial) for publicly funded home and community-based services; 2. Impact on the use of home and community based services vs. institutional services; and 3. Documentation of the cost impact to public programs, including Medicaid.

Aging & Disability ResourceCenter
TECHNICAL ASSISTANCE EXCHANGE

Aging and Disability Resource Center Fully Functioning Assessment
June 2012

This document presents The Lewin Group's assessment of the progress that South Dakota has made toward realizing the ACL/CMS vision of a fully functioning ADRC. In the first two columns, the ADRC program components and recommended metrics describe the criteria of a fully functional ADRC. The status rating in the third column identifies state strengths as well as areas for future growth. In the last columns are lessons learned and TA resources that relate to the different Program Components.

Criteria	Metrics	State Status	Lessons Learned from Other States	Related Resources
Information, Referral and Awareness				
Outreach and Marketing Plan	• ADRC has a proven outreach and marketing plan focused on establishing operating organizations as highly visible and trusted places where people can turn for the full range of long-term support options as well as raising awareness in the community about LTSS options. The outreach and marketing plan includes: (1) Consideration of all populations served including different age groups, people with different income levels, different types of disabilities, culturally diverse groups, underserved populations, individuals at risk of nursing home placement, family caregivers and professionals; (2) A strategy to assess the effectiveness of the outreach and marketing activities; and (3) A feedback loop to modify activities as needed.	Meets Criteria	**Lesson Learned:** A statewide marketing plan can save local ADRC program sites resources, build consistency in branding and messaging to the public, and raise statewide recognition of the mission and purpose of ADRCs; statewide plans should still allow flexibility for local ADRC program sites to adapt the plan to reflect their local markets, resources, culture, and community.	TAE Issue Brief - Marketing to External Audiences: http://www.adrc-tae.org/tiki-download_file.php?fileId=2833 TAE Issue Brief - Cultural Competence and ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=29293 TAE Issue Brief - Private Industry Lessons: Branding and Marketing: http://www.adrc-tae.org/tiki-download_file.php?fileId=26301
Marketing to and Serving Private Paying Populations	• ADRC actively markets to and serves private pay individuals in addition to those that require public assistance.	Meets Criteria	**Lesson Learned**: Raising visibility, awareness, and knowledge about long term service and support (LTSS) options among private paying populations is a critical role for ADRCs. It is a key strategy to prevent Medicaid spend down and promote diversion from institutions by helping people use resources wisely. It also promotes Options Counseling for individuals who need assistance with futures planning and is an important way to build a broader base of public support for the initiative by creating a message that the ADRC serves all persons, regardless of income.	TAE Training – Reaching and Serving Private Pay Consumers: http://www.adrc-tae.org/tiki-index.php?page=ReachingPrivatePayConsumersTraining TAE Training - Making a Profit in a Non-Profit World: http://www.adrc-tae.org/tiki-download_file.php?fileId=28123
Information and Referral	• ADRC uses systematic processes across all operating organizations to provide Information and Referral/Assistance (I&R/A).	Meets Criteria	**Lesson Learned:** Encouraging/ requiring that I&R/A specialists receive Alliance for Information and Referral Systems (AIRS) certification is one approach to ensuring that every contact made to the ADRC is handled professionally and services adhere to the highest standards of I&R/A provision. In No Wrong Door models, implementing standardized processes for referrals among operating organizations promotes consistency in how services are delivered and received by individuals, which in turn improves the ADRC's perception as "seamless" and "transparent".	AIRS Certification Information: http://www.airs.org/i4a/pages/index.cfm?pageid=3309 NASUA's Information and Referral Support Center: http://www.nasuad.org/I_R/ir_index.html NASUA's Vision 2010: Toward a Comprehensive Aging Information Resource System for the 21st Century: http://www.nasuad.org/documentation/I_R/vision2010whitepaper.pdf
I&R Follow-Up	• ADRC consistently conducts follow-up with individuals receiving I&R/A to determine whether more assistance is needed.	Partially Meeting Criteria	**Lesson Learned**: Follow-up calls with as many ADRC contacts for whom you collect identifying information about can help ADRCs track the appropriateness of referrals, whether the information provided met the individual's needs, determine if the individual was able to make the necessary connections and if not, what the reason was and whether further assistance such as Options Counseling is necessary. The information collected during follow-up can be used to identify service gaps in the community. Staff can discuss follow-up results with one another as a way of promoting peer-to-peer learning, best practices, and improving ongoing ADRC service delivery.	Wisconsin Follow-up Policy: http://www.dhs.wisconsin.gov/LTCare/adrc/professionals/referencetools/P&P/InformationAssistanceFollow-up10-8-10.pdf
Resource Database	• Whether the ADRC has single or multiple operating organizations in the service area, all organizations use the same comprehensive resource database with information about the range of LTSS and resources in the service area and: (1) A system is in place for updating and ensuring the accuracy of the information provided; (2) Resources in the database conform to established inclusion/exclusion policies; these policies specifically address inclusion of resources and providers for private paying individuals and families; and (3) The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities.	Meets Criteria	**Lesson Learned**: Centralizing resource databases at the state level saves money, promotes consistency in information about programs and services and eliminates duplicate data entry at the local level. **Lesson Learned:** Developing a formal inclusion and exclusion policy is especially important when your database includes both public and private providers. **Lesson Learned:** Ensuring the resource database is publicly-available and accessible to persons with disabilities supports consumer direction and promotes self-determination, has the potential to reduce the reliance on I&R/A calls for simple program and service information, and provides staff with tools to electronically share resource information with individuals and organizations.	ADRCs' I&R/A Online Searchable Databases Review – 2008: http://www.adrc-tae.org/tiki-download_file.php?fileId=27994 ADD - Strategies for Public Searches in the AIRS Taxonomy: http://www.adrc-tae.org/tiki-download_file.php?fileId=29159 Setting Inclusion/Exclusion Criteria: Determining the Scope of a Resource File: http://www.airs.org/files/public/inclusion_exclusion.pdf
Options Counseling and Assistance				
Standards and Protocols	• Standards and protocols are in place that define what Options Counseling entails and who will be offered Options Counseling based on the AoA national draft Options Counseling standards. At a minimum, this will include any individual who requests it and individuals who go through a comprehensive assessment. Options Counseling should be incorporated into all state and local rebalancing efforts, systems integration activities, transition supports activities, and participant-directed programs. • ADRC has the capability, through one or multiple operating organizations, to provide objective, accurate and comprehensive Options Counseling to individuals of all income levels and with all types of disabilities. • All ADRC operating organizations that serve as entry points for individuals use standard intake and screening instruments. • Options Counseling sessions are conducted by staff trained and qualified to provide objective, person-centered assistance and decision support to individuals, as evidenced by certification, minimum qualifications and/or training/cross-training practices.	Partially Meeting Criteria	**Lesson Learned:** Incorporating cross-training, particularly focused on working with special populations and cultural competencies, ensures consistency and quality in service delivery across ADRC operating organizations. **Lesson Learned:** Developing a common Options Counseling tools for use across operating organizations helps ensure consistency in processes, promotes team approaches to delivery of Options Counseling across operating organizations, facilitates data sharing, and improves the quality and measurement of quality of services across partners. **Lesson Learned:** Implementing minimal expectations for staff education, training, and experience ensures a base level of knowledge for all Options Counselors regardless of which operating organization they may work in. Promising practices to incorporate into training curricula include motivational interviewing techniques, active listening, use of person-centered tools, and consumer-direction.	Current Draft National Options Counseling Standards October 2011: http://www.adrc-tae.org/tiki-download_file.php?fileId=31218 OC Training Resources and Tools: http://www.adrc-tae.org/tiki-index.php?page=AdvancedOC

Criteria	Metrics	State Status	Lessons Learned from Other States	Related Resources
Short-Term Crisis Support	• ADRC provides intensive support to individuals in short-term crisis situations until long term support arrangements have been made.		**Lesson Learned:** Finding the resources to provide this type of support may be difficult, but honing Options Counseling skills and reaching out to ADRC operating organizations to team up will help staff work more efficiently with individuals and families to get them through times of crisis and create sustainable plans for community living.	Current Draft National Options Counseling Standards October 2011: http://www.adrc-tae.org/tiki-download_file.php?fileId=31218
Options Counseling Follow-Up	• ADRC consistently conducts follow-up with individuals receiving Options Counseling to determine the outcome and whether more assistance is needed.		**Lesson Learned:** Options Counseling often involves multiple sessions or contacts, so it may already include following up as individuals continue to weigh the pros and cons of decisions and develop an action plan. Creating a desired window for follow up within a certain period of time after the last contact/session is completed is very important, and is one of the distinguishing essential components of Options Counseling - to conduct follow up with 100% of individuals who receive Options Counseling. Follow up is important to find out if the individual was able to follow through on the steps outlined in the action plan, what decisions he or she made, identify any barriers experienced in following through on the action plan, determine whether further assistance is required and whether the Options Counseling was helpful.	Current Draft National Options Counseling Standards October 2011: http://www.adrc-tae.org/tiki-download_file.php?fileId=31218
Planning for Future LTC Needs	• ADRC provides individuals and families with assistance in planning for future LTSS needs directly or contractually by staff that possess specific skills related to LTSS needs planning and financial counseling.		**Lesson Learned**: In building capacity to help individuals plan for future LTSS needs, ADRCs can do equally well to train in-house staff to become counselors as identifying a community partner to provide this service for ADRC consumers; developing off-the-shelf informational materials and tools for consumers is an easy way to make information available to all ADRC consumers. The Options Counseling process offers an opportunity to customize this support to a specific individual's situation in the context of a relationship of trust.	Home Equity Conversion Mortgage (HECM) Program The Role of the Aging Network in Assisting Older Mortgagees: http://www.aoa.gov/AoA_programs/Special_Projects/HECM/index.aspx National Clearing House for Long Term Care Information: http://www.longtermcare.gov A House in Order: How Planning for Your Aging Brings Peace of Mind: http://www.adrc-tae.org/tiki-download_file.php?fileId=26901 AARP Prepare to Care Booklet: http://www.adrc-tae.org/tiki-download_file.php?fileId=26466
Streamlined Eligibility Determination for Public Programs				
Overall Coordination and Integration	• Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by the ADRC, so individuals experience it all as one process.		**Lesson Learned**: Working with consumer advisors, advocates and partnering organizations (especially Medicaid) to identify bottlenecks and barriers is the best way to prioritize streamlining activities. Use the Streamlining Access Self-Assessment Workbook to systematically consider the different steps consumers must go through to access public services. **Lesson Learned:** In No Wrong Door, multiple entry point ADRCs, designing and implementing clear protocols for how each operating and partnering organization works together to assist individuals from the point of contact (I&R/A) to service delivery is critically important to reduce duplication of effort, build consistency, and promote seamlessness from the consumer perspective.	General Streamlining Access materials: http://www.adrc-tae.org/tiki-index.php?page=GenStreamlining Universal Assessment and Streamlining Access to Long Term Care: http://www.adrc-tae.org/tiki-download_file.php?fileId=28594 TAE Presentation - Streamlining Access - ADRC Strategies, Progress, and Lessons Learned: http://www.adrc-tae.org/tiki-download_file.php?fileId=29062 NCOA National Center for Benefits Outreach & Enrollment: http://www.ncoa.org/enhance-economic-security/center-for-benefits/
Intake and Screening	• ADRC has a standardized process for helping individuals access all publicly-funded LTSS programs available in the state. • In multiple entry point systems, the intake and screening process is coordinated and standardized across operating organizations and key partners so that individuals experience the same process wherever they enter the system.		**Lesson Learned:** Developing common intake or screening tools across programs and/or service networks can be a complex and time-consuming task, but it saves consumers from filling out multiple forms and saves staff time spent translating or repopulating data into multiple systems. It also improves the quality and consistency of data collection.	Arizona Common Intake Form and Instructions: http://www.adrc-tae.org/tiki-download_file.php?fileId=27501 Minnesota NHD Proxy Rapid Screen: http://www.adrc-tae.org/tiki-download_file.php?fileId=27818 New Jersey Automated Screen for Community Services: http://www.adrc-tae.org/tiki-download_file.php?fileId=2604
Uniformly Assess Risk of Institutionalization	• ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk.		**Lesson Learned:** A universal assessment / level of care determination process for all public programs and all target populations (with different modules as needed) is a powerful long term care balancing tool and a key criteria for the Balancing Incentive Payment Program (BIP). It reduces the need for consumers to repeat information that is common across multiple assessments and reduces staff time in asking repetitive questions. It can help ensure that individuals are matched with the most appropriate program and service, standardizes consumer data across programs and services, assists in the development of common reimbursement methodologies built from universal assessments, can help end the default of institutionalization, and can simplify protocols and procedures for staff.	TAE Resource - Universal Assessment and Streamlining Access to LTC: http://www.adrc-tae.org/tiki-download_file.php?fileId=28594 New Jersey At-Risk of Nursing Facility Placement Criteria: http://www.adrc-tae.org/tiki-download_file.php?fileId=26088 Minnesota NHD Proxy Rapid Screen: http://www.adrc-tae.org/tiki-download_file.php?fileId=27818
Functional Eligibility Determination	• Staff located on-site within the ADRC conduct level of care assessments that are used for determining functional/clinical eligibility, or ADRC has a formal process in place (e.g. MOUs, written protocols) for seamlessly referring individuals to the agency that conducts level of care assessments.		**Lesson Learned**: Even if ADRC staff do not directly determine functional eligibility the process should be seamless to the consumer and coordination between entities should ensure that individuals do not fall through the cracks. ADRCs should pay attention to national conversations about "conflict free case management" in examining functions moving forward, particularly in the managed care arena.	BIP Manual: http://www.nasuad.org/documentation/newsroom/friday_updates/Balancing_Incentive_Program_Manual_FINAL_Draft.pdf
Assistance with Financial Applications	• ADRC staff assist individuals as needed with initial steps in completing the application (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews).		**Lesson Learned:** One of the simplest strategies ADRCs can use to streamline access is to assist consumers who request such support with completing applications and gathering the necessary paperwork in order to apply for Medicaid and other publicly-funded programs. This minimizes application errors and the resulting processing delays. In this way, ADRCs can contribute to the efficient and effective administration of the Medicaid program and help consumers access needed services quicker.	TAE Presentation - Streamlining Access - ADRC Strategies, Progress, and Lessons Learned: http://www.adrc-tae.org/tiki-download_file.php?fileId=29062
Financial Eligibility Determination	• Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of applicants.		**Lesson Learned:** Even if ADRC staff cannot determine financial eligibility, the consumers they serve do not need to know that. By establishing an agreement with Medicaid, ADRC staff can help consumers complete and submit applications, track the application through the system and let the consumers know the determination.	TAE Presentation - Streamlining Access - ADRC Strategies, Progress, and Lessons Learned: http://www.adrc-tae.org/tiki-download_file.php?fileId=29062

Criteria	Metrics	State Status	Lessons Learned from Other States	Related Resources
Tracking Eligibility	• ADRC is able to track individuals' eligibility status throughout the process of eligibility determination and redetermination. • ADRC is routinely informed of individuals who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals to provide further Options Counseling. • In localities where waiting lists for public LTC programs or services exist, the ADRC is routinely informed of individuals who are on the waiting list and conducts follow-up with those individuals.		**Lesson Learned:** One of the most valuable services ADRCs can provide is to offer Options Counseling to individuals on waiting lists or who have been denied eligibility for public programs. Even when electronic data sharing between the ADRC and Medicaid is not possible, ADRCs can establish a protocol by which Medicaid informs them of determinations, particularly denials for Medicaid, so they can follow-up. Additionally, State agencies can issue program instructions for local Medicaid offices requiring staff to refer all Medicaid financial denials to their local ADRC.	TAE Presentation - Streamlining Access - ADRC Strategies, Progress, and Lessons Learned: http://www.adrc-tae.org/tiki-download_file.php?fileId=29062
Person-Centered Transition Support				
Formal Agreements with CPPs	• ADRC has formal agreements with local critical pathway providers, such as hospitals, physician's offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and ICFs-MR that include: (1) An established process for identifying individuals and their caregivers who may need transition support services; (2) Protocols for referring individuals to the ADRC for transition support and other services; and (3) Regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations.		**Lesson Learned**: Including leadership from critical pathways (hospital administrators, geriatricians, etc.) on your ADRC board can aid in developing a strong care transitions program. **Lesson Learned:** Care transitions interventions and diversion programs require strong partnerships with the providers that will be involved, such as hospitals and nursing facilities. These relationships take time to develop and should be planned with the idea of ample time, resulting in formalized MOUs and referral protocols. **Lesson Learned:** Choosing an evidence-based model can simplify the process of designing your care transitions initiative and training (most evidence-based care transitions programs offer training).	TAE Issue Brief: Hospital-Based Nursing Facility Diversion Initiatives: http://www.adrc-tae.org/tiki-download_file.php?fileId=27079 ADRC MFP Collaborative Partnership Toolkit: http://www.adrc-tae.org/tiki-download_file.php?fileId=31510 TAE Issue Brief - ADRC Roles in Diversion: http://www.adrc-tae.org/tiki-download_file.php?fileId=2805 TAE Care Transitions Resources: http://www.adrc-tae.org/tiki-index.php?page=CareTransitions
Local Contact Agencies	• ADRC works with the State Medicaid Agency to serve as Local Contact Agencies (LCAs) to provide transition services for institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment.		**Lesson Learned:** ADRCs, in partnership with their State Medicaid Agency, should develop clear protocols and procedures for nursing facilities, LCAs and any other parties involved (i.e. MFP staff, ombudsman, etc.), regarding the referral and follow up processes for Section Q.	Informational Overview of Local Contact Agencies in MDS 3.0 Section Q: http://www.adrc-tae.org/tiki-download_file.php?fileId=29258 Section Q ADRC Roles and Transitions Roadmap PowerPoint: http://www.adrc-tae.org/tiki-download_file.php?fileId=31726
Consumer Populations, Partnerships and Stakeholder Involvement				
Target Populations	• ADRC serves individuals with all types of disabilities, either through a single operating organization or through close coordination with multiple operating organizations. • ADRC staff demonstrates competencies relating to serving people of all ages and types of disabilities and their families, including people with dementia and people of different cultures and ethnicities.		**Lesson Learned**: It is not necessary for one place or organization, such as the AAA, to become the only entity in the community that serves all populations. The goal of the ADRC is to improve coordination across all operating organizations involved in the process so that the experience of accessing services appears to be seamless for the consumer and the consumer benefits from the collective expertise of the entire network of service providers. **Lesson Learned:** ADRCs should incorporate ongoing cross-training across operating organizations in No Wrong Door, multiple entry point systems, regarding the varying philosophies, services, and best practices in working with special populations across service networks.	TAE Issue Brief - Strategies for Building Collaboration: http://www.adrc-tae.org/tiki-download_file.php?fileId=2821 TAE Issue Brief - Facilitating a Productive Advisory Committee: http://www.adrc-tae.org/tiki-page.php?pageName=Advisory+Committee+Brief
Consumer Involvement	• There are formal mechanisms for involving consumers on state/local ADRC advisory boards or governing committee and in planning, implementation and evaluation activities.		**Lesson Learned:** ADRCs should be aware of, and plan for, the necessary accommodations for engaging consumers on state and local advisory boards to ensure maximum participation and engagement. **Lesson Learned:** It is important to keep Advisory Boards active and engaged in supporting activities and program sustainability. Encouraging reengagement of existing members by hosting a meeting on ADRC accomplishments to date and highlighting the valuable contributions of the group.	TAE Issue Brief - Facilitating a Productive Advisory Committee: http://www.adrc-tae.org/tiki-page.php?pageName=Advisory+Committee+Brief
Medicaid	• ADRC has formal partnership agreements with the single State Medicaid Agency and with local level Medicaid agencies (if applicable) that describe explicitly the role of each partner in the eligibility determination process and information sharing policies. • ADRC staff are involved as partners or key advisors in other state long term support and service system reform initiatives (e.g. Money Follows the Person initiatives).		**Lesson Learned**: Having a formal partnership with Medicaid is critical to making progress toward streamlining access. A basic MOU that outlines a general commitment to partner and meet regularly to discuss streamlining access strategies is a good place to start. Later, a more formal protocol or agreement with regard to day-to-day operations can be developed.	ASPE - A Guide to Memorandum of Understanding Negotiation and Development: http://www.adrc-tae.org/tiki-download_file.php?fileId=29295 TAE Issue Brief: Engaging Medicaid Agencies About ADRCs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26973 Example MOUs between ADRC and Medicaid: http://www.adrc-tae.org/tiki-index.php?page=Medicaid
Aging and Disability Partners	• In multiple entry point systems, the ADRC has formal service standards, protocols for information sharing, and cross-training across all ADRC operating organizations. • In single entry point systems, there is strong collaboration, including formal agreements, at the state and local levels between the ADRC and all other critical aging and disability agencies and service organizations serving the same area that are not ADRC operating organizations.		**Lesson Learned:** Involving all disability partners in the planning of the ADRC initiative, even if the ADRC will take on additional disability populations gradually, will contribute to a more successful program and stronger commitment across all operating organizations and community partners. If you wait to involve some networks after the program has been designed and implemented, they will not have had a chance to provide input into the system and may not be as willing to be a partner in this effort.	TAE Training - Creating Successful Aging and Disability Partnerships: http://www.adrc-tae.org/tiki-index.php?page=PartnershipsTraining
Other Stakeholders	• State Health Insurance Assistance Program (SHIP), Adult Protective Services, and 2-1-1 programs are operated by the ADRC, or there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals between the ADRC and these three programs. • There is evidence of strong collaboration with other programs and services instrumental to ADRC activities.		**Lesson Learned:** The ADRC may have to devote time to working with partners to define the role of 2-1-1 (referral provider) vs. the ADRC (comprehensive I&R/A and Options Counseling) and educate the community and funders. The two entities complement and work well together when roles are clearly defined and understood by stakeholders.	Example Partnership Agreements and MOUs: http://www.adrc-tae.org/tiki-index.php?page=MOU
VD-HCBS or other VA Partnership	• ADRC operating organizations (e.g., AAA or SUA) have a Provider Agreement with a VA Medical Center to provide Veteran-Directed HCBS or there is a formal agreement at the state or local level between the ADRC and VA system outlining a protocol for linking Veterans with needed LTSS and making mutual referrals.		**Lesson Learned:** ADRCs should work with AoA and consult the VD HCBS Starter Kit for information about launching a VD-HCBS program. Operating sites have reported that one of the most important facilitators of success has been building a good working relationship with the Veterans Affairs Medical Center staff (VAMC). Extending an invitation to meet with staff and assisting one another with task groups and advisory boards is a good place to start.	VD HCBS starter kit: http://www.adrc-tae.org/tiki-index.php?page=NewVDHCBS

Criteria	Metrics	State Status	Lessons Learned from Other States	Related Resources
Quality Assurance and Continuous Improvement				
Sustainability	• State operates in accordance with a formal written plan (e.g., the ADRC 5-Year Plan) that details how ADRC services will be made available statewide and sustained through a diverse set of public and private funding sources.		**Lesson Learned:** ADRCs must use several strategies and funding streams to sustain functions and services such as I&R, Options Counseling, Care Transitions, Streamlining Access, and CQI. Creative ways to sustain activities might include tapping into local funding opportunities, proactively pursuing strategic partnerships with the private sector, exploring fee for service and sliding scale models, and partnering among operating organizations to pursue larger funding opportunities both at the federal, state, and local levels. **Lesson Learned:** States should continually seek to embed ADRCs within other initiatives and systems reform activities by clearly articulating the role(s) the ADRCs may play in supporting such efforts, and how they might secure funding to support their involvement.	Making the Business Case for a Comprehensive Long Term Services and Supports (LTSS) Strategy: http://www.adrc-tae.org/tiki-download_file.php?fileId=30841
Staffing and Management	• In multiple entry points systems, the ADRC has one overall coordinator or manager with sufficient authority to maintain quality processes across operating organizations. • ADRC has adequate staff capacity to assist individuals in a timely manner with long term support requests and referrals, including referrals from critical pathway providers.		**Lesson Learned**: Staff training must be an ongoing activity to ensure that ADRC staff have the capacity, proficiency, and sensitivity required to serve people with all types of disabilities. Operating organizations can contribute significantly; reciprocal cross-training arrangements can provide inexpensive training for ADRC staff and partners on a regular basis. **Lesson Learned:** The role that good management and leadership plays, especially in No Wrong Door/ multiple-entry point systems, cannot be emphasized enough. ADRCs should consider creating a leadership team comprised of the respective management of each operating organization as well as the overall coordinator/manager to discuss operational direction, sustainability, marketing and outreach, how staff will be supervised and evaluated, and overall performance and continuous quality improvement.	TAE General ADRC Staffing Resources and Materials (Job Descriptions, Supervisory Tools, Standards of Practice): http://www.adrc-tae.org/tiki-index.php?page=Staffing ILRU Training Materials – Independent Living History and Philosophy Staff Orientation: http://www.ilru.org/DVD.html TAE Online Training Resources: http://www.adrc-tae.org/tiki-index.php?page=Training
IT/MIS	• ADRC operating organizations use management information systems that support all program functions. • ADRC has established an efficient process for sharing resource and client information electronically across ADRC operating organizations and with external entities, as needed, from initial contact to service delivery.		**Lesson Learned**: States should build the capacity for data sharing with internal and external operating organizations within any new or enhanced IT system. Web-based platforms allow ADRCs to make electronic referrals and share client data safely and securely with operating organizations and community partners. For operating organizations with different systems, IT interfaces should be built to allow separate systems to share data. **Lesson Learned:** As part of any MOU, ADRCs should include confidentiality and IT/MIS HIPAA compliance language addressing the sharing of any identifiable client information.	Moving Forward: Opportunities for IT Advances in the Aging Network: http://www.adrc-tae.org/tiki-download_file.php?fileId=26984 Selecting an IT/MIS Vendor Checklist and Timeline: http://www.adrc-tae.org/tiki-download_file.php?fileId=29207
Continuous Improvement	• ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered such as consumer satisfaction evaluations and surveys. • ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances.		**Lesson Learned:** Business improvement processes such as "Plan, Do, Study, Act" can help ADRCs figure out which changes to policy and procedures have had the most positive impact and which should be considered "best practices." Involving front line staff in testing the impact of the change can help you improve standard operating procedures and minimize resistance to change within the organization.	ADRC-TAE Issue Brief – Excellent Customer Service in an ADRC: http://www.adrc-tae.org/tiki-download_file.php?fileId=2838 Plan Do Study Act Framework for Quality Improvement: http://www.adrc-tae.org/tiki-download_file.php?fileId=31748 Steps to Creating a Comprehensive Quality Improvement Plan: http://www.adrc-tae.org/tiki-download_file.php?fileId=31750 Quality Schematic for Continuous Quality Improvement: http://www.adrc-tae.org/tiki-download_file.php?fileId=31752
Performance Tracking (Program Level)	• At the local or programmatic level, ADRC routinely tracks service delivery and individual outcomes and can demonstrate: (1) That the ADRC serves people in different age groups, with different types of disabilities and income levels in proportions that reflect their relative representation in the community; (2) That the Options Counseling provided enables people to make informed, cost-effective decisions about LTSS; (3) The number of individuals diverted from nursing home/institutional settings; and (4) The number of individuals successfully transitioning from institutional settings (i.e. number of people assisted through formal coordinated or evidence-based transitions programs).		**Lesson Learned:** Performance tracking at the local ADRC level is key to documenting successes and improving the quality of services. Frontline staff, in addition to management, should have the opportunity to review and discuss organizational performance and findings (e.g. customer satisfaction surveys) on a regular basis. **Lesson Learned:** ADRCs should identify several core performance outcomes and measures (either within a single organization or across operating organizations in a No Wrong Door, multiple-entry point system) to monitor on an ongoing basis. The outcomes should be accurately and easily measured, support your overall goals, and assist in continually improving services.	TAE Training – ADRC Evaluation: http://www.adrc-tae.org/tiki-index.php?page=Evaluation%3A++Documenting+Success+and+Improving+Program+Quality WA Option D Care Transitions Evaluation Plan: http://www.adrc-tae.org/tiki-download_file.php?fileId=31135 AoA Options Counseling Evaluation Template: http://www.adrc-tae.org/tiki-download_file.php?fileId=30434 TAE Resource - Measuring Options Counseling: Goals and Objectives Grid: http://www.adrc-tae.org/tiki-index.php?page=PreviousEvaluationPeerWorkGroupCalls TAE Resource - Selected Measures of Streamlining Access: http://www.adrc-tae.org/tiki-download_file.php?fileId=29116 TAE Issue Brief - Options for Assessing the Impact of ADRCs on Long Term Care Costs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26986
Performance Tracking (State Level)	• States evaluate their ADRCs' overall impact in the following areas: (1) Reduction in the average time from first contact to eligibility determination (both functional/clinical and financial) for publicly funded home and community-based services; (2) Impact on the use of home and community based services vs. institutional services; and (3) Documentation of the cost impact to public programs, including Medicaid.		**Lesson Learned:** Development of an ADRC dashboard or sharing of an annual performance report is a useful tool for the tracking progress and activities and assisting with ongoing policy planning and budgeting **Lesson Learned**: In developing new policies and protocols and designing streamlining access activities, states should keep in mind how they will measure the impact of their efforts. The data needed to track certain impacts may need to come from sources outside the ADRC, so keep evaluation and data collection issues on the regular agenda to discuss with Medicaid and other partners.	TAE Resource - Measuring Options Counseling: Goals and Objectives Grid: http://www.adrc-tae.org/tiki-index.php?page=PreviousEvaluationPeerWorkGroupCalls WA Option D Care Transitions Evaluation Plan: http://www.adrc-tae.org/tiki-download_file.php?fileId=31135 AoA Options Counseling Evaluation Template: http://www.adrc-tae.org/tiki-download_file.php?fileId=30434 TAE Resource - Selected Measures of Streamlining Access: http://www.adrc-tae.org/tiki-download_file.php?fileId=29116 TAE Issue Brief - Options for Assessing the Impact of ADRCs on Long Term Care Costs: http://www.adrc-tae.org/tiki-download_file.php?fileId=26986