Massachusetts Money Follows the Person Demonstration Sustainability Plan

Appendix B

The Massachusetts Aging and Disability Resource Consortia Five-Year Strategic Plan

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Massachusetts' Aging & Disability Resource Consortia
5-Year Strategic Plan

Executive Summary

In 2003, Massachusetts was one of the first 12 states funded to develop an Aging and Disability Resource Center program, which in Massachusetts is known as Aging & Disability Resource Consortia (ADRC). Due to its initial success, Massachusetts received a two-year continuation grant from AoA in 2006 to expand the ADRC model to other regions of the state. MA received an additional three-year ADRC grant in 2009 to develop a five-year strategic plan that evolves its ADRCs to "fully-functional" status.

The Massachusetts model builds upon the existing infrastructure of two key agency networks: twenty-seven (27) Aging Service Access Points (ASAPs) and three free-standing Area Agencies on Aging (AAAs) serving elders age 60 and over, and eleven (11) Independent Living Centers (ILCs) serving people of all ages with disabilities. While the Massachusetts model includes formalized partnerships among ASAPs/AAAs and ILCs as the core "members" of the regional ADRCs, the Commonwealth supports regional variation and is open to the inclusion of additional networks should a region desire.

Upon receipt of the 2009 ADRC Strategic Planning Grant award, ADRC member agencies in partnership with the Executive Office of Elder Affairs (EOEA) and the Massachusetts Rehabilitation Commission (MRC) immediately began discussing the approach and tactic it would take to develop a collaboratively-driven 5-year strategic plan. Building upon an important "Shaping Our Vision" meeting facilitated by The Lewin Group in May 2009, the State and ADRC member agencies proposed and adopted a comprehensive process.

The Task Force met monthly from November 2009 – March 2011. Representatives on the Task Force agreed to voice the opinions of their collective ADRCs. It was agreed to at the outset that the Task Force would not function as the decision-making body for the ADRC membership, but rather as the idea generator and "think tank", with recommendations voted upon and taken back to be "vetted" with their respective ADRC member agencies not on the Task Force.

The resulting plan builds upon all of the collective work done to date, supporting and embracing a "No Wrong Door" model of collaborative partnerships, while valuing the

independence and autonomy that each member agency retains. The MA ADRCs, through this strategic plan, seek to further mechanisms to work together to better serve consumers in need of long term services and supports (LTSS), and to build the role of the ADRCs into the fabric of the State's system of LTSS.

The plan is organized by a Plan Vision Statement, Mission Statement, Guiding Principles, Role(s) of ADRCs, Statewide Outcomes, and task-oriented Goals, Objectives, and Activities. The specific core functions of Information & Referral, Options Counseling, and Transitions are described, followed by a Five Year Plan at a Glance and a discussion of Sustainability.

The Role of ADRCs in Massachusetts:

1. Increase awareness of and provide reliable information about LTSS.
2. Support individuals who need assistance in seeking services and making person-centered decisions.
3. Simplify and streamline an individual's access to desired LTSS through "no wrong door" collaborative partnerships.
4. Promote and embody principles of consumer-centeredness, self-direction, cultural competency, and accessibility

Statewide Outcomes for ADRCs in Massachusetts:

1. Individuals, communities, and critical pathways are aware of the information and LTSS and services they receive from their ADRC member agencies.
2. Individuals have the relevant information they need to make individually-directed choices about LTSS within their communities.
3. Individuals have streamlined access to the LTSS they determine they need and want, enabling them to maintain independence and community living as long as they choose to do so.

Key areas that the ADRCs, in partnership with the State, need to address over the next five years to sustain ADRCs going forward include support for the core functions of I&R, Options Counseling, and Transitions activities, along with development and refinement of information technology and data systems that support "virtual" partnerships. The role of State and local coordination is critical for the creative thinking, work plan development and implementation, and communication to continue. Lastly, building evaluation and quality improvement activities within and across the ADRC functions and at the

State level will provide the legitimacy and data to tell a story of why ADRCs are important—to the community, the State and federal government, and most importantly, to the individuals they serve.

Historical Context

The Aging & Disability Resource Center (ADRC) grant program, referred to in Massachusetts as the Aging & Disability Resource Consortia, began as a jointly sponsored national initiative funded by the US Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to create visible, trusted places in the community that provide a coordinated system of information and access to long term services and supports (LTSS) for individuals, family members and providers, regardless of age, disability or income.

In 2003, Massachusetts was one of the first 12 states funded to develop an ADRC model. Due to its initial success, Massachusetts received a two-year continuation grant from AoA in 2006 to expand the ADRC model to other regions of the state. Using the 2006 reauthorization of the Older Americans Act as its vehicle, AoA has committed itself to expanding the ADRC concept nationwide. MA received an additional three-year ADRC grant in 2009 to develop a five-year strategic plan that evolves its ADRCs to "fully-functional" status.

Much work has been done over the past decade to create access points for publicly funded LTSS for elders. Similar efforts have been made for programs serving persons with disabilities. However, prior to this grant opportunity, efforts to streamline access to LTSS for all persons regardless of age, income or disability continued absent a clear plan. Fortunately, because of ADRC program funding opportunities, the Massachusetts ADRC model brings together two key networks serving elders and persons with all disabilities for the first time. These partnering organizations have created a virtual "no wrong door" for consumers, providers, and caregivers that builds upon established infrastructures.

National Expectations

AoA and CMS developed an overall vision for ADRCs that has been incorporated into each progressive grant solicitation since 2003. To date, the long-range vision remains the same,

to have ADRC programs fully operational and available to individuals in every community across the country serving as highly visible and trusted sources of information on the full range of long-term

services and support options along with one-on-one help in understanding and accessing the services and supports they need[1].

Additionally, AoA and CMS outlined core functions it expects ADRCs to provide. The definitions of these core functions continue to be refined over time as ADRCs evolve and learn through experience and as AoA and CMS learn from ADRC development nationwide.

The key operational functions of a fully developed ADRC include:

- Information, Referral and Awareness
- Options Counseling and Assistance
- Streamlined Eligibility Determinations for Public Programs
- Person-Centered Care Transitions
- Quality Assurance and Continuous Improvement

AoA and CMS remain committed to the vision and core functions, while allowing states the flexibility to implement ADRC models that work at the State and local level. There is no "cookie cutter" ADRC but rather a desire to achieve the vision and mission, while supporting the core functions. The Commonwealth of Massachusetts embraces this vision, and has worked to build a model that supports the full realization of this vision within existing agency infrastructures.

Through the evolution of ADRCs nationwide, it was expected that the following **stated goals** would be achieved[2]:

- *Better choices* for individuals about where they live and what kinds of services and supports they are able to receive to meet their needs;
- *Improved access* to services;
- *Improved quality* through a focus on health and social outcomes;
- A *cost-effective system* for the future.

The following interventions, outcomes and long-term impacts were identified through the national ADRC grant process:

[1] U.S. Administration on Aging

[2] The Lewin Group, ADRC Technical Assistance Exchange

ADRC National Level Expectations[3]		
Interventions	**Intermediate Outcomes**	**Long Term Impacts**
Increase awareness and provide reliable information	*Awareness* among a number of internal and external groups, including those critical pathways where institutional versus community placement decision are often made	Visibility/Awareness
Provide assistance in seeking services and making decisions	*Visibility* of the ADRCs and the aging and disability networks' role in access to LTSS	Visibility/Awareness
Simplify and streamline access to public programs through a physical or virtual one stop shop	Fostering *understanding* among the target populations, providers and the critical pathways of available resources and options through the awareness and information activities Gaining the *trust* of consumers, their families, providers and others by providing responsive information, assistance and systems of access *Integrated access* to public programs through combining intake, eligibility and assessment processes that, along with visibility, fosters ease of access.	Enhanced access Informed choice Consumer focus Efficiency Effectiveness

In response, Massachusetts identified the following problems and possible solutions within its own state:

[3] Administration on Aging and The Lewin Group, ADRC Technical Assistance Exchange

Massachusetts ADRC Model	
Problems—The MA ADRC model was created to address the following system deficiencies.	**Solutions—What will result from the development of ADRCs in MA?**
A lack of statewide, uniform coordination and collaboration across the two different service networks, which is confusing to consumers and forces community agencies to forge local, often problem-specific coalitions (*as stated in the original 2003 proposal*).	Consistent quality service, staff knowledge and experience, appearing almost seamless, regardless of whether the call or referral originates at the local ASAP/AAA, ILC, or other member agency.
No formal systems within the community to ensure that the information and assistance given by the myriad community organizations is comprehensive, consistent, and appropriate for all of an individual's needs.	Accurate, current, professional and consistent information across member agencies regardless of which agency a consumer contacts first; efficient and effective customer service; seamless and appropriate referrals among member agencies.
The existence of groups of consumers who are un-served by either network who could benefit from expertise, even if they are being served by another state agency.	Consumers are served regardless of whether they are "in" the ADRC member agency's service area; staff are trained and educated about comprehensive resource options in the community.
A lack of cultural and philosophical parity across the elder and disability networks, demanding that they learn to accommodate different advocacy styles and different priorities.	Consumers and families are served, following the MA ADRC Guiding Principles that promote the Community First policy and embrace the ILC philosophy.

The Massachusetts Model

The Massachusetts model builds upon the existing infrastructure of two key agency networks: twenty-seven (27) Aging Service Access Points (ASAPs) and three free-standing Area Agencies on Aging (AAAs) serving elders age 60 and over, and eleven (11) Independent Living Centers (ILCs) serving people of all ages with disabilities. While the Massachusetts model includes formalized partnerships among ASAPs/AAAs and ILCs as the core "members" of the regional ADRCs, the Commonwealth supports regional variation and is open to the inclusion of additional networks should a region desire. As an example, one regional ADRC includes a PACE (Program for All-Inclusive Care for the Elderly) provider, and most recently, its local employment and training office as "member" agencies. Organizations that come together to form an ADRC enter into formalized Memoranda of Understanding (MOUs) among each other,

and with the Executive Office of Elder Affairs (EOEA) and the Massachusetts Rehabilitation Commission (MRC), to clearly articulate the overall relationship, expectations and points of accountability related to the ADRC initiative.

Why did Massachusetts choose to execute the model it did? The reasons are many. From an infrastructure perspective, ASAPs across Massachusetts are established in statute as the one-stop entry points for elders in the state. ASAPs are responsible for providing information and referral services to elders; conducting intake, comprehensive needs assessments, preadmission screening and clinical eligibility determinations for individuals seeking institutional and many community-based services; developing a comprehensive service plan based on the needs of the individual; arranging, coordinating, authorizing and purchasing community LTSS for individuals as indicated in their service plan; and monitoring the outcomes of and making periodic adjustments to their service plan. The ILCs, at a minimum, must provide the federally-mandated core services of information and referral, peer counseling, skills training, and advocacy. Each member agency brings its own unique strengths and experiences to the table, allowing for richness in philosophies and perspectives.

More discrete reasons include:

- Infrastructure and critical core functions already exist, including dedicated funding streams to support required functions (e.g. I&R, options counseling, assisting with clinical and financial eligibility determination/streamlining access to LTSS, nursing facility transitions);
- Partnering together increases consumer access to a broader array of options for living independently;
- This model provides an opportunity for aging and disability networks to advocate together on legislation and policies that enhance the ability of individuals to live independently in the community;
- Networks share compatible vision and mission;
- Networks serve populations who need functional assistance;
- Networks are local non-profits with local consumer-controlled boards;
- Various funding bases exist:

a. ASAPs/AAAs: Older Americans Act, Executive Office of Elder Affairs (EOEA), MassHealth/Medicaid, other State/local

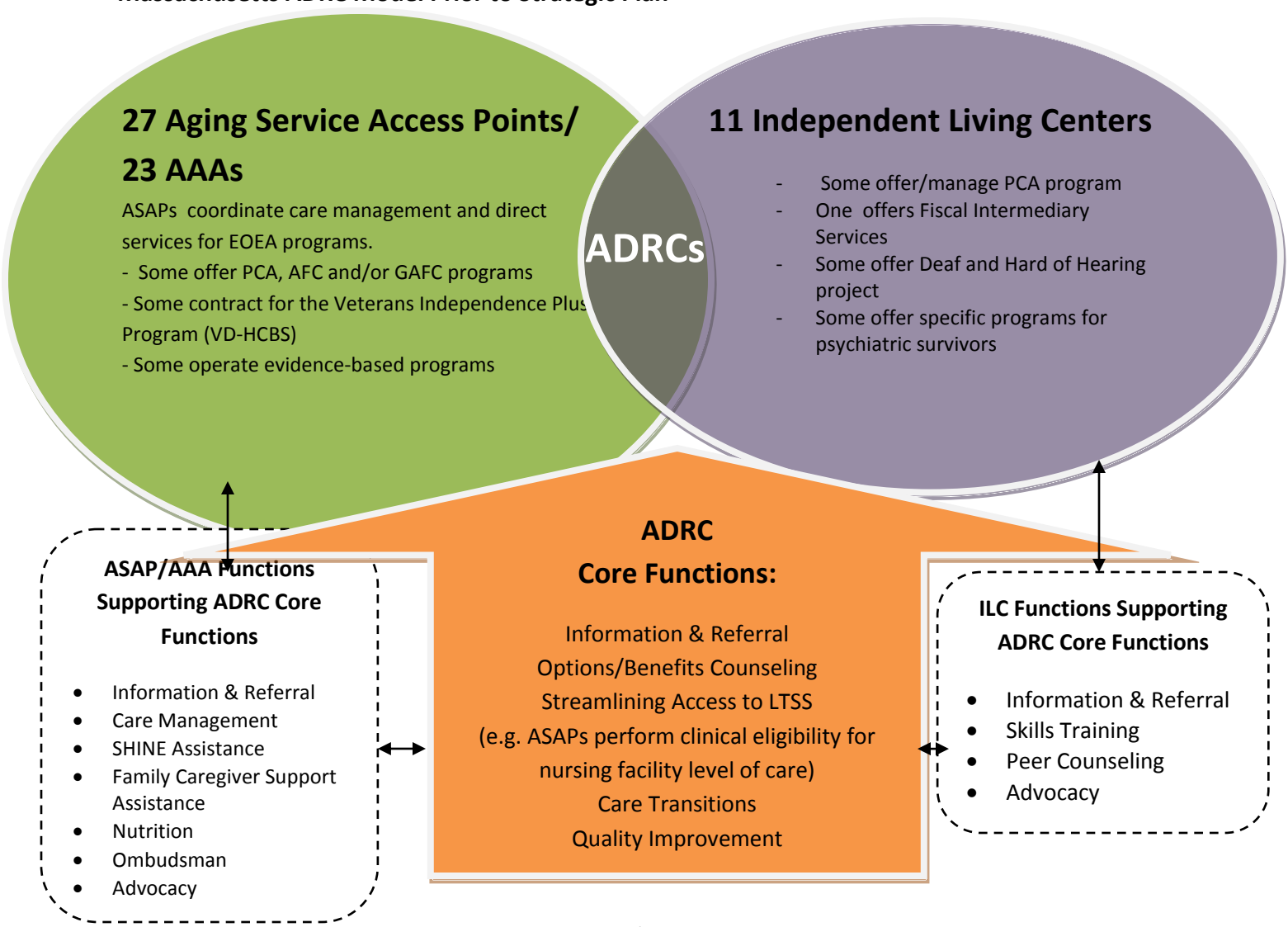
b. ILCs: Title VII of the 1973 Rehabilitation Act, other State/local

- Networks use core client-centered databases and management information systems (although divergent and incompatible at this point in time); and
- Shared commitment to serving individuals in the settings and manner of their choice and to diverting individuals from institutionalization and/or transitioning individuals out of institutions to home and community-based supports.

Key components that the local networks insisted upon when developing the ADRC model include:

- EQUAL partnerships from the beginning
- **Retain autonomy as individual agencies**, but come together as unique partners to support common missions, vision and provision of core functions—they are stronger as partners to better serve individuals
- Support and magnify cross trainings on philosophy and service networks
- Do not build something NEW
- Do not build "entities" or "physical locations"
- Build *concept* of virtual partnerships—what is done behind the scenes in partnership results in better outcomes for consumers—not necessarily visible to the public.

Massachusetts ADRC Model Prior to Strategic Plan



ADRCs represent equal partnerships between ASAPs/AAAs and ILCs. Many of these member agencies also operate service programs designed to help individuals remain in the community. While the management/oversight of these services is not a core FUNCTION of what ADRCs do, they in effect are interconnected with the ADRC in its ability to rapidly refer individuals to needed assistance and services in a more streamlined manner given the interconnections that exist by design. The intent of this visual is to show how existing core functions of the ASAPs/AAAs and ILCs already support what AoA envisions as the core functions of ADRCs. In addition, due to the design/expectations of ASAPs and some ILCs, there are additional services that these organizations offer that are not directly connected to ADRC activities, but are mutually supportive of ADRC activities.

Who does the ADRC serve?

The national expectation is that ADRCs serve at a minimum the 60 and over population through the network of AAAs, and at least one additional target population[4]. In Massachusetts, the ADRCs serve, primarily, all persons age 18 and over regardless of disabilities and income. MA does not describe particular disability populations or service networks, with the exception of identifying ILCs and ASAPs/AAAs as the two networks to be included as core member agencies.

The ADRC is also expected to serve the loved ones, caregivers, and support persons of said individuals as well as the community-based and institutional organizations supporting individuals needing information and access to LTSS[5]. The goal of the ADRC (and all member agencies) is to be recognized as "THE" experts and expected referral sources for anyone seeking information and access to LTSS.

The ADRCs serve persons of all incomes; ADRCs provide support and guidance to all persons whether or not they are eligible for publicly funded programs and services, as well assisting individuals desiring "futures-planning" around their LTSS needs[6].

MA Strategic Planning Process

Upon receipt of the 2009 ADRC Strategic Planning Grant award, ADRC member agencies or ASAPs/AAAs/ILCs, in partnership with EOEA and MRC immediately began discussing the approach and tactic it would take to develop a collaboratively-driven 5-year strategic plan. Building upon an important "Shaping Our Vision" meeting facilitated by The Lewin Group in May 2009, the State and ADRC member agencies proposed and adopted the following process to shape its plan.

1. Create a Strategic Planning Task Force comprised of representation across all ADRCs and key State leadership.

2. Develop a communication protocol, Task Force roles, responsibilities, and expectations to assure maximum involvement of all 41 ADRC member agencies and stakeholders in each stage of the process.

[4] U.S. Administration on Aging ADRC Grant Solicitation, 2003

[5] Ibid.

[6] Ibid.

3. Agree to the most efficient and desired strategic planning process and template to guide its work.

4. Propose and organize topic areas that need to be discussed and included in the strategic plan.

5. Schedule required meetings among Task Force members organized around identified topic areas.

6. Prepare materials reflecting decision points made by the Task Force and strategic plan direction to share with the rest of the ADRC Leadership Teams and non-Task Force ADRC members to ensure input at all levels.

7. Create ad hoc workgroups, as necessary, to address specific areas of the strategic plan and ongoing operations.

8. Develop a review process and opportunities for comment.

The Task Force met monthly from November 2009 – March 2011. Representatives on the Task Force agreed to voice the opinions of their collective ADRCs. It was agreed to at the outset that the Task Force would not function as the decision-making body for the ADRC membership, but rather as the idea generator and "think tank", with recommendations voted upon and taken back to be "vetted" with their respective ADRC member agencies not on the Task Force. Each representative was responsible for sharing materials and key decision points with their member agencies, and concerns and comments circulated back to the Task Force for final incorporation into the plan. Therefore, a circular process was adopted, ensuring the broadest input possible across myriad stakeholders.

The Task Force accomplished its tasks effectively and efficiently, and not without challenges and frank discussion. What follows is the recommended ADRC Five-Year Strategic Plan, as designed by and on behalf of the ADRCs across the Commonwealth, in partnership with their local community partners and State partners at EOEA and MRC. The ADRC Strategic Planning Task Force membership is listed in Appendix A.

The Massachusetts ADRC Five-Year Strategic Plan

MA ADRC Vision Statement

To have ADRCs serving every community as highly visible and trusted places where all persons regardless of age, income and disability can find information on the full range of LTSS options and can access public long-term support programs and benefits via a no wrong door model.

MA ADRC Mission Statement

The MA ADRC provides consumers, regardless of age, disability, or income, with access to information and referral services and assist them with decision support, service planning and consumer-directed options regarding their choices of services and supports.

MA ADRC Guiding Principles

The MA ADRC initiative is seen as a philosophy that member organizations subscribe to and promote in the way they conduct their business. The MA ADRC seeks to be as inclusive as possible to encourage other community organizations and interested parties to be involved in providing better service to consumers. ADRCs encompass a set of principles (herein described below) and standards of service which members of the ADRC pledge to honor. The ADRC members embrace the following guiding principles:

1. ADRC members believe in the philosophy of consumer direction and choice.
2. ADRC members agree to promote a "Community First" policy and program approach to services and supports.
3. ADRC members subscribe to a "no wrong door approach" whereby consumers will be provided with information no matter where they enter the system.
4. ADRC members agree to act in ways that will create a seamless system of information and referral that promotes consumer choice.
5. ADRC members embrace the independent living philosophy, including the following practices:

    a. Consumer Control—ADRCs ensure that each individual holds power and authority over the services they receive. ADRCs do not have a list of services

from which a person can choose, but rather the ADRC provides information and access to the services requested by the consumer in the manner requested by the consumer.

b. Consumer Direction – ADRCs ensure that individuals with disabilities will hold policymaking, managerial, and staff positions to the degree possible to ensure that consumers of services are involved in determining the policies and procedures of the member agencies.
c. Self-Determination – ADRCs ensure that individuals are supported in a way that builds on their strengths, promotes community life, and honors the individual's preferences, choices, and abilities.
d. Autonomy – ADRCs ensure that its policies and procedures are not restricted by entities that provide services using the medical model but are established independently of those service providers. ADRCs will have the capacity to pursue private and public funding to create sustainable programs.
e. Dignity of Risk – ADRCs reject the historical patronizing attitude that individuals with disabilities are to be protected, so that the ability to fail and learn from failure is an acceptable outcome.

6. ADRC members believe in "Nothing About Us Without Us"—ADRC members have, at their core, a philosophy of maximizing individuals' independence, dignity, choice and flexibility. Decisions are not made *for* participants but rather *by* and *with* participants. ADRCs do not speak for people with disabilities and older adults—rather they support people with disabilities and older adults speaking for themselves in all venues.

7. ADRC members believe in ensuring access for all. Access means 100% inclusion in all provided services by persons with all types of disabilities and ages. Each ADRC will work to be fully accessible—architecturally and programmatically—regardless of whether the disability is physical, sensory, speech, emotional, cognitive, systemic or any combination thereof.

What is a "FULLY-FUNCTIONAL" ADRC?

The ADRC member agencies commit to collaborating together to continue to build capacity for, refine, and enhance the provision of the following core functions that define an ADRC:

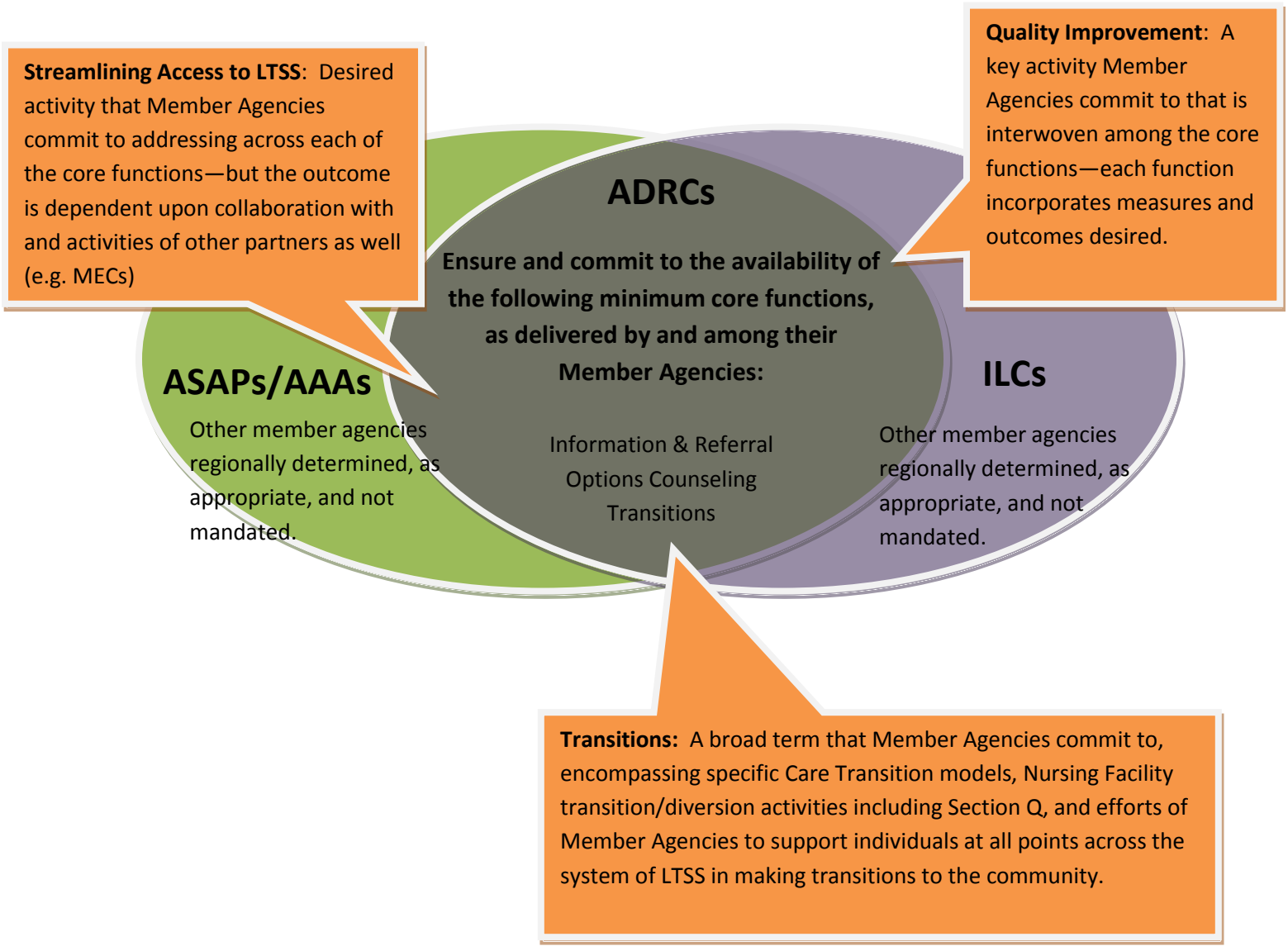
1. Information and Referral (I&R)

2. Options Counseling/Decision Support (OC)

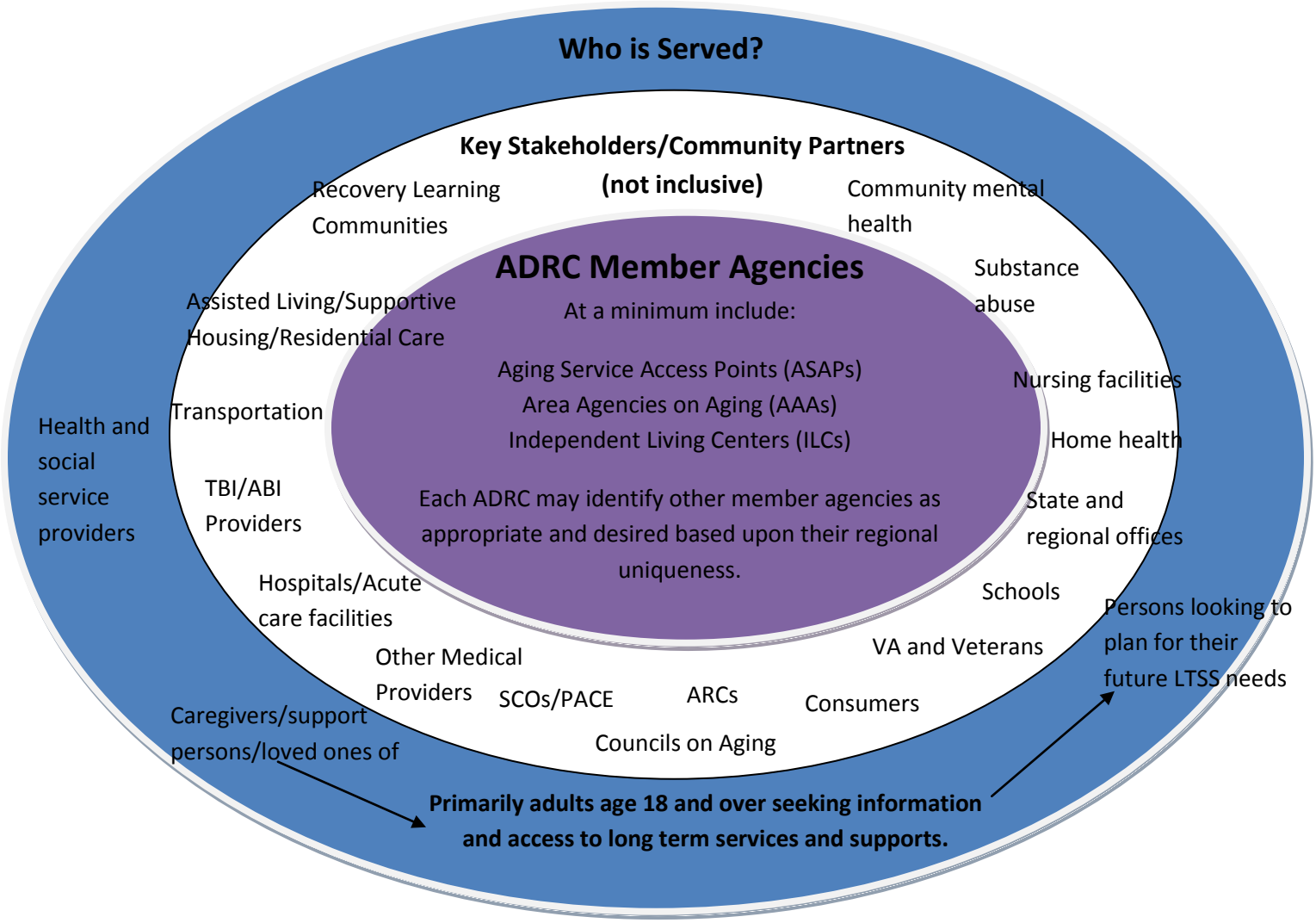
3. Transitions

The ADRC member agencies support and desire to enhance the role of streamlining access to LTSS and quality improvement as central components to the provision of the aforementioned core functions. These areas are not seen as separate and distinct functions of an ADRC, but as integral aspects of the core functions. Streamlining access and quality improvement are critical to I&R, options counseling, and transitions.

The following visual depicts the relationship of these core functions and components to one another, as described and recommended by the Strategic Planning Task Force.



The Massachusetts model as seen from an outside lens looks like this:



Please note: ***ADRCs*** are defined by "Member Agencies"

Key Stakeholders/Community Partners are "champions" and integral and critical community collaborators for several reasons: to refer individuals who are looking for information and/or access to LTSSS to an ADRC; to be there as referral resources for ADRCs to refer to for LTSS; to support and assist with outreach and getting the word out about what ADRCs do; build community relationships; partner with ADRCs on community initiatives to better serve individuals needing LTSS. Partnership development is the foundation of ADRC activities.
Who is Served is broad, and is at the heart of why the ADRCs exist—with primary focus on individuals seeking information about and access to LTSS as well as their loved ones, caregivers, and support persons, etc.

Co

Role of MA ADRCs

1. Increase awareness of and provide reliable information about LTSS.
2. Support individuals who need assistance in seeking services and making person-centered decisions.
3. Simplify and streamline an individual's access to desired LTSS through "no wrong door" collaborative partnerships.
4. Promote and embody principles of consumer-centeredness, self-direction, cultural competency, and accessibility.

MA ADRC Statewide Outcomes

1. Individuals, communities, and critical pathways are aware of the information and LTSS and services they receive from their ADRC member agencies.
2. Individuals have the relevant information they need to make individually-directed choices about LTSS within their communities.
3. Individuals have streamlined access to the LTSS they determine they need and want, enabling them to maintain independence and community living as long as they choose to do so.

How do we build a system of statewide, fully-functional ADRCs?

Strategic Plan Objectives, Activities, and Desired Outcomes

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
State-Level Operations	
Commit to unified and shared voice from State leadership	1. Advocate for ADRCs as the vehicle for implementing the Olmstead principles and "Community First" activities. 2. Develop State-level internal ADRC committee that involves leadership across the Office of Health and Human Services, led by EOEA and MRC, to build State-level understanding and ongoing communication about the role of ADRCs in LTSS and State-level activities/initiatives. 3. Continue to identify resources to support ADRCs in building their capacity to perform core functions and coordinate activities as the local level.
Commit to and develop IT/ MIS infrastructures that address the fragmentation across the ASAP/AAA and ILC networks	4. Develop capacity within existing and new IT/MIS systems to do the following: a. communicate HIPAA-compliant referrals electronically across member agencies. Example: electronic transmission and use of the ADRC Referral Form (for I&R and Options Counseling). b. communicate necessary client-level data among member agencies to support implementation and monitoring of Options Counseling (including data tracking, documentation and reporting). c. support member agencies to access their own client-level data and run reports locally without seeking State support (in particular for I&R and Options Counseling).
Develop State-level "Outreach & Education" plan for ADRCs	5. Develop State ADRC webpage. 6. Develop links to ADRC member agency websites from central State-level webpage. 7. Develop State-level Fact Sheet and educational materials describing the MA ADRC model and a unified voice for the "no wrong door" model.
Build and sustain relationship with Medicaid Enrollment Centers (MECs) and State-level MassHealth staff to support streamlined eligibility for Medicaid and	8. Educate state and regional MassHealth and MEC staff about ADRCs. 9. Determine capacity for new protocols at local MECs to refer denied LTC Medicaid applications to ADRCs for options counseling. 10. Develop and implement new protocols and educate MEC staff. 11. Foster ongoing relationship and communication with MassHealth leadership to support streamlining access goals and activities via the ADRC member agencies.

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
other publicly-funded programs	
Support local ADRCs in continued capacity-building and refinement	12. Provide technical assistance and "best practices" to local ADRCs, as appropriate and desired. 13. Communicate national and federally-driven information regarding ADRCs and related projects/initiatives to local ADRCs to ensure they remain connected to the national landscape. 14. Function as the repository for "hot topics", challenges, and barriers that need State-level input and discussion.
Build and sustain systems for quality improvement	15. Develop and build data system capacity to track outcomes and indicators for ADRCs. 16. Develop quality improvement plan inclusive of State staff, local ADRCs and other key stakeholders. 17. Build capacity to review and report on ADRC quality data that is shared across ADRCs and State leadership, as well as nationally as required. 18. Build capacity and roles for consumers in evaluating the impact of ADRCs on the target population it serves.
Sustain State-level coordination and project management	19. Seek vehicles for sustaining role of staff to coordinate and manage ADRC activities and reporting. 20. Develop Statewide ADRC Leadership Team using the Strategic Planning Task Force as a model for sustained communication and support of the local ADRCs across the Commonwealth. 21. Foster interagency communication among leadership regarding national and State-level topics impacting ADRCs and their roles in the long term service and support system.
Identify necessary resources (staff/money/other) to support and sustain a fully-functional ADRC as defined by the strategic plan	22. Seek further funding to support ADRC member agency delivery of core functions, with a desired goal of achieving equal participation across all member agencies in the implementation of the core functions as articulated in this plan. 23. Support staffing at ILCs for I&R—continue to explore enhanced funding to support ILCs to achieve the desired outcomes for I&R. This includes support for training and additional staffing. 24. Support staffing for Options Counseling—continue to advocate for ongoing funding for Ch. 211, including any enhanced funding that might be made available to support further penetration into broader areas. 25. Support staffing for Transitions—explore new resources to support targeted efforts within specific models such as Coleman, as well as generalized care transition/NF transition work already underway.

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
Local Level Operations	
Commit to ongoing cross training across all ADRC member agencies, including necessary community partners who serve populations in common (e.g. mental health, developmental disabilities, substance abuse, brain injuries)	1. Formalize ADRC cross training curricula that is locally-driven and supported. 2. Build ADRC cross training into staff orientation. 3. Seek opportunities to pursue ongoing continuing education of staff to support advanced knowledge in the areas of I&R and options counseling, in particular.
Commit to support and participate in development of IT infrastructures that address the fragmentation across the ASAP/AAA and ILC networks	4. Implement "warm transfers" across member agencies if the ADRC so desires—resulting in "one call, one contact", regardless of where the call originated. 5. Once available, implement use of HIPAA-compliant electronic referrals among ADRC member agencies resulting in "one call, one contact" and reduction in duplicated contact data entry across agencies. 6. Develop protocols and agreed upon processes for how the ADRC member agencies will utilize, benefit from, and support 1800 AgeInfo and MADIL (MA Aging & Disability Information Locator).
Identify necessary resources (staff/money/other) to support and build a fully-functional ADRC as defined by the strategic plan	7. Seek further funding to support ADRC member agency delivery of core functions, with a desired goal of achieving equal participation across all member agencies in the implementation of the core functions as articulated in this plan. 8. Support staffing for I&R—utilize existing funding streams from Older Americans Act and Title VII of the Federal Rehab Act as they are currently used for the provision of I&R at the AAA and ILC member agencies. 9. Support staff for options counseling, including continued exploration of ways to maximize existing staff performing the function of options counseling. 10. Transitions—collaborate with State to identify and obtain new resources to support targeted efforts within specific models such as Coleman, as well as generalized care transition/NF transition work already underway; pursue private and other funding to support locally-driven activities.
Formalize protocols in support of Core Functions as outlined and articulated in the Strategic Plan	11. Develop protocols regarding the implementation of the core functions, including delineation of member agency roles in the provision of core functions, if necessary. 12. Develop protocols for the sustainability and implementation of cross training in core functions. 13. In collaboration with Elder Affairs and MRC, develop protocols regarding documentation, including use of IT to support outcome measurement. 14. Collaborate with State agencies in development of outcomes measurement and reporting, including consumer

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
	satisfaction.
Increase awareness of member agencies' roles as community focal points for information about and access to LTSS	15. Agree upon local approaches to regional ADRC outreach and marketing strategies to build community awareness of their role as "no wrong door" access to LTSS. 16. Work to expand member agencies' influence among community stakeholders and consumers in increasing knowledge about planning for future LTSS needs. 17. Work to increase community understanding that member agencies serve persons of all incomes, including private pay.
Core Function: Information and Referral **Outcomes Desired:** 1. Callers to ADRC member agencies will receive I&R services in a timely fashion. 2. Callers will receive useful and helpful information from the ADRC member agency. 3. Callers to ADRC member agencies will report being satisfied with the information and referral service they received.	
I&R Goal: To provide accurate, comprehensive and confidential information and referral that respects an individual's value system, empowering the individual to the maximum extent possible to access the most appropriate service(s) in the community based on his or her preferences.	
Objective	**Activity**
1. Develop and adopt common statewide referral form across all ADRC member agencies 2. Create and adopt use of electronic version of statewide referral form for	*1) Warm transfer capability:* explore effectiveness and value of implementing warm transfer capability across all ADRC member agencies. Several ADRCs have implemented this technology with success. Develop protocols for coverage that ensure all warm transfer referrals not answered immediately are returned within a specified period of time. *2) Collaboration and utilization of 1800 Age Info and MADIL*: develop protocols and agreed upon processes for how

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
use within both SIMS and future system for ILCs 3. Develop and adopt common standards of performance in the provision of I&R (see Appendix B) 4. Each ADRC member agency develops and conducts staff cross-training	the ADRC member agencies will utilize, benefit from, and support 1800 Age Info and MADIL. *3) SIMS and ILC database system connectivity:* develop necessary SIMS and ILC database systems to support streamlined service to consumers that includes import/export functionality within both systems and reporting capacity at the member agency level for functions as well as ADRC reporting requirements. *4) Telephone live coverage:* develop live telephone services on weekends and after regular business hours, such as an answering service. *5) Accessibility:* develop capacity across all ADRC member agencies to offer information via the web that is accessible to ethnic and linguistically diverse populations. *6) Quality improvement:* develop capacity to utilize recorded referral information to assess the effectiveness and objectivity of an ADRC member agency's referral policies.

Core Function: Options Counseling

Outcomes Desired:

1. Individuals accessing Options Counseling receive timely, quality services (to be defined) regardless of their individual circumstance or setting.

2. Individuals served are able to make informed decisions and develop next steps based on their needs and preferences as a result of the information and decision support provided.

3. Individuals served have access to their preferred options for home and community based services.

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
4. Individuals served will be able to transition from an institution to a community based setting as desired.	
Options Counseling Goal: To provide Options Counseling as a core service to consumers statewide.	
Objective	**Activity**
1. Develop and adopt working protocols that define "primary" and "secondary" or "lead" ADRCs and how referrals are made among ADRC member agencies 2. Make appropriate modifications to MIS to accommodate data reporting needs at both local and State levels 3. Adopt Options Counseling Standards statewide (See Appendix C)	1. Collaborate on national Options Counseling workgroup to develop national standards and performance measures for Options Counseling. 2. Modify State Options Counseling standards as necessary and appropriate for the MA model. 3. Organize IT/MIS workgroup to identify and address IT/MIS infrastructure shortfalls at both State and local operational and data monitoring levels. 4. Through the Outcomes & Data Workgroup, identify outcomes, indicators, and strategies necessary to monitor overall execution and impact of Options Counseling statewide.
Core Function: Transitions **Outcomes Desired:** 1. Individuals experience smooth transitions across the LTSS system. 2. Individuals and critical pathways know who to contact regarding transition support.	

Goal: Statewide availability of robust, fully-functioning, consumer-centered, and sustainable ADRCs	
Objective	**Activity**
Transitions Goal: Support individuals in their desire to remain, or transition back to, the community for as long as they choose to do so.	
Objective	**Activity**
1. Introduce and begin conversations about Transitions within ADRC Leadership Team discussions at the local level. 2. Determine each ADRC member agencies' interest in, and desire to, engage in specific transition initiatives and projects. 3. Support and build greater connections and collaboration across existing transition activities such as ILC nursing facility transition staff, ASAP CSSM staff, and ASAP/ILC Options Counselors	1. Develop Transitions Workgroup including ADRC member agencies, hospitals, home health and visiting nurse associations, disability organizations, care transition experts, and State leadership to develop unified approach to national and State-level care transition opportunities.

Sustainability

Key areas that the ADRCs, in partnership with the State, need to address over the next five years to sustain ADRCs going forward include the following. It is important to note that embedding new initiatives within the fabric of existing State activities and priorities, particularly within any systems change efforts is a critical strategy. Given the role ADRCs can play as central to the hub of many State initiatives, connecting ADRCs early on to these other initiatives validates their roles, clarifies where they fit within the LTSS system, and ground ADRC member agencies in their everyday thinking and business practices related to the larger system. In this way, ADRCS are always front and center in systems planning and change. It would be normal for the State to ask: How can the ADRC further advance State LTSS reform? If truly embedded and woven into the fabric of a State's LTSS system, answers will come naturally.

Key Areas to Sustain Regardless of Funding	Key Areas to Sustain but Ongoing/New Funding Required	Key Areas to Sustain as State-Level Responsibility
Information and Referral	Transition Activities	Local ADRC Coordination
Options Counseling		IT/MIS
Cross Training		State-Level Coordination
		Quality Improvement

The above table represents the recommendations of the Strategic Planning Task Force to sustain and support ongoing ADRC functions and activities. As a "value" exercise, the ADRC members agree to continue to commit to the provision of I&R, Options Counseling, and Cross Training regardless of whether any new funding is available. This assumes that the Options Counseling funding from the State remains in effect. The member agencies agree that the funding they receive from Older Americans Act, Title VII of the Federal Rehab Act, and State-level funding from EOEA and MRC are critical elements to support and sustain all of these activities.

New funding is necessary to support and sustain activities in the area of Transitions. While there is a small amount of existing funding supporting activities in this area, the ADRCs believe that an infusion of new funding is critical in order to pursue a fully-developed strategy to engage in any "new" transitions work (e.g. implementation of specific evidence-based care transition models).

It is recommended that the State assume responsibility for ensuring funding exists for the areas of State and local ADRC coordination, IT/MIS development and improvement, and quality improvement beyond

what the local ADRC member agencies already engage in operationally and across functional areas. AoA funding has supported the role of local ADRC coordination, and in the absence of continued grant or other State funding, the local ADRCs will be challenged to sustain this critically-needed, focused and dedicated role to coordinate activities at the local level.

Other sustainability topics that need to be addressed over the next five years to build fully-functioning ADRCs across the Commonwealth include the following:

1. Developing a reporting structure that allows for the long-term evaluation of outcomes is essential.

2. Recognizing and continuing to advocate for resource parity across the ADRC member agencies in their desire to deliver the core functions of I&R, Options Counseling, and Transitions activities. It is widely recognized that nationally and within the State there are resource challenges across the aging and disability networks. It is a desire of the MA ADRCs to bridge this gap collaboratively so that all members may participate equally.

Timeline:

Five Years At A Glance State Fiscal Year (July 1 – June 30)
Year 1: by June 30, 2011 A. Clearly articulate the geography and membership of ADRCs B. Fully implement Options Counseling statewide C. Implement I&R and Options Counseling Standards of Performance (Attachments C and D) D. Design and implement Strategic Plan I&R and Options Counseling Core Function Protocols E. Develop IT work plan developed for ILC and ASAP/AAA IT system integration F. Define and implement Section Q Protocol(s) defined and implemented
Year 2: by June 30, 2012 G. Implement MRC IT system implemented H. Implement sustainability work plan I. Develop and implement common ADRC consumer satisfaction survey developed and implemented A. Transitions strategies developed by each ADRC B. Complete IT interconnectivity between SIMS and ILC data system C. Track and evaluate benchmarks for Options Counseling
Year 3: by June 30, 2013 D. Community Advisory Boards (may call it something different) established by each ADRC A. ADRCs implementing Transition models as articulated regionally via local strategic plans B. Develop benchmarks for Transitions C. Establish IT/MIS to track Transition benchmarks
Year 4: by June 30, 2014 A. Identify and track ADRC cost effectiveness measures B. Identify and implement new sustainable resources to support expanded role(s) of ADRCs C. Ensure that ADRC member networks have adequate resources to serve populations in need of streamlined access to LTSS
Year 5: by June 30, 2015 A. ADRC role within the CLASS Act and other emerging initiatives are explored and determined B. Formalized relationships with MCOs and other Affordable Care Act initiatives established

Appendix A: MA ADRC Strategic Planning Task Force Membership November 2009 – March 2011

Name	Organization	ADRC Representing
Ann Ruder/Erin Atchue	Center for Living and Working	Central MA ADRC
Ann Shor	MRC	State
Bill Henning	Boston Center for Independent Living	Suffolk County ADRC
Bob Dwyer/Nicole Jimino	Central MA Agency on Aging	Central MA ADRC
Carline Louizia	Independence Associates, Inc.	Southern MA ADRC
Carole Malone	EOEA	State
Cathy Carchedi	Ad-Lib, Inc.	ADRC of the Berkshires
Diana DiGiorgi	Old Colony Elder Services, Inc.	Southern MA ADRC
Ellen McDonough	Elder Services of Cape Cod and Islands, Inc.	ADRC of the Cape and Islands
Ginger Wills-Howe	Tri-Valley Elder Services, Inc.	Central MA ADRC
Heather Johnson	Consultant/Facilitator	State/ADRCs
Jim Kruidenier	Stavros Center for Independent Living	ADRC of the Pioneer Valley
Joan Butler	Minuteman Senior Services, Inc.	Greater Boston ADRC
John O'Neill	Somerville-Cambridge Elder Services, Inc.	Greater Boston ADRC
June Cowen	Northeast Independent Living Program	ADRC of the Merrimack Valley
Laura Connors	MRC/ EOEA	State

Appendix A: MA ADRC Strategic Planning Task Force Membership November 2009 – March 2011		
Name	**Organization**	**ADRC Representing**
Linda George	Boston Senior Home Care	Suffolk County ADRC
Lisa Lungo	Elder Services of Berkshire County, Inc.	ADRC of the Berkshires
Lisa Pitta	Southeast Center for Independent Living	ADRC of Southeastern MA
Mary Margaret Moore	Independent Living Center for the North Shore and Cape Ann, Inc.	ADRC of the Greater North Shore
Nancy Munson	Bristol Elder Services, Inc.	ADRC of Southeastern MA
Patricia Cox	North Shore Elder Services, Inc.	ADRC of the Greater North Shore
Rachel Weiner	EOEA	State
Rosalie Edes	Office of Disability and Policy Studies	State
Roseann Martoccia	Franklin County Home Care	ADRC of the Pioneer Valley
Roseanne DiStefano	Elder Services of the Merrimack Valley, Inc.	ADRC of the Merrimack Valley
Ruth Palombo	EOEA	State
Sue Temper	Springwell, Inc.	MetroWest ADRC

Appendix B: MA ADRC Information and Referral Standards of Performance

The ADRCs agree to uphold and maintain the following standards of performance:

Contacting ADRC Member Agency:

1. The ADRC member agency's physical sites are well marked and clearly identifiable.
2. The ADRC member agency's services are provided in environments that ensure confidentiality.
3. The ADRC member agency has access to space to meet with all potential service populations.
4. The ADRC member agency's main offices and satellite offices maintain regular business hours.

Provision of Information and Referral Services:

5. Live telephone services are available during regular business hours.
6. Live telephone services are accessible to people who are Deaf or hard of hearing.
7. An answering service or automated phone attendant service answers calls after hours and when staff are not available.
8. Messages left in automated answering systems are answered in a timely manner and no later than the next business day, if possible.
9. The ADRC member agency provides Information & Referral for target populations and the community at large.
10. Referrals are made in a way that maximizes consumer choice.

Data Collection and Reporting:

11. All telephone contacts are documented and recorded to support reporting for both federal, state, and member agency level purposes.

12. Contact information is collected from callers, as appropriate, to support monitoring and provision of follow-up services.

13. Information about referrals made to other organizations or service providers is recorded.

Resource Database and Website:

14. The ADRC member agency has a website with up-to-date information about the agency, directions, hours of operation, contact information and services that are available.

15. The ADRC member agency's website has a link to or access to a searchable database of resources and long term services and supports for populations in the service area.

16. All information on services in the ADRC member agency's resource database included on their individual websites is updated on a regular basis.

17. The ADRC member agency maintains and uses resources that contain comprehensive information regarding long-term services and supports (such as housing, transportation, employment).

18. The ADRC member agency has established relationships with other local and/or statewide I&R providers.

19. The ADRC member agency's resources include services and information for consumers who can pay privately for services.

20. ADRC member agency websites meet Section 508 accessibility standards.

Appendix C: MA ADRC Options Counseling Standards of Performance

The ADRCs agree to uphold and maintain the following standards of performance:

Model for Options Counseling in Massachusetts

The goal of Options Counseling is to assist individuals in need of long term services and supports to make informed choices of setting and services, resources to help pay for supports and services, referrals to experts in the individual's particular disability as needed, and assistance in connecting with appropriate resources. Options counseling is a core function of the Aging and Disability Resource Consortia and supports the mandate under MGL, Chapter 211 to provide counseling about community-based options to individuals seeking nursing facility admissions. The Massachusetts Options Counseling model furthers the Commonwealth's Community First policy and establishes a systematic approach in implementing options counseling services statewide.

Requirements of ADRCs Performing Options Counseling:

Prior to the provision of Options Counseling, a recognized ADRC shall agree to meet the following Service Standards. For purposes of this initiative, an entity must be a recognized ADRC (signed MOU with the Commonwealth).

1. Options Counseling Service Provisions:

Counseling Approach: Options Counseling is an interactive, short-term decision-support process to assist consumers, family members, caregivers and/or significant others to make an informed choice about long term services, supports, and setting.

Settings where counseling service is provided include but are not limited to:

- Hospitals
- Nursing Facilities
- Rehabilitation Facilities
- Community Settings

Methods of delivering services:

- Telephone
- Face-to-face
- Counseling via e- mail

Service Provided to Consumer:

- Unbiased information about long term services and supports;
- Information about resources available to pay for the services;
- A consumer-driven approach that ensures the consumer's personal goals and preferences are respected;
- Options Counseling provided in a timely and appropriate manner based on the consumer's situation;
- Identification of next steps;
- Assistance in facilitating referrals and resources as needed;
- 30 days after the final counseling session, the counselor contacts the consumer to determine whether their intended goal was met and to identify barriers; and,
- Survey: at the 30 day follow up and the counseling is complete, the consumer will be offered to participate in a consumer experience survey via telephone, mail, or web based.

2. Documentation and Reporting Requirements:

- Data entry in SAMS and IDMS specific to OC activity;
- Quarterly reports will be generated through a joint process between Elder Affairs and each individual agency (ASAPs and ILCs). Reports provided to Elder Affairs and MRC include: number of consumers served (records opened); number of records closed; information on closed records includes consumer goals; consumer outcomes; number of in-person; number of telephone counseling sessions; and email sessions; and number of referrals. Information about outreach and community education programs will include types and number of facilities/agencies reached and the number of people participating in each outreach or educational effort. Data related to the distribution of the consumer experience survey is also required;
- Provide Elder Affairs and MRC with additional documentation regarding implementation as needed.

3. Marketing:

- Develop marketing materials, such as brochures, bookmarks, etc. to educate the public, service providers, and community agencies about Options Counseling services;
- Include on all marketing materials the following: *Options Counseling is a service supported by the Massachusetts Executive Office of Elder Affairs and the Massachusetts Rehabilitation Commission;*
- Disseminate marketing materials within the ADRC service area;

- Track distribution of marketing materials.

4. Outreach and Community Education:

- Establish an outreach plan which identifies specific hospitals, rehabilitation facilities, nursing facilities, community agencies and other providers for outreach efforts to heighten awareness of OC services and generate referrals;
- Implement outreach plan;
- Educate the community about the OC services through public forums, media or other methods.

5. Staffing Requirements:

- Each ADRC must identify a lead OC contact person (either from the ASAP or ILC) who will be the primary contact for OC services to Elder Affairs and MRC;
- The OC lead will work directly with the State Director of Options Counseling to ensure effective communication between all ADRC member agencies and the State;.
- The OC lead will also be responsible for submitting the semi-annual ADRC options counseling report and for responding to requests for additional information;
- Each agency must also identify a staff person who will be responsible for the quarterly reports (see documentation and reporting under 2 above);
- Each ADRC is required to staff a minimum of 2 FTEs who will be primarily responsible for the provision of options counseling services;
- Each ADRC will identify additional agency staff who will be trained in options counseling to support overall implementation;
- Additional staff may be hired to carry out related OC activities at the discretion of the ADRCs;
- All options counseling staff will receive on-going supervision from their respective agency personnel;
- The administrative lead will be responsible for submitting the proposed ADRC budget to MRC and Elder Affairs. This position is someone who has signatory responsibility for the agency.

6. Training Requirements:

- The OC lead, the designated options counselors, and other identified agency staff associated with OC services will attend training sessions offered by Elder Affairs and

MRC related to Options Counseling. The curriculum includes one day core training, one ADRC agency cross-training, and two additional electives to be completed within one year;

- All OC staff will be required to attend training on reporting elements for OC activity within the SIMS and IDMS systems.

7. Other responsibilities:

- Work with Elder Affairs and MRC on the administration of OC Consumer Experience Survey to help assess satisfaction and effectiveness of the service and to help maintain and improve quality of service;
- Participation in monthly or bi-monthly meetings with ADRC leads, and staff from Elder Affairs and MRC.