## Utah ADRC : Project Narrative

### *Summary/Abstract*

The Utah Commission on Aging is seeking funding to create a state-wide ADRC in collaboration with the Utah Division of Aging and Adult Services, Division of Services for People with Disabilities, Medicaid Program, 2-1-1, Access Utah Network, Area Agencies on Aging, Centers for Independent Living, and Utah State University. **Goal 1** is to establish the organizational structure necessary to establish the ADRC. Objectives include employing staff, convening committees, developing ADRC model and evaluation/reporting plan. **Goal 2** is to establish and maintain a state-wide database of long term support options. Objectives include assessment of the current system, developing a plan, and evaluation. **Goal 3** is to create a statewide awareness, information, and individualized counseling system. Objectives include assessment of the current system, development of a plan, identification and funding of pilot site, and evaluation. **Goal 4** is to create a seamless single point of entry to publicly funded long-term support programs. Objectives include assessment of the current system and development of plan. **Goal 5** is to create a care transition system that provides individuals and caregivers with timely and accurate information about long term support options. Objectives include an assessment, consideration of models, and development of a plan. The target population is individuals aged 60 and older and disabled adults aged 18 and older, statewide. Identified products will be an operational ADRC, a statewide computerized database of information, a 5-year state plan, and an on-line application for Medicaid long-term support programs.

## Current Status

### *Information and Awareness & Individualized Options Counseling*

Utah's already effective network of Area Agencies on Aging (AAAs) is poised to provide many of the services that the ADRC will offer. In addition to the Older Americans Act programs, such as nutrition programs, transportation, senior centers, and information and referral, Utah's

AAAs deliver services to individuals statewide who are eligible for the Medicaid Aging Waiver Program and the Alternatives Program. Both of these community-based long-term care programs provide care to low-income adults who meet Medicaid functional eligibility criteria, but most Alternatives and Waiver enrollees never transition to facility-based care. Every AAA in Utah employs professional case managers who understand long-term care options and local community resources; these case managers are committed to providing personalized services to older adults in need of long-term care. Several AAAs also provide case management services to individuals under the New Choices Waiver, another option on Utah's continuum of care, which allows adults who are eligible for long-term care Medicaid to reside in assisted living facilities.

Other programs around the state also offer information about long term support options to older adults. The Senior Health Insurance Information Program trains volunteers to help older adults with questions about Medicare, Medicaid, Social Security, Medicare Supplements, and Long-term Care. The Alzheimer's Association, AARP, Valley Mental Health, HelpForMyParents.com, Neighbors Helping Neighbors at the University of Utah College of Social Work, and Jewish Family Services also provide information about long-term care options for older Utahns.

Utah's Centers for Independent Living (CIL) are also poised to serve as partners in Utah's ADRC. CILs assist individuals with disabilities to achieve or maintain self-sufficient and productive lives in their own communities. Each of Utah's six CILs have at least one facility-based care Diversion/Transition Specialist and CIL specialists in other areas, such as housing, assistive technology, and independent living skills who provide information and individualized counseling about long-term care options.

The Utah Department of Human Services' (DHS), Division of Services for People with Disabilities, provides the supports necessary to allow individuals with disabilities to lead self-determined lives. DSPD oversees a home and community-based service program, including several Medicaid home and community-based waiver programs. Support includes community living, day

services, family respite, and supported employment services. DSPD offers a self-administered services option, and provides links to information and referral sources on its web site.

Since 1990, Access Utah Network has been the state's preeminent source of information and referral for individuals with disabilities and their caregivers. Operators provide basic information, such as where to apply for social security, or where to find used equipment, but they also have the in-depth training, experience, and knowledge base that allows them ferret out and address questions that callers may not know to ask. Access Utah Network also provides personal options counseling about long term supports. Recently, Access Utah Network has begun to use web-based technologies – social networking, blogging, and Webcasts – to reach individuals in need of information about services for individuals with disabilities.

Other Utah agencies, such as the Disability Law Center, Utah Legal Services, the Utah Parent Center, Utah Developmental Disabilities Council, and the State of Utah's Work Ability program provide information and referral to individuals with disabilities and their caregivers.

2-1-1 Information and Referral (I&R) maintains the state's most comprehensive database of state programs and non-profit providers. From the database, 2-1-1 publishes a comprehensive human services directory and targeted resource lists. In addition, 2-1-1 provides general I & R services to all but one county in the State of Utah, with financial support from the Utah Department of Health (UDOH), the Department of Human Services (DHS), and the Department of Workforce Services (DWS). The organization is working to assure that data is current and accurate for the impending launch of a new interface. 2-1-1 is testing new strategies to assure that it effectively serves older adults and their caregivers, with a focus on assuring that a full spectrum of information is available, including information about long-term care services for middle-income adults. 2-1-1 operators transfer calls about older adults to the AAA in which the person lives, and operators transfer calls concerning disability services to Access Utah Network, creating a virtual network of experts.

### *Information and Referral and Individualized Counseling Gaps*

Two-thirds of professionals in the aging/disability fields who responded to a survey conducted for this application cited the lack of information or the lack of in-depth, individualized counseling as a barrier that limits both private and public-pay individuals' choice of long-term care options. Although individualized options counseling is available in the settings described above, what is available is not meeting the need. Lack of funding and lack of options are barriers, but information about long-term support options must be accessible and convenient for individuals and caregivers when they need it, and we need creative models for counseling individuals about their long-term support options.

## *Streamlined Access to Public Programs*

Utah has developed, and is in the process of launching, a modernized and computerized application system for eligibility for state medical assistance programs. A gap that will remain is that the system will not include eligibility for the state-funded Alternatives Program or for Older Americans Act Programs. The benefit to the modernization is that it will allow any advocate with internet access the ability to assist a person in need of services to complete the application for many of the major public programs. The recently-created Eligibility Division of the Department of Workforce Services has expressed its interest in training ADRC staff to help to assure access to programs through the system that will be launched in October.

## *Person-Centered Hospital Discharge Planning*

CILs and AAAs have established relationships with discharge planners in areas across the state to receive referrals. But it would not be feasible on the Wasatch Front, for example, where Medicare beneficiaries have 38,000 in-patient hospital stays in a year, for a CIL or AAA to provide personalized information to the individuals or caregivers in need of information about long term support options. The Utah Commission on Aging is well-positioned to develop this aspect of the ADRC. The Commission is administered by the University of Utah Center on Aging, which is

situated in the University Health Care System. Because many of the Commission's legislative and policy efforts have addressed health care issues, it has strong bonds and trusted relationships with health care systems throughout the state.

Another strength is in Utah's knowledge base: HealthInsight, Utah's Medicare Quality Improvement Organization (QIO), has recently conducted a detailed analysis of care transitions in Utah, which will be built upon to develop this component of the ADRC. Another strength is the relationship between the Commission on Aging and the Veterans Administration Western Regional Rural Health Resource Center, based at the Salt Lake City VA Health System (see letter of support from its Director, Byron Bair, MD) with which the ADRC can collaborate to explore care transition models.

## Goals and Objectives

**Goal One:** Establish the organizational structure necessary for effective implementation of the key operational components of the ARDC, including evaluation and continuous quality assurance.

***1.1*** Hire and train program office staff and contract with evaluation consultant.

***1.2*** Create and convene ADRC Steering Committee.

***1.3*** Create and convene Community Partner Advisory Board.

***1.4*** Establish community-wide communication channels.

***1.5*** Design evaluation system including continuous quality assurance process and evaluation outcomes.

**Goal Two:** Establish and maintain a central state-wide database of long term support options for private and public pay individuals.

***2.1*** Assess the strengths and gaps in current electronic I & R systems.

***2.2*** Develop a plan to assure that a central database of long term support options is available state-wide.

**Goal Three:** Create a statewide awareness, information, and individualized counseling system to provide public and private pay individuals and caregivers with objective, trusted, accessible information about their full range of long-term support options.

***3.1*** Conduct a detailed, state-wide assessment of availability of information and awareness and individualized counseling about long-term support options.

***3.2*** Integrate feedback from the evaluation into the long term plan.

***3.3*** Determine selection criteria for pilot ADRCs, draft, distribute and publicize RFP, and select pilot site.

***3.4*** Collaborate with state agencies to assess the impact of pilot sites on enrollment in community-based and facility-based programs and after the fact satisfaction with choices.

***3.5*** With data generated from objectives 3.1-3.4, generate a five-year plan to implement a statewide awareness, information, and individualized counseling system, including a plan for financial sustainability.

**Goal Four:** Create a seamless single point of entry to publicly funded long term support programs.

***4.1*** Assess the complexity or ease of access of entry into the current system.

***4.2*** Identify tools, activities, procedures, and processes that will enable ADRCs to serve as a single point of entry to all publicly funded long-term support programs.

***4.3*** Develop a plan, in collaboration with state agencies, to work toward a seamless point of entry to publicly funded long term support programs.

**Goal Five:** Create a care transition system that maintains or decreases Utah's low hospital readmission rate and that provides individuals and caregivers with timely and accurate information about long term support options.

***5.1*** Conduct an assessment of current care transition projects and programs.

***5.2*** Consider care transition models and programs.

***5.3*** With data generated from objectives 5.1-5.2 generate five-year plan to implement a care transition system, including a plan for financial sustainability.

***Geographic reach and target population:*** The target population for is individuals aged 60 and older and disabled adults aged 18 and older statewide. The geographic reach of the pilot sites will be determined by the steering committee, but the goal of the program is to reach statewide.

## Proposed Project

An initiative of the scope of the proposed ADRC is far too complex to permit detailed specification of an intervention strategy at the beginning of the conceptualization phase. To the contrary, specification of a detailed strategy would defeat the purpose of the collaborative and inclusive process that will be necessary for successful development and implementation of the ADRC. We therefore propose a process that begins with a detailed assessment of the current system including identification of strengths and weaknesses, followed by an iterative process of designing and building structures, testing what we've built, refining those structures, and so on, thereby developing a statewide system through an adaptive, dynamic process, not a static model.

We will achieve the goals and objectives by extending the reach of state agencies and state programs into the community through a virtual network with AAAs, CILs, and other community-level partners. Although the details of the ADRC will be developed by the Steering Committee, the overarching vision will be to work together as a network to make optimal use of the resources already available at the state, regional, county, and local level that are being spent on programs to provide long term services and supports to the individuals who need them, and to support caregivers who provide most of the long-term care in this state.

Because Utah is a first-time grantee, we are unable to provide more detail about the program beyond what is provided in the Goals and Objectives, the Project Work Plan, the Project Outcomes, and the Quality Assurance, Evaluation and Reporting sections of this narrative.

## Involvement of Key Stakeholders

The involvement of key stakeholders will occur in their leadership role on the Steering Committee, which will make all important decisions in the design and implementation of the organization. Recognizing the time constraints of the individuals who will serve on this governing body, the staffing of the ADRC is designed to provide the support necessary to allow the Steering Committee members to serve as executive decision makers, not as staff. In an extension of their roles on the Steering Committee, the key stakeholders will seek opportunities as organizations to collaborate with the ADRC to work toward the ADRC goals and objectives.

## Project Outcomes

*We anticipate that these project outcomes will be expanded as the ADRC is developed.*

1. The ADRC Program Office will be fully operational and a Steering Committee will be in place to govern the ADRC by 1/1/2010.
2. A consumer-friendly database of long term supports will be available statewide by 10/1/2010.
3. At least one project site will be operational by 10/1/2010. The site will provide information and one-on-one counseling on long-term support options for older adults and younger adults with physical disabilities.
4. At least one project site will provide streamlined access to all publicly funded long-term services and supports by 4/1/2011.
5. By 9/30/2010, individuals can apply for Medicaid long-term care programs on line, in person, or via the telephone.
6. By 4/1/2011, the ADRC will submit to AOA and CMS a 5 year plan that has been developed by the steering committee and approved by the directors of DAAS, DSPD, and Medicaid, describing how the state is going to optimally coordinate the existing information and access functions of the state and federal programs it administers to meet the goals and objectives.

7. By 10/1/2012, the ADRC will complete a pilot program to assess a care transition designed to address Utah's unique care transition challenges.

## Quality Assurance, Evaluation and Reporting

The Quality Assurance, Evaluation, and Reporting activities of the UT ADRC will be guided by an Evaluation Team comprised of the Executive Director and Project Coordinator, a sub-committee of the Steering Committee, the aging and disability consultants, and the evaluator. During the first quarter of the project (October-December 2009), the primary focus of the Evaluation Team will be the Evaluation Plan (EP). The EP will be constructed to be inclusive of the three major interrelated requirements – evaluation, reporting, and quality assurance. The EP will include both process (formative) and outcome (summative) components. The initial focus will be to systematically consider the methods and techniques to be used to measure the accomplishment of the goals and objectives. The Evaluation Plan will include the following: (a) design; (b) the evaluation tasks for each of the objectives, and as applicable, the implementing activities; (c) the data to be collected, timelines, and frequency; (d) the instruments to be used to collect the data, which will include the "Basic ADRC Data Elements" found in Attachment I of the Full Program Announcement; (e) person(s) responsible; and (f) any discrepancies in either the data actually collected or the method of collection.

The ADRC will use a management information system (MIS) to track all data gathered through the EP; the ADRC will develop its MIS with reference to lessons learned from current ADRC grantees, the MIS, and other technology tools found at www.adrc-tae.org. The EP and MIS will be reviewed and approved by the Steering Committee. The Evaluator will have the responsibility for preparing quarterly and annual reports detailing the progress to date of all activities, and noting any delay in implementation of such activities, unanticipated barriers, and recommendations for consideration to improve the overall quality of the project activities. In an iterative manner, the director and key staff and collaborators will use the formative findings to ensure that the project is

implemented smoothly, any concerns/barriers are identified and activities modified, revised, and/or redesign to ensure the successful accomplishment of the outputs and short and intermediate outcomes on key constituencies, policies, and practices.

## Project Management

Maureen Henry, J.D. (CV attached), has served for the past four years as Executive Director of the Utah Commission on Aging and will devote 0.65 FTE as Director of the ADRC. Louise Tonin (CV attached), who coordinated a statewide project for the Utah Education Network and has been with the Commission for two years, will devote 1.0 FTE as the Project Coordinator. Judith M. Holt, PhD (CV attached), will lead the evaluation, quality improvement, and reporting component, in addition to advising on issues affecting individuals with disabilities. All are poised to assume these roles on October 1, 2009, if this proposal is funded.

## Organizational Capability Statement

The Utah Commission on Aging will be the lead agency in the ADRC. The Utah State Legislature created the Commission within the Governor's Office in 2005. The Commission's Executive Director reports administratively to the Executive Director of the University of Utah Center on Aging (see letter of support). The Executive Directors of the Departments of Health, Human Services, and Workforce Services are among the 21 Commission members appointed by the Governor. The Commission was designed to reach across the silos that sometimes form in state government, and was directed to involve regional, county, and local government, plus the private for-profit and private non-profit sectors in addressing the needs of Utah's aging population. Among its statutory mandates is to "facilitate coordination of the functions of public and private entities concerned with the aging population." Utah Code Annotated §63M-11-102(2)(d). For these reasons, the Commission is situated in a unique and ideal position to serve as the lead coordinating agency for the ADRC. The Commission also has available the administrative and financial accounting expertise of the University of Utah Center on Aging to support it in this role.