Nevada Aging and Disability Services Division

Nevada's Care Connection
ADRC OPERATIONS MANUAL

June 2013, V3.0

Update Prepared by:
Wanda Brown, SHIP, ADRC Director
Cheyenne Pasquale, ADRC Project Manager

FOREWORD

The National Association of State Units on Aging and Disabilities (NASUAD) and the National Association of Area Agencies on Aging (n4a), conscious of the financial pressures facing states and the federal government, have developed a coordinated national long-term care strategy called *Project 2020-Building on the Promise of Home and Community Based Services* that will generate savings in Medicaid and Medicare at the federal and state levels while enabling older adults and individuals with disabilities to get the support they need to successfully age where they want to—in their own home and community.

The three elements of Project 2020, *also introduced as S.1257/H.R. 2852, include:*

1. Person-Centered Access to Information
2. Evidence-Based Disease Prevention and Health Promotion
3. Enhanced Nursing Home Diversion Services

For the long-term care strategies and solutions proposed, the National Association of Area Agencies on Aging (n4a) and NASUAD are seeking funding to support federal outlays of $2.5 billion over the next five years to be administered through the Aging Services Network of State and Area Agencies on Aging. For consumers, this program will empower individuals to make informed decisions and to better conserve and extend their own resources using lower cost evidence-based programs, including consumer-directed options for care in the community. ADRCs are a vital resource in this cause by helping consumers become aware of the options available to them and the assistance to obtain needed services.

According to preliminary estimates by The Lewin Group in April 2009, the program has the potential to reach over 40 million Americans and will reduce federal Medicaid and Medicare costs by approximately $2.8 billion over the first five years. Estimated cost reductions will result in a net savings to the federal government of nearly $250 million.

The Nevada Care Connection: ADRC program **Operations Manual** provides official guidance for the operation of all local Aging and Disability Resource Centers (ADRC) funded by the State of Nevada, Aging and Disabilities Services Division (ADSD).

This manual contains policies and procedures related specifically to the management and operation of the Nevada's Care Connection project. ADRC staff will be subject to the organizational policies and procedures of their site (hiring entity). This manual is intended to guide the operation of the ADRC and should be viewed as supplemental to sites' existing internal policies and procedures.

The operational policy, procedures, and standards outlined in this manual should be followed and enforced by all ADRC sites. ADRC site staff designated by the grantee site must be familiar with the contents of this manual and are responsible for

implementing its provisions. The ADRC Project Manager is responsible for periodically updating the manual as directed by the ADSD (also referred to herein as the "Division." Additionally, the ADRC Project Manager will offer periodic reviews of this manual during designated site meetings.

This manual was originally introduced in draft form effective October 1, 2007 and finalized in May 2010. Updates will be released along with version control memos. Periodic program updates and process changes will also be released through Tools for Improving Programs & Services (TIPS). In case of any perceived discrepancy between this manual and other materials the ADRC Project Manager should be consulted for clarification.

The ADRC program Operations Manual (2013) consists of five (5) Sections and an appendix.

- **Section I:** Introduction & Background
- **Section II:** Required Functions and Program Components
- **Section III:** ADRC Staff and Volunteers
- **Section IV:** Operational Definitions and Acronyms
- **Section V:** Publicly Funded Programs
- **Section VI:** Appendix

All ADRC site staff involved with the ADRC program should be familiar with the Operations Manual. Site staff may need to refer to particular sections of the manual on a regular basis, and therefore the manual has been designed so that specific sections may be reproduced and distributed as necessary. Supplemental to this manual is the SAMS Desk Reference Manual which provides procedures and general guidance on SAMS, the client information system used by ADSD.

Operations manuals are, by their nature, dynamic documents subject to revision as legislative and policy changes occur. When legislative or policy changes require that the manual be updated, the Division will send all ADRC grantee agencies a memorandum announcing the change(s). Copies of the updated manual pages, with revision dates, will accompany the memorandum (These may come digitally by email). The current manual is also available at the Nevada Care Connection web site www.nevadaadrc.com.

Nevada's Care Connection:
ADRC Operations Manual

I. INTRODUCTION and BACKGROUND

In 2003, the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) launched the national Aging and Disability Resource Center (ADRC) demonstration grant initiative. The ADRC concept is part of the New Freedom Initiative, which aims at overcoming barriers to community living for people with disabilities of all ages. ADRCs are a tool to help states redirect their systems of support. This tool will be consumer-driven and supportive of home and community-based service options. During the first year, twelve states were awarded the three-year demonstration grants, another twelve states were added in 2004. The Nevada Aging & Disability Resource Center (ADRC) administered by the Nevada Aging and Disability Services Division (ADSD) became one of 19 resource center projects funded in 2005. Today, ADRC programs exist in 54 states and territories.

Administration on Aging – Nevada Care Connection Vision

To have Resource Centers available to every community across the country serving as highly visible and trusted sources. People of all ages, incomes and disabilities can access information on the full range of long-term support options and a single point of entry to public long-term support programs and benefits.

Nevada's Care Connection: Aging and Disability Resource Center program (ADRC)

The Nevada ADRC program - Nevada's Care Connection aims to improve access to long-term services and supports (LTSS) for Nevada's elders, persons with disabilities, their families, caregivers, and those planning for future long-term support needs. The aim is to provide one-stop-shop access to a seamless system of support that is consumer-driven so individuals are empowered to make informed decisions about the services and benefits they need or want. The Care Connection is designed to

streamline eligibility processes with public partners and provide consumer access to a variety of public benefit programs. The regionally based ADRC sites have been established within existing community-based organizations to provide unbiased information and gain public trust.

Since 2007, Nevada's Care Connection has provided consumers with access to six community-based one-stop shop entry points that offer consumers "walk-in" access to specialists. In 2012, the web portal was also launched to supplement the efforts of the community based sites.

As required by ADSD, these sites provide at a minimum:

- Information and Referral (I & R),
- Assistance and Advocacy (A & A) – also known as Options Counseling
- Eligibility and Access (E & A) – also known as Benefits Counseling

In addition, the ADRC sites, community partners, and consumers have access to www.NevadaADRC.com. This site, Nevada's online Resource Center, provides urban, rural, and frontier consumers with access to information, services, and tools at any time of day, seven days a week (24/7). This web-based tool also serves a need for those who prefer internet-based access, as well as serving those whose geographic location limits walk-in access (e.g. rural and frontier areas, out of state consumers).

- The on-line "Resource Center" provides statewide access to an interactive provider and resource directory;
- a consumer self-assessment tool;
- a "Learn About" section or library of information where visitors can search information on a variety topics or link to other long-term service and support websites;
- an "On-Line Community" where visitors can search under the calendar feature for events, classes, workshops, programs, and support groups.
- The "Forum" feature allows individuals to post questions and comments, and
- a "Website Registration" enabling consumers to customize their own personal account and request updates to topics, forums, articles, and site specific updates through email, account updates, and Really Simple Syndication (RSS) feeds.

The online Resource Center has been designed to meet all accessibility and Web standards, be search engine friendly, and support multiple languages for added accessibility. The online Resource Center also provides access to training resources by ADRC site personnel and partners such as the Division's Information Technology (IT) staff, division program staff and other future partners as authorized.

ADSD also developed an integrated IT system-SAMS. This system allows for the collection of consumer data, tracking of care management activities, and facilitation of

the completion of public program applications without the need for duplicative data entry by ADRC sites or Division staff.

Nevada's Care Connection Mission

The mission of Nevada's Care Connection is to maintain or enhance quality of life of our consumers and communities in a respectful, efficient and fiscally responsible way.

Nevada's Care Connection Goals

The Care Connection overarching goal is to increase public awareness about the importance of advanced planning for future LTC needs. An estimated 65% of individuals age 65 and over will at some point require some type of long-term care (LTC). Where appropriate, the ADRC will use concepts consistent with *Own Your Future*, a long term care awareness campaign developed and sponsored jointly by the Centers for Medicare and Medicaid Services (CMS), Office of the Assistant Secretary for Planning & Evaluation, Administration on Aging (AoA), and the National Governors Association. The planning website (www.longtermcare.gov) includes information on determining future LTC needs (futures planning); financial considerations; LTC insurance; the need to establish clear legal directions (putting legal affairs in order); sharing plans with family, friends; learning what community services are available; and housing considerations as an individual ages.[1]

The specific goals of the Nevada's Care Connection are to:

- Better coordinate aging and disability service systems
- Raise visibility about the full range of options that are available
- Provide objective information and assistance
- Empower people to make informed decisions about their long-term supports as a means to maintain independence
- Serve as convenient entry points for all public and private long-term services and support programs
- Streamline eligibility processes for the consumer when working with public benefit partners

These goals fall in line with the overall agency mission and goals set forth by the Division's State Plan – Services for Nevada's Elders (2012). This document can be obtained online, by going to www.nvaging.net and clicking on 'State Plan'.

Nevada's Care Connection System Design

ADSD in consultation with its initial Advisory Board, grantees, partnering public agencies, and other stakeholders, has designed and implemented the Nevada Care Connection program. The program enables seniors, people with disabilities, families, caregivers, and anyone else planning for future long-term support needs to be offered choices.

---

[1] Own Your Future: Planning Guide for Long-Term Care (2008).

The program is meant to build a better, more coordinated network. Through partnership and coordination, the system is designed to:

- Actively promote public awareness of both public and private pay long-term support options, as well as awareness of the resource center, especially among under-served and vulnerable populations.
- Provide information and guidance, as needed, on all available long-term support options.
- Help people to access short-term assistance and/or care management to stabilize long-term support for individuals and their families in times of immediate need.
- Help people plan for their future long-term support needs through futures planning.
- Help people assess their potential to utilize their private funds/resources to obtain the assistance they need or want.
- Help people assess their potential eligibility for public long-term support programs and benefits.
- Refer consumers to appropriate services; and assist with applications and follow-up for services.
- Coordinate with Division of Health Care Financing and Policy (Medicaid) to assist with applications for programmatic eligibility for public long-term support programs and benefits, including referrals for nursing home and home and community-based services (HCBS) waiver programs.
- Assist people with the financial Medicaid eligibility determination process in collaboration or coordination with the Welfare and Supportive Services staff.
- Organize and simplify access to public long-term support programs.
- Provide information and referral to other programs and benefits that can help people remain in the community, such as disease prevention and health promotion programs, transportation services, income support programs and private-pay services.

The Nevada Care Connection system is compromised of the local ADRC sites, state and community partners, the ADRC web portal and the client information system (SAMS). These four tools working together allow Nevada to realize the goals of the ADRC program and assist people in planning for their current and future long term support needs. The local ADRC sites are pivotal in this process in that they:

- *provide agencies the opportunity to move from experts working in isolation to partnership through co-location, coordination, routine communication, and cross-training.*

- *provide agencies the opportunity to move from focus on eligibility and offering set menu of services to a proactive consumer-oriented approach, intensive outreach to individuals of all ages and income levels, and comprehensive options counseling*

- *are not about replacing existing organizations and networks. They're about building a better, more coordinated network.*

Nationally, the ADRC system is an integral component in long-term services and supports rebalancing efforts. Since the inception of the Affordable Care Act, a variety of initiatives have become a primary focus of ADRC programs. This includes, but is not limited to the following:

- Money Follows the Person
- Care Transitions
- Veteran's Directed – Home and Community Based Services
- Nursing Home Diversion
- Caregiver Supportive Services, including Lifespan Respite programs
- Balancing Incentives Payments
- Information, Referral and Assistance programs (2-1-1)

In Nevada, the Care Connection program is working with several partners to build a more coordinated network. Of particular value is the service of Options Counseling offered by ADRC sites. See page 15 for more information about Options Counseling.

ADRC is more a process than an entity!

Nevada's Care Connection Program Design

The initial sites have served as the testing environment for the ADRC model developed by the Division and the ADRC Advisory Board. The Advisory Board was comprised of community stakeholders and consumers. The selected pilot sites were willing to test the model within the service delivery system. Selected sites may choose to consolidate aging and disability networks or provide multiple entry points for seniors and for persons with disabilities, but must ensure that access and services are coordinated and standardized.

The ADRC model will consist of the following framework:

Information and Referral (I&R): Assess and identify individual's wants and needs and provide them with information and assistance. The ADRC will serve as the entryway that connects consumers to an array of public and private pay long-term supportive services. Sites must assure access to service delivery through the provision of information, referral, and follow-up. All sites must utilize the Intake Assessment form for new consumers accessing ADRC services.

Assistance and Advocacy (A&A): (Also known as Options Counseling) Is a service approach that is an "interactive decision-support process where consumers, family

members and/or significant others are supported in their planning to determine appropriate long term choices in the context of the consumer's needs, preferences, values, and individual circumstances. This may include the provision of information, making referrals, counseling, advocacy, conducting home visits (as necessary), case management, options screening, short-term involvement, assisting in the development of a plan for care/services, and follow-up.

Eligibility and Access (E&A): (Also known as Benefits Counseling) Involves assisting in applying for benefits, recertifying for benefits and offering guidance regarding appeals for benefits.

Advisory Board

The Nevada ADRC advisory board included members from the senior, disability, advocacy, and provider communities. It began meeting in 2009 and concluded in September 2012 upon completion of the ADRC Enhancement grant received by the U.S. Administration on Aging. Throughout the course of the three years of meetings, the Advisory Group met quarterly to assist ADSD in the development of Nevada's Care Connection: ADRC program. This included the development of a comprehensive 5-year Strategic Plan for the Care Connection. The 5-year Strategic Plan is available on the Division's website (www.nvaging.net).

As ADSD pursues additional funding streams or special projects, it may become necessary to convene special advisory boards. Specifically, these boards may be used for the following five key tasks:

- Identify goals and assess needs
- Develop performance measures
- Identify, screen and rank options
- Develop public relations message
- Support ADRC development efforts

Population Served

The ADRC will make efforts to provide equitable services to the population eligible for participation in Nevada's Care Connection. These efforts must include outreach to ADSD priority populations (2009): frail elders at highest risk for nursing home admission, low income elders, minority elders, and elders who reside in rural areas.

To be eligible for participation in the Nevada ADRC Project, an individual must meet one or more of the following criteria.

- **Senior**
  A person age 60 years or older
- **Person with a Disability**
  A person of any age with restricted capability or medical condition that creates an inability to perform some or all tasks of daily life

- **Caregiver**
  An individual who may provide assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and otherwise assures that the physical, psychological (including emotional health), and/or social needs of a senior or person with a disability are met. This includes paid or unpaid individuals as well as family members.
- **Anyone else planning for their future long term support needs**
  Examples of this population include individuals who have some resources to pay privately for services, individuals who have been recently diagnosed with a disability or an individual who is considering transitioning from an institutional setting.

Service Regions

The DHHS generally determines the geographic boundaries for at-risk individuals in a manner that guarantees each county receives adequate services based on the service delivery system of each region.

In 2013, ADSD established service regions for ADRC sites to ensure statewide coverage of the Nevada Care Connection program. Each ADRC site is expected to partner to ensure consumers throughout each service region has access to the ADRC framework. These service regions include the following counties:

- Las Vegas Region: Clark, Lincoln, Nye, Esmeralda
- Carson Region: Mineral, Carson, Storey, Douglas
- Elko Region: Humboldt, Elko, Eureka, White Pine, Lander
- Reno Region: Churchill, Pershing, Lyon, Washoe

To the extent possible, ADRC sites must develop local partnerships to ensure access to the ADRC throughout the service region versus limiting services to a single, specific geographical location (i.e. a single county).

Activities of ADRCs in the Service Region

- **Join aging and disability communities** and effectively coordinate resources in order to address gaps in the system. Shared aims should be identified by Nevada ADRC, partnering sites, and other stakeholders to determine where there are redundancies and disparities (gaps) that require attention.

- **Develop multiple partnerships** that utilize the strengths of various organizations and partner agencies. Determining resources and asset building among Nevada ADRC sites and community partners facilitates the development and implementation of successful one-stop shop models.

- **Effectively use technology** to streamline access to care and services. Utilization of technology assists in the streamlining of services through pathways such as client-responsive systems and administrative information exchanges.

- **Exhibit a strong consumer orientation** in order to avoid duplicative processes and increase the simplicity with which services are obtained. Uniform standards

allows for increased ease of navigation for the consumer to plan for the future and access services.

- **Offer MORE than I & R** by conducting benefits and options counseling as well as follow-up. Site staff should utilize the ADSD prescribed assessment tools to help consumers plan for long-term supports that are person-centered and consumer directed. The Nevada ADRC's response to a consumer's need is proactive and adapts to the individual's needs over time.

- **Efficiently navigate pathways** with an understanding that the consumers' circumstances change over time and so may the methods by which support services are attained.

Role of Nevada ADRC Sites

The ADRC will serve as a gateway that connects consumers to a variety of public and private pay long-term supportive services.

The first level of responsibility by an ADRC is to conduct Information and Referral (I&R). This includes, but is not limited to, assessing and identifying an individual's wants and needs and then to provide appropriate and relevant information and assistance.

The second and third levels of responsibility, Assistance and Advocacy (A&A) and Eligibility and Access (E&A), are more complex. They include, but are not limited to, options and benefits counseling, employment guidance, long-term futures planning, advocacy, short-term involvement, assessment, reassessments, and documented follow-up.

The diagram in Appendix A was adapted from the ADRC Technical Assistance Exchange (ADRC-TAE) and developed in conjunction with the Nevada ADRC sites to visually demonstrate the role and functioning of an ADRC that is providing all expected services (I&R, A&A and E&A).

Staffing Structure

ADSD anticipates the existing staff model of selected program sites will support the functions envisioned in the ADRC model. At a minimum, ADRC sites will need staffing dedicated to the following roles:
- Intake Specialist to include I&R
- Options Counselor
- Benefits Access Specialist
- Outreach & Training Specialist
- Administrative Staff to include: Director, Project Manager and Admin Assistant

II. REQUIRED FUNCTIONS and PROGRAM COMPONENTS

Grantee Performance Standards

The purpose of performance standards is to promote quality of service. ADSD has established service specifications that contain general guidelines. ADSD will use these service specifications as the basis for assessing program performance and suggesting a corrective action plan (as necessary).

As mentioned previously, ADRC staff must comply with the service specifications as outlined by the State of Nevada, Aging and Disability Services Division (ADSD) for the ADRC project.

ADRC staff also must comply with the State of Nevada, Aging and Disability Services Division (ADSD), Older Americans Act (OAA) service specifications for general requirements.

The current Service Specifications can be found on the Division website. http://www.nvaging.net/grants/serv_specs/service_specifications.htm

Site Monitoring

ADSD monitors grantees' programmatic and fiscal activity on an ongoing basis. ADSD Resource Development (RD) Specialists conduct program assessments and provide technical assistance according to two sets of service specifications – programmatic and those prescribed by the Older Americans Act. RD Specialists will review participant records, site files and policies and procedures during these periodic assessment visits. A written report from the site's RD Specialist containing recommendations and a corrective action plan will be sent to the grantee's project authority or project director within one month of the visit. Corrective action plans and compliance dates must be approved by the ADRC Project Manager and must guarantee the basic ADRC service delivery expectations are met on a timely basis to sustain project integrity.

ADRC Business Process

Each ADRC site must at a minimum offer these three levels of service in addition to performing regular outreach to the community:

- Information and Referral
- Assistance and Advocacy (known as Options Counseling)
- Eligibility and Access (known as Benefits Counseling)

Three Levels of ADRC Service

A. **Information and Referral (I&R):** Assess and identify individual's wants and needs and provide them with information and assistance. Assure access to service delivery through the provision of information, referral, and follow-up. In an effort to standardize processes, all ADRC sites must utilize the provided Intake Assessment prescribed by ADSD.

   Criteria:
   a) **Information Provision:** Service should provide information to an inquirer in

response to a direct request for such information. Information can range from a limited response (such as an organization's name, telephone number, and address) to detailed data about community service systems (such as explaining how a group intake system works for a particular agency), agency policies, and procedures for application.

b) **Referral Provision:** The referral process consists of assessing the needs of the inquirer, identifying appropriate resources, devising a plan to contact agencies able to meet those needs, providing enough information about each organization to help inquirers make an informed choice, helping inquirers for whom services are unavailable by locating alternative resources, and when necessary, actively participating in connecting the inquirer to needed services.

c) **Follow Up Provision:** After providing information or referral to an inquirer it may be essential to ask the inquirer if they will inform the ADRC Specialist if their referral was viable and it worked out. The specialist may also offer to call after a couple of days to perform a follow up inquiry.

B. **Assistance and Advocacy (A&A):** (Also known as Option Counseling) A service approach that attempts to find an assortment of services for the overall needs of the consumer.

Criteria:

a) **Options Counseling**

Options Counseling is an "interactive decision-support process whereby consumers, family members and/or significant others are supported in their planning to determine appropriate long term choices in the context of the consumer's needs, preferences, values, and individual circumstances (p. 4)." This may include the provision of information, making referrals, counseling, advocacy, conducting home visits (as necessary), case management, options screening, short-term involvement, assisting in the development of a plan for care/services, and follow-up.

The National Association of State Units on Aging and Disability (NASUAD) has provided the following scenarios as examples of opportunities to provide options counseling (p. 10-11):[10]

- Ms. Apple is seventy years old. She is still able to care for herself but it is becoming more difficult. She is determined to live in her home until she dies. To assure that she can, she may need to consider getting some supports now (such as help with grocery shopping) and find out how her increasing needs might be met
- Mr. Berry is a construction worker. He is injured in a worksite accident. He is no longer able to care for himself and has no relatives nearby who can assist him. Following his stay in the hospital, he is admitted to a nursing

home. He is not happy.

- Mrs. Smith was admitted to the hospital with a broken hip. Her doctor unexpectedly discharged her on a Friday afternoon. The doctor advised that she was not ready to return to her own home. Mrs. Smith's immediate problem was identifying a long term care facility with an available bed in her community. Mrs. Smith does not want the nursing home to become her permanent long term support solution.
- Mrs. Jones is caring for her husband with Alzheimer's disease. Mr. Jones gets up in the middle of the night and wanders around the house and sometimes outdoors. Mrs. Jones is not getting enough rest. She is exhausted and her health is declining. She cannot continue to care for her husband much longer. Not far away is an assisted living facility with a special Alzheimer's unit, but she wants her husband to continue living at home.
- Mr. Johnson is 66 years old and living in Las Vegas. His mother is 96 and lives in the family home in Pahrump. During his last visit at his mother's, he notices that she is increasingly frail and forgetful. He talks with her about moving to Las Vegas but she refuses to go. He suggests that she consider moving to a senior living community. She makes it clear that she intends to stay in her home.

Options counseling can occur face-to-face, over the telephone, or during a home visit. Take time to understand the person's situation, try not to solve their problems, but empower them to understand the issues and available options.

Offer the right amount of assistance:

- Prioritize needs and wants
- Identify and consider values and preferences
- Identify options available to meet needs
- Identify personal resources to meet his / her needs
- Identify the next steps for addressing long-term care needs
- Helping the consumer develop a list to help guide future decisions and actions.

While a "key component of a comprehensive system of supports for older individuals and persons with a disability, options counseling is not for everyone and it is not routinely provided to all persons who contact the ADRC" (p. 4-5).[2] Rather it is for those individuals who want assistance (not just information) over time. This process is flexible and adapts to the consumer's needs and choices.

b) **Short-Term Involvement** - is used to stabilize individuals and their families in times of immediate need or crisis before they have been connected to ongoing

---

[2] National Association of State Units on Aging, Long-Term Support Options Counseling, January 2007.

support and services. It often involves more than one follow-up contact.

   c) **Futures Planning –** Educating and assisting individuals to make a "plan" for future long-term care needs on their own. Tools such as Own *Your Future* guide in the ADRC Learning Path can help this process. The guide includes practical advice, steps that can be taken now, and resources for more information.   This could also include referrals to resources for retirement planning, financial planning, LTC insurance, reverse mortgages, etc. Additional resources and planning support can be found at the National Clearinghouse for Long Term Care Information located at:

http://www.longtermcare.gov/LTC/Main_Site/Index.aspx

C. **Eligibility and Access (E&A):**   (Also known as Benefits Counseling) Involves offering consultation to individuals about public benefits that may be available to them, assisting in applying for benefits, and offering guidance regarding appeals for denied applications. When appropriate, Nevada ADRC sites will assist individuals in applying for, or making referrals to the ADRC partnered public programs listed on page 40.

Benefits Counseling also includes the provision of follow-up as necessary.

Key ADRC Functions[3]

These three services are accomplished through a specific business process which includes the following key functions:

1. **Intake (and Assessment)** – initial contact with the ADRC site, engage consumer in a dialogue, listen carefully to identify needs, effectively question and clarify, complete hard copy Intake Assessment form on the available and provide Notice of Privacy Policy prior to collecting and entering caller information into SAMS database, provide information and referral, identify next steps including assessment.

2. **Information and Referral (I&R)–** links the individual to the services and activities that are available; provides current information and referral regarding long-term support options and resources to seniors, people with disabilities, their caregivers, and those planning for future long-term care needs.

3. **Options Counseling** – identifies the strengths, needs, preferences and difficulties of an individual to meet their long-term service needs/wants through completion of the Options Counseling Assessment; provides sufficient information in order for individual to make informed choices based upon preferences; brainstorm with consumer to identify strategies

---

[3] Technical Assistance Exchange: ADRC Business Plan Template, 2005.

and long-term support plan; review preferred options; evaluate and map next steps. Options Counseling is a key function of ADRC sites which includes these functions:

 a. **Advocacy** – advocate, as necessary, for an individual's rights, interests and benefits.

 b. **Short-term Involvement** – provide short-term assistance necessary to assist individuals and their families in times of immediate need through temporary assistance before being connected to ongoing support and services. It often involves more than one follow-up contact.

 c. **Case Management** – assessing needs, developing a plan to access services/benefits needed/wanted, identifying available providers, follow-up and as necessary, reassessment.

 d. **Futures Planning** – help people plan for their future long-term support needs. A planning tool, Own *Your Future,* has been provided in the ADRC Learning Path on the web portal.

4. **Benefits Access** – facilitate access to appropriate long-term services and supports by initiating the applications necessary for financial and programmatic eligibility determinations for identified publicly funded programs and monitors the status of submitted applications to their completion. Benefits Access may also include:

 a. **Financial and Programmatic Eligibility Determinations** – assist individuals in obtaining eligibility determinations for publicly funded long-term benefit programs *(In Nevada, we assist in this process only by collecting data and completing applications.)*

 b. **Benefits Counseling** – informs individuals regarding applicable publicly funded benefits, assists with applying for benefits, and offering guidance regarding appeals for denied applications.

5. **Follow-Up** – a practice that verifies whether an individual has received the services/benefits they needed/wanted to the maximum extent reasonable.

6. **Marketing and Outreach** – offer presentations to potential community partners and providers at critical pathways to long-term care (e.g. hospital discharge planners, nursing home administrators and staff) and establish more formal working agreements with community partners as appropriate.

7. **Program Evaluation and Data Reporting** – collection of information and data, feedback in quality management activities and data reporting through SAMS, quarterly reports, site visits, and surveys.

ADRC key functions can occur via several methods:
- over the telephone,
- face-to-face (walk-in or home visit), or
- via the Internet or electronic mail

ADRC key functions can be utilized by any number of consumer types including:

- an individual requiring assistance and service,
- a family member,
- caregiver, or
- a provider of service.

ADRC key functions make it possible for seniors, people with disabilities, their families and caregivers, and those planning for their future long-term support needs, to be informed of and to access services and benefits of their choice in order to meet their long-term support needs. "Many people today do not think about their future long-term care needs and therefore fail to plan appropriately."[4] Too often, individuals are unaware that Medicare and most health insurance plans do not cover long-term care services. In fact, Medicaid has become the largest payer for these services; however, only low income individuals qualify.

Planning ahead is crucial and allows greater dignity, control, and independence over how one's future needs are met.

Concepts to Consider When Performing Key ADRC Functions

There are some key concepts to be aware of and keep in mind when helping consumers:

- **Ageism – How Judgments Impact Others**

    Ageism is making judgments about people based entirely on their real or perceived age (young or old). Making judgments about an individual without specific knowledge about who they are, what they need, and their individual preferences as a person can negatively impact the long-term support services planning process.

…but you look so natural and life like!

---
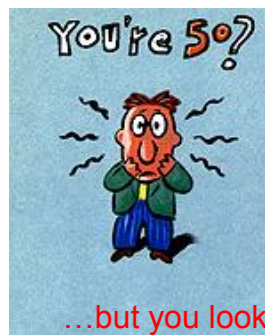
[4] Own Your Own Future Campaign Summary, 2008.
http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/Reports/Documents/2008/CampaignSummary2-2008.pdf

- **Consumer Directed Care – Gives the Consumer the Power of Voice and Choice**

  Consumer Directed Care takes the consumer's preferences into consideration and provides them with the information they need to participate in planning. The first step is to identify and meet short-term needs. Then, the consumer will be able to decide what benefits are available after evaluating available options, so they can make informed decisions regarding the services and care they need/want. ADRC sites must help the consumer realize the risks as well as the benefits.

- **Health Literacy – How the Information is Communicated Makes All the Difference in the World**

  According to the Institute of Medicine (2004), an estimated 45 million adults in the United States have some level of difficulty understanding health information. This lack of understanding gets in the way of an individual's ability to read and write, their ability to listen, make decisions, participate in long-term planning, navigate the health care system, fill out forms, follow directions, compute basic math, and interact with service providers. Health status, cognitive function (including memory impairments), prescription drug use, and substance use / abuse can all impact health literacy.

  Low literacy is common, often overlooked and easy to cover up. What you may hear from a consumer is "I'll take the information home and discuss it with my family" or "I'll read this later, I forgot my glasses."

  Health literacy is defined as the degree to which individuals can obtain, process, and understand basic health information and services they need to make appropriate health decisions.

  When providing information, consider the following[5]:
  1. Is the information appropriate for the user?
  2. Is the information easy to use?
  3. Are you speaking clearly and listening carefully?

  Some tips:
    o Talk more slowly
    o Use simple language to express information (short words are easier to understand than big words).
    o Avoid industry jargon and heavy use of acronyms.
    o If providing a consumer with information in writing, make sure handwriting is legible. When in typed format, use large plain fonts (nothing fancy like script). Color of print and paper should be high contrast (no bright colored or neon paper).

---

[5] U.S. Department of Health and Human Services (n.d.). Quick Guide to Health Literacy and Older Adults.

- o Use open-ended questions to elicit answers, "Tell me about…"
- o Repeat questions as necessary.
- o Ask the consumer to repeat back information or explain directions.

- **Imminent Risk – Keeping Individuals Living in the Community as Long as Possible**

A goal of the ADRC program is to prevent nursing home placement and spend-down to Medicaid. Offering information early for planning is important for those at risk of nursing home placement. Planning ahead allows greater dignity, control, and independence over how future needs are met. People need to start thinking about their resources and choices, so they can plan and pay for their own care for as long as possible.

ADSD has developed targeting criteria and questions to identify those at imminent risk or those needing long-term care planning, so they can remain independent as long as possible. It is important for an ADRC specialist to be aware of the following situations when working with consumers as they could represent a need to start planning for more care. The consumer:
- o needs assistance with at least three of the following Activities of Daily Living (ADLs): Eating, Bathing, Dressing, Toileting, Transferring In/Out of a Bed/Chair, or Walking.
- o has been hospitalized two or more times in the past year.
- o was admitted to a nursing facility in the past six months.
- o has experienced increased memory loss that effects day to day activities and decision making.
- o requires assistance with at least three of the following Instrumental Activities of Daily Living (IADLs): Preparing Meals, Shopping, Taking Medication, Managing Money, Housework, Using the Telephone, or Using Transportation Services.
- o states concern about moving to a nursing home or full-time care facility in the near future.
- o does not have family members/friends who visit or help out (perhaps isolated).
- o appears or states she/he is depressed.

Below are some common signs and symptoms of depression:

- o Feelings of helplessness and hopelessness. A negative outlook—nothing will ever get better and there's nothing you can do to improve your situation.
- o Loss of interest in daily activities. No interest in or ability to enjoy former hobbies, pastimes, social activities, or sex.
- o Appetite or weight changes. Significant weight loss or weight gain—a change of more than 5% of body weight in a month.
- o Sleep changes. Either insomnia, especially waking in the early hours of the morning, or oversleeping (also known as hypersomnia).
- o Loss of energy. Feeling fatigued and physically drained. Even small tasks are exhausting or take longer.

- o Feeling bad about one self.   Strong feelings of worthlessness or guilt. Harsh criticism of perceived faults and mistakes.
- o Concentration problems.   Trouble focusing, making decisions, or remembering things.

- **People First Language – Word Choice Makes a Difference**

When serving people with disabilities, the goal is to recognize the person first. Acknowledge the individual's "personhood" before their disability status. The physical disability is a part, but not all of who they are. People First usage is about respect for the human being and involves utilizing words that support the concept. For instance, replace "disabled person" with "person with a disability." Replace "deaf people" with "people who are deaf." When we describe people by their medical diagnoses, we fail to recognize and disrespect them as individuals.   Acceptable language:
- o People who are blind
- o People living with disabilities
- o People living with autism
- o People who use wheelchairs

The concept of People First language should also be applied when describing older adults. Older adults are not "fossils," "geezers," "over the hill," etc. They are elders, seniors, older adults, or people age 60 and older as defined by OAA.

- **Crisis Intervention**

Although most I&R services do not promote themselves as formal crisis intervention centers, most receive occasional requests for assistance from people in crisis and must therefore equip their staff to handle them appropriately. The I&R service shall be prepared to assess and meet the immediate, short-term needs of inquirers who are experiencing a crisis and contact the I&R service for assistance. Included is assistance for individuals threatening suicide, homicide or assault; suicide survivors; victims of domestic abuse or other forms of violence, child abuse/neglect or elder/dependent adult abuse/neglect; sexual assault survivors; runaway youth; people experiencing a psychiatric emergency; chemically dependent people in crisis; survivors of a traumatic death; and others in distress. This is considered short-term involvement for an ADRC specialist.

- **Follow-Up**

Follow-up must occur at various intervals along the service continuum; I&R, A&A, and E&A to increase the effectiveness of the initial contact. Follow-up is a crucial element of the care planning process by serving to enhance the streamlining process and provide opportunities to fill service gaps. It is an act or an instance of following up with the consumer to ascertain receipt of services or benefits, or review new developments in order to proceed with service delivery action.

- **Importance of the Initial Contact**

  The initial contact is vital because the person may need assistance as soon as possible.
    - May be the only opportunity to provide assistance.
    - The more accurate the information, the better the assessment and provision of appropriate service(s).
    - An early and accurate intake process can identify individuals at various stages across the imminent risk continuum which can reduce the need for long-term care (nursing home placement).

  "It all begins with the initial contact"

- **Motivational Interviewing from the ADRC perspective**
    - This is NOT a passive (**not actively taking part)** process.
    - This is a "process" not a "change or no change." It's about the consumer gaining insight to what may be needed for continuing independence.
    - It's a focused process whereby the ADRC specialist is trying to move the planning process along by questioning, guiding, and exploring.
    - It's a well thought-out, line of questioning to get the client to the "Aha moment."

- **Issues to consider:**
    - We tend to jump to options too quickly. Make sure you explore larger issues and concerns when developing a plan. Perhaps the underlying reason the individual is contacting the ADRC site has not yet been revealed
    - Staff must remain patient particularly when working with a client who may not accept their help or see the need for a particular service (yet). If this is the case, do not take it personal.
    - When we struggle with accepting a consumer's resistance or ambivalence toward service options, we become "expert advisors" on what is available and what needs to be done.
    - Avoid attempting to "fix" a situation. Instead, explore the consumer's ideas/solutions about what they think might work for the situation.

Appendix B has additional guidance on motivational strategies to consider during Options counseling.

There's one reason people fail to reach their goals – they never take the first steps!

GOALS

SUCCESS

It does'nt matter if it's a small step – just take it!

POSITIVE POOCH!

Marketing and Outreach – A Combined Effort

Marketing and outreach is critical to the success of any program or initiative. Nevada's Care Connection it is particularly important to help bring awareness to community partners as well as consumers who maybe have not yet begun to think about long-term services and supports. In general, marketing efforts are undertaken at both the state level and the local ADRC site level. ADRC sites are required to conduct a minimum of three outreach events per month for the program.

Sites Role in Marketing

The marketing initiative for Nevada's Care Connection will focus on providing information to community providers, individuals age 60 and older, persons with disabilities, caregivers and anyone else planning for their future long-term support needs. The ADRC sites will outreach to inform the general public and others of the ADRC program and its role in the community and long-term support system. ADRC outreach efforts increase awareness making the LTSS planning process relevant and useful to those involved including community and public partners.

Marketing efforts will utilize multiple distribution modalities including person-to-person interactions, print media, and television/radio/internet presentations when available.

Each ADRC site should have a plan for providing training and outreach to the organizations most likely to make referrals for LTSS in their assigned service region. In addition, ADRC sites should identify places that individuals and their families turn to or interact with during a crisis situation. The ADRC can expect that a major group that should receive training in this effort will be hospital discharge planners. Establishing these relationships/connections now are vital as the state endeavors to improve care transitions and its overall system of support for consumers. Other target organizations are likely to include physicians and their staff, home health and home care agencies,

nursing facilities, grantees/partners of Care Transitions or Money Follows the Person initiatives, entities operating HCBS waivers or personal care programs, and other social service agencies.

Obligations

- Each site should outreach and market at a minimum 3 times per month. Each site should infuse Nevada's Care Connection marketing as a part of their daily operations via the methods identified previously: person-to-person interaction, print media distribution, television/radio/internet participation, or professional community interaction. See page 26 for additional information on types of marketing/outreach activities.

- Nevada ADRC site staff will be required to actively participate in marketing strategies to reach consumers that require public assistance as well as private pay consumers. For private pay consumers, ADRCs will likely provide more LTSS counseling such as futures planning on LTC needs for families, rather than assistance with accessing public benefits.

- Each outreach or marketing event should be recorded in SAMS as prescribed in the ADRC SAMS Desk Manual.

Purposes

- To increase awareness and visibility of the Nevada ADRC.

- To provide information in a clear format that consumers, providers and partners will understand.

In an effort to be time and fiscally efficient, these efforts will take on the format of "grass roots," meaning basic fundamentals to spread the word about Nevada's Care Connection and its services. When the opportunity exists to discuss the ADRC program, site staff are expected to grab it.

ADSD Roles in Marketing

- The ADRC project manager is responsible to develop and distribute outreach materials or templates to the sites. These materials can be adjusted to be site specific or all inclusive depending on the use.

- ADSD will sponsor a statewide educational conference with local grantees and service providers to inform and update them on the ADRC as well as encourage them to submit and/or update their resource information on the ADRC website. This may occur every two years as funding allows.

- The ADRC Project Manager will comply with requests for in-service presentations to community partners or organizations to educate them about ADRCs and their services with the intent of gaining support and possible interest for participation in the project.

Types of Marketing/Outreach Activities

Person-to-Person Interaction

- The ADRC sites will participate in community health fairs, provider events and other community programs that allow site staff to personally speak with the target audience about the ADRC program.

- Sites may also engage in community presentations or host open houses and invite their surrounding community to participate for the benefit of bringing awareness and visibility.

- The ADRC sites will market to the faith-based community in order to help them better understand the benefits and services of the ADRC.   These contacts may improve outreach to private pay consumers.

Print Media

- Brochures, introduction flyers, ADRC Quick Facts and posters related to imminent risk populations highlighting the benefits of the ADRC have been produced, distributed, and are available to download from the web portal.

- Articles describing the ADRC program and activities can be written and submitted for publication to: The Challenger newspaper, ADSD New Directions newsletter, senior center newsletters, hospital newsletters, Senior Spectrum Newspaper, Generation Boomer Magazine, Veterans Consumer Council newsletter and other print media sources.

Television/Radio/Internet

- ADRC sites will take part in local television programs aimed at community events in their service region.

- ADRC sites will take part in local community radio programming shows to highlight the ADRCs and the services offered. This could include, but is not limited to: KLAV internet radio, Spotlight internet radio, or Sunday AM PSA Program in Southern Nevada, Insights with Connie Wray in Northern Nevada, or AM Drive Interview in Rural Northeastern Nevada.

- ADRC sites will use Public Service Announcements (PSA) on local radio stations to distribute information on Nevada's Care Connection. These PSAs run at the discretion of the station based on availability.

- Any print media distributed will have the NevadaADRC.com website address included so the target audience may identify the website and want to explore the various capabilities it has to offer.

- ADRC sites are encouraged to utilize social media sites such as Facebook, LinkedIn and YouTube to promote the ADRC program.

- ADRC sites will encourage community partners to submit their resource information online via www.NevadaADRC.com.

Documentation and Reporting

A comprehensive management information system (SAMS) exists to document program participation and the use of funds. **ADRC staff are required to collect consistent information on each case, which generally includes demographics, service delivery and assessment documentation for all ADRC activities and consumers.** At a minimum, ADRC sites will maintain client files that will include these elements (either has hard copy files or as part of the SAMS record):

- Intake Assessment (Form 1)
- Options Counseling Assessment (Form 2)
- Copies of applications, documentation or other items pertaining to an individual case record.
- SAMS Data records

The case management tracking system designated by the Division is the Social Assistance Management System (SAMS). Grantees must not disclose information viewed in SAMS without consumer permission and must adhere to requirements for record keeping for ADRC work. ADSD has provided each grantee with a standard Notice of Privacy Policy (Form 3) that must be provided to every client who is entered into the SAMS system. If the ADRC site collects data in another type of case management system, the site must devise a way to upload all the required demographics, service delivery and assessment documentation into SAMS.

ADRC staff can find instructions for data entry in the SAMS General Overview ADRC Desk Manual. ADSD provides on-line technical assistance to its grantees through the Nevada ADRC web portal. You must create an account and log-in in order to submit a HelpDesk Ticket. Instruction on accessing the HelpDesk and submitting a ticket are also included in the ADRC Desk Manual.

NOTE: Timeliness of data provision by the ADRC sites to the Project Manager is critical. Timeliness is important and late data submissions can cause requests for funding to be delayed. Receipt dates will be monitored and corrective action plans developed with the grantee's RD Specialist. Future funding will be dependent upon the grantee's ability to comply with the service specifications and reporting requirements.

Recording Units of Service

SAMS Service Delivery tracks the units of service provided to a consumer per the unit of service definition in the [Service Specifications](). ADRC sites are required to track three (3) units of service within the SAMS system:

Consumer/Caregiver Supportive Services: A program to prevent excess disability in clients and the reduction of stress-related problems in their caregivers. This service promotes the maintenance of Nevadans in their homes, while maximizing their lives and their caregiver's quality of life.

One unit of service equals one contact with or on behalf of a consumer or caregiver.

ADRC Service Delivery: Provides older individuals, people with disabilities, caregivers and those planning for future long term services and supports with information, assistance and access to services to meet their long term support needs.

One unit of service equals ¼ hour of time assisting a consumer with long term services and supports.

Education: Provides social service providers, healthcare professionals, community organizations, consumers, caregivers and other stakeholders with information regarding ADRC services and other long-term support services as deemed necessary.

One unit of service equals ¼ hour training/educational meeting in a group setting.

Each contact made by a consumer may involve 1 or more levels of service. In recording your service delivery, you should record each level of service provided as well as the number of contacts provided to the consumer.

Program Evaluation and Quality Management

ADSD must establish measurable performance goals and indicators in order to track ADRC progress. A Program Evaluation Plan has been developed for Nevada's Care Connection.

Evaluation measures consist of indicators used to track progress and levels of performance applicable to each indicator. Measurement areas which are designed to promote continuous quality improvement and development of Nevada Care Connection include:

A. **Visibility** extent to which the public is aware of the existence and functions of the ADRC;
B. **Trust** on the part of the public in the objectivity, reliability, and comprehensiveness of the information and assistance available at the ADRC;
C. **Ease of Access** (e.g., reduction in the amount of time and level of frustration and confusion individuals and their families experience in trying to access long-term support);
D. **Responsiveness** to the needs, preferences, unique circumstances, and feedback of individuals as it relates to the functions performed by the ADRC;

E. **Efficiency and Effectiveness** (e.g., reduction in the number of intake, screening, and eligibility determination processes, diversion of people to more appropriate, less costly forms of support, improved ability to match each person's preferences with appropriate services and settings, ability to rebalance the state's long term support system, ability to implement methods that enable money to follow the person, etc.).

In addition to these key factors, ADRCs are evaluated based on a set of fully functioning criteria annually. This criterion currently includes the following concepts/services:

- Information, Referral and Assistance
- Options Counseling and Assistance
- Person Centered Transition Support
- Consumer Populations, Partnerships and Stakeholder Involvement
- Quality Assurance and Continuous Improvement

There are five (5) components of the evaluation and quality management plan for Nevada's Care Connection.

1. *Consumer Intake Survey* (Form 4)
   Aging and Disability Resource Center sites have the ability to respond to a wide variety of needs of our target population; critical to this process is the initial contact the consumer has with the program. For this reason, we have prescribed a Consumer Intake Survey (CIS) for all sites to disseminate and collect information from consumers who have completed the initial intake screening with their program.

   The CIS is a 20 question survey that asks consumers and/or their caregiver about their experience with the ADRC. There are also questions that provide insight into the services received by the consumer.

   Each ADRC program site will be responsible for disseminating and collecting the survey from consumers. Additionally, each site may add additional questions to the survey as needed for other funding sources.

2. *Consumer Follow Up Survey* (Form 5)
   The most beneficial, and certainly, the most popular service offered by the ADRC program is Options Counseling. Through the Options Counseling Assessment, consumers are supported in an interactive decision making process that helps them to identify and access the programs and services that best meet their current and future needs. Options Counseling has four major goals:

   - To provide people with the information they need to make informed choices – thereby maximizing consumer choice.

- To provide appropriate guidance to proactively match people's needs, preferences and values with available services.
- To help people plan for the future and avoid the "if I'd only know" scenario.
- To help improve the quality of life of consumers receiving long-term care services in community based settings.

In order to measure the extent to which ADRC programs are able to meet these goals, a consumer follow up survey has been developed. This survey will be disseminated and collected by each ADRC site.

To support the survey data, the client information system- SAMS will be used to document services, topics, follow up and outcomes of all activities within Options Counseling and Benefits Access. Please refer to the SAMS Desk Manual for detailed instructions for client data entry.

3. *Quarterly Performance Report (formerly Monthly Performance Report)*
Data from SAMS, Intake Forms and Program Site records will be used to facilitate a quarterly performance report. All data is requested to be submitted to ADSD by the 15th day after the quarter. A final report will be provided to the sites by the last day of the month following the quarter.

4. *Stakeholder & Partner Satisfaction Survey*
This survey is done on an annual basis to capture data on the overall awareness of partners and stakeholders of the Care Connection program as well as to collect data on their level of satisfaction with the program.

This survey will be administered in April of each fiscal year via the web portal. Results will be reported as part of the ADRC Annual report.

5. *ADSD Start/Stop/Continue Survey*
This simply survey is administered to a sample of ADRC site staff and managers on an annual basis as a mechanism for feedback to ADSD regarding the Care Connection program. There are three questions asked:
- What can ADSD **start** doing to support the Care Connection program?
- What can ADSD **stop** doing to support the Care Connection program?
- What should ADSD **continue** to do to support the Care Connection program?

This survey will be administered in April of each fiscal year via the web portal. Results will be reported as part of the ADRC Annual report.

Process and Outcomes
Nevada ADRC performance measurement will be conducted utilizing document review, meetings with the ADRC project manager, site visits, ADSD reports including minutes from ADRC Site Meetings, minutes from Advisory Board Meetings, and other

documents as necessary, SAMS data, website visitor reports and trends (Google Analytics), website review, as well as data from the five components of the program evaluation plan mentioned above. An Annual Report will be completed at the end of each fiscal year.

Site Staff are required to participate in the evaluation process by:

1. Entering consumer and consumer group data into SAMS,
2. Disseminating Consumer Intake Surveys (CIS) to new consumers,
3. Completing the ADRC Forms (Intake, Options Counseling Assessment) and the Quarterly Reports as prescribed by ADSD.
4. Completing the Lewin Group online data entry tool as part of the Division's Semi-Annual Reporting Tool (SART) process (April and October).
5. Completing staff training evaluation surveys
6. Responding to questions concerning data and process
7. Participating in site visits by evaluators

Responsible Entity – The Nevada ADRC sites will have full responsibility for administering the Consumer Intake Survey (CIS) and the Consumer Follow-Up survey to their consumers. This ongoing survey will be administered either on-site at intake or if the intake was conducted over the telephone, site staff will mail the survey to the consenting consumer's home. Each site will provide copies of the collected surveys to ADSD for review and evaluation at least on a quarterly basis.

Partnerships and Stakeholder Involvement

Nevada's Care Connection is based on the meaningful involvement of a variety of partners and stakeholders in planning, implementation and evaluation activities. A no wrong door system is created by defining and documenting strategic partnerships to streamline access to programs and services.

ADSD and ADRC specialists must maintain involvement with the following partners.

DIVISION OF WELFARE AND SUPPORTIVE SERVICES (DWSS)

ADSD has an agreement with Welfare to ensure that access to Medicaid and Food Stamp (SNAP) benefits is as streamlined as possible for consumers. This agreement includes data sharing and access to the DWSS NOMADS system which allows ADSD staff to check eligibility status of applications.

ADRC specialists should establish a contact within the local Welfare Office to follow up on submitted applications and establish a working relationship that improves service delivery.

DIVISION OF HEALTH CARE FINANCING AND POLICY (DHCFP OR MEDICAID)

ADSD has an agreement with Medicaid to ensure that access to Medicaid service programs, such as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for children, Waiver for Independent Nevadans (WIN) or Personal Care Services (PCS), is as streamlined as possible for consumers.

ADRC specialists should establish a contact within the local Medicaid Office to follow up on submitted requests for services and establish a working relationship that improves service delivery.

AGING AND DISABILITY SERVICES DIVISION (ADSD)

ADRC is part of the service delivery system for ADSD. Therefore, ADSD staff members are available to ensure access to programs, such as the Home and Community Based Services Program (HCBS), State Funded Personal Assistance Program (PAS), Senior and Disability Rx, is as streamlined as possible for consumers.

ADRC specialists should establish a contact within the local ADSD Office to follow up on submitted requests for services and establish a working relationship that improves service delivery.

COMMUNITY PARTNERS

ADRC specialists should be aware of the numerous aging and disability service providers in their area, such as Senior Companion, Nevada Caregiver Support Center, Medication Therapy Management (MTM) program, and the Alzheimer's Association to name a few, and establish a working relationship to **improve collaboration** within the services offered. See page 33 for additional guidance on community partners.

STAKEHOLDERS

ADRC specialists should be aware that consumers, Welfare staff, Aging and Disability Partners, and parties interested in ADRC functions are stakeholders. Stakeholders can be a person, group, organization, or system who affects or can be affected by their actions. Strong collaboration with stakeholders is required with home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways.

Critical Pathways[6, 7]

The ADRC project will create formal linkages between and among the critical pathways to long-term support.

---

[6] ADRC Technical Assistance Exchange: Fully Functioning Single Entry Point System/ADRC February 7, 2008. *www.adrc-tae.org/tiki-download_file.php?fileId=27036*
[7] The Lewin Group, TAE. ADRC December Critical Pathways Call Summary, December 29, 2004.

<u>Critical pathway</u> - a time or a place when people make important decisions about long-term support needs (e.g. hospitals, physicians, and pharmacies).

Why is talking about critical pathways important?

1. ADRC sites are charged with providing information about long-term support options to the public. To fulfill this mission, ADRCs must make themselves visible and accessible. Given the limited resources ADRCs have for marketing and outreach activities, it makes sense to direct your marketing activities toward these critical pathways.

2. ADRC grantees are also charged with streamlining access – meeting people when they are ready. This means going to where they are, rather than waiting for them to come to you.

3. This is a crucial part of rebalancing the state's long-term services and support system. Federal and state governments are working hard at providing more information and access to home and community-based systems of support in lieu of institutional care.

Community Partners

The ADRC program is a long-term care systems change initiative aimed at improving and streamlining access to information, assistance and long-term services. ADRC sites are encouraged to form strategic partnerships at the local level. This would include developing working agreements with local health and human services agencies, service providers, and other private partners. These partnerships should include a range of agencies and organizations such as:

- Centers for Independent Living (CILs)
- Other aging and disability service providers
- State Health Insurance Assistance Program (SHIP)
- Senior Medicare Patrol (SMP)
- Employment
- Housing
- Transportation
- County Social Services
- Advocacy Groups
- Long-Term Supports and Services Providers (e.g., home health agencies, nursing facilities)
- Critical pathway providers (e.g., hospital discharge planners, physicians, pharmacies)
- Universities where students actively seek opportunities in the community to volunteer and engage in service learning activities

The Community Partner Agreement (Form 6) was designed for the purpose of establishing a shared understanding of roles and services and to outline referral processes between the ADRC site and a community partner as they are oriented to the ADRC program. The document is intended to outline guidelines to be used by ADRC

community partners when it is determined that a referral or information sharing protocol is required to the meet the needs of a consumer.

The Community Partner Agreement is a sample template developed by ADSD for sites to use when the opportunity presents itself to establish a partnership. Sites may create their own format by using some parts of the example, depending on the circumstances of the partnership. Additionally, if the template is used, it should be specifically tailored to capture the defined roles of each partnership.

Sites should consider the following when establishing partnerships:

- Involve partners early in the planning process.
- Set clear and realistic expectations for partners.
- Recognize and account for differences in staff and organizational capacity across organizations.
- Focus on similarities between organizations and where mission, values and goals align.
- Pick a specific project to work on together to get started.
- Be aware of differences in terminology or interpretation (client, peer, consumer-direction, case management, peer counseling).
- Collaboration makes you stronger and helps you serve your community better.
- Collaboration is critical to sustainability.

ADSD has created a training module, Building Partnerships, for ADRC site staff that are responsible for developing local partnerships at their site.

Project Sustainability

Sustainability is the capacity to maintain a certain process or state indefinitely. While the Administration on Aging (AoA) funding assists Nevada in designing and implementing ADRC sites, the initiative also strives to sustain the key activities of the ADRC sites in the long term through additional funding and processes that promise success.

There are two types of sustainability that the project strives to achieve:
- Service Delivery Philosophy
- Financial Sustainability

Service Delivery Philosophy

In order for the ADRC program to receive continued support from the Division, a program site must:

- Maintain the program or its components in an identifiable form.
- Maintain the staffing capacity to deliver program services as outlined in the ADRC Service Specifications and the Older Americans Act (OAA) General Service Specifications.

- Apply established uniform statewide standards, procedures, and training especially regarding consumer service and use of technology.
- Document project success or compliance as outlined by the Division.
- Work in conjunction with the Division and other ADRC sites to build a coordinated, statewide system.
- Maintain a commitment to person-centered, consumer directed services.

Strategies to strengthen service delivery philosophy at the ADRC site

- ✓ Commit to make every policy and procedure "consumer-centered" and consumers will support the sustainability of the program.
- ✓ Involve consumers and stakeholders in meaningful ways, so they become advocates of the ADRC.
- ✓ Use diverse partnerships to create "information bridges" to the community.
- ✓ Select staff with enough experience to effectively serve the target populations and who share the ADRC vision and values.
- ✓ Commit to continuous staff training, cross-training, and quality improvement.

Financial Sustainability

While ADSD continues to seek and advocate for additional funding streams to enhance and expand Nevada's Care Connection program. Each ADRC site will need to develop a plan to sustain operations over time. ADRC sites may draw from several funding sources, including:

- State or County funds
- Federal funds
- Private Donations
- Cost Sharing
- Spin-off/Public-Private Partnerships
- Volunteers

As the program progresses, it is essential for each ADRC site to obtain support from outside entities to ensure that if Division funding becomes reduced or unavailable, the sites are able to continue uninterrupted service delivery.

Strategies to strengthen financial sustainability at the ADRC site

- ✓ Expansion into new service areas or actively planning for future expansion.
- ✓ Providing additional services, such as Medicare Counseling.
- ✓ Continuous marketing and outreach activities to raise awareness of ADRC services among consumers, as well as community and state leaders.
- ✓ Building partnerships – as other agencies incorporate the ADRC into their daily operations, everyone will begin to realize the value of this program.

- ✓ Demonstrating successes, efficiencies and the positive impact of ADRC service delivery to legislators and others who are looking to partner with and fiscally support a successful project.
- ✓ Promoting private partnerships and support to control and combine resources in creative ways.
- ✓ Earning the trust and support of the consumers and diverse partners; be open, inclusive and responsive to consumer and stakeholder priorities and feedback.
- ✓ Developing partnerships with private foundations; seek out public and private funding opportunities that will support ADRC activities, and think creatively to design and implement fundraising strategies.

Project Integrity

Project integrity is the process by which local ADRC sites implement a plan, deliver quality services to consumers, and develop effective partnerships between affiliated organizations.

Any individual authorized to perform ADRC functions on a state or local level play a vital role in maintaining project integrity.

Project integrity is grounded in identifying processes and assuring all site staff understand and comply with the following:

- **Confidentiality**
  The preservation, in confidence, of all information concerning consumers that may be disclosed between these individuals and ADRC specialists, the health care providers or their staff, and vendors where release of such information would constitute an invasion of privacy.

  Consumers will not be asked to disclose more personal information than necessary to make a referral, conduct a screening or assist with an application. All information obtained during the conduct of an interview will be deemed confidential.

  With consumer consent, an ADRC intake worker or specialist will only release the minimum amount of information needed to make a referral, process a request, or application.

- **Conflict of Interest**
  Any inappropriate relationship, real or apparent which jeopardizes the fair and objective administration of the project.

  ADRC sites are committed to delivering services to consumers without regard to gender, culture, socioeconomic background or other circumstances.

- **Fraud**

Fraud is defined as an intentional deception or intentional misrepresentation made by a person or organization with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person or organization.

Cases of suspected recipient fraud are referred to local enforcement authorities for investigation. Cases of alleged provider fraud should be reported to Senior Medicare Patrol (SMP) for Medicare related fraud and the Attorney General's Medicaid Fraud Unit for Medicaid fraud. Suspicion of abuse, neglect, and/or exploitation (fraud) of persons age 60 and older must be referred to the Nevada ADSD Elder Rights Intake Specialist for the purpose of investigation by Elder Protective Services (EPS). For persons age 59 and younger, a referral should be made to Adult Services through Washoe County or local law enforcement if in another county.

III. ADRC STAFF AND VOLUNTEERS

ADRC Staff Requirements

ADRC sites are selected based on organizations who have similar values and processes in place within their organizations. In addition, they demonstrate an ability to perform the require functions and program components as a seamlessly as part of their existing processes. The ADRC program is not meant to run separate from existing services; rather it is an enhancement of existing services. Site staff must be able to perform the required functions of the ADRC. In order to assist sites in recruiting staff, ADSD has developed minimum qualifications by staff function, see Appendix C.

General Staff Guidelines and Skill Requirements

ADRC staff should demonstrate:
1. Ability to relate to clients and respect client choice.
2. Skill in interviewing, listening, assessing, documenting, planning, assembling resources, implementing service, and conducting follow up.
3. Proficiency in communicating clearly, both verbally and in writing.
4. Knowledge of community resources and service terminology.
5. Understanding of program eligibility requirements and ability to apply them in specific situations.

ADRC staff must be able to:
1. Provide information and assistance to consumers regarding available long-term support services.
2. Conduct screenings of consumer needs.
3. Assist in the development and implementation of person/family-centered care plans which address living situation, employment, daily routine and assistance for care, participation in community, confidentiality issues, fair treatment, health and wellness, abuse and neglect, and connection to natural support networks.
4. Meet with or contact community partners to ensure plan implementation and

serve as a navigator to access available community resources.

5. Refer consumers to appropriate services; assist with applications for services; and follow-up with service agencies.
6. Provide benefits counseling to assure consumers have long-term support choices.
7. Maintain records, enter data, and prepare reports as required to document services requested and/or provided (SAMS; Semi-Annual Reporting Tool (SART); Monthly Performance Report or MPR (formerly the Data Tracking Tool or DTT).
8. Assist in the distribution of outreach and public information materials.
9. Conduct community presentations regarding ADRC and develop community partnerships.
10. Access Nevada ADRC resource directory to provide current information on long-term support service resources available to consumers.

Staff Training

ADRC specialists or *staff* must complete trainings offered or identified by the Division. Trainings are to focus on Elder Abuse Awareness training, program regulations, eligibility criteria, documentation, SAMS training, and eligibility processes for publicly-funded programs. ADSD has a set of training requirements and recommendations for site use (Appendix D). At a minimum, site staff must receive annual training on each of the public programs partnered with ADRC ().

Staff must receive **five** additional hours of relevant training each year. Additional training can be from any relevant source, including the ADRC training modules available on the web portal. ADRC modules available in the Learning Management System within the Nevada ADRC portal include:

1) Aging and Disability Awareness
2) Behavioral Health
3) Consumer Directed Care
4) Effective Communication and Interviewing
5) Grief and Loss
6) Imminent Risk
7) Memory and Dementia
8) Managing Difficult Behaviors in Patients with Dementia
9) Options Counseling
10) Assisting Private Pay Consumers
11) Self-Care for the Caregiver

The OAA Service Specifications also require training on suicide prevention at least every other year. The ADRC project manager is available to arrange for introductory training in suicide prevention.

ADRC site staff must also attend regularly scheduled ADRC site meetings. These meetings are vital for staying current with programmatic developments, IT, program

evaluation, and site compliance with service specifications and updates regarding ADRC operational expectations. Meetings are scheduled every other month on the third Wednesday of the month.

Volunteers for ADRC Program

In 2013, ADSD started the *Volunteers are IN* initiative to develop and implement a volunteer component for the ADRC sites. This initiative is meant to enhance existing site staff efforts, not replace them. The ADSD has developed general guidance, volunteer management tools and training to assist ADRC sites in implementing a volunteer program at their site. The initiative focuses on three types of volunteers to expand the capacity of the ADRC sites and increase service delivery.

Each ADRC site has the ability to recruit and manage volunteers in ways that will assist them in achieving success as an ADRC; this may include using volunteers in ways beyond the original three types listed below.

The Volunteers are IN project believes volunteers can assist:

1. *IN the community (Outreach Specialist).* These are opportunities to participate in special events, short-term and/or one-time projects to assist with outreach and public education events. Volunteers will provide outreach and in-service presentations at various community events and organizations to increase the awareness and access of ADRC services throughout the state. Another key to the ADRC program is educating people on the need for LTC futures planning. Volunteers will assist the ADRC program through offering various workshops and trainings on an array of topics associated with LTC futures planning.

2. *IN meaningful experiences (Futures Planners).* These are regularly scheduled services opportunities to provide ADRC services to consumers in person, on the phone or within community settings. Volunteers will be recruited to hold regular office hours at local ADRC sites to provide information and referral services, triage new consumers for priorities and offer options counseling long term care (LTC) futures planning. LTC futures planning can include a wide variety of topics ranging from long term care services to advanced directives. Volunteers will be trained on a wide array of resources available in the community as well as LTC tools, such as the Department of Health and Human Services Long Term Care website.

3. *To INcrease independence (Benefits Access Advocates).* These opportunities are on call assignments that are available for higher level ADRC services such as case management, advocacy and follow up. These opportunities would be made available to seasoned volunteers who have the necessary qualifications to provide these services, e.g. retired social workers, retired occupational therapists, etc.

The complete program overview and guidance is contained in the comprehensive *Volunteers are IN* program manual. **Note:** Implementation of a volunteer component is highly recommended, but not required at this time.

IV. PUBLICLY FUNDED PROGRAMS

Publicly Funded Programs

ADRC site staff shall serve as trusted sources of information regarding publicly funded programs which promote the use of home and community-based and long-term support services, consumer-directed care and self-determination to avoid spend-down to Medicaid.

A quick reference guide for each of the required publicly funded programs has been provided in the ADRC Learning Path on the web portal. Each of these programs are administered by Aging and Disability Services Division (ADSD), Department of Welfare and Supportive Services (DWSS), or Department of Health Care Financing and Policy (DHCFP).

Interagency Agreements

ADSD has worked on initiating cooperative arrangements with sister agencies in the Department of Health and Human Services (DHHS) in order to become a strong ADRC program and model. These agreements are designed to potentially allow for referral protocols, co-location of staff, cross-training, collaboration on client services, and regular communication. This includes working agreements with the Division of Welfare and Supportive Services (DWSS) to ensure timely eligibility processing and potential access to Medicaid and Food Stamp (SNAP) benefits and the Division of Health Care Financing and Policy (DHCFP or Medicaid) to facilitate timely access to Medicaid service programs and benefits.

ADSD has administrative control over a majority of the public programs that ADRC sites are expected to be trained and knowledgeable in. Therefore, an interagency agreement is not necessary.   ADSD staff will be available to offer training to the ADRC sites on program regulations, eligibility criteria, documentation, and eligibility processes for publicly-funded programs.

Publicly Funded Programs that are partnered with ADRC include, but are not limited to:

1. Nevada Medicaid (Medical programs including MSP)
2. Nevada Medicaid Waiver for Independent Nevadans (WIN);
3. Nevada Medicaid Transition Services including Money Follows the Person (MFP) and FOCIS;
4. Supplemental Nutrition Assistance Program (SNAP);
5. Homemaker Program (Title XX);
6. Home and Community Based Waiver (HCBW);

7. Community Options Program for the Elderly (COPE);
8. Assisted Living Waiver- southern NV only (AL);
9. State-Funded Personal Assistance Services Program (PAS);
10. State-Funded Independent Living Program (ILAT);
11. Autism Treatment Assistance Program (ATAP)
12. State Prescription Assistance Programs (SPAP);
13. Deaf and Hard of Hearing Advocacy Resource Center (DHHARC)
14. Lifespan Respite Program (LRIS)
15. Elder Protective Services (EPS)
16. Long Term Care Ombudsman Program (LTCOP)
17. Senior Medicare Patrol (SMP);
18. State Health Insurance Assistance Program (SHIP) certification;
19. Nevada Early Intervention Services (NEIS); and
20. Developmental Services offered through Regional Centers.

ADRC Role in Streamlining Access to Public Partner Benefits

ADRC ROLES IN STREAMLINING

- Eligibility screening
- Forms completion
- Online applications
- Appeal and Grievances

The intent of the Nevada ADRC is to work with Medicaid to streamline the application process, from intake and assessment, to eligibility screening and options counseling, to final determination and service provision. Often, consumers are unaware of all the programs for which they may qualify, such as Supplemental Nutrition Assistance Program (SNAP), Low Income Home Energy Assistance Program, and Nevada state-funded public programs. The ADRC sites provide intake, screening, and assistance to inform consumers about the programs and benefits that may be available to help meet their needs.

Nevada ADRC site staff perform only "initial processing" functions, such as taking applications, assisting individuals in completing applications, obtaining required documentation to complete the application, conducting necessary interviews, and following up with the consumer. The DWSS is responsible for financial eligibility determinations for SNAP and Medicaid. The DHCFP and ADSD are responsible for completing functional eligibility determinations for Medicaid services.

Poverty Guidelines

In January of each year, the federal government releases an official income level for poverty called the Federal Poverty Income Guidelines, often informally referred to as the "Federal Poverty Level." The benefit levels of many low-income assistance programs are based on these poverty guidelines. A pregnant woman counts as two for the purpose of the chart. ADSD provides the poverty guidelines for their grantees at their website: http://www.nvaging.net/grants/poverty.htm

A strong collaboration between ADRC and provider organizations ensures that consumers experience little if any difficulty in accessing their services.

V. OPERATIONAL DEFINITIONS AND ACRYONMS

The following definitions and acronyms are offered as a quick reference for staff and volunteers. These lists are not intended to be all inclusive, rather they are some of the most common terms and acronyms.

Definitions

Activities of Daily Living (ADL): Behaviors such as eating, bathing, dressing, toileting, transferring in/out of bed/chair, walking in their own home.

Advocacy: With regards to ADRC, specifically refers to **civil advocacy**, advocating or representing the upholding of rights for specific groups of individuals (people with cognitive impairments, people who are deaf) as opposed to **social advocacy** which is seeking policy change at the group level.

Assessment: To evaluate the individuals' needs beginning with the initial communication (e.g. telephone call, e-mail, or walk-in).

Assistance and Advocacy (A&A): Refers to providing long-term support options counseling; employment options counseling; crisis intervention; helping people to plan for their future long term support needs.

Assistive Technologies: Devices and tools that maintain or increase mobility, hearing, vision and communication capacities. Examples of such tools include wheelchairs, prostheses, mobility aides, hearing aids, visual aids, and specialized computer software and hardware.

Benefits Counseling: Refers to providing accurate and current information on private and government benefits and programs. This includes assisting individuals with navigating the application process for Medicare, Social Security, or other benefits.

Care Recipient: An individual with a chronic illness or disabling condition who needs ongoing assistance. The person needing assistance may also require primary and acute

medical care or rehabilitation services (e.g. occupational, speech and physical therapies).

Caregiver: Individuals who provide a range of activities. These activities can be relatively undemanding, such as driving the person you care for to an appointment or the activities can be highly demanding, such as bathing, dressing, and feeding the care recipient.

Care Transitions: the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

Case Management: Refers to the coordination of services such as health, legal, or financial on behalf of an individual. This includes creating a case file and following-up to ensure delivery of services. A case is handled by a case manager or case team.

Client: Any individual who contacts ADRC that results, at minimum, information being provided. The client may be a caregiver, care recipient or other individual needing long term care planning assistance. *Also may be known as customer or consumer.*

Contact: Any call or visit to the ADRC that results, at minimum, information being provided to the customer.

Consumer: Any individual who falls with the Care Connection target population. This could include an older adult (age 60 or older), a person with a disability, a caregiver or someone planning for future long term care needs.

Consumer-Directed Care: provisions that takes the consumers' preferences into consideration and provides the consumer with the information needed to participate in the choice of care plan.

Crisis Intervention: Provides assistance for people in crisis with assessment, identification of resources, service acquisition, and follow-up. Essentially crisis intervention is a response to a situation where short-term assistance is needed to support an individual until a plan for long-term support services can be put in place. For example, an individual whose existing support system has fallen apart may need immediate support to assist them while a more comprehensive plan is developed and implemented. If an individual is exhibiting difficult behaviors and appears to be a danger to self or others, centers would coordinate with, existing supports such as Elder Protective Services (EPS), in accordance with state laws and agency procedures. In extreme situations, a call to 911 may be warranted.

Custodial Care: Refers to non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do

themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Ease of Access: The state in which there is reduction in the amount of time and level of frustration and confusion individuals and their families experience in trying to access long term support.

Eligibility/Access (E&A): Provide eligibility screening; benefits counseling; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination; one-stop access to all public programs for community and institutional long term support services.

Eligibility Determination: The process of evaluating the financial or programmatic parameters an individual must meet in order to receive services.

Efficiency and **Effectiveness**: The ability to produce a reduction in the number of intake, screening, and eligibility determination processes, diversion of people to more appropriate, less costly forms of support, improved ability to match each person's preferences with appropriate services and settings, ability to rebalance the state's long term support system, ability to implement methods that enable money to follow the person, etc.).

Event: For reporting purposes, equals one community presentation, one provider training, one PSA "hit/run", one in-service, or one of any other marketing/outreach activity.

Family Resource Centers: Community-based entities which provide information, referrals, and case management to residents in a service area. FRCs collaborate with local and state agencies and organizations to help individuals and families access needed services and support.

Follow-Up: Ensuring and documenting delivery of services or alternative options such as filing a grievance or filing for other services.

Futures Planning: The process of planning for one's future long-term support needs. For ADRCs, this may involve the provision of information, counseling and resources about retirement planning, financial planning, LTC insurance, and reverse mortgages.

Grievance: A complaint about the way services are given. For example, a grievance is filed if a consumer has a problem receiving services or is unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Hospice: A special type of care for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well.

Imminent Risk: Refers to either the increased likelihood of nursing home placement, or of spending down to Medicaid.

Informed Choice: Providing reliable information that helps consumers make the best choices for their care plans.

Information and Referral (**I&R)**: Refers to providing public education; information on long term support options; referral to other programs and benefits.

Instrumental ADLs (IADLs): Behaviors such as preparing meals, taking medication, heavy housework, using the telephone, using transportation services, shopping, managing money, light housework.

Intake: Refers to a decision-making process for determining how a case will be handled. The intake process typically involves documentation of basic demographic data and initial eligibility screening for services.

Life Skills Training: Refers to assisting client in learning (or relearning) basic skills needed for activities of daily living, including higher level ADL's such as grooming, meal preparation and household management.

Long-Term Care: The variety of services that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. It is important to remember that you may need long-term care at any age. Types of long-term care include, nursing homes, adult day care, retirement communities, board and care, assisted-living, and community based services.

Medical Care: The provision of services related to the maintenance of health, prevention of illness, and treatment of illness or injury by physicians (including specialists and psychiatrists), physician assistants, advanced practice nurses, registered nurses, LPNs, chiropractors, pharmacists, dentists, etc.

Medicare: A federal program that pays for certain health care expenses for people aged 65 or older, persons with end stage renal disease and some younger persons with disabilities. Enrolled individuals must pay deductibles and co-payments, but much of their medical costs are covered by the program. Medicare is less comprehensive than some other health care programs, but it is one source of post-retirement health care.

Medicaid: The State and Federal Government program that pays for certain health services and nursing home care for older people with low incomes and limited assets. In most states, Medicaid also pays for some long-term care services at home and in the community. Who is eligible and what services are covered vary from state to state. Most often, eligibility is based on your income and personal resources.

Options Counseling: Includes some combination over time of the following activities: provision of information, making referrals, counseling, assisting with applications, advocating, home visits, short-term case management, and conducting needs assessments and reassessments.

Options Screening: An initial selection procedure conducted to determine if an individual may be eligible for services by an appropriate.

Own Your Future: A project, started in January 2005, to increase consumer awareness about, and planning ahead for, long-term care. It is a collaboration of the Centers for Medicare & Medicaid Services (CMS), the Office of the Assistant Secretary for Planning & Evaluation (ASPE), and the Administration on Aging (AoA), and has support from the National Governors Association (NGA). A planning guide has been provided in Appendix F.

Personal and Social Adjustment: Refers to the issues pertaining to an individual's involvement in the community and how well they are able to adjust and cope with the stresses of daily life. A well rounded social outlet and an ability to cope with daily life can improve the quality of life of the individual, and may reduce the effects of chronic illness and improve the overall health of an individual.

Planning for Care/Services: Includes assessment, information provision and options counseling for clients who may need long term care services in the future. It relates to preventing spend down to Medicaid and reducing the risk of institutionalization.

Private Pay Consumers: Includes consumers who are able to pay for some services and/or are ineligible for public programs. Consumers with a range of incomes fall under this definition, including the following: Eligible for public programs but able to pay for some services on a sliding scale or reduced fee basis; not eligible for public programs and unable to purchase services; not eligible for public programs but able to pay for some services on a sliding scale or reduced fee basis; and not eligible for public programs and able to purchase services at market value.

Psychosocial Intervention: An approach aimed at improving well-being of people. It acknowledges the psychological health of the individual, knowledge and skills of the individual, economic and material resources, culture and values, and social support that influence an individual's experience.

Rebalancing: Refers to the rebalancing of state and federal resources to promote

home and community based services versus institutional care.

Respite Care: Refers to short term, temporary care provided to people with disabilities in order that their families can take a break from the daily routine of care giving. Unlike child care, respite services may sometimes involve overnight care for an extended period of time. Respite care enables families to take vacations, or just a few hours of time off.

Responsiveness: Encompasses the needs, preferences, unique circumstances, and feedback of individuals as it relates to the functions performed by the Resource Center.

Short-Term Case Management: Short-term case management is used to stabilize individuals and their families in times of immediate need before they have been connected to ongoing support and services. It often involves more than one follow up contact.

Spend-down: Refers to individual's risk of being in a financial situation that precludes immediate eligibility for Medicaid assistance, but allows the option of spending their assets until they do qualify.

Trust: Refers to the public perception in the objectivity, reliability, and comprehensiveness of the information and assistance available at the Resource Center.

Visibility: The extent to which the public is aware of the existence and functions of the ADRC.

Acronyms

Acronym	Meaning
A & A	Assistance and Advocacy (Options Counseling)
ADA	Americans with Disability Act
ADLs	Activities of Daily Living
ADRC	Aging and Disability Resource Center
ADRC-TAE	ADRC Technical Assistance Exchange
ADSD	Aging and Disability Services Division
AL	Assisted Living
AoA	Administration on Aging
ASL	American Sign Language
ASPE	Assistant Secretary for Planning & Evaluation
ATAP	Autism Treatment Assistance Program
CBC	Community Based Care
CILs	Centers for Independent Living
CIS	Consumer Intake Survey
CMM	Client Management Module
CMS	Centers for Medicare and Medicaid Services
COA	Commission on Aging
COPE	Community Service Options Program for the Elderly
DCFS	Department of Children and Family Services
DHCFP	Division of Health Care Financing and Policy
DHHARC	The Deaf and Hard of Hearing Advocacy Resource Center
DHHS	Department of Health and Human Services
DTT	Data Tracking Tool
DWSS	Division of Welfare and Supportive Services
E & A	Eligibility and Access (Benefits Counseling)
EAP	Energy Assistance program
EPS	Elder Protective Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment for children
FCIS	Follow-up Consumer Intake Survey
FRCs	Family Resource Centers
HCBS	Home and Community Based Services
HCBW	Home and Community Based Waiver
HIWA	Health Insurance for Work Advancement
I & R	Information and Referral
IADLs	Instrumental Activities of Daily Living
ICF-MR	Intermediate Care Facilities for the Mentally Retarded
INS	Immigration and Naturalization Service
IT	Information Technology

LRBI	Lifespan Respite Balancing Initiate
LRP	Lifespan Respite Program
LTCO	Long-Term Care Ombudsman
LTSS	Long-Term Services and Supports
MPR	Monthly Performance Report
MSP	Medicare Beneficiary Programs or Medicare Savings Plan
MTM	Medication Therapy Management
NASUAD	National Association of State Units on Aging Directors
NGA	National Governors Association
OAA	Older Americans Act
PCA	Personal Care Assistance
PAS	Personal Assistance Services Program
PCS	Personal Care Services
PERS	Personal Emergency Response System
PSA	Public Service Announcements
QDWIs	Qualified Disabled Working Individuals
QMBs	Qualified Medicare Beneficiaries
RD	Resource Development
RSDI	Retirement and Survivor's Disability Insurance
SAMS	Social Assistance Management System
SART	Semi-Annual Reporting Tool
SCA	Sanford Center for Aging
SHIP	State Health Insurance Assistance Program
SLMBs	Special Low Income Medicare Beneficiaries
SMP	Senior Medicare Patrol
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facilities
SPAP	State Prescription Assistance Program
SPSS	Stakeholder Partner Satisfaction Survey
SSDI	Social Security Disability Income
SSI	Social Security Supplemental Income
TANF	Temporary Assistance to Needy Families
VHO	Volunteer Host Organization
WEARC	Waiver for the Elderly in Adult Residential Care
WIN	Waiver for Independent Nevadans

VI. Appendices

General Reference

Appendix A – ADRC Program Diagram
Appendix B – Motivational Interviewing Strategies
Appendix C – ADRC Staff Qualifications
Appendix D – ADRC Training Recommendations

Forms and Tools

The following forms and tools are available in the Learning Path for ADRC on the ADRC web portal.

<u>Forms</u>
Form 1 – Intake Assessment
Form 2 - Options Counseling Assessment
Form 3 - Notice of Privacy Policy
Form 4 – Consumer Intake Survey
Form 5 – Follow Up Consumer Survey
Form 6 – Options Counseling – Service Plan

<u>Tools</u>
Own Your Future Guide
Public Program Quick Reference Guides

Helpful Websites

- *ADSD General Information-* includes service specifications, reporting requirements, etc.
  www.nvaging.net
- *ADRC Web Portal-* your source for resources, training and general information.
  www.nevaadrc.com
- *Long Term Care Planning Guide* – an online resource created by the U.S. Department of Health and Human Services to help peple plan for their long term care.
  www.longtermcare.gov
- *ADRC TAE site-* an online collection of resources from states across the nation with materials specific to ADRC and ADRC initiatives. Hosted by the Lewin Group, the national consultant for ADRC. www.adrc-tae.org