

UTAH ADRC 5-Year Statewide Plan

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* The above participants have indicated that they have actively participated with the planning of the ADRC Statewide Plan and agree with its content. Letters of support are also acceptable for documenting active participation and support.

Section I: Vision and Goals

State ADRC Vision Statement:

Utahns in need of long term services or supports, regardless of age, income, or disability status, can receive information and assistance, options counseling, care transition assistance, and streamlined access or referral to public long term support programs and benefits.

State ADRC Goal #1:

Establish the infrastructure to support a statewide ADRC in Utah.

Description of Approach

The ADRC has established a program office at the University of Utah, which has administrative responsibility for establishing the statewide ADRC. Although the University is administering the program, the ADRC is directed by a governing board that makes decisions about prioritization of activities, pilot sites, etc. The board members and the agencies they represent are listed in Appendix 1. This approach results in a powerful forum where state Medicaid (services and eligibility), aging, disability, and mental health agencies, local aging and disability agencies, and other non-profit entities, such as 211, Access Utah Network, and HealthInsight (the state's QIO), come together, with each member having a vote, and where expertise and experience can be shared across disciplines and specialization to create the most effective ADRC structure possible for the State of Utah.

Utah is using a hub and spoke approach to ADRCs. We view the current network of Area Agencies on Aging, (AAAs), Independent Living Centers, (ILs), and other community-based agencies serving individuals in need of long-term services and supports as the basis of the statewide infrastructure. We have created four ADRC pilot sites, two in AAAs and two in IL Centers, where we can develop operational models to serve their populations, and better determine the most effective approach to collecting accurate and adequate data at both the local and state level. The work that has occurred at this level is reflected in SART reports.

Utah will expand to two additional sites between October 2011 and April 2012. While the focus of the first round of sites was to pilot the ADRC concept, build our Options Counseling protocols, and test different models (e.g. ADRCs in both the AAA and CIL serving an area, an ADRC in the CIL but not the AAA, and an ADRC in the AAA but not the CIL), the current two-site expansion will dramatically increase the ADRC coverage of Utah. By adding Salt Lake County Aging Services and Tri-County Independent Living Center, more than 85% of Utah's population will live in an area that is served by an ADRC.

To date, the selection of sites has occurred by working through the Steering Committee to establish criteria that will help to achieve both long- and short-term goals, such as the criteria for the initial sites mentioned above. Those criteria are communicated to the statewide associations of AAAs (U4A) and Independent Living Center Directors through their

representatives on the Steering Committee. The statewide associations then determine which agency or agencies will be the next to become an ADRC site.

We are exploring funding models that will provide adequate support for agencies wishing to undertake the systems change that is required for an agency to become an ADRC site.

In order to build toward systems change among all the AAAs and IL Centers in the state, the ADRC invites participation from all of these entities, as well as any other interested agencies, in training sessions on options counseling, person-centered thinking, and content related to the ADRC services. Training is webcast and archived, which enables an unlimited number of people from around the state to participate real-time, or to watch at a later date or time.

In addition, Utah has moved substantially toward the goal of establishing an evidence-based care transitions program in the state. This effort includes both current ADRC sites and AAAs and CILs that are not yet ADRC sites. All agencies in the state will be offered the opportunity to receive training materials and support from the state ADRC program office and HealthInsight (Utah's QIO) to create local evidence-based care transitions programs. See Goal 5 for more information.

The ADRC is also continually seeking opportunities to improve the capacity of ADRC sites, as well as AAAs and IL Centers, to provide assistance to individuals in need of long-term services and supports. This is occurring by facilitating contacts between potential revenue streams (e.g. CCTP, VDHCBS, EPAS, FFP) that would flow from state or federal agencies directly to the local ADRC site. In other instances, the ADRC is responding to solicitations that would bring in revenue that would flow through the ADRC state office to local ADRC sites.

The ADRC is also building capacity in local ADRC sites by working closely with every site to assure that relevant data is being collected for the purpose of 1) efficient business operations and quality customer service, 2) to understand the populations being served, and 3) for reporting to grantors and other funders. Data collection is one of the most important (and the single most difficult) aspects of shifting from the roles as AAAs or CILs to ADRCs.

Although more information on consumers is collected by the CILs serving as local ADRC sites, neither of the two initial pilot sites has a way to access that information except on a client-by-client basis, despite the fact that both sites are using off-the-shelf programs used by substantial numbers of CILs around the country. Neither of the AAA sites were collecting I & R data beyond a mere head count (and not an unduplicated head count) prior to becoming ADRC sites. The ADRC state office is working to assure that each site collects relevant data about encounters and consumers.

It is common for sites to view collection of data as either irrelevant or too intrusive. But the same sites remark that they have calls from multiple individuals in the same family calling about the same person, or from one individual who is carrying on conversations with different agency employees, and they are often not aware because they do not track contacts. The ADRC state office is building a case for data collection as being both a powerful tool for

increasing efficiency and better serving consumers, as well as a way to tell a story of what they do. For example, the ADRC provided a web cast on the importance of data collection.

A second example of building capacity is by working to address gaps in the system that make it difficult for ADRCs to effectively serve consumers. Every site identified the challenges of getting information about VA eligibility and services as among the most difficult problems they face. The state office offered a webcast training about Salt Lake City VA Medical Center programs serving individuals in the community, as well as establishing collaborations with the State Department of Veterans' Affairs and the Western Regional Veterans' Rural Health Resource Center to assure that the ADRCs can get the information their clients need.

A final example of capacity building is our efforts to assist ADRCs, CILs and AAAs to develop evidence-based care transitions programs. The program is described below under Goal 5.

How will you measure progress toward your goal?

Outcome measures:

Operational program office (Complete)

Steering Committee measures program office as satisfactory or better on an on-line survey (every six months)

Increase of one site per six-month period beginning October 1, 2011

Successful application for grant(s) to support care transition program and other services

What are your anticipated barriers? How will you address these challenges?

The ever-present barrier is funding. As noted above, the ADRC is applying for funding opportunities that come available, whether those opportunities will flow through the state office, or whether they will flow directly to the ADRC sites. In addition, the ADRC program office is exploring private pay models that have been developed in other states. It is the goal of the program office to be as small as it can be while effectively serving the support needs of local ADRCs so that all possible funding can be used to provide services to individuals in the community with long-term support needs.

Currently, each site receives \$14,000 annually to spend in any manner that supports its role as an ADRC. That amount was set by the Steering Committee. In addition, travel to the national ADRC meeting, and travel to training and meetings within the state is covered separately. Finally, funds have been contributed to agencies to address IT systems. In one case \$4,000 was paid to a vendor to modify its off-the-shelf product to meet ADRC tracking and reporting needs.

The University of Utah will not support the ADRC program office after the current grant funds unless there is a funding stream or a department or program that will support the ADRC out of a discretionary funding stream. The ADRC program office is addressing that reality in two ways: First, it is seeking funding from various sources. Second, in the event that the ADRC is unsuccessful in obtaining additional funding, every action taken by the state office is designed to assure that existing local ADRCs can continue to operate as ADRCs if the program office can no longer operate. Included in these efforts are training on Options Counseling and related skill sets, and support to assure that each site's data collection systems are adequate to provide operational support and to meet the reporting requirements for ADRCs.

A second barrier that is a disincentive for potential ADRC sites is the challenge of collecting data required for AoA reporting, evaluation, and quality assurance. Exacerbating this challenge is Utah's commitment to assure that the ADRC system serves both older adults and younger adults with disabilities. Although neither AAA nor IL Centers are fully standardized, there are significant differences between the types of agencies that create more complexity for the program office than we would be facing if all ADRC sites were AAAs, or if all sites were IL Centers. The complexity is a challenge, but it is not prohibitive. We are working with the four pilot sites to solve the challenges that we have encountered in the first six months of ADRC site operations, and to develop models to avoid these challenges as we bring new ADRC sites on line. For example, we are seeking input from experts on IL Center reporting to better understand how that system can effectively support the data needs of ADRCs, and we are working with the AAAs to evaluate both home-grown data systems, as well as off-the-shelf products used widely by other AAAs.

The final challenge is the complexity and demand of being a purely voluntary and truly cross-agency entity. No agency is mandated to participate in the ADRC governing board, and no agency is required to become an ADRC site. To address this challenge, the program office must remain highly effective to maintain the involvement and support of state agencies and other participants, and the statewide ADRC must provide sufficient support and incentives to local ADRC sites to maintain their willingness to participate in the ADRC system.

The evidence that the state program office has been effective is the involvement of six local sites. Despite the fact that functioning as an ADRC brings only minimal financial benefit, the sites have chosen to participate based on the shared vision of ADRCs as valuable resources in the community. Participating sites contribute far more resources than the \$14,000 annual contribution would cover, and the state's largest AAA volunteered to become an ADRC with no funding, though it eventually determined that the \$14,000 support could be useful as the county's budget was slashed. Sites have reported that education, support, and facilitation of entry into other programs offer sufficient value in exchange for their participation.

What is your overall timeline and key dates?

Target:

Operational program office: Completed January 2011
October 1, 2011 to March 31, 2012: Add Salt Lake County Aging Services and Tri-County Independent Living Center
April 1, 2012 to September 30, 2012: Add one ADRC site designated by U4A
October 1, 2012 to March 31, 2013: Add one ADRC site designated by AILU
April 1, 2013 to September 30, 2013: Add one ADRC site designated by U4A
October 1, 2013 to March 31, 2014: Add one ADRC site designated by AILU
April 1, 2014 to September 30, 2014: Add one ADRC site designated by U4A
October 1, 2014 to March 31, 2015: Add one ADRC site designated by AILU
April 1, 2015 to September 30, 2015: Add one ADRC site designated by U4A
October 1, 2015 to March 31, 2016: Add one ADRC site designated by U4A
April 1, 2016 to September 30, 2016: Add one ADRC site designated by U4A

State ADRC Goal #2:

Establish and maintain a state-wide database of long term support options.

Description of Approach

The first step in achieving Goal #2 was to conduct an evaluation of current databases of services and supports in the state. We found no database that would meet the needs of ADRCs.

Although the ADRC was in the final stages of negotiating a contract with 211 in May of 2010, the 211 agency underwent a major change in direction that began at that time and is only now setting out. The 211 system was moved from the state's largest food pantry to the county United Way agency. With that move, a change to the inclusion/exclusion policy that would have allowed the listing of for-profit licensed providers of services to older adults and adults with disabilities was retracted. Because Utah's personal care, home health, hospice, assisted living, and nursing facility agencies are overwhelmingly held by for-profit providers, a database that excluded for-profit providers would be of limited help to individuals in need of information about long-term services and supports.

In addition to 211, the I & R committee considered proposals from vendors offering off-the-shelf I & R products, including Network of Care and SAMS, as well as a proposal from a local vendor, Universal Advertising Solutions. The ADRC evaluated the various options and concluded that Universal Advertising Solutions could best meet the needs. The ADRC entered into a contract with Universal Advertising Solutions, and development is underway.

The database is populated with approximately 9000 Utah entries. The data is organized according to the AIRS Taxonomy. The ADRC program office and the pilot sites will work with the vendor to assure the quality of the listings, to establish inclusion/exclusion policies, and to assure that the database effectively serves local ADRC sites by allowing targeted searches and generation of focused resource lists.

The database will allow organizations to add, update, edit, or delete listings, but an authorized person (ADRC staff or the vendor) must approve changes before they appear in the publicly available database.

Work on listings will be ongoing by the vendor, ADRC staff, and local ADRC sites. The launch of the site has been delayed by a number of reasons, including staff turnover and staff illness at the ADRC and extensive changes recommended by the ADRC's I & R committee. The focus of staff for November and December is assuring that the database goes live by January 31. The database can be previewed at www.helpwithmyparents.net.

How will you measure progress toward your goal and what is the timeline?

- Soft launch the site by February 1, 2012
- Test product through Spring 2012
- PR campaign beginning in summer 2012
- Collaborating with ADRC sites to assure that their local resources lists are reflected in the contents of the database, to be complete by March 2012
- Collaborating with AAAs and IL Centers that are not already ADRC sites to assure that their local resource lists are reflected in the contents of the database, to be complete by September 2012
- On-line surveys of members of the public show satisfaction with the product, beginning no later than March 1, 2012, then ongoing

What are your anticipated barriers? How will you address these challenges?

Assuring comprehensive and accurate listings is an ongoing effort and challenge. The ADRC project manager will supervise staff and students in entering and updating listings. We will actively solicit feedback from ADRC sites, professionals, and members of the public to help assure quality. The project manager is obtaining education on I & R systems, and will work with experts within the state to assure quality.

State ADRC Goal #3:

Create a statewide awareness, information, and individualized counseling system.

Description of Approach

Each ADRC site must commit to providing information and referral (I & R) and options counseling to individuals with a near term or future need for long-term services and supports.

I & R

Standard Operating Procedures (SOPs), which were modeled on those developed by the State of Indiana, were developed with information specific to Utah providers. Training will be provided on I & R and the use of the statewide database of long-term services and supports after the launch of the database. This will be available to all AAA and IL Center personnel, in addition to the ADRC pilot sites. In addition, an evaluation process will assure quality of data and quality of I & R service at pilot sites.

Options Counseling

Options Counseling is a new concept, though all four pilot sites were providing some elements of options counseling prior to the creation of the ADRC. During the first year of ADRC operations, an Options Counseling Committee, along with the governing body, spent a tremendous amount of time defining the elements of Options Counseling and developing Options Counseling procedures. The result of that process is a set of Options Counseling guidelines. Options Counseling is also supported by the SOPs described above.

An intensive evaluation process is underway, whereby the Options Counselors at each ADRC site are required to tape an Options Counseling session with an individual (with the individual's consent). The tapes are sent to the ADRC evaluation contractors, Dr. Judith Holt and Dr. Gina Cook at Utah State University, where the tapes are transcribed. The evaluators reviewed the transcripts and the tapes to consider compliance with process, person-centeredness, and accuracy of factual representations. The results of this process will be used to identify training needs and to support further development of Options Counseling protocols.

The Options Counseling Committee will continue to meet to address questions, to clarify ambiguity, and to fine-tune the options counseling process.

How will you measure progress toward your goal and what are key dates?

Process measures:

Survey pilot tested and being offered to all individuals receiving Options Counseling and a sample of individuals receiving I & R (Target date: October 1, 2011)

Number of people who receive I & R at ADRC sites increases in each successive reporting period (ongoing)
Number of people who receive Options Counseling at ADRC sites increases in each successive reporting period (ongoing)
Number of individuals assisted with transition from facility-based setting to community-based setting (ongoing)
Number of individuals assisted with transition from acute care hospital to post-acute care (ongoing)

Outcome measures:

Documented cases of assistance that results in care in setting of the individual's choice (reported semi-annually)
Documented cases of assistance that uses resources to avoid the need for Medicaid-funded long term care (reported semi-annually)
Interviews and surveys show that a minimum of 80% of the services provided is in accordance with protocols (reported semi-annually)
Interviews and surveys show that a minimum of 80% of individuals receiving services are satisfied (reported semi-annually)
Interviews and surveys show that a minimum of 80% of individuals receiving services report that the services helped them make progress toward their goals (reported semi-annually)

What are your anticipated barriers? How will you address these challenges?

Our primary challenge in I & R and Options Counseling is the lack of concordance between current data collection practices in all Utah AAAs and CILs and AoA's data collection requirements. There is no desire to standardize IT systems across AAAs in Utah. The program office is working with each local ADRC program on its data tracking system. In some instances needed changes are being made to in-house IT systems; in the case of CILs, the program office is working with vendors who provide off-the-shelf tracking systems to the CILs in Utah.

In addition, Options Counseling is a sufficiently new concept that there is confusion and resistance to making the changes necessary (e.g. person-direction) to doing it well. These challenges will continue to be managed through the Options Counseling Committee and by providing ongoing training through local, state, and national opportunities.

State ADRC Goal #4:

Create a seamless single point of entry to publicly funded long-term support programs.

Description of Approach

The ADRC has been coordinating with the Department of Workforce Services (DWS), the state's Medicaid eligibility agency, to consider how to use the new technologies to enable ADRCs to better support individuals in need of long-term services and supports. The new technology allows one data entry process to populate various program applications. Utah's "My Case" system, many years in the making, provides individuals with extensive access to their records on line when applying for benefits. See the article on eRep for additional information about the system. My Case is a consumer-centric eligibility program. It is viewed nationally as a very successful computerized eligibility system. The focus on technology, however, can present challenges to older adults and adults with disabilities. To a young adult who has been raised on computers, My Case is a slick and powerful program, but to older adults and adults with disabilities, it may present barriers. ADRC staff can help to provide the additional support necessary for some individuals.

A specific impact that the ADRC has had on the My Case system is that the ADRC emphasized the need to allow an advocate to access an individual's My Case file, with the consent of the individual, so that the advocate can assist the individual and assure that paperwork problems do not get in the way of eligibility. Because of the ADRC's communications with DWS about this need, DWS accelerated its plan to create an advocate password and protocol for allowing advocates to access an individual's account. In addition, the ADRC and DWS are in the process of drafting an MOU that will commit to cross-training and an ongoing feedback loop.

Applicants to all of the Medicaid HCBS waivers and a state-funded long-term care program called The Alternatives Program must apply to the agency administering the waiver (for example, AAAs for the Aging Waiver, the New Choices Waiver, or The Alternatives Program, or the Division of Services for People with Disabilities for other HCBS waivers). These programs are not included because the person must first be found to meet functional/level of care requirements before an application may be submitted. Functional eligibility for programs are not scheduled to be added to My Case at this time, but financial eligibility for the Medicaid programs is on the system.

Additional MOUs will be entered into with DHS, which administers home-and-community-based Medicaid Waiver programs and a state-funded HCBS program, and the State Medicaid Agency to assure that the ADRC is supporting both applicants and the state agencies who administer the relevant programs.

How will you measure progress toward your goal and what is the timeline?

- Launch of the advocate add-on to My Case with training for ADRC staff (January 31, 2012)
- Completion of ADRC/DWS MOU (December 31, 2011)
- Completion of ADRC/DHS MOU (January 31, 2012)
- Completion of ADRC/UDOH MOU (January 31, 2012)
- Satisfaction surveys among ADRC customers who access publicly funded long-term care services and supports that show that the system works for the consumer (ongoing beginning October 1, 2011)

What are your anticipated barriers? How will you address these challenges?

Some long-term care programs are not part of the DWS My Case system. The ADRC must collaborate with the other state and local agencies (e.g. AAAs, the Utah Department of Health and the Division of Services for People with Disabilities) to integrate this application process as smoothly as possible into the larger system, from the perspective of the individual in need of services.

ADRC sites fear that the role of assisting with applications for Medicaid and other long-term service and support programs will be all consuming. MOUs will need to assure that sites can help to support the needs of individuals and can obtain support from the agencies, without imposing uncompensated and potentially devastating liability on either side.

State ADRC Goal #5:

Create a care transition system that provides individuals and caregivers with timely and accurate information about long term support options

Description of Approach

The ADRC will expand to care transitions. The ADRC will work with HealthInsight, Utah's federally-designated Medicare Quality Improvement Organization, to apply for various care transitions funding opportunities that would allow us to accelerate progress in care transitions. Care transitions work will build on the work done in options counseling and on the Medicaid Waiver administration functions that many of the ADRC sites currently perform. Our next step is to evaluate the various evidence-based care transitions programs. Relationships have been built between two ADRC sites and seven local hospitals.

Utah has been accepted as an Illinois Bridge Model Replication Site. The Utah program office is working to establish a training program that will be open to all Utah AAAs and CILs, in addition to the ADRC sites.

How will you measure progress toward your goal and what is the timeline targeted for progress?

A group including ADRC/AAA/CIL sites is interested in creating a care transitions program. There is a group of hospitals, local ADRCs, the state ADRC program office, and HealthInsight meeting to draft the CCTP proposal. Once the proposal is completed, a more general subcommittee will be formed with any interested hospitals, the state ADRC office, local ADRCs, as well as non-ADRC AAAs and CILs, and HealthInsight, and will be convened.

Prepare a CCTP application in collaboration with HealthInsight (December 31, 2011) File the application when CMS announces rolling application reviews.

Each ADRC will establish a formal relationship with at least one local hospital to encourage hospitals to coordinate care transitions with ADRC sites through formal or informal programs (June 30, 2012))

What are your anticipated barriers? How will you address these challenges?

Once again, funding is a barrier, but because HealthInsight is obligated under its contract with Medicaid to establish care transition programs, it is able to provide technical support to interested agencies.

A second anticipated challenge will be in merging non-medical and medical models in providing needed support for individuals in need of transition services. We will address the challenges through the thoughtful development of the program, choosing a model that is a

good fit with the ADRC model, and approaching it incrementally. The ADRC has attempted to develop models that are effective in both AAAs and CILs. In some instances, the decisions have been better fits for AAAs. In other cases, the programs are a better fit for CILs. The Bridge Model is a better fit for AAAs. We will explore ways that we can assure the inclusion of CILs in the hospital discharge planning program, although most in Utah do not employ the social workers that are the heart of the Bridge Model.

A final challenge is creating new relationships across different parts of the care continuum, from acute care hospitals to rehab facilities. The impending financial penalties for avoidable readmissions appears to have increased hospital interest in these programs to an unprecedented level.

Section II: Partner Involvement

Who are the key players and responsible parties?

The most important players are the ADRC sites that are providing services and helping to establish a model for the State of Utah. This includes Mountainland Area Agency on Aging, Scott McBeth, Director, Bear River Area Agency on Aging, Michelle Benson, Director, Active ReEntry Center for Independent Living, Nancy Bentley, Director, and Ability First Center for Independent living, Sandra Curcio, Director. In addition to directing the sites, these individuals represent all of the state's AAAs and CILs, respectively, on the Steering Committee. In addition, Salt Lake County Aging Services, Sara Brenna, Director, Five County Area Agency on Aging, Carrie Schonlaw, Director, and Utah Independent Living Center, Deb Mair, Director, provide additional representation for AAAs and CILs that are not currently serving as ADRC sites.

Three departments, Health, Human Services, and Workforce Services, and various divisions of Human Services, including DAAS, DSPD, and DSAMH, participate in the governance of the ADRC (see the names of those representing these agencies at the beginning of this plan). In addition, these agencies participate in training and they have collaborated on addressing policy concerns raised by ADRC sites. The specific roles and interactions are identified in the attached letters of support.

A number of other agencies are represented on the Steering Committee, including HealthInsight, the state's QIO. In addition to governance, HealthInsight is taking the lead on drafting the ADRC's CCTP grant application to support care transitions work. Access Utah Network, an I & R provider that is supported by the Developmental Disabilities Council, serves on the steering committee and has been involved in choosing a vendor to provide the ADRC's statewide database and in designing and launching the final product. Andrew Riggle, an adult with a physical disability, represents members of the public with a disability.

The administration of the ADRC is provided by the Utah Commission on Aging, which is located in the Center on Aging of the University of Utah. The director is Maureen Henry, and the project coordinator is Louise Tonin. The evaluation contractor is Utah State University's Center for Persons with Disabilities, with Judith Holt, PhD, in the lead, and Gina Cook providing design and analysis.

Section III: Financial Plan – Resources to Sustain Efforts

What existing funds/programs are currently being used to carry out ADRC activities?

Currently the funding is from the federal ADRC grant. The University of Utah donates space and other overhead and administrative costs through the waiver of indirect costs. As a systems change program, the funds provided to local sites serves as seed money to help support a portion of one person's time, but every site provides far more ADRC services than are compensated through the ADRC funding.

What additional programs and service offerings are necessary to operate fully functional ADRCs across the state?

- Expand geographic coverage of Options Counseling and I & R
- Implement a care transitions program

What is your estimated cost to expand statewide (e.g., new MIS purchase)?

If the ADRC were to fund all AAAs and IL Centers at the current funding level (\$14,000/site), the total amount needed would be \$252,000 per year, plus costs for state-wide administration. The expectation is that, as challenges such as data tracking are addressed, the costs of overall program administration will decrease substantially.

How will you access the resources and create the revenue opportunities necessary for sustainable ADRC implementation on a statewide basis?

First, the approach taken is focused on systems change: we anticipate that short-term funding will positively change the way AAAs and IL Centers serve individuals in need of long-term services and supports.

Second, we will pursue all available funding opportunities, including local and federal grants, such as the CCTP funding opportunity, as well as NIH research projects that can provide support for projects that can be studied for future replication.

Third, the state will engage in a structured process to consider the feasibility of fee-for-services in ADRC sites. The process will consider how other states have effectively implemented fee-for-service programs, and will evaluate where consumers/clients pay for all or a portion of services received from AAAs or CILs.

Finally, the steering committee will continue to evaluate whether the Commission on Aging is the best administrative home for the ADRC's state-wide program office, considering whether financial viability will be improved if ADRC administration were to be moved to the state unit on aging or an AAA.

What are the estimated projected cost savings/offsets of having fully functional ADRCs statewide?

Separate attachment.

Project Checklist	Yes	No
Are these goals reflected in the State Plan on Aging?	x	
Do these goals require changes that must be proposed through the current budget cycle?		x
Does implementing these goals require regulatory, legislative, or statutory changes?		x
Does your plan seek private funding to augment public resources to support sustainability?	x	
Have the necessary stakeholders been identified and contacted?	x	
Are your data systems prepared to track progress towards these goals?	x	

ADRC Five Year Statewide Plan Approval

/s

 Director of the ADRC

/s

 Director of the State Unit on Aging

/s

 Director of the State Disability Agency

/s

 Director of State Medicaid Agency

/s
