

# Transforming State LTSS Programs and Functions into A No Wrong Door System for All Populations and Payers:

## How To Build Successful Partnerships Across the ADRC Network

**July 2014** 







## **Our Learning Objectives**

- Understand the role of the CIL and AAA in the collaboration with the ADRC led agencies and community partners
- Understand the benefits of a collaborative effort between the CILs, AAAs and the ADRC to strengthen the No Wrong Door System
- 3. Understand the potential challenges to establishing and sustaining successful partnerships
- 4. Understand effective strategic approaches to building and sustaining successful partnerships







#### **The Presenters**

- Elizabeth Leef, Project Officer, ACL: Co-Moderator
- Lindsay Baran, Disability and Aging Specialist, NCIL: Co-Moderator
- Mary Margaret Moore, CIL Director, North Shore MA
- Valerie Parker-Callahan, Director of Planning and Development, Greater Lynn Senior Services, Inc. and Chair, Planning and Development Committee, Aging and Disability Resource Consortium of the Greater North Shore, Inc., MA
- Eileen Healy, Executive Director, Independence Northwest CT
- Sarah Launderville, CIL Director, VCIL







#### The Vision for a NWD System

In collaboration with states, develop a National NWD/ADRC System for all populations and all payers which is person centered, financially sustainable and high quality that supports individuals to achieve their goals for community living.

## NWD System Vision









Public Outreach and Links to Key Referral Sources

Counseling

Local Schools Family Members Individuals Providers Non-Profits & Friends 1-800 #'s/211 Acute Care Systems VA Medical Cente Nursing Homes MFP/ Local I&R Veteran Directe Hospitals Section Q Programs **HCBS** 

Person Centered

Confirming Need For/Interest in Person Centered Counseling

Support Any Immediate LTSS Needs, Conducts Personal Interview and Identifies Goals, Strengths and Preferences

Comprehensive review of private resources and informal supports

Facilitates the development and implementation of the Person Centered Plan

#### Linking Individuals to Private Pay Resources

Helps individuals connect to services that will be covered out of pocket or through other community resources

Streamlined Access to Public Programs Preliminary Functional Eligibility
Assessment for Public Programs:

Collects any additional functional data needed for public programs including, if appropriate, Medicaid

Final Determination of Functional Eligibility for Public Programs:

Completes the process that officially determines that individuals are eligible for public programs

#### Preliminary Financial Eligibility Assessment for Public Programs:

Supports the individual in submitting applications for public programs including, if appropriate, Medicaid

#### Final Determination of Financial Eligibility for Public Programs:

Completes the process that officially determines that individuals are eligible for public programs

#### Follow-up

Ensures the plan's services are initiated, meets the needs of the individual and is adjusted as needed.

State Oversight, Management and Financing of the NWD System

Must include State Medicaid Agency, State Agencies Administering programs for Aging, Intellectual and Developmental Disabilities, Physical Disabilities and Mental/Behavioral Health needs.

Administration includes input from external stakeholders, including consumers and their advocates, on the design, implementation and on-going operations of the system

MIS tracks clients, services, outcomes, expenditures and organizational performance, enables information to flow with client from initial person centered plan through follow-up, and supports on-going evaluation and continuous quality improvement

Governance and Administration of the NWD System







## Why Develop a NWD System?

- Empowers individuals to make informed choices
- Enables staff to provide wrap around services and work collaboratively with partner agencies.
- Demand for services will increase.







### **2014 Funding Opportunity**

- Builds upon the accomplishments of both the ADRC and Balancing Incentive Program initiatives, as well as the lessons learned from the experience of the participating Part A states.
- Goal is to recognize the variation in functionality and capacity that exists across the states to create a fuller vision for a NWD system for all populations and all payers.
- ACL, CMS and the VHA decided now is the time to draw upon these experiences in this new FOA.







# NWD Funding Opportunity Vision

- At the end of the 12-month planning period a 3-Year Plan will be developed that includes a detailed strategy, work plan, and budget.
- The following state agencies <u>must be involved as full partners</u> in coleading this planning process: the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with all disabilities, including intellectual and developmental disabilities, as well as the state authorities administering mental health services.
- The planning process <u>must involve meaningful</u> input from key stakeholders including AAAs, CILs, local disability advocacy groups and individuals who use LTSS.







# NWD Partnerships in CT, MA and VT

# CT ADRCs & The No Wrong Door

State of Connecticut

## History of ADRCs in CT

Early 2000's CT applies for & does not receive initial round ADRC grants

June 2007 SDA hosted ADRC Planning Meeting

Included state stakeholders, ACL and Lewin Group Sept 2007

CT receives NHD Grant forms 1st ADRCs Sept 2009

CT receives 1st official ADRC grant
3rd formed

Sept 2012

CT receives Enhanced OC Grant achieves statewide ADRC coverage

- All 5 AAAs, CILSs & CCCI
- Focus shifts from ADRC Program to NWD System

## CT NWD VISION

Connecticut residents have access to a full range of high-quality long-term care options that maximize autonomy, choice and dignity.

### Strategy

Streamline access by:

Maximizing information technology Standardizing assessments Building NWD access points in each community







Health Exchange Private Health and Social Supports-Public

Health and Social Supports -Local

Integrated - Person Centered
Options for telephonic or 1:1 assistance

## Strengths and Challenges

#### Strengths

- 51% persons with disabilities and/or family members on Steering Committee
- Organizational structure
- Shared leadership

#### Challenges

- Finding the right people
- Providing information in an actionable format
- Strategic coordination with other groups working on similar goals
- Assuring integrated approach
- Communication
- Diversion & Serving non-Medicaid Population

## Commitment to Strengthen CT NWD

- Focus on strategic coordination with other groups working on similar goals
  - Further define niche of ADRCs in CT's NWD system (i.e. 1:1 assistance, PCP)
  - Examine and define role of SDA: Where does aging population fit outside of CHCPE? OAA programs, Wellness/Prevention programs; ADRC
- Examine and re-envision ADRCs in the context of a NWD system
  - Maintaining existing ADRC partners while growing broader vision
- More attention to Non-Medicaid population
- Create Access Points in local communities







## The Massachusetts Experience









## ADRC of the Greater North Shore, INC!

- Developing extensive infrastructure
- Hiring staff including the first Executive Officer
- Convening bimonthly partner
   meetings with
   45+ diverse
   agencies

## Expanded Outreach and Inclusion

- Over the Rainbow
- North Shore Pride
- Legislative
  advocacy and
  impact
  Candidates
  forums

#### **Expanded Contracts**

- OptionsCounselingOne Care –
- innovative LTSS pilot enhanced with capacity grant
- Money Follows the PersonHousing Search Entity

#### **Special Initiatives**

- Sponsorship of Transportation Regional Coordination Council
- Sponsorship of regional *Kiosks* for Living Well
- Sponsorship of Safe Passages Discovery Initiative

#### Trainings and Conferences

- 7<sup>th</sup> Annual ADRCGNS Conference
- Sponsorship of Strengthening Mobility Symposia
- Extensive internal crosstraining
- Developing community trainings

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#### **Lessons Learned**

#### Challenges

- Shifting the paradigm
- Managing collaborative resources
- Navigating the bureaucratic systems

#### What We Learned

- •Importance of Cross-Training...large and small groups
- Importance of Communication
- •Importance of being at the table



## The Vermont Experience

## Vermont's Aging and Disability Resource Connection











## **Vermont's ADRC History**

2005 **Vermont receives** first ADRC Grant

2009 **Vermont receives ADRC Strategic Planning Grant** 

2010 **Vermont receives Options Counseling** Grant

2012 Vermont receives Part A Enhanced **Options** Counseling/NWD Grant

- Includes four key partners: AAAs, CIL, BIAVT, and I/DD in 2 regions of state
- Assess readiness & capacity to perform key functions
- Need to build trust, collaboration & commitment

- Move to one statewide ADRC comprised of 10 core partners
- ADRC grant funding shared among all partners
- I/DD partners not ready yet
- Develop 5-year **ADRC** strategic plan
- ADRC partners agree to implement its **Options** Counseling Program statewide inclusive of all partners
- **Draft Options** Counseling Standards
  - Identify the 5 AAAs and VCIL as the Local Contact Agencies for Section Q

- I/DD partners rejoin as core partners
- Articulate what functions each partner will play
- Focus on streamlining access and Medicaid match for Options Counseling
- VCIL, BIAVT, and AAAs pilot Care Transitions Program
- Focus on Governance & Administration, Branding, and Sustainability

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## Vermont's Partnerships

## Strengths and Lessons Learned

- All partners equal voice and at table since inception
- Sharing of ADRC grant funds across all partners
- Embrace differences
- Seek understanding of varying philosophies
- Understand language and meaning behind it

## Challenges and Opportunities

- Maintaining equal voice among larger partner networks
- Language and meaning behind it: coming to common understanding
- Varying capacities to perform key functions
- Valuing and respecting partner choices regarding which key functions will be performed as a core partner, e.g. Medicaid eligibility assistance

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#### Vermont's ADRC Future

- Expand Care Transitions Collaborative Model statewide, inclusive of other ADRC partners
- If State leadership approves, identify ongoing Medicaid match for Enhanced Options Counseling and expand to other ADRC partners and statewide
- Build sustainable ADRC Governance structure that supports the NWD vision inclusive of ADRC Leadership, State leadership, Consumers, and Key Stakeholders/Advocates
- Formalize Protocols and Processes among ADRC Core Partners that clearly outlines roles and expectations, value, and commitment
- Build necessary IT connections across various systems that ADRC Core Partners use to support Results-Based Accountability and Continuous Quality Improvement/ADRC Business Management Tool needs
- Identify other partners necessary to support and sustain a true NWD for all persons with all disabilities and ages needing long term services and supports







## **Open Discussion**