Aging and Disability Resource Connection (ADRC)

California Implementation Guide

March 2011 Edition

This document was developed under Grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

California Implementation Guide

March 2011 Edition

Table of Contents

California Implementation Guide 0

March 2011 Edition *0*

California Implementation Guide 1

March 2011 Edition 1

1. Introduction 3

About This Guide 3

Why Implement the ADRC Model? Why Now? 4

Learn More about the ADRC Model 6

2. Bringing the ADRC Vision to Your County 8

a. Establish the Core ADRC Partnership 8

ADRC Overarching Goals *8*

Embrace the ADRC Vision *9*

b. Establish an ADRC Advisory Committee 11

Convene Stakeholders Who Become ADRC Champions *11*

Identify Critical Pathways Providers (CPP) *12*

c. Discuss What No-Wrong-Door Looks Like in Your Community 13

Think Outside the Silos to Inventory Community Resources *13*

d. Plan, Develop and Launch Your ADRC 16

i. Identify an ADRC Launch Date *16*

ii. Reach Consensus on ADRC Principles and Services *17*

iii. Shift to New Assumptions About Consumers *19*

iv. Develop Protocols for the Four Core ADRC Services *21*

ADRC Core Service #1: Enhanced Information and Assistance 23

Identifying ADRC Consumers and Their Needs *24*

Table 1: Enhanced I&A Screening *25*

Enhanced I&A – Call Center Screening for Consumer Risk or Urgent Need 25

ADRC Core Service #2: Options Counseling 27

ADRC Core Service #3: Short-Term Service Coordination 30
ADRC Core Service #4: Transition Services 32

3. Monitor for Continuous Quality 33

4. Strategies for ADRC Sustainability 34

CalCareNet 34
Medi-Cal State Plan and Waiver Services 35
California Community Transitions 35
Minimum Data Set (MDS) 3.0 35
Options Counseling Quality Improvement Project 36
Talent Knows No Limits 36
Medi-Cal Working Disabled Program 37
Evidence-Based Health Promotion 37
Federal Grant Opportunities 38
California's Future ADRCs 38

ADRC Implementation Guide Attachments 40

1. ADRC Readiness Calendar/Timeline (Sample)
2. ADRC Readiness Review Template (Sample)
3. California ADRC Brochure Template
4. Enhanced I&A Protocol Drill
5. ADRC Data Metric
6. Medi-Cal Options for Long-Term Care

1. Introduction

About This Guide

The California Health and Human Services Agency (CHHS), in partnership with the California Department of Aging, the Department of Rehabilitation and the Department of Health Care Services has provided technical assistance and grant funding from the federal Administration on Aging (AoA) and the Centers of Medicare & Medicaid (CMS) to seven local Aging and Disability Resource Connections (ADRC) partnerships. ADRCs offer consumers a coordinated system of long-term services and supports through integration and partnership between Area Agencies on Aging (AAA) and Independent Living Centers (ILC), as well as other community partners. Early pioneers in California's ADRC network have provided personal vision and innovation that benefit consumers of any age and any disability, regardless of income.

The pioneer ADRC counties in California are Riverside, Orange, San Francisco, San Diego, Del Norte, Northern County Partnership (Butte, Colusa, Glenn, Tehama & Plumas) and the newest ADRC in Nevada County. This Guide is dedicated to their innovation and commitment.

The ADRC development work discussed in this Guide presents a road map, a sequence of events, a description of core ADRC principles and services, and concrete suggestions for activities and ideas that can contribute to an ADRC initiative in any area of California. The Guide is not intended to impose a "cookie cutter" approach to implementing the ADRC model, given California's communities are diverse in size, culture and program infrastructure. This Guide will describe core partnerships, core services and building blocks; however, each ADRC is expected to have features that are unique. While language in this Guide focuses primarily on consumers, the intent is to include caregivers, providers and any other individuals providing support to a consumer.

This Guide presents a shift from multiple single population service networks (for example, senior service networks and disability service networks) to a coordinated ADRC

partnership serving a broader and more diverse consumer public. The focus shifts away from consumer deficit and disability to a focus on providing the widest array of options to any consumer. The Guide describes a No-Wrong-Door model of service delivery and why that model is best for California. The Guide allows for unique variations on the ADRC theme. For example, each ADRC can customize the series of steps and the time taken to accomplish the shift. This Guide captures the steps taken and the deliverables produced by communities that received grant funding. Local organizations are encouraged to begin planning and forming ADRC partnerships without waiting for funding. The collaborative process itself may reveal resource efficiencies; for example, leveraging outreach and marketing campaigns, shared staffing, and co-locating intake functions across multiple programs.

This Guide will be periodically updated and made available to current and future ADRC partnership organizations on the California Community Choices website (http://communitychoices.info).

Why Implement the ADRC Model? Why Now?

The 1999 U.S. Supreme Court's Olmstead Decision underscored a person's right under the Americans with Disabilities Act to receive long-term services and supports in the most integrated environment. Implementing the ADRC model of community service delivery puts that principle into practice by informing consumers of various options and supporting the decision process. Since Olmstead, local, state and federal policy makers have focused on system changes that would enable and empower consumers to identify where, how and with whom they access long-term services and supports. AoA and CMS are also increasingly recognizing the critical role of ADRC partnerships in improving consumer access to information and long-term services and supports.

AoA and CMS originally funded 43 states and territories to develop ADRC programs between 2003 and 2005. In September 2009, $11 million in grants were awarded to 49 states and territories to implement or expand the Aging and Disability Resource Center Program. In 2009, Congress directed federal funds through the Patient Protection and

Affordable Care Act (signed into law by President Obama on March 23, 2010) to strengthen core ADRC services and improve coordination of related federally funded projects and initiatives such as the Money-Follows-the-Person Demonstrations. California received funding under all four categories of the AoA/CMS grant Affordable Care Act solicitation in 2010. More information is available at
http://www.hhs.gov/news/press/2010pres/09/20100927a.html

The U.S. Department of Health and Human Services and specifically, AoA and CMS, have developed and funded ADRC initiatives across the nation citing these rationale:[1]

1. The national long-term care system is evolving with successes under CMS Real Choice Systems Change Grants, Cash and Counseling, and other consumer-centered and consumer-directed programs.
2. There is an opportunity to build upon these successes to resolve inefficiencies in the nation's long-term care system.
3. State budgets are challenged to support the current system of Medicaid spending for long-term care.
4. The over-65 population adds yet another challenge to states and local service networks as they anticipate increases to call volume and service requests as "boomers" age. Demands on service organizations and caregivers will be proportionately impacted in the coming years.
5. The economy and shrinking public resources prompts innovation and system change so that communities can respond to a growing and diverse consumer population.

[1] Paraphrased from information that can be downloaded at http://adrc-tae.org/tiki-index.php?page=Message,

Learn More about the ADRC Model

Although each organization has a distinct mission and vision, all ADRC partners support and adopt federally defined ADRC principles and core services:

Vision & Leadership	Locally-based lead organization(s) and individual(s) to facilitate the local ADRC initiative.
Local Partnerships	A fundamental component of the local partnerships is a core partnership of an Area Agency on Aging (I&A call centers in particular) and an Independent Living Center.
Stakeholder Involvement	Active participation of consumers, caregivers, front line service providers, advocates, local leaders and other interested parties in the planning, implementation and evaluation of the ADRC program as a member of the Advisory Committee.
Broad Outreach & Education	Outreach and education for consumers of any age, any disability and any income status
Core ADRC Services *(A detailed discussion of core services begins on page 21.)*	Enhanced Information & Assistance (I&A)
	Options Counseling (OC)[2]
	Short-Term Service Coordination
	Transition Services (hospital to home/facility to home)

ADRC progress in California has relied heavily on the technical guidance and publications available at the federal ADRC Technical Assistance Exchange (TAE). ADRC partners and stakeholders visit this website frequently as they investigate technical aspects of launching an ADRC initiative. In addition, the state has created a California-specific ADRC website for sharing resources, materials and information.

---

[2] Readers may also see Options Counseling (OC) referred to as Long-Term Care Options Counseling. The subject of the counseling service covers many topics related to how a person receives ongoing (long-term) services and supports as a result of chronic conditions or disability. The phrase "long-term care" has been dropped to avoid confusion. To some individuals, long-term care means nursing facility care exclusively.

ADRC Technical Assistance Resources	Owner	Location
Federal ADRC Technical Assistance Exchange (TAE) Website	Lewin	http://www.adrc-tae.org/tiki-index.php?page=ADRCHomeTest
California ADRC Website	CHHS	http://communitychoices.info/adrc/

The technical resources from other states on the ADRC-TAE website generally discuss either a Single Entry Point (SEP) or a No-Wrong-Door ADRC model. California's current No-Wrong-Door ADRC approach allows local ADRC partnerships to build on existing expertise and infrastructure. Service provider networks and existing call centers are rich with approaches and solutions to contemporary health care and social support issues, not to mention being culturally and linguistically part of the local community. See Attachment 2, ADRC Features Matrix.

2. Bringing the ADRC Vision to Your County

a. Establish the Core ADRC Partnership

ADRC partnerships streamline access to information and long-term services and supports for consumers of any age, any disability and any income source. The No-Wrong-Door approach enables consumers to contact any community service or health care "door" to access the full range of information and services so they can make informed decisions about long-term services and supports and to continue living in the most integrated community setting possible. – Vision statement to be considered by the CA ADRC Coalition

> *ADRCs are more a process than an entity.*

ADRC Overarching Goals

- Improve consumer **Awareness** of long-term care options, especially community-based alternatives to inpatient facility care.
- Provide consumer **Access** to information and services on many topics and across programs and service networks.
- Provide **Assistance** through ADRC core services: Enhanced Information and Assistance (I&A); Options Counseling; Short-Term Service Coordination and Transition Services.
- **Streamline** consumer access to **Critical Pathways Providers** creating expedited application assistance, peer mentoring, or other ways of eliminating barriers to critical services that enable independent living[3]

---

[3] The term critical pathways refers to the commonly used consumer access channels that exist between health facilities, nursing facilities and the home and community-based network of services (Regional Centers, Area Agencies on Aging, Independent Living Centers, county social services and county mental health services).

Embrace the ADRC Vision

The single most important hallmark of an ADRC partnership is local leadership and a renewed vision to serve any consumer seeking long-term services and supports—any age, any disability and whether or not a person is eligible for public programs.

Implementing an ADRC model relies heavily on the local leadership of a key individual or lead organization. Implementing the ADRC vision begins with convening local health care, social and community service leaders who will chart the course and nurture partnerships and linkages among Critical Pathways Providers. The goal in the beginning stages is to break down any barriers that could hinder organizations from serving as a first responder to inquiries from consumers of any age, any disability and whether or not they are eligible for public benefits. These first responders need not take on new case load, but rather re-envision how the community as a whole responds to consumers who seek to understand what services and supports are available to them from a holistic perspective. Organization types that are leading the ADRC vision in California include:

TIP from San Francisco ADRC: New partnerships work best if they are based on common tasks and responsibilities. Rather than a "lead organization", we share coordination of our ADRC between the AAA and the ILC. The result is a partnership of individuals leading to a partnership of organizations.

County	ADRC Partner Organizations
Orange	County Operated Health System (CalOptima)
	County Office on Aging (AAA)
	Dayle MacIntosh (ILC)
Riverside	County Office on Aging (AAA)
	Community Access Center (ILC)
San Francisco	City/County Department of Aging & Adult Services (AAA)
	Resource Center of San Francisco (ILC)

County	ADRC Partner Organizations
San Diego	County Aging and Independence Services (AAA)
	Access to Independence (ILC)
Butte, Colusa, Glenn, Tehama & Plumas	PASSAGES (university)
	Independent Living of Northern California (ILC)
Nevada	FREED (ILC)
	211 Call Center
	Helpline (an AAA I&A Call Center)
Del Norte	Area 1 Agency on Aging

ADRC pioneers have introduced some flexibility in the ADRC model. The diversity and very size of California's service areas have developed service networks and local organizations that could effectively lead the ADRC vision. Regardless of who leads the local ADRC initiative, core elements must include an individual or organization with community-wide/population-wide vision, at least one ILC and local AAA and include a call center. Each ADRC partnership listed above has also formed expanded partnerships with numerous organizations in their service areas.

The original ADRC model was developed to dissolve the service delivery silos that developed as single funding streams were dedicated to specific subgroups of the long-term care population; e.g., seniors, disabled adults, those with developmental disabilities and others. Over time, federal and state policies rolled out for sub-groups of the long-term care population have resulted in fragmented service delivery networks specializing in serving only those consumers. Supports for these networks has ebbed and flowed depending on political momentum and budget appropriations for these dedicated funding streams and programs; for example, the Older Americans Act and Rehabilitation Act. Building a shared vision and operating partnership between an AAA and ILC starts dissolving these barriers enabling a shared and broad view of serving the long-term care population in their service area.

A common reaction to this broader vision is the fear that each organization will have increased workload at a time of shrinking staff resources and funding. However, recent experience has shown the net result of ADRC work is a renewed and shared view of consumer needs and improved support network for professionals. ADRC development work often results in discovering opportunities for reducing duplication, co-locating similar program functions and sharing of limited resources.

TIP from San Francisco ADRC: ADRCs are natural partners. When we disregard our restrictive language (for example: disability, functional limitation, chronic medical condition, etc.) we end up talking about the same people with a focus on a particular age or disability group. That is the starting point for AAAs and ILCs to discover their common agenda.

b. Establish an ADRC Advisory Committee

Convene Stakeholders Who Become ADRC Champions

There are champions in every community who are respected for their knowledge and skills in the social or health care arenas. Additionally, in California, there are groups of service experts, consumers and advocates who have been advancing the Long-Term Care Integration agenda along for over ten years. Since the ADRC is not an "add on", these champions bring their expertise, ideas for innovation and influence to accomplish system changes. The common "glue" for forming the vision is the shared concern for improving consumers' access to information about long-term care and how people who have ongoing chronic conditions or disability can remain connected to their home community and avoid or delay lengthy inpatient facility care whenever possible. These individuals can be excellent ADRC champions to serve on your local ADRC Advisory Committee.

The **ADRC Advisory Group** assists in the development and implementation of the ADRC program. The Advisory Group will provide guidance on: (a) ADRC vision and partnerships; (b) design and operations of the ADRC; (c) products and program strategies; and (d) progress toward achieving program goals and vision. They also serve as champions to promote the ADRC. The Advisory Group should include individuals representing all populations served by the ADRC program, including individuals who have a disability or chronic condition requiring long-term supports, direct service providers, and representatives of government and non-governmental agencies impacted by the program. The guiding principle for consumer representation on an ADRC Advisory Committee is 20%.

TIP from San Francisco ADRC: Some of the best thinking our core partners have done about our relationship with each other has come as a result of responding to great questions from our Advisory Committee.

Identify Critical Pathways Providers (CPP)

The term critical pathways refers to the commonly used consumer access channels that exist between health facilities, nursing facilities and the home and community-based network of services (Regional Centers, Area Agencies on Aging, Independent Living Centers, county social services and county mental health services). There is no one long-term care service network. Each county is unique. Consumers are faced with a mixed bag of health care and social service supports when someone is at-risk of institutionalization. ADRCs play a very important role in helping consumers navigate among these service types and service settings by implementing effective triage and linkage systems and designating certain providers as Critical Pathways Providers (CPPs). To create an effective team of CPPs, the ADRC may:

- Expand representation of CPPs on the ADRC Advisory Group.

TIP from San Diego ADRC: The success of the ADRC relies heavily on leveraging partnerships, resources and services.

- Facilitate partnerships with program supervisors who can expedite urgent consumer requests.
- Work with mental health crisis teams and law enforcement to intervene with services rather than incarceration for people with psychiatric disability or dementia.
- Confer with CPPs relative to current trends and events that impact consumers; for example, economic downturn, natural disasters and others.
- Enlist CPPs to train other health care and community service professionals.
- Provide public acknowledgment of effective CPPs; for example, website highlight, newsletter acknowledgments, etc.

c. Discuss What No-Wrong-Door Looks Like in Your Community

A No-Wrong-Door approach to implementing the ADRC model depends more on a renewed vision for service delivery than on new funding, new organization or new staff resources.

It is quite likely that a No-Wrong-Door ADRC model already exists to some degree in your area. Launching an ADRC can serve as the catalyst for examining what works and what doesn't work in the delivery of community services and streamlining access for consumers. Convene discussions about what a No-Wrong-Door approach means in the context of your local service area and in the context of the complete pool of long-term care consumers—any age, any disability and any income. Typically, two or more lead organizations work together to develop and facilitate the ADRC. The ADRC model then grows as leaders collaborate to form new procedural linkages and new relationships with stakeholders and consumers.

Think Outside the Silos to Inventory Community Resources

A formal, an informal, or even an existing inventory of services and information resources will typically reveal service delivery systems that are clustered around the sub-groups of long-term care consumers; e.g., people with developmental disability, psychiatric disability, those over 60 and others. These clusters reflect how federal and state policy and funding streams have evolved over time. Use the local inventory to complete an analysis of gaps in

information and service delivery resources. The ADRC model does not include implementing more service silos to fill the gaps. Instead, the ADRC broadens information, strengthens decision support and makes more visible consumer traffic links among existing programs and services. There is a wealth of expertise, skill sets and knowledge among service organizations that focuses on specific sub-populations. These experts become key ADRC partners and their knowledge and expertise becomes the platform from which the ADRC is launched.

TIP from Riverside ADRC: We leveraged outreach activities for the 2010 US Census so that public messages also included a message to caregivers about the resources available to them through the ADRC.

As the partnerships grow and linkages are made, planning groups brainstorm new ways of doing business and new ways of informing and assisting long-term care consumers. An inventory identifies not only consumer service gaps but staff training gaps and information sources that, when shared, become the basis of the No-Wrong-Door ADRC.

Cross-training is critical to overcoming the silo effect of single population programming. Cross training between senior service staff and independent living staff can yield positive results in rounding out ADRC partners' knowledge and skills for:

- Independent living skills
- Assistive devices
- Disability competence
- Peer mentoring
- Services & supports for folks with dementia
- Supportive & affordable housing
- And many others

By discussing these topics as resource information for any consumer, they become the common language of the ADRC partners.

Procedural changes can also work to benefit both service organizations and consumers. Consumers who need home-delivered meals may also need home modifications or training to reduce risks of falling. Delivery of meals can also be a vehicle for fall prevention outreach by including an informational flyer with the meal. Integrating program functions like intake and application assistance across programs create efficiencies where there was duplication of operations. Staff and consumers alike benefit when consumers needs are viewed broadly and one transaction yields information and other resources. Consumers have long been frustrated by multiple assessments of need, wait lists, telephone wait times and answering the same questions for different programs.

TIP from Orange ADRC: The importance of cross training cannot be emphasized strongly enough. Each partner contributes his/her perspective and expertise so that referral channels between organizations and communications among professionals becomes natural and a way of doing business to better serve consumers.

A No-Wrong-Door model is implemented through cross training, sharing of provider listings (e.g., databases), joint outreach efforts and other methods that streamline consumer access to information and service delivery.

The ADRC partnership "grows" over time as ideas reach consensus and are put into practice. Some changes will be internal and procedural requiring little in the way of long-term planning or staffing changes. Some changes may arise as major system reforms that involve funding and re-assignments of staff resources. The local ADRC team will determine what level and type of changes are effective and necessary in their area.

Some examples of shifting to a No-Wrong-Door model include:

- Co-location and funding of intake functions across programs; In-Home Supportive Services, Adult Protective Services, Multipurpose Senior Services Program
- Telephone and video conferencing for application assistance or Options Counseling
- Shared provider resource listings (e.g., databases, resource guides) enabling a broader base of information that can be searched as consumers request information and services
- Cross agency in-service training sessions; e.g. disability awareness/interview techniques, Medi-Cal waivers, etc.

TIP from Orange ADRC: We've launched a Lunch & Learn series where a specific professional or organization discusses current issues and trends. Now we are discovering even more about our partners and brainstorming new ways of doing business. Everybody wins!

An indicator of successfully shifting to a No-Wrong-Door ADRC might be consumer feedback. If consumers report receiving broader information and decision support as they consider options, No-Wrong-Door has been partly or fully implemented. If consumers report referrals to other agencies without follow-up or a chance to discuss alternatives, then more work needs to be done on implementing the No-Wrong-Door ADRC.

The federal ADRC TAE website lists documents and tools used by other states. Components of a Fully Functional ADRC are outlined in a publication of the Lewin Group that is available on the TAE website.

d. Plan, Develop and Launch Your ADRC

i. Identify an ADRC Launch Date

Based on California ADRC experience, six months is a reasonable length of time to establish partnerships, collaborate with stakeholders and draft ADRC protocols prior to formally launching an ADRC. This aggressive timeline to launch an ADRC is realistic since the model

is based on existing expertise and organizations already serving consumers. Lead organizations for an ADRC initiative develop a work plan and timeline for presentation and discussion with an Advisory Committee and the various collaborative partners. Readiness for launching the ADRC can be measured by:

> *TIP from San Diego ADRC: How an ADRC looks and functions must reflect the local community. Don't hesitate to think "out of the box." Creativity breeds innovation.*

- ✓ Achieving consensus regarding the ADRC vision and core principles.
- ✓ Understanding and applying the ADRC model to the unique features of the local service area.
- ✓ Stakeholder support and ownership of ADRC services.
- ✓ Organizational and governmental support for systems changes.
- ✓ Staff input to procedural changes.
- ✓ Revised or re-targeted outreach and marketing the ADRC to consumers of any age, any disability and any income.
- ✓ Discussion and adoption of written protocols for the four core ADRC services.
- ✓ Technology infrastructure that can support data gathering and reporting on ADRC successes and effectiveness so that improvements can be made.

Attachment 3 provides a sample six-month ADRC development calendar/timeline and Attachment 4 is a sample Readiness Review Tool. Other helpful tools are available on the California ADRC and the federal ADRC-TAE websites.

ii. Reach Consensus on ADRC Principles and Services

An ADRC Advisory group(s) could be an entirely new group of individuals, a sub-group of an existing stakeholder group or a new task for an existing group. The important concept is to have ADRC champions and ambassadors who will advance the agenda for making system improvements for consumers seeking access to information and services--especially those

options that are alternatives to inpatient nursing facility care and information that assist consumers with informed and meaningful decisions.

Launching an ADRC is an evolutionary process. Advisory groups and ADRC champions may find some ADRC design principles more challenging than others. Conversely, some components of the ADRC model may already be in operation. Each principle focuses on improving consumer awareness and access to information, services and supports.

ADRC Design Principles	
Vision & Leadership	Locally-based lead organization(s) and individual(s) to facilitate the local ADRC initiative.
Core Partnership	A fundamental component of the local partnerships is the core partnership of an Area Agency on Aging (I&A call centers in particular) and an Independent Living Center.
Stakeholder Involvement	Active participation of consumers, caregivers, front-line service providers, advocates, local leaders and other interested parties in the planning, implementation and evaluation of the ADRC program as a member of the Advisory Committee.
Broad Outreach & Education	Outreach and education for consumers of any age, any disability and any income status.

These themes, consistent with federal ADRC concepts, are used in ADRC report templates and ADRC technical guidance materials. The activities below are examples of how ADRCs have approached planning for their ADRC:

- Develop outreach and marketing campaigns that focus on educating and empowering consumers; avoid campaigns that focus entirely on age groups, disability types or single program eligibility.
- Create a recognizable ADRC "brand" by using the state ADRC brochure and ADRC logo template (Attachment 5).
- Refine marketing activities that educate the community about long-term care options in general; including information about community-based alternatives and considerations in lieu of inpatient facility care.
- Leverage other "neutral" campaigns such as census, energy saving, and others to also use the ADRC "brand".
- Expand partnerships to childrens' programs, employment and others not ordinarily associated with long-term services and supports.
- Use and refer consumers to websites that can be helpful as a follow-up to telephone and face-to-face discussions.
- Form partnerships with 211 and other call centers.
- Empower advisory groups and stakeholders to set priorities for systems change by discussing and prioritizing ADRC activities. Systems changes are best when formulated and implemented by those most affected. The ADRC becomes the platform for embracing what works well and adopting plans to change what isn't working well for consumers. Review examples of tools and processes used by other ADRCs and adapt them to local culture and service infrastructure.

iii. Shift to New Assumptions About Consumers

Implementing the ADRC model requires a shift in how policy and program experts view consumers. Consumers who are likely to use long-term services and supports in their lifetime are any age, any chronic condition, any disability and any level of income status. They are from any culture, any language, any literacy level, and any family structure. Federal policy has evolved away from limited and prescribed service menus for a specialized sub-group of consumers toward a broader vision that encourages states to support consumer-directed services and informed consumer decisions.

This is not to say each program (organization) has to be all things to all people. The shift to the ADRC vision simply puts each program (organization) into a larger resource pool of references so the consumer can make informed choices. The hospital discharge planner, the home health nurse and the independent living skills trainer can talk to consumers with a wider array of options rather than strictly assessing the need or only their particular set of services.[4] To continue to make the point, here are some **NON-ADRC concepts**[5]:

TIP from San Francisco ADRC: The consumer is the expert on living in the community with disability. Options Counseling (a core ADRC service) is the challenge to us to change our service delivery paradigm from meeting someone's needs to empowering the consumer (the expert).

- Consumers must choose from a limited menu of services.
- Self-directed services are the exception.
- Staff may not have information or training in options beyond the particular program or service.
- Each program assesses consumer need for only their particular consumer profile and informs consumers about what services they can have. Consumers found not to be eligible are referred but not informed about a broad array of options.
- Social, medical, nutritional, assistive technology and other needs are reviewed and services authorized without reference to the whole array of services and supports that make up a person's home and community plan, including housing, transportation and income.

[4] Examples were chosen randomly just to make the point.

[5] These assumptions are over-stated to make the point about how policy has evolved over time. These assumptions are not intended to negatively comment on any existing program or service.

In contrast, below are some concepts that demonstrate the shift to a more **inclusive ADRC model**:

- Consumers may need long-term services and supports at any age, including children, adults and seniors.
- Consumers are in charge. Consumers have individual values and preferences for how they receive assistance from others.
- Consumers need more information about how personal income and resources impact Medi-Cal eligibility; for example, Medi-Cal Share of Cost (SOC) options and the Medi-Cal Working Disabled program.
- Consumers need role models for living independently with disability.
- Consumers need information about many options. Consumers are typically rushed and ill informed at the time of a hospital discharge or other transition from one service setting to another.
- Options for community services include considerations about housing, income and transportation.
- Some housing options can be considered with modifications for accessibility.
- Grandparents caring for grandchildren are challenged when they themselves need supports for chronic conditions and/or disability.

iv. Develop Protocols for the Four Core ADRC Services

The goal of re-envisioning existing services as ADRC core services is to streamline consumer access, eliminate duplication where possible, reduce consumer confusion about multiple intake, screening and assessment procedures and proactively provide a broad base of information upon which consumers can make informed decisions. The process of developing written protocols for core ADRC services has been an effective way for ADRC

> *TIP from San Francisco: Numerous drafts (of protocols) are a gift when they reflect continuous discussions about how we actually do things.*

partners to discuss and create local system changes that streamline consumer access. As ADRC partners implement core ADRC service protocols, there will be a change in relationship with consumers, at least in some cases. In the context of trust and empowerment, a consumer may bring up additional questions and needs where, before, that consumer would call back for more information later.

While the ADRCs are principally designed to serve consumers and caregivers, they also provide additional support to front-line, direct-service professionals. The ADRC model brings together the health care and social support systems to enable I&A professionals to quickly identify and connect callers with risk (to shelter, food, health and safety) to the ADRC's Critical Pathways Providers.

ADRC Core Services	
Enhanced I&A	Call center staff/volunteers have been cross-trained and utilize a broader resource database. I&A staff proactively and tactfully nurture trust in a longer (if desired) conversation that likely covers many topics. The goal is for the consumer to benefit from the staff's broad knowledge of long-term services and supports.
Options Counseling (OC)	One-on-one decision support for consumers investigating one or more among a wide variety of topics that relate to their own or a loved one's need for long-term services and supports. Topics include health care, social supports, public benefits, housing, transportation, and referrals to legal or financial experts.
Short-Term Service Coordination	Coordination assistance for consumers who urgently need help with multiple services and programs, generally for 90 days or less and until a longer term plan is in place. Without intervention these consumers would be at risk for health and safety.

ADRC Core Services	
Transition Services	ADRC partners have become trained and staffed to conduct hospital-to-home and/or nursing facility-to-home transition services. This service includes evidence-based transition models such as Care Transitions Intervention (CTI) and may also include coordination with the state's Money-Follows-the-Person Demonstration (CA Community Transition), ILC transitions programs and serving as primary local contact point for the new MDS 3.0 implementation.[6]

ADRC Core Service #1: Enhanced Information and Assistance

The hub of the ADRC is the Information and Assistance (I&A) call center. I&A typically exists in most areas of California as part of a community's information and service infrastructure under the Area Agency on Aging Plan, the county's Community Service Block Grant (CSBG) services or 211 call centers. I&A call centers, regardless of funding source, have already adopted staff protocols, forms, and procedures that can be leveraged for the ADRC model. Implementing the ADRC model builds on the existing infrastructure and procedures that are serving consumers well in the local network. The basic task becomes how to enhance the current I&A resources so they become

TIP from San Francisco: Cross-training is more than just sharing information. We share our ways of thinking and solving problems. We share appreciation for the skills the other person already has. It's more about developing relationships than teacher/student dynamics.

---

[6] MDS 3.0 is a revised version of the Minimum Data Set used by all Medicaid/Medicare certified nursing facilities. The MDS is both a data gathering tool and a document that is used for resident assessment of need and care planning. More information about MDS 3.0 is available at http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

the ADRC core service, which may be accomplished by:

- Expanding I&A databases to incorporate both aging and disability provider resources
- Providing cross-training to I&A specialists to increase breadth of knowledge about long-term services and support across both aging and disability sectors
- Developing provider manuals incorporating both aging and disability resources

Attachment 6 is an internal organizational Enhanced I&A Drill that can assist in an inventory of resources and intake tools across programs in your service area. It can be used as a discussion guide and a basis for writing an Enhanced I&A protocol.

Identifying ADRC Consumers and Their Needs

Discuss among ADRC partner organizations, especially the call center staff and volunteers, a wider view of consumers they all serve—consumers of any age who need information about long-term services and supports because of disability or chronic conditions. Table 1 offers an aid for discussing how call centers can envision ADRC core services as a way to triage or prioritize responses to consumer calls (and walk-ins) based on the urgency of need. A natural progression of this subject is a discussion about where, how and who conducts assessment of need, goal setting and service planning in your community for consumers who seek long-term services and supports.

TIP from Orange ADRC: It is not uncommon for call-centers to experience an increase in the average length of a call. This demonstrates the change in the ADRC's relationship with

Table 1: Enhanced I&A Screening

Enhanced I&A – Call Center Screening for Consumer Risk or Urgent Need Low Urgency ◄————————————————► High Urgency			
Simple Request for Info	**Options Counseling (OC)** **(One-on-One Decision Support)**		**ST Service Coord** **Or** **Transition Services** **(Need Services Now)**
May or may not be counted as ADRC. I&A staff can determine if they called for LTC info.	**Simple**	**Complex**	Consumers who have no one to help navigate multiple applications for services and or lengthy assessment processes. They are frustrated and need a guide. You keep a record of the actions and follow them up to 90 days until there is a longer range plan in place. Multiple service and information needs with urgency if no other service coordinator or peer mentor is available.
	Information about one or more LTC options or related topic for themselves or a loved one. Diverse needs primarily for information. May be urgent but coordination primarily done by others.		
Examples			
Requests for Bus Route, meal sites, senior center address, etc.	Mother recently fell and confused. Daughter needs info on housing, Medi-Cal and transportation. Father newly diagnosed with Alzheimer's. Family gathering care and financial information to better plan his future.		Single person recently discharged from hospital post-hip replacement. Has no one to help while he applies for Medi-Cal, MSSP, IHSS, etc. Person who has no family support requests transition services to move from facility to a home in the community.

Sharing and brainstorming among ADRC partners is key to streamlining consumer access and providing Enhanced I&A. Each ADRC partner brings existing tools and procedures to the ADRC table. A goal for some is adopting a uniform and consistent procedure for responding to consumers as they learn about their own service needs and preferences for a community living plan. Language surrounding these tasks is symptomatic of the silo effect. Some call it a care plan, assessment of need, service plan, goal setting or independent living plan. Any number of I&A tools, forms and protocols can be discussed with ADRC partners to facilitate a community response to supporting consumers in making informed decisions.

TIP from San Diego ADRC: We have integrated intake functions by integrating funding for call center staff. Staff are funded by IHSS, APS and other county services so that these intake functions happen on-the-spot and seamlessly.

I&A call centers and other consumer information centers like 211 have existing procedures and protocols for responding to callers who have varying levels of need and over a wide variety of service types and information topics. Additionally, callers may have differing degrees of urgency depending on their situation of health and safety. Intake procedures can be re-envisioned by building relationships with consumers that can reduce call backs and, in the extreme, prevent emergencies by identifying risk.

ADRCs that conduct analysis of call center tasks may discover opportunities for staffing alternatives and even budgeting options.

TIP from San Diego ADRC: There are several software applications that can be used to assist I&A staff to determine risk. The investment in an application or the adoption of a paper-risk assessment tool is worthwhile.

New ADRCs are encouraged to incorporate the State's long-term care website, CalCareNet, www.calcarenet.ca.gov, as a working tool for professionals and an online information support for consumers. More information about CalCareNet will appear in the next edition of this Guide.

ADRC Core Service #2: Options Counseling

Options Counseling (OC) is defined by federal policy makers as one-on-one decision support for a consumer while he/she gathers information on several topics and considers service and financing options.[7] The OC service provides consumers a valuable overall perspective to the multi-faceted long-term care decision-making process. Community service organizations often offer a fixed menu of services or serve only certain consumers (based on age or type of disability) leading to consumer frustration and confusion. OC is based on a relationship of trust with the consumer so that many options can be considered in the context of the personal preferences, language and culture of each consumer.

The search for long-term services and supports can be confusing due to misconceptions about Medicare, Medi-Cal and private insurance benefits and, more specifically, what services are not covered by insurance. With a few limited exceptions, there is no organization tasked with informing consumers about a broad view of options when someone with chronic conditions or disability has ongoing needs for personal care and daily living. A nursing home is often the default solution for a lack of trustworthy and accurate information about all alternatives. Options Counseling is intended to address that consumer need by providing a broad base of information on many topics and one-on-one support while they consider and decide among options.

---

[7] Independent Living Research Utilization & National Association of State Units on Aging, Long-Term Support Options Counseling: Decision Support in Aging and Disability Resource Centers, January 2007.

An ADRC staff person trained for the OC service maintains communication with the consumer as needed until the consumer feels his/her information and decision support needs have been met. For ADRCs to effectively provide this service, ADRC and their partner staff need accurate and updated information and collaborative relationships with many of the long-term support organizations in the community, e.g., Medi-Cal, Health Insurance Counseling and Advocacy Program (HICAP), Family Caregiver Support Program, Alzheimer's Disease services for both consumers and families, health promotion and disease prevention programs, transportation, employment, affordable housing, adult education and many others. ADRCs providing this service find that consumer discussions are longer in duration and discussions and cover a wider array of topics.

Tip: Proactively offer information about Medicare and Medi-Cal. People are often shocked to learn that after a few days of rehabilitation, Medicare does not cover long-term care in a facility or at home. People are fearful about spending private resources for long-term assistance and support. Emotions add to the complexity of discussing public benefit options. A trusted options counselor offers consumers accurate information on a wide array of topics that are frequently misunderstood.

ADRCs in California develop written Options Counseling (OC) protocols that incorporate and build on existing call center and service coordination services. Again, OC broadens the view of existing resources and offers a broader array of information to consumers. Procedures and information that are pieces and parts of OC already are part of existing programming: Medi-Cal application; IHSS application; housing search; program eligibility determination; etc. OC brings those together into a package of options that is meaningful to the consumer.

ADRCs staff the OC service in a variety of ways. Some designate a point person who specializes in OC. Others train all call center staff to provide the OC service. Follow-up contact with OC consumers can be a valuable source of quality improvement initiatives and future ADRC service planning.

NEW: In September 2010, CHHS received a federal grant to develop and test standards for the OC service. In the Year 2 of the grant project, several ADRCs in California will test the standards developed with stakeholders in Year 1. After the conclusion of the 2010-2012 grant period, the OC service will be implemented in California according to core standards. Until that time, these activities may be helpful when developing the OC protocol:

- Identify staff strengths and preferences for OC workload and interpersonal communication skills.
- Consider and discuss the I&A functions that already form parts of the OC service; for example, multiple application assistance, coaching consumers on various topics such as caregiver respite and supports for families of people with dementia, peer support and independent living skills training, etc.
- Consider methods for recording the specifics of Options Counseling encounters for future quality monitoring and ADRC planning.
- Discuss with ADRC partners how to identify OC consumers.
- Refine the qualifications and responsibilities of OC staff.
- Plan and carry out in-service training for OC staff.
- Develop/refine administrative tools, materials and/or curriculum. Many are already IA tools, including information on:
    - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, etc.)
    - Employment (to include information about the Medi-Cal 250% Working Disabled Program)
    - Health promotion/disease prevention

    - Affordable Housing
    - Transportation
    - Personal Care Services/In-Home Supportive Services (IHSS)
    - Assistive Technology
    - Home Modifications
    - Independent Living Skills Training
    - Crisis/Emergency services
    - Transitions across providers and settings; e.g., hospital to home, nursing facility to home, home to assisted living, etc.
    - Services for family caregivers
    - Residential care; including assisted living
- Refine/enhance consumer data and service data gathering tools.
- Develop/refine procedures that follow-up with consumers (via phone calls, e-mail, mail, etc.) to determine outcome of options counseling.

ADRC Core Service #3: Short-Term Service Coordination

Short-Term Service Coordination for consumers who urgently need help with multiple services and programs is the third ADRC core service. This service is intended for individuals who have no supportive advocate to help when they have urgent needs that cross multiple programs and service organizations. Existing ADRCs have defined short term to mean 90 days or less.

Short-term service coordination can address urgent issues and needs while a sustainable,

TIP from San Diego ADRC: Short-Term Service Coordination can be offered to consumers who are on a care management or other program wait lists. A short term intervention can reduce risks to health and safety, emergency room visits and unnecessary returns to the hospital.

longer-term solution is put in place. The intent of short-term service coordination is to provide a bridge for consumers needing help with connecting to multiple services and supports, long-term case management, crisis services, food programs, housing, or other support services.

Short-term service coordination may be already offered by the ADRC under a different name. It can be offered directly by an ADRC partner or through contracts or other agreements. Defining it as a core ADRC service helps multiple service organizations define who/what best serves consumers' needs.

In order to write the Short-Term Service Coordination protocol, ADRCs can review provider resources that offer service coordination, case management, peer mentoring, coaching or other interventions that can address urgent needs across programs and services. Each ADRC has the purview to decide how this service will be provided, e.g., in-house or via contract with a partner organization. As with the other ADRC core services, the focus is on the process of taking inventory of information and service resources and coordinating use of these resources across programs and across consumer profiles.

> *TIP from Orange ADRC: We have multiple organizations that specialize in some form of "case management." We met with them early on to reach consensus on which organization(s) can do Short-Term Service Coordination (60 days or less). In this way we agree as a community how to respond to a specific consumer(s) need.*

ADRC Core Service #4: Transition Services

People living with disability or chronic conditions have narrow margins of health that change over time.[8] A person may transition through various settings for care and services, for example, hospital, home, nursing facility, assisted living, and others.

The fourth core ADRC service, Transition Services, varies from ADRC to ADRC. Some have implemented evidence-based hospital-to-home care transition and some nursing facility transitions services. Transition services have, most often, been phased in over time as ADRC partners are prepared with training and adequate staff.

> *TIP from San Francisco ADRC: People living successfully in the community are not exceptions to the rule, they are the rule. Peer mentors and role models are essential.*

One model for providing Transition Services is the ADRC's implementation of the Care Transitions Intervention (CTI). The CTI model, developed by Dr. Eric Coleman from the University of Colorado, is an evidence-based, four-week intervention designed to empower and support patients to take a more active role in their health care following a hospital stay. A detailed CTI Implementation Booklet is available on the California ADRC website and also on the ADRC-TAE website.

Together with CTI implementation to improve hospital-to-home transitions, the ADRCs are also creating linkages with the following transition initiatives in California:

- California Department of Health Care Services -- The California Community Transitions -- Money-Follows-the-Person Demonstration

---

[8] A narrow margin of health refers to chronic conditions that may worsen, causing the need for frequent medical assessment and/or intervention.

- California Department of Rehabilitation, the State Independent Living Council—Flexible funding for non-medical necessities and services that support people transitioning back to community living
- California Department of Public Health/Licensing and Certification Division and Nursing Facilities – Section Q of the Minimum Data Set version 3.0
- The California Department of Health Care Services Medi-Cal Medical Case Management (MCM)—hospital to home support

3. Monitor for Continuous Quality

Implementing an ADRC partnership and a No-Wrong-Door is a cumulative process that is based on continuous improvements. The pool of potential consumer supports flexes over time as consumers are impacted by changing health care needs, financial security, changing family and friend circumstances, improvements in technology, affordable housing supply and any number of other forces that affect day-to-day life. The ADRC Advisory Committee and any internal quality assurance programs can be the trigger for making improvements in the responsiveness of the ADRC partner organizations to consumer accessibility to information and services.

Some of the measurement tools ADRCs have used include:

- Consumer satisfaction surveys
- Call center and service center volume
- Staff workload
- Service (or organization) wait lists
- Length of I&A calls, OC encounters
- Follow-up percentages

TIP from San Francisco ADRC: Building an ADRC partnership is a process not an event. If the ADRC is not an evolving entity, then it is a dead entity and deserves a dignified burial.

The purpose is not to measure positive or negative findings, but to inform ways to improve the quality of ADRC services. Collecting meaningful consumer demographic data across ADRCs is a challenge due to the terminology used by various service networks and providers and disparate data systems. A component of readiness for ADRC implementation includes an assessment of the current data systems' functionality and ability to collect data to inform local, state and federal ADRC efforts. Attachment 7 is a list of the current data collected by ADRCs.

4. Strategies for ADRC Sustainability

Even as ADRC initiatives are launched, it is prudent to plan for ADRC sustainability. High on the list of considerations would be linking the ADRC partnership to Medi-Cal, Medicare and other local, state and federal initiatives, such as but not limited to:

CalCareNet

Arranging for long-term services and supports can be complex and frustrating and finding trustworthy information all the more important. A companion to the ADRC initiative is the launch of the CalCareNet website. www.calcarenet.ca.gov. CalCareNet provides one-stop information about long-term services and support needs. It is being piloted with Aging and Disability Resource Connection (ADRC) programs in Riverside and Orange counties from February 2009 to September 2011. In addition to community-based information for Riverside and Orange counties, CalCareNet and its search functions provide statewide information for everyone on licensed facilities and programs. The California Care Network portal, CalCareNet, is a pilot project sponsored by CHHS under the California Community Choices Project, with funding by a federal Real Choice Systems Transformation Grant. The CalCareNet vision includes a plan to be a working tool for professionals. More information about CalCareNet will appear in the next edition of this Guide.

Medi-Cal State Plan and Waiver Services

Medi-Cal (Medicaid) is the largest payer of long-term facility care. Attachment 8 provides a list of Medi-Cal State Plan and Waiver services that can be community alternatives to facility long-term care. Call center staff and other local program staff can effectively link consumers with Medi-Cal options when in-service training and trustworthy information is available. The list attached to this guide includes contact information for Medi-Cal subject matter experts.

NEW: The Department of Health Care Services has submitted and received federal approval to reform service delivery under a new Medi-Cal Demonstration waiver called "California's Bridge to Reform." More information about this reform package can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx

California Community Transitions

In January 2007, DHCS was awarded a special federal grant number to implement a Money Follows the Person Rebalancing Demonstration, "California Community Transitions" (CCT). CCT demonstration services are available through September 30, 2016. For more information: http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx

Minimum Data Set (MDS) 3.0

ADRCs have been identified as capable responders to nursing facility residents who want to return to community living. Beginning October 1, 2010, all Medicare- and Medicaid-certified nursing facilities are required to use a new iteration of the Minimum Data Set (MDS 3.0). MDS 3.0 is the required assessment and data gathering tool used by nursing facilities to assess and document resident conditions and need for services. The MDS is filled out upon admission, quarterly, and when there has been a significant change in status. The new MDS 3.0 includes a direct question to residents about his/her preference for returning to a community home. Local community agencies will be designated as the

state's responders to those resident requests for information about community living. More information will be posted by state departments as soon as it becomes available.

Options Counseling Quality Improvement Project

Funded under a federal Affordable Care Act grant, CHHS will be launching the *Options Counseling Quality Improvement Project* that will inform state and federal policy by developing, implementing and evaluating a comprehensive set of Options Counseling standards. The project began October 1, 2010 and will involve ADRCs and organizations designated by DHCS as California Community Transitions (MFP) Demonstration Lead Organizations. Project activities are organized around three sets of outputs: 1) Options Counseling Framework and Standards -- Service Modules, Methods and Scope, Hiring Guidance, Training Curriculum, Training, and online Options Counselor support; 2) State Uniform ADRC Designation Criteria -- Collaboration with Stakeholders on Future ADRC Planning, Recommended ADRC Designation Criteria relative to partners, service area, core services, quality and other systems that maintain fidelity to the ADRC model; and 3) Evaluation of the OC Service Standards. The evaluation will include measures for business systems and consumer outcomes.

Talent Knows No Limits

A project of the California Health Incentives Improvement Project (CHIIP), the Talent Knows No Limits (TKNL) public information campaign serves to spread awareness of the myriad of services and resources available to the disabled job-seeking community as well as to employers who can benefit from this valuable labor pool. TKNL also strives to break barriers and to address misconceptions about the employability of people with disabilities.

CHIIP is a multi-agency collaborative effort working to remove barriers to employment and self-sufficiency of people with disabilities, particularly health care and personal assistance barriers. Administered through The Interwork Institute at San Diego State University, CHIIP works closely with the California Governor's Committee on Employment of People

with Disabilities to develop a Comprehensive Employment Strategy consistent with state law – The Workforce Inclusion Act (AB925).

Medi-Cal Working Disabled Program

The Disability Benefits 101 (DB101) website helps workers, job seekers, and service providers understand the connections between work and benefits. The DB101 *attitude* is that the disability experience is unique for each individual, and that benefits programs can affect that experience in different ways at different times. *With planning*, people with disabilities can take control of finding the programs and jobs that meet their needs. For service providers and program managers, information sharing helps everyone understand how programs interact with each other.

DB101 brings together rules for health coverage, benefits, and employment programs that people with disabilities use. These programs may be run by state, federal government, non-profit, or private organizations. DB101 provides benefits planning calculators to use with all kinds of benefits planning strategies. Experts at DB101 will also respond to questions on benefits. For more information:
http://www.disabilitybenefits101.org/ca/programs/health_coverage/medi_cal/250/

Evidence-Based Health Promotion

In September 2006, CDA was awarded a three year $750,000 grant to implement evidence-based health promotion programs in five California counties (Fresno, Los Angeles, Madera, San Diego and Sonoma). Two programs, the "Chronic Disease Self- Management Program" and "A Matter of Balance," which focuses on fall reduction and strength-building strategies, are being implemented in these counties. The programs are targeted to older adults with chronic health conditions who are able to attend the sessions in the community. Classes are being provided in English and Spanish. Expansion into new counties was envisioned in

Years II and III. However, San Francisco and Orange Counties have already joined the initiative in Year I. Two in-home programs are being offered to frail older adults unable to go out to the other classes: "Medications Management" and "Healthy Moves," which encourages these seniors to do simple exercises that improve their strength, mobility and stamina. CDA's goal is to have 6,000 older adults complete these programs over the three-year period. See the California Department of Aging website for more information: http://www.aging.ca.gov/federal_grants/default.asp

Federal Grant Opportunities

The Affordable Care Act indicates future funding opportunities tied to the ADRC model of service delivery will be available.

General federal grant opportunities: http://www.grants.gov/
AoA grant opportunities: http://www.aoa.gov/AoARoot/Grants/index.aspx

California's Future ADRCs

CHHS, along with numerous state departments, share a vision of ADRCs in all parts of California. State designation criteria for new ADRCs will be developed and reviewed by stakeholders in 2011 through 2012 as part of Affordable Care Act Options Counseling federal grant. During that same period, standards for the Options Counseling service will be developed and tested. Additional state initiatives to be alert to ADRC-related opportunities include:

- Medi-Cal reforms under a new demonstration waiver
- Follow-up Initiatives to the Financing Report -- *Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians,* Robert Mollica, Ed.D. National Academy for State Health Policy Leslie Hendrickson, Ph.D.

Hendrickson Development, November 2009. The report is available on the Choices website listed below

- Health care and supportive service priorities of the Brown Administration

ADRC partnerships, whether they implement with or without federal funding, are encouraged to become active members of the ADRC Coalition. Organizations and individuals are invited to begin an ADRC journey by viewing and downloading resources posted at the CHHS ADRC website:

http://communitychoices.info/adrc/

ADRC Implementation Guide Attachments

(Attachments are provided in two separate files)

Note: *Attachments, forms and technical assistance documents will be updated over time as improvements and ADRC policy and practices change.*