Appendix A

ADRC Hawaii Protocols Manual

Appendix A

ADRC HAWAII

AGING AND DISABILITY RESOURCE CENTER

Aging and Disability Resource Center Hawaii Protocols Manual

Executive Office on Aging
State of Hawaii

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I. Introduction and Purpose of the ADRC Hawaii Protocols Manual

The Aging and Disability Resource Center (ADRC) Hawaii Protocols Manual describes the minimum requirements for ADRC sites, recommended strategies, and the core operational procedures and processes. Its purpose is to serve as a set of standard guidelines for current and future ADRC sites throughout the State of Hawaii. It is intended to be:

- An orientation tool for new ADRC sites and staff,
- An ongoing source of direction/resource for staff; and
- A means to ensure consistent services across the ADRC sites throughout the State.

This is a working document which will be reviewed and updated on an annual basis at minimum, to ensure that it is current, accurate and reflective of the practices of the ADRC serving each county in Hawaii.

The manual incorporates the federal requirements and definitions of a "Fully Functioning Single Entry Point System/ADRC" and other ADRC protocols established by the Lewin Group, U.S. Administration on Aging and Centers for Medicare and Medicaid Services. ADRC Hawaii wishes to acknowledge the ADRC sites in other states for sharing their own operational/protocol manuals and other references that served as the framework for this document. The manual also includes the procedures/products developed by Hawaii's original pilot sites on the Big Island of Hawaii and Honolulu, the State Advisory Board subcommittees, and the University of Hawaii School of Social Work, ADRC Project Management and Evaluation Team.

II. Background of Aging and Disability Resource Centers

Collaboration between the Administration on Aging and the Centers for Medicare and Medicaid Services

In the summer of 2003, the US Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) issued a solicitation for states interested in developing Aging and Disability Resource Centers (ADRC). This was a historic venture, as never before had these two federal agencies collaborated on a joint grant solicitation. A total of 12 states were funded for a 3-year project period. The solicitation contained very specific requirements based upon the federal vision for Aging and Disability Resource Centers. This vision is the creation of a single, coordinated system of information and access for all persons seeking long term support services. Such centers will be highly visible and trusted places where people of all incomes, ages and disabilities can turn for information on the full range of long term support options, both public and private. The goal of these centers is to minimize confusion, enhance individual choice, support informed decision-making and increase the cost effectiveness of long term support systems. As a part of the larger Real Choice grant program and the President's New Freedom Initiative, AoA and CMS see the ADRCs as a critical component of a long term support system that supports and facilitates consumer choice. Access to service information across the public

and private sectors, options counseling and assistance in linking to services underpin a consumer driven system.

From a system standpoint, AoA and CMS recognize the future need for coordinated long term supports as the population continues to age, waiting lists for home and community-based services for persons with disabilities continue to grow, and long term care costs mushroom. Additionally, federal and state agencies are concerned about the ability of the federal government (as the primary payer for long term care) to meet this growing challenge. It becomes more critical that consumers become wise users of long term supports, knowing what is available and using them in a cost efficient manner. However, persons in need of long term support services and their families are faced with disconnected services, redundant and confusing application forms, and a lack of consolidated easy-to-understand information on available options. Faced with such daunting barriers, consumers and their families may not find adequate or quality services, spend too much time and money on the wrong service or course of action, or find themselves in a care setting they do not prefer. ADRCs, through options counseling and integration of information about private as well as public resources, are a powerful tool for empowering consumers.

As of September 2009, there are 201 ADRC sites among these forty-three states/territories, covering over 961 counties and serving 38% of the U.S. population. $42 million of federal seed money established these 43 states. State funding contributions, not including the required match for the grants, exceeds $37 million. Four additional states are also engaged in the ADRC development but are funded with non-federal dollars. This brings the total of 47 states/territories involved in the ADRC efforts.

The History of ADRCs in Hawaii

In 2005, the State of Hawaii received an $800,000 federal grant from the U.S. Administration on Aging (AoA) and the Centers of Medicare and Medicaid Services (CMS) to develop the Aging and Disability Resource Center (ADRC) within a 3 year funding period starting from October 2005 - September 2008. It became one of 43 states and territories receiving this federal grant to initiate the ADRC project.

The Executive Office on Aging (EOA), in partnership with the Hawaii County Office of Aging, and the City and County of Honolulu Elderly Affairs Division was awarded with the grant to develop the Aging and Disability Resources Centers (ADRC) on the islands of Hawaii and Oahu, with the goal of expanding statewide. Serving as the project manager and lead agency, the Executive Office on Aging contracted with the University of Hawaii, School of Social Work to hire a state-level project coordinator and project evaluator to assist in the overall project coordination and work closely with the two pilot sites by providing them with technical assistance. The county area agencies on aging were responsible for developing, implementing and operating the ADRC sites on their respective islands. In Hawaii's 2005 ADRC original grant application proposal, the project focused on three goals: 1) Start up one ADRC site in Hawaii County that may serve as a model for other sites throughout the state; 2) Develop strategies for statewide access such as telecommunications and website, 3) Seek resources for the second ADRC in Honolulu.

Of the $800,000 federal funds, Hawaii County received $495,693 to initiate its start up for the 3 years project period. The federal funds were used for key project staff, office equipment and planning activities. Hawaii County also committed additional county funds to lease the former Sun Sun Lau restaurant for a minimum of 10 years and co-locate the Hawaii County Office of Aging and other aging and disability agencies and programs in the facility. Between the lease rent and additional staff, Hawaii County is contributing over $4.5 million dollars to the project over the next 10 years. Total square footage of the main level is 14,747, 2,397 for basement, and the new 2nd level additional space is 5,472 square feet. The total facility space is 22,616 sq. feet plus parking. This additional funding support from the County has made the renovation and construction of the ADRC physical site in Hilo a reality.

Meanwhile, the Honolulu's Elderly Affairs Division was scheduled for its start up in the second year of the grant. In the first phase of the project, EAD actively participated in the State Advisory Board and subcommittees in project planning while assessing its internal infrastructure and service provider network to establish the second ADRC site for the State. Kauai and Maui counties participated in many of the planning subcommittees as well to provide their input and begin their own preparation as future ADRC sites. The late start up schedule for Honolulu provided the extra time needed to seek additional funding from other funding resources such as the State Legislature. Honolulu received its federal funds allocation of $131,779 and began in 2007, a little later than originally scheduled. $300,000 was later appropriated by the Hawaii State Legislature (Act 204) to provide additional funding that supported the website development, statewide telephone system, marketing and community outreach, staff training and ongoing statewide coordination and evaluation.

III. What is an Aging and Disability Resource Center?

FUNCTIONS OF AN ADRC

The goal of ADRCs is to create a single, coordinated system of information and access for all persons seeking long term support. The intent of the centers is to minimize confusion, reduce the number of hoops that must be jumped through by a consumer to receive services, enhance individual choice, support informed decision-making, and increase the cost effectiveness of long term support systems.

To accomplish this goal, the ADRC must perform the following functions:

Awareness & Information

- Public Education and Outreach – ensuring all potential users of long term support and their families are aware of both public and private long term support options, as well as awareness of the existence of the Center.

Assistance

- Options Counseling – providing comprehensive, objective, up-to-date, user-friendly information about the full range of available, immediate and long-range options; helping individuals understand available community support options, assess their

needs and resources and assisting them in developing and implementing their long-term support choices.

- Benefits Counseling – helping people learn about and, if desired, apply for public and private benefits including private insurance (such as Medigap), SSI, Food Stamps, Medicare, Medicaid and private pension benefits.
- Referral – providing comprehensive and accurate information on services and programs that help people remain at home and in the community such as direct services, generic community resources and public or private insurance.
- Crisis Intervention – responding to situations of immediate jeopardy to the health or welfare of an individual in a timely manner with appropriate means.
- Planning for Future Needs – helping the consumer to assess long range needs and make appropriate plans.

Access

- Eligibility Screening - helping all individuals who may be eligible for publicly funded programs with a non-binding inquiry into their income and assets to determine eligibility for programs, services and benefits, including Medicaid.
- Private Pay Services – when appropriate and desired, helping individuals to access programs and services in the private sector.
- Comprehensive Assessment – looking broadly at the needs of individuals, without regard to specific programs or eligibility for specific funding streams.
- Programmatic Eligibility Determination – determining non-financial eligibility for publicly supported benefits or services; may require functional assessment of an individual's health and environment, including a level of care assessment for Medicaid services.
- Medicaid Financial Eligibility Determination - ensuring that an individual can receive a determination of Medicaid eligibility through an integrated or coordinated system that eliminates redundancy and fragmentation.

REQUIREMENTS FOR ADRCS

- Target Groups - the ADRC must, at a minimum, include the elderly population (age 60 and above) and one other disability target group. In Hawaii, the ADRC's are initially serving adults with physical disabilities and then branching out to serve other groups of people with disabilities.
- Streamlining Access - the ADRC must provide one-stop access to all public programs for community and institutional long term support services administered by the state under Medicaid and those portions of the Older Americans Act programs that are devoted to long term support services, and any other publicly funded services related to long term care.
- Public and Private Pay Clients - the ADRC will be a resource for private-pay individuals, those eligible for publicly funded services, and health and long term support professionals and others who provide services to the elderly and to adults with physical disabilities.
- Critical Pathways - the ADRC will create formal linkages between and among the critical pathways to long term support (hospitals, nursing homes, etc.).

- Management Information System - the ADRC program will have a management information system that supports the functions of the program, including tracking client intake, needs assessment, care plans, follow-up, service utilization and costs.
- Evaluation - the ADRC must establish measurable performance objectives including objectives related to visibility, consumer trust, ease of access to services, responsiveness to consumer needs, efficiency of operations and effectiveness of the ADRC.

Hawaii ADRC Design Strategy

The overall design strategy was to build the ADRC from the core functions of the local Area Agencies on Aging (AAA). The Hawaii ADRC project used the "No Wrong Door" approach for accessing public and private services. Unlike the single entry point (SEP) model, Hawaii's consumers would be able to access long term care options and resources through multiple entry points that were well coordinated and supported.

In the original grant proposal, EOA recognized early on that a single ADRC entity for all of Hawaii was not feasible due to the island geography and the fact that not all seven major islands have the same types or quantity of service and resources for long term care. However, it was important that there were uniformity and standardization among the sites in key functions and process as outlined by the federal ADRC Fully Functioning Criteria and that there is a seamless system statewide. Both AoA/CMS and the State recognized and allowed each ADRC site to have some flexibility for adaptation to the sites' respective circumstances (i.e. staffing pattern, flow of operations) as needed and used the No Wrong Door approach as its strategy. Building an infrastructure that is uniform yet flexible for an island-state requires tremendous amount of collaboration and planning. The progress is slow and deliberate.

The ADRC statewide website, telephone system (which include a statewide number) and a physical site in Hilo are the major access venues or tools available to the public. In working with other service providers and groups identified in the critical pathways, the ADRC is marketed so that the consumers know how to access the ADRC for assistance. The website is organized in a standardized format in which consumers will be able to: Find services, Learn about resources in the library section, and Apply for public programs and benefits within any of the 4 counties. The single number server (statewide telephone number) is linked to the closest ADRC site in the State. Consumers only have to remember one phone number to obtain assistance (643-ADRC) and one website (www.HawaiiADRC.org). Honolulu has already established 2 satellite sites with two more sites under renovation in strategic locations on Oahu. ADRC pilot sites have been oriented /trained in the ADRC model.

The first ADRC site in Hawaii County is a physical model. Former Mayor Harry Kim and Hawaii County Council had identified the ADRC as one of their priority projects, and supported the project development on the Big Island with additional county funds. The former Sun Sun Lau restaurant, a landmark in Hilo, was completely renovated to house the Hawaii County Office of Aging and other aging and disability agencies such as the Coordinated Services for the Elderly, Hawaii County Nutrition Program, Senior Training and Employment Program, Department of Human Services Adult Protective and

Community Care Services, Arc of Hilo, Hawaii Centers for Independent Living (Hilo), and access by other public and private groups such Alzheimer's Association, Legal Aid Society, Public Health Nursing offering a one-stop shop for information and resources. The University of Hawaii at Hilo College of Pharmacy is projected to soon provide free medication management consultation services and community education on-site.

Honolulu's ADRC is a virtual model in which a comprehensive website has been customized and built by a website development consultant/team in conjunction with the Kauai County and the State Department of Health IT staff. Instead of purchasing an off-the-shelf ADRC website product produced for numerous ADRC sites across the country, Hawaii opted to build its own. This strategy had been determined by the 4 counties and EOA to be more cost-effective and sustainable in the long run since the State owns and hosts this website, and avoids paying high annual website maintenance fees to private vendors. The website was launched in late 2009. Upon completion, this project successfully released a statewide entry point and four county-specific ADRC websites (Hawaii, Kauai, Maui and City and County of Honolulu) which have uniform features, design and functions. The sites contain county-specific information, calendar of events and resources as well as commonly used federal and state program information and applications. The State EOA programs such as Sage Plus, SAGEWatch and the Long Term Care Ombudsman are also included in the website. This website project combined the services of contracted technical and management resources and existing information technology (IT) resources from several state and county agencies, to create the Hawaii ADRC as a content management template using DotNetNuke, and tailored to the local needs of the participating county Area Agencies on Aging (AAA).

IV. Establishing An Aging and Disability Resource Center

DEVELOPING A VISION

The State of Hawaii shares the same national vision which ***is to have Resource Centers in every community serving as highly visible and trusted places where people can turn for information on the full range of long term care support.*** This also serves as Hawaii's philosophy.

For developing ADRC sites, having a successful long term care systems change requires commitment to a vision of what the new system will look like and how it will improve access to services for consumers. It must be a vision that is shared by critical partners and by staff and must be able to be articulated by all of these groups. Systems change is difficult and slow; it is the vision of how consumers will be better served that sustains the commitment to make these hard changes. The vision must always remain "front and center." And it must drive policy and operational decisions. While this may seem self-evident, failure to articulate the vision and to keep it in focus can lead easily to designing policies and procedures that take the system in far different directions than intended.

Core Values

To reflect this vision and philosophy, Hawaii's ADRC has adopted the following core values:

- Respect	- Courtesy	-Accessible	- Reliable
- Warm, Comforting	- Customer-oriented	-Unbiased	
- Trustworthiness	- Responsive	-Caring	

Who Needs To Be Involved in Developing the Vision?

Developing an ADRC involves comprehensive systems change and as such requires partnerships and working agreements among state agencies, local health and human services agencies, the faith community and private partners such as service provider organizations. Everyone who has a stake in the existing system needs to have an opportunity to be involved in envisioning the changes: consumers, providers, advocates, advisory boards, and staff. Any of these groups can become effective at blocking or impeding desired changes if they are not on board with the vision. It is expected that all ADRCs will share the over-arching federal and state vision while modifying it to fit unique needs and concerns of the partners and service environment. The vision also will include the target groups who will be served which may vary regionally and a concept of how the ADRC will operate: stand alone center, part of an umbrella organization, virtual, co-locations, etc.

Developing Partnerships

Because of the complexity of the long term care system and the many different consumer and provider groups, successful change only can occur with their buy-in. Listening to the partners to identify their concerns and the changes they see as beneficial is important as the vision is developed but also as the detail of the implementation issues begin to arise. While all of the partners are important, some may be more critical than others in addressing specific goals of the ADRC. These groups have served on the State and local advisory boards, working subcommittees, website development, and provided their input, expertise and resources to assist in the ADRC development.

Hawaii ADRC partners (state-level) have included but not limited to:

- AARP Hawaii
- Alzheimer's Association
- Alu Like, Inc.
- Core Group One
- Department of Human Services (Medicaid, Adult Protective and Community Care Services)
- Department of Health – Developmental Disabilities, Adult Mental Health
- Developmental Disabilities Council
- Project Dana
- University of Hawaii, School of Social Work, Center on the Family, Travel Industry Management, and Center on Aging
- Disability Communications Access Board
- All Four Area Agencies on Aging
- Hawaii Center on Disability Rights
- Hawaii Centers for Independent Living
- Hawaii Long Term Care Association
- Healthcare Association Hawaii
- Kapiolani Community College
- Kokua Kalihi Valley Health Center

As noted above, specific partners will depend upon the target groups selected and specific goals to be addressed by the ADRC. Other potential groups may also include:

- Social Services Agencies
- Faith-Based organizations and community
- Hospitals
- Community Health Centers
- Media
- Transportation Agencies
- Home Health Agencies
- Housing Agencies
- HR Dept. of Local Major Employers
- Employment Agencies (Voc Rehab, One-Stops, ESC)
- Veterans Administration

Roles and Relationship Between the State EOA And County AAAs

As the Hawaii State Unit on Aging, the Executive Office on Aging serves as the lead agency and provides the project oversight and leadership for the ADRC development. EOA is the primary liaison with the U.S. Administration on Aging and Centers for Medicare and Medicaid services and ensures compliance to the grant requirements including submitting progress reports and data information. It also convenes the State ADRC Advisory Board and works closely with other state-level partners such as the Department of Human Services, Department of Health and other agencies to streamline and improve access to long term care information. EOA provides technical assistance to the ADRC sites, resources such as state-level project management, coordination and evaluation, advocates and promotes the ADRC at the State legislature and other key community partners, Governor's office, and media.

The county Area Agencies on Aging are responsible for planning, developing and operating the ADRC in their respective areas. The staff performs the key functions of the ADRC which includes intake/screening, assisting in eligibility determination, providing information, referral and linkages to other agencies and programs, and offers short term case management and follow up to ensure that consumer obtains the needed services. They work closely with local agencies and community partners especially within the aging and disability network for client referrals, organize staff cross training, and conduct community outreach and education. Businesses, educational institutions, labor unions and civic groups are also important stakeholders and partners. Memorandums of agreements are encouraged to define and strengthen the functions and roles between the ADRC and its community partners whenever applicable. (See Appendix A for Sample MOA)

There should be a respectful and symbiotic relationship between the State and Counties to ensure a successful replication statewide. It is critical to maintain the integrity of the ADRC mission while allowing flexibility for counties to adapt the ADRC functions/processes within the uniqueness of each site's environment and infrastructure. Each partner brings valuable resources toward the ADRC development which should be leveraged to achieve the overall ADRC goal.

Developing A Work Plan And/Or Business Plan

A work plan or business plan translates the vision into reality. It tells what is going to be done, who will do it, how it will be done, when it will be done and the resources required doing it. The original two pilot sites in Hawaii developed and followed a work plan which served as their compass in project development and management. (See Appendix B – Hawaii and Honolulu Work Plans) This plan should be continuously updated since it is often very difficult to accomplish tasks as scheduled due to unforeseen obstacles which may arise during the course of the project development. It is also not unusual to change strategies in mid-stream when there are insurmountable barriers or unexpected opportunities that present themselves.

A more comprehensive formal planning tool is a business plan. The Aging and Disability Resource Center Technical Assistance Exchange (ADRC-TAE) has prepared a business plan template that is useful. It may be found at www.adrc-tae.org under "Resources by Type, Briefing Papers." It is recommended that this template be used when developing a Business Plan. However, in lieu of a formal business plan, the work plan should require, at a minimum:

Components of the Plan

1. General description of the ADRC. A description will include specification of target populations, sponsor and organizational structure, and location.
2. Statement of specific goals, timelines, person(s) responsible and resources needed.
3. Description of how the ADRC will perform the required functions: awareness and information; assistance; and access. The description should clearly identify how these business will be done differently under the ADRC; i.e., a before and after picture. What ADRC model will be implemented?
4. Identification of partners, partner roles and board or advisory committee
5. Coordination with critical pathways
6. Client confidentiality
7. Management and organization, including organization chart, staffing pattern, job descriptions and staff training.
8. Information and technology systems
9. Marketing plan
10. Evaluation methods
11. Budget for ADRC operations
12. Sustainability plan

Visits to or contacts with existing ADRCs within the state will be helpful in developing the business plan. The Executive Office on Aging (EOA) is also available to provide assistance, especially in the beginning phases. Helpful information may also be found on the national technical assistance website, www.adrc-tae.org. Contact the EOA Director or State ADRC Project Coordinator to authorize access to the ADRC technical website for designated ADRC staff members.

The business plan or work plan should be endorsed by the advisory board or committee of the ADRC and then submitted to the Executive Office on Aging for review and approval.

Staffing the ADRC

Most ADRCs will likely find themselves without sufficient new funding to hire additional staff for the ADRC. This will require examining existing staffing patterns and staff skills to determine how best to organize the staff to perform the added functions of an ADRC. Change in job duties and functions are often difficult for staff. Successful change is most likely when there has been staff involvement in development of the vision and business plan, so that their expertise and concerns are adequately addressed.

In most Area Agencies on Aging, the available positions (i.e., building blocks) to staff the ADRC will include the ADRC Specialist/Information & Referral/Assistance Specialist or the Caregiver Specialist. Many ADRCs in other states have found it necessary to find a way to add a combination Disability Specialist/Medicaid Intake worker, as most Aging staff has not acquired the expertise to handle the wide range of inquiries from younger adults with physical disabilities. As a physical site, the Hilo ADRC has access to the staff's assistance and expertise from the Hawaii Centers for Independent Living to help ascertain the needs of a diverse disabled population.

Most Area Agencies on Aging will find it helpful to designate a person to serve as the manager or coordinator of the ADRC. As the ADRC gets started and begins to mature, coordination and integration of the various staff, coordination with the partners, developing or modifying policies and procedures, and ongoing evaluation of operations are time-consuming activities. In addition, there is a tendency for operations to revert back to "how we used to do things" if there is not constant attention to reinforcing the new paradigm. One of the most significant challenges a new ADRC will face is how to best integrate the functions of these positions in a way that is most consumer friendly; i.e., that prevents repetition and duplication that avoids consumers being routed from one staff to another, and that gets the job done most efficiently for the consumer. The ADRC is not just about adding another position or a new target group. It is about doing business differently.

Governance

The ADRC is served by an Advisory Board or committee generally reflecting the diversity of the ADRC network and representing the major consumer groups served by the ADRC. At the State-level, the Hawaii State Aging and Disability Resource Center (ADRC) Advisory Board assists in the development and implementation of Hawaii's ADRC program. The Advisory Board advises the Executive Office on Aging (EOA), the lead state agency of the ADRC initiative on: a) the design and operations of the Resource Centers; b) provide stakeholders' input; c) the State's progress toward achieving the goals and vision described in the grant; and d) other program and policy development issues related to the State's Resource Center program.

EOA has ultimate authority over the program and the Advisory Board. The Advisory Board is composed of (a) individuals representing all populations served by the state's Resource Center program including individuals who have a disability or a chronic condition

requiring long term support, (b) representatives form organizations that provide services to the individuals served by the program, and (c) or representatives of the government and non-government agencies that are impacted by the program.

Advisory Board Memberships may include but are not limited to:

State Agencies

Hawaii State Health Insurance Program Grant – SagePlus
Hawaii Senior Medicare Patrol grant – SageWatch
Department of Health, Developmental Disabilities Division
Department of Health, Disability and Communications Access Board
Department of Health, Adult Mental Health Division
Department of Health, Evidence-Based Practices Project
Department of Health, State Health Insurance Assistance Program
Department of Human Services, QUEST Expanded Managed Care
Department of Business, Economic, Development and Tourism
Department of Transportation, Assisted Transportation Grants Management
State Housing Authority
University of Hawaii, School of Medicine, Geriatrics Division
University of Hawaii, Center on Aging, School of Social Work
University of Hawaii, Community Colleges
University of Hawaii, Center on the Family

Area Agencies on Aging

City and County of Honolulu, Elderly Affairs Division
Hawaii County Office of Aging
Kauai County Agency on Elderly Affairs
Maui County Office on Aging

Community Organizations/Advocacy Groups/Consumers

AARP Hawaii
Alu Like, Inc.
Alzheimer's Association
Kokua Council for Senior Citizens
Governor's Policy Advisory Board for Elder Affairs
Hawaii Long Term Care Association
Hawaii Caregivers Coalition
Hawaii Center for Independent Living
Hawaii's Meals on Wheels
Healthcare Association of Hawaii
Project Dana

Other Possible Members

Adult Day Services Hawaii, Inc.
Catholic Charities- Services for the Elderly
Honolulu Gerontology Program
Palolo Chinese Home
Adult Residential Care Homes Association

Case Managers Association
Hawaii Community Foundation
UH ElderLaw Program
Kokua Kalihi Valley Comprehensive Health Center
Waianae Comprehensive Health Center
HMSA
AlohaCare
Tripler Medical Center/Veterans Administration
Kaiser
Chamber of Commerce
Options for Assisted Living

Role and Tasks of ADRC Advisory Board

To support EOA and the local AAAs in promoting long term care system changes by:

1) Serving as a working board that will be actively involved in the planning and development of the ADRC implementation;
2) Identifying and solving issues and barriers to implementing ADRCs in Hawaii;
3) Providing resources and expertise in addressing the multi-layered needs of the aging and disability populations, consumers, providers and government;
4) Promoting and communicating the role and function of the ADRCs to the public, providers, legislature and county councils, and policy makers for future sustainability which include political and financial support.

Meeting Requirements

The Advisory Board meets on quarterly basis, at a minimum, to monitor the progress of the ADRC implementation. The Board assists EOA and the AAAs address issues and barriers related to the ADRC. Subcommittees may meet more frequently and will report to the Executive Committee and/or the general board.

Membership Terms and Size of Board

Terms on the ADRC Advisory Board may be staggered with members having either a one year, two year or three year terms. As critical partners in the ADRC development, several organizations will have standing memberships such as but not limited to: Department of Human Services, Disabilities and Communications Access Board, Developmental Disability Council, and the four Area Agencies on Aging. These organizations may designate different representatives to attend the meetings. It is recommended that no individual should serve more than six consecutive years. To ensure appropriate representation on the Advisory Committee, members may be recruited or nominated from but not limited to the suggested consumer groups, agencies or advocates identified above.

To provide and maintain sufficient board management and meeting logistics planning, the size of the ADRC board membership should not exceed 25 members. Since there are many consumer groups that could be engaged in the ADRC, it is recommended

that these groups be invited to serve on the subcommittees that address focused areas of the ADRC function or components.

Proposed Sub-Committees

The Advisory Board has formed sub-committees comprised of Advisory members and/or other representatives from other organizations. Because of the complexity of the project, there may be more than one representative from the same organization serving on one or more subcommittees. The sub-committees are the work groups behind the ADRC planning and development. Sub-committees may include additional experts and representatives outside of the main Advisory Board, to provide their special knowledge, skills and experience. The Sub-committees are as follow:

- Executive Committee
- Evaluation
- Sustainability/Finance/Statewide ADRC Replication Planning
- MIS System, Website, Telecommunication
- Forms/Assessment
- Communication/Marketing/Consumer Education/Access and Linkages

To assist each subcommittee, the State ADRC Project Coordinator and other EOA staff and consultants will provide administrative support, coordination and follow up as needed.

State Advisory Board Relationship with County/Local ADRC Advisory Board

The State Advisory Board planning and development activities will be shared with the respective AAAs and their advisory boards/steering committees involved in the ADRC program. The State and local ADRC Project Coordinators, EOA and the AAAs will serve as the primary communication liaisons.

Operational Policies And Procedures

Operational policies and procedures are being developed as ADRC sites are implementing the operational processes for intake, screening, referrals and case management/follow up and other functions The experiences of the pilot sites can help identify areas where policies and procedures are most needed and provide examples that may be adopted or modified. Some of these policies and procedures are still being developed by the pilot sites and will be included in this manual as samples upon completion.

Areas where policies and procedures are likely needed include:

Confidentiality – Ensuring client confidentiality is absolutely essential for earning consumer trust, as well as for conforming to federal and state law and regulations. Confidentiality requirements must be a part of staff training and operational practices of the ADRC and must at all times reinforce these requirements. New staff should be immediately briefed on the requirements and asked to sign a confidentiality statement. The requirements are extended to all ADRC partners who exchange client information with the ADRC, especially those partners using the electronic referral process. A technical assistance brief regarding the ADRC and HIPAA requirements is available through the ADRC Technical Assistance Exchange at www.adrctae.org under "Resources by Type, Client Confidentiality." (See Appendix C – Confidentiality Policy)

Customer Service Standards – The implementation of specific customer service standards by the ADRC keeps ADRC operations focused upon the consumer. Such standards provide specific guidance to staff about how good consumer service is provided. (See Appendix D - UH School of Travel Industry Management Customer Service /Communications Training Curriculum)

Information Flow Within the ADRC – Designing the flow of information within the ADRC is important to both consumer service and the efficiency and economy of labor within the ADRC. In designing the flow chart, it is usually helpful to develop hypothetical cases and "walk" them through the ADRC functions. The kinds of questions to be asked include what happens when a call comes into the ADRC: who answers the call; what do they do with the call; how is the call recorded; does the call need follow up? It is how the ADRC handles these basic operational questions that largely will determine customer satisfaction. (See Appendix E – Information Flow)

Record Keeping – Complete and accurate record keeping documents the activities and services of the ADRC. Funding agencies, the community and partners of the ADRC look at the data generated from the ADRC records to judge the accomplishments of the center and how well it is working. Additionally, data from the center may be used by a variety of agencies for planning and advocacy purposes. Therefore, good record keeping must be a job responsibility for all staff of the center.

Unfortunately, because of duplicate data systems required by different federal programs, the task of record keeping is not an easy one. There are instances in which the same data must be entered multiple times. This takes time away from the important business of directly helping clients and indeed may become a burden for staff. However, until the issue of duplicate systems is resolved by state and/or federal action, it is important that staff make every effort to capture the necessary information in all pertinent systems. Failure to do so may mean the necessary information is not available to the right staff person when it is needed to assist the client. It may also result in a serious understatement of the level of activity of the ADRC or other program and have negative consequences for funding support. It is

incumbent upon management to enforce appropriate practices to ensure that complete and accurate record keeping does occur. (Pending Policies/Procedures)

Coordination with Partner Agencies – Coordination with partner agencies is vital to the success of the ADRC. It is better not to leave interaction between these agencies to informal understandings. A written memorandum of agreement or understanding that specifies the roles and responsibilities of the agencies to one another helps to ensure that the needs of each is met and minimizes potential misunderstandings that may threaten the relationship. Partners should have defined roles and these roles should be spelled out in a written memorandum of agreement (MOA) or memorandum of understanding (MOU). Not all partners will have the same roles nor be equally involved in the operation of the ADRC. Regular, easy methods of communication should be developed to facilitate quick problem identification and resolution, as well as sharing of resource information. (See Appendix A- Sample MOA)

Other Recommended Areas for Standardization

It is paramount that the ADRC program is comprehensive, standardized, and accessible while recognizing the uniqueness of each county's communities, finances, and resources. Resources, expertise and information will be shared and coordinated among the respective AAAs and advisory boards to ensure the success of the ADRCs in the State. Some of the suggested areas for standardization are:

- Assessment Forms (Initial Intake Assessment/Screening, Medicaid eligibility, Long Term Level of Care, Service Plans, Data Collection)
- Evaluation Methodologies
- One Central Phone Number – with linkages to local ADRC Centers
- Website
- Marketing
- Staff training program
- MIS System

Other services and activities are discretionary and can be developed by the respective ADRC sites. For example:

- Co-location of other agencies and services such as the Hilo ADRC site

V. A Management Information System to Support the ADRC

Hawaii ADRC is a system that provides information, referral and assistance for persons needing aging or disability services. The philosophy of Hawaii ADRC's no wrong door creates a system that does not "bounce" consumers from person to person or agency to agency. Hawaii ADRC is a vital link between people who need help and the social service organizations ready to provide that help. The service is free and confidential. The computerized database has referral sources including government and private nonprofit organizations, self-help support groups, community organizations, faith based organizations, professional associations, and much more.

There are two different parts to Hawaii ADRC: the public side and the secure side (for registered staff users). The public side has:

- A community calendar of events, workshops and trainings;
- A "Learn About" section for easy to understand information on topics such as Housing options, Assistive Technology, Community Life, Transportation, Education, Employment, Civil Rights, Financial Benefits, and Health;
- Information on how to hire and manage a personal care worker, understanding SSI/SSDI and Medicaid waiver services; and
- On-line (e-forms) for public programs which can be downloaded and printed out for completion and submission. (At this present time, the listed forms cannot be submitted electronically).

The secure side (registered staff users only) supports:

- Caller/Client intake and management
- Case management/short term monitoring
- Follow-up that will alert the user on the follow-up date
- A variety of search tools to assist in finding service providers and the capability to document referrals made
- Electronic referral capability (pending)
- Sharing all or part of client data with other agencies
- Reports – both standardized and customizable
- Data maintenance including on-line updating of provider data

One of the responsibilities of the partners of an ADRC is to assist with the maintenance of referral data in their area. If existing data on Hawaii ADRC is outdated or providers are not listed that should be, it is requested that the partner agency notify staff at their local ADRC who will then make the necessary contacts and correct or add the information. The ADRC has an Exclusion/Inclusion policy and website contents selection policy which guides the selection of the organizations/agencies or resource linkages that can be included or excluded from the ADRC website. (See Appendices F & G – Exclusion/Inclusion Policy and Website Content Selection Policies)

Reorganizing the existing management information system within the Area Agency on Aging can be a laborious process. A MIS consultant was contracted to assist the Honolulu ADRC in assessing its internal management information system and processes to reduce duplication involving coordination or interaction with other agencies and providers, improve efficiencies and quality of service, reduce paperwork, repetitive data entries on the same information or client, and integrate information on clients, produce quality reports. The sites are striving to upgrade and enhance current MIS system to support multiple functions such as client intake/screening, client/case management, referral and data collection for reporting outcomes. (See Appendix H for the Honolulu MIS/IT Development Plan)

As a first step towards streamlining the MIS system statewide, all four counties have agreed to purchase similar software applications, tools and products (i.e. Harmony) that will interface with the ADRC website as well as with each county. The ADRC project

focused first on upgrading the AAAs to a uniform, modern I & A, case management and reporting suite- i.e. Harmony SAMS. This was urgent and necessary due to the complexity of collecting data from the existing different sources. Once the Harmony tools are installed by the AAAS, additional licenses can be purchased for services providers to have the option to use the same tools to expedite and make more their processes more efficient by electronically exchanging information with the AAA. The following products are already in place or in process of being integrated.

Aging Network

The AgingNetwork.com service is an online delivery platform for the other Harmony functions. It alleviates the necessity for management of servers, software, and communication by EAD, County, or State IT departments to host the Harmony software. Each user requires only a PC with Internet connectivity. (Hawaii County is not using AgingNetwork at this time)

SAMSIR

This is the Harmony module that provides information and referral capabilities, including the ability to create and maintain a service provider database or directory. A forth-coming version expected to be released Q2 2008 integrates BeaconIR and SAMS under one SAMS user interface.

SAMSWEB

This is an optional service provided by Harmony that can "push" provider/service information from a BeaconIR database to a website that includes a resource directory search tool suitable for use by consumers.

Omnia/Omnia Interviewer

This is an optional module for use with SAMS and/or BeaconIR to collect program/intake assessment information for clients via electronic forms in an "interview" approach. To minimize data entry time/effort, the tool can automatically populate form fields from entries made during prior assessments. A catalog of fields is maintained by Harmony that can be added to customize a form. The Interviewer optional module allows laptops or PDAs to be used in the field without being attached to the AgingNetwork. Data collected from Interviewer is then synchronized with the AgingNetwork database when Internet connection is established.

SAMS (formerly SAMS2000)

This is the supported version of the Harmony SAMS case management tool.

There are other functional tools and applications which ADRC sites may want to consider installing in the future pending their budgets and software upgrade priorities. The following modules are examples from Harmony:

SAMS-BCU

This is an optional module permitting NCOA's Benefits CheckUp capabilities to be integrated with SAMS systems. A SAMS user can then automatically assess eligibility from SAMS for BCU programs. (Currently limited to Medicare Part D Low Income Subsidy program.)

SAMScdi

This is an optional SAMS module that permits a website to include an electronic form that may be used by a consumer to submit needs information into SAMS as a client request. The SAMS I&A staff may then review this information and be better prepared to follow-up with the client.

SAMSapp

This is an optional service provided for SAMS systems that permits users to complete electronic program application forms on behalf of clients. Forms will be automatically populated with any information from prior data that was collected.

Document scan/management tool

This tool is being considered for value to store electronic (scanned) images of paper forms and attach to client records in SAMS. This would permit SAMS users to review information (such as assessments, notes) without needing to enter via keyboard into SAMS. Another version of the tool could perform optical character recognition on the forms so that information could become part of the SAMS database.

www.HawaiiADRC.org

As described in the Hawaii Design Strategy, the development of Hawaii's website was a collaborative effort in which a comprehensive website had been customized and built by a website development consultant/team in conjunction with the Kauai County and the State Department of Health IT staff. Using Dotnetnuke, an open-source contents management system, Hawaii's website is organized in a standardized format in which consumers are able to: Find services, Learn about resources in the library section, and Apply for public programs and benefits within any of the 4 counties. A state portal page serves as the gateway for users to access each county website. The state portal page also lists the statewide long term care programs available through the Executive Office on Aging. This includes Sage Plus, SageWATCH, and the Long Term Care Ombudsman service.

Statewide Website Advisory SubCommittee

A statewide advisory group was established to provide oversight of the ADRC website. The role and functions of this subcommittee are as follow:

1. Establishes standard guidelines in the maintenance and enhancement of the ADRC website, and provides a venue for sharing ideas, issues related to the website.
2. Assures uniformity and integrity of the website design and format, purpose and function.
3. Shares contents management issues, new ideas, features, links and resources that may have statewide relevance and applications.
4. Reviews and approves changes to the DotNetNuke Skins application, features, and functions.
5. Reviews statistical data on the number of hits, visits, feedback/comments received by users and staff.
6. Provides quality assurance oversight.
7. Develops the statewide website protocols and procedures.

Decision making authority at the county-level and EOA sites for county specific or program contents additions and changes.

Aside from site specific calendar events, announcements postings, service provider information, the subcommittee shares/posts all other additions/changes for group discussion and exchange of ideas – at least initially as sites are learning more about contents management and becoming familiar with the website.

Role of Key Staff

1) Super User Administrator – This designation/access is currently limited to a designated EOA staff, Mataninet, Inc (the website consultant), and Kauai IT's web developer. The Super User has the access code to go into each county/state website and make any technical changes as needed. This account should be authorized only and used by individuals who are highly experienced with IT designs and have a technical background. Administrators can add new modules applications.
2) Site Administrators; Each county and EOA designates one person to be the Site Administrator who will oversee their specific sites and authorize specific staff as contents editors. The Site Administrator's access is limited to their county website only. Site Administrators can authorize new users and add tools. Their role is similar to the Super User Administrator, except Site Administrators do not have access to other county sites.
3) Content Editors are in-house staff authorized to add/change information or data into their specific county/EOA sites. These may include information on service providers' information, program changes, calendar of events, announcements, and new articles. Each county and EOA should designate their own contents editors.
4) Department of Health, IT (HISO) provides oversight of the hardware/software Platform Maintenance Activities – these tasks are performed typically by a qualified IT staff or contractor to maintain the stability of the baseline hardware and systems software platforms to support development/test and production services. Specific tasks include:
    a. Monitor hardware for failures and repair/replace as required.
    b. Apply patches/updates to systems software (operating system and database). Administration of systems software.
        i. Monitor server, database logs.
        ii. Archive/optimize database. (Automated)
        iii. Backup. (Automated)
    c. Support system help desk for reporting of outages, performance issues, or other platform-related questions.

VI. Marketing of the ADRC

Creating a new system for accessing information and assistance about long term supports in the community may be a much-needed change; however, the new system must become known and visible in the community to be of real service to consumers and

professionals. Social marketing is the term frequently used to describe strategies for attracting consumers to new programs and resources.

Effective social marketing requires an in-depth understanding of how the target audience views the issue at hand and then using that information to craft messages and outreach materials that are uniquely persuasive to the target group. The tools of social marketing can be effective in increasing and promoting public awareness of the ADRC as a trusted source of information and assistance. Social marketing emphasizes the target audience's point of view and incorporates consumer feedback into the development of campaign materials and messages.

Marketing Plan

Through the statewide communications/education/access and linkage committee, Hawaii developed an ADRC marketing plan that provides the general guidelines and strategies in communicating, promoting and targeting the primary and secondary markets to ensure consistency, accuracy and clarity of the ADRC vision and goals. Each ADRC pilot site, however, should customize their marketing activities and strategies accordingly to their respective community culture, timeline and resources.

I. STATE AND COUNTY OFFICIAL ADRC NAME

State of Hawaii	Aging and Disability Resource Center Hawaii
Hawaii County	Aging and Disability Resource Center Hawaii- Kahi Malalma (A Place of Caring)
City and County of Honolulu	Aging and Disability Resource Center Hawaii – A Program of the Elderly Affairs Division, City & County of Honolulu

II. VISION AND GOALS

National and State of Hawaii's Vision

ADRC is a highly trusted, unbiased source of information for public and private paying individuals. It is a one stop source of information that offers a full range of long term support options and services.

National Goal

Empower individuals to make informed choices and streamline access to long term support.

State Goals

- Establish the ADRC to be a one-stop source of information to long term care programs, services and benefits

- Have two pilot sites established initially in Hawaii and Honolulu Counties, and to be followed by Maui and Kauai thereafter

- Streamline process for screening, intake, assessment and eligibility determination

III. ADRC PHILOSOPHY AND CORE VALUES

The ADRC philosophy reflects the national vision to establish a highly trusted and unbiased source for long term care information and where people can obtain assistance to make informed decisions about their long term care. To reflect this philosophy, Hawaii's ADRC has adopted the following core values:

- Respect	- Courtesy	-Accessible	- Reliable
- Warm, Comforting	- Customer-oriented	-Unbiased	
- Trustworthiness	- Responsive	-Caring	

IV. OVER ARCHING MARKETING STRATEGY/POSITIONING

Position Hawaii ADRC as an essential resource and emphasize its impact on all sectors of the community as well as the importance to Hawaii's future.

V. OVERALL STATE MARKETING OBJECTIVES

1. Create top of mind awareness of ADRC among legislators to pave the way for future government funding
2. Create top of mind awareness of ADRC among the business community to pave the way for private funding and sponsorships
3. Create top of mind awareness of ADRC in Hawaii County and drive "business" to the new center in Hilo
4. Create and market an ADRC vehicle for Oahu' virtual ADRC (website and telephone)
5. Create top of mind awareness with other aging - advocacy groups
6. Create top of mind awareness with disability network and advocacy groups (i.e. DCAB, Medicaid, Cerebral Palsy Association, UH Center on Disability Studies, etc)

VI. TARGET MARKETS

A. Primary Markets

- People 60 years and older
- People 18 years and older, with physical disabilities

B. Secondary Markets

- Service Providers
- Caregivers
- Government Officials
- Business Community
- General Public

C. Critical Pathways for Access and Linkages (referrals and outreach)

- Home and Community Based Programs (i.e. adult day care, senior centers)
- Civic Groups (i.e. Lion's Clubs, Rotary)
- Health Care/LTC Facilities (i.e. discharge planners)
- Special Care Facilities/Programs (i.e. Hospice)
- Faith-Based Groups (i.e. churches, Project Dana)
- Government (Federal, State, County, VA, Dept of Health)
- Native Hawaiian (i.e. Alu Like)
- MedQuest (Dept of Human Services)
- Academia (i.e. UH School of Social Work, Medicine, community colleges)
- Foundations (i.e. Hawaii Community Foundation)
- Trade Associations (i.e. HealthCare Association, Unions)
- Housing (i.e. Condominium Association, Public Housing, Property Managers)
- Insurance Companies (i.e. HMSA, John Hancock)
- Retail Stores/Restaurants (i.e. Longs Drugs, McDonalds)
- Businesses (i.e. banks, hotels)
- Advocates Resources (i.e. Legal Aid Society)
- Public Safety (i.e. fire department, police)
- Transportation (i.e. taxis, Oahu Transit Services)
- Caregivers' Support Groups (i.e. Alzheimer's Association, Caregivers Coalition)
- Disability Network
- 211
- Access Line Crisis Center

D. General Barriers to Successful Access and Linkages

- Privacy Protection
- Civil Rights
- Complexity of aging issues/information overload
- Lack of awareness, need for public education on basic issues
- Scope of community outreach (insufficient staff, time and money)
- Families
- Need to get buy-in from the groups (vested interest for companies)
- Denial of aging, need for assistance
- Cultural differences
- Language
- Demographics (distance, geographic isolation)
- Money for outreach efforts
- Need for consistent follow up, sustaining the outreach effort with repeat visits and promotion
- Need WiFi Access for visual presentations
- Identifying the right contacts for agency to deliver ADRC presentation and materials (get the foot in the door)

VII. OVER ARCHING MESSAGE

"ADRC is a one-stop resource for long term care information and services for seniors and people with disabilities and their caregivers".

Market	Messaging	Insight	Channel
Senior Market (60 y.o.+)	ADRC can improve your quality of life	Peace of Mind	Personal One to One Through Group Presentations Services Providers
Disabled Individuals (18 y.o. and older)	ADRC can help you live more independently	Convenience Empowerment Quality of Life	Service Providers Electronic newsletters Support Groups Websites
Caregivers	In your busy life, ADRC provides valuable support to you and your ohana	Time Linkages to services Relief Respite	Media, Workplace Support Groups Faith Based Groups
Service Providers	ADRC connects your clients to needed services.	Inclusion Better customer services Increases knowledge of network	Collateral Materials (brochures, handouts) Presentations Trade Newsletters
Government Officials	ADRC can be a safety net for Hawaii's increasing senior and people with disabilities. Bottom line: ADRC reaches the critical mass in the most efficient, effective and coordinated manner. A collaborative project partnered at every level of government and private sector.	Constituency Return on Investment (ROI)	Media, Personal/one-to-one Meeting Need ADRC Newsletter

VIII. TARGET MARKETS INSIGHTS AND TOUCH POINTS

A. Senior Market Insights and Touch Points

- Have difficulty in identifying or recognizing their needs
- Denial of self care needs
- Reluctant or afraid to ask for help because of cultural issues of shame, don't want to be a burden
- Isolated
- Use media and technology less than the general public
- Unaware of services available to them
- Lack of transportation to access services

B. Service Provider Insights and Touch Points

- Busy
- Understaffed
- Under-funded
- Resources are stretched – staff performs multiple functions and are required to do more than less
- Overworked and underpaid, but generally very dedicated and passionate about their work
- Have an understanding of client needs and can help identify service gaps
- Fundraising and excessive paperwork takes away from providing direct services
- Liability restrictions, funding silos and regulatory requirements crate barriers to providing direct services
- Often now well-known, recognized and/or appreciated in the general public
- Not aware of all the services available to clients
- Turf issues can lead to lack of collaboration and duplication of services.

C. Caregivers Insights and Touch Points

- Caregivers start by "telling their story" before asking questions
- Often caregivers don't know what questions to ask
- Generally, caregivers are women between ages 45-55 years old.

Storylines

- "My mother is being discharged from the hospital in two days and the doctor says that she can't live alone. We don't have the space for her to live with us and we both work full time".
- "My dad is acting strange, confused and forgetful. I think he could be suffering from Alzheimer's Disease".
- "My aunt cannot drive and she doesn't want to use public transportation. Taxi cabs are too expensive".
- "My mom is terribly ill and in the hospital, but she wants to come home".
- "Caring for my dad is too much for me to handle. I need to send him to a nursing home".
- "I care for my mom 24/7 who has dementia. I need time away from her or I will go crazy".

- " My uncles doesn't want a stranger coming into the home to give him a bath or to watch him while I do my grocery shopping"

D. Government Officials Insights and Touch Points

- Concerned about public image and serving constituent group
- Bottom line ($$) – getting the most bang for your buck
- Can relate to aging and long term care issues through personal stories

E. Business Community Insights and Touch Points

- Require one to one meetings
- Concerned about the bottom line ($$)
- Can related to aging and long term care issues through personal stories
- Beginning to recognize the need to support employees who are dealing with caregiving and other age related issues

F. General Public Insights and Touch Points

- Can relate to aging and long term care issues through personal stories
- Often don't think about planning for future LTC needs or other age related issues until the crisis hits or go through personal experience
- Have misconceptions or narrow definitions about long term care is, how it's paid, etc. (often think it only deals with nursing homes)
- Need to avoid industry jargon- use simple, easy to understand language
- Often don't know where to go, who to call or what to ask for when need help
- Don't want to wait to get answers to questions –want the right service at the right time, right now

G. People with Physical Disabilities Insights and Touch Points

- Always emphasize the person first and use "people first language", as people with disabilities.
- People who have disabilities or who are elderly often need the same or similar services (i.e. caregivers, home chore services or transportation. Therefore, servicing these groups can be a more integrated versus a separate process.
- There really is no such thing as the "Disability Community." People with disabilities often tend to socialize and interact among those with similar disabilities as they, for example, advocate for the same causes and services. (i.e. deaf, intellectual disabilities, muscular dystrophy, TBI, mental illness).
- Often times, people with disabling conditions will define their condition based on the limitations and barriers encountered in their environment and daily activities versus a medical condition or diagnosis, and will relay this information by telling their stories. It is important to ask the appropriate question to elicit key information to identify the needs that the individual is asking and be honest if services are or are not available.

IX. COMMUNICATIONS STRATEGY AND TACTICS

- Create customized messages and use appropriate distribution channels for each large group

- Convey to each target group how ADRC Hawaii impacts them profoundly, as well as the greater good

Additional information on marketing the ADRC can be found on the www.adrctae.org website under "Resources by Topic" then "Service Components."

Seven Steps of Planning, Implementing and Evaluating a Social Marketing Campaign (Source: The Lewin Group)

In Hands-On Social Marketing, Nedra Kline Weinreich outlines a step-by-step guide to social marketing.

Step 1. Define the Target Audience - The first step in a social marketing campaign is to clearly define the target audience, which may be made up of a primary audience and secondary audiences. The primary audience is the group whose beliefs, attitudes or behaviors the campaign is attempting to influence. Secondary audiences are groups who influence the target audience's beliefs, attitudes and behaviors with respect to the subject of the campaign.

Step 2. Research and Segment the Target Audience - Develop an understanding of the backgrounds, attitudes and perceptions of the target audience about the product or service being promoted in order to tailor messages that will be persuasive to this particular audience.

Step 3. – Decide on the Type of Media to Use - The message may be in brochures, print advertisement, radio or television advertisements, billboards, or other forms of advertisement. The materials selected should be those that the audience pays attention to and should be designed to reach them where or when they will be most receptive to the message.

Step 4. Pretest Materials - Pre-testing materials is a critical stage of a social marketing campaign and can help marketers ensure that the campaign will have the desired effect. During this stage of the campaign, share the prototype materials with members of the target audience to solicit their feedback. Some of the areas that the target audience might provide feedback on are:

- *Whether the messages are comprehendible.* Do they understand the message being conveyed, the statement of the problem and the suggested action? Do they understand the language used in the materials? Is it the same language they would use? Is the reading level of the materials appropriate? Are concepts, terms or ideas explained clearly?
- *Whether the messages are on target.* Does the target audience react to the materials as intended? Do they find the messages persuasive? Is there any part of the materials that they do not relate to or does not seem to support the message? Do they find anything in the materials to be offensive?
- *Whether the materials are appealing.* Does the audience like the look of the materials? If it's a brochure, is it something they would want to pick up and

read? Is the design and look of the materials appealing? Do they like/relate to the visuals?

- *Whether there are mistakes in the materials.* The audience may catch mistakes that those developing the materials might miss.

Step 5. Implement Campaign - When you have finished revising your materials, the next step is to develop a plan for implementing the campaign. Part of the planning includes being sure that you have the internal capacity to move forward, that staff have received adequate training and preparation, that partners have been appropriately briefed and that someone is ready to act as spokesperson for the ADRC.

Step 6. Evaluation - Evaluation is a key step to implementing a social marketing campaign and should not be overlooked. The evaluation phase of the campaign will tell you what aspects of the campaign are working well and where there are areas for improvement. Consumers should be asked how they found out about the ADRC and that information should be recorded in the client record in Hawaii ADRC.

Step 7. Refine Materials and Messages - The results of the evaluation can be used to improve your social marketing campaign. If the campaign is ongoing, you can use the feedback to refine materials and messages, improve operations, or change communication vehicles. If the campaign is not ongoing, the lessons learned can be applied to future social marketing endeavors. The feedback from the campaign may provide insight into program operations as well as the outcomes of the campaign. You might find in talking with members of the target audience about the campaign that they have comments about which aspects of the program's operations are and are not working well. If that is the case, the evaluation of the campaign will give you the chance to adjust the program to better meet the needs of the target audience.

More detailed information about these steps and how to implement them can be found in Sarah Stout's technical assistance brief, located at www.adrc-tae.org under "Resources by Topic."

Marketing to younger adults with disabilities and their families is a new experience for most Area Agencies on Aging. The National Organization on Disability (NOD) is an excellent resource for learning how to be effective in reaching this group. In addition, the Robert Wood Johnson Community Partnership for Older Adults has useful information about cultural and linguistic competencies at www.partnershipsforolderadults.org. The Hawaii Department of Health- Disability and Communications Access Board also has reference materials on interacting with persons with disabilities and choosing words with dignity.

ADRC Hawaii Logo

Guidelines are established for the use of the Aging and Disability Resource Center (ADRC) Hawaii logo. This maintains the proper logo usage and integrity of the design. One of its goals is to effectively establish a highly recognizable symbol of Hawaii's ADRC in the state and throughout the U.S.

Design

The ADRC logo closely resembles the pattern and style commonly seen in Hawaiian embroidery and quilts. The design has four hands which symbolize "multiple helping hands and diversity". This reflects the ADRC vision and philosophy to assist people in accessing reliable information and resources that will address with their long term care needs. The color selection (green and brown) depicts Hawaii's lush tropical surroundings and rich fertile soil.

The logo must be reproduced exactly as shown in this Logo Standards manual with no unauthorized variation. The ADRC sites are allowed to add their respective county tag lines as long as the fonts and colors remain consistent to the original design. The logo must never be re-drawn or traced. It should be reproduced from approved logo sheets or electronic files.

The logo was designed by Core Group One with input from the State ADRC Advisory Board, Executive Office on Aging and the four Area Agencies on Aging staff and local advisory boards, ADRC subcommittees and other stakeholders including consumer focus groups.

Colors

The ADRC logo should always appear in full color (green and brown) whenever possible. The Pantone or PMS Reference numbers for the logo colors are:

- PMS 378 (green)
- PMS 469 (brown)

If only one color is utilized, it should be in brown (PMS 469). This color may be easier to distinguish especially for those with visual impairment. When photocopying, the logo should appear in solid back (see sample on last page).

Logo Type

The ADRC Logo uses the font style Lucinda Bright for the lettering. County ADRC sites should use similar font and typeface for their respective tag lines.

Logo Placement

1. Brochures, Posters, Print Advertisements, Rack Cards, Business Cards, etc.

The ADRC logo should be consistently included in all marketing materials so that it will be an easily recognizable icon with the public. The logo placement can vary depending on the text and art layout of the marketing material. If possible, the ADRC logo should be placed prominently and in full color.

2. ADRC Stationary/Letterhead

Since the ADRC sites are operated by the designated Area Agency on Aging, each site should abide with its respective county's protocols regarding the use of ADRC logo on the county's official printed and on-line materials related to their ADRC project and site, including letterhead, stationary, flyers and brochures. This includes the State Executive Office on Aging.

3. Website
The ADRC website will prominently display the official ADRC logo since it will serve as the portal entry to each of the county ADRC sites. The counties may use a slightly modified ADRC logo to include the county's tagline.

State/County Seals and Other Logos

The use of the Hawaii State Seal on ADRC marketing materials must be approved by the State Department of Health Communications Office and/or the Governor's office. Any misrepresentation and use of the State Seal is guilty of a misdemeanor (Hawaii Revised Statutes). Each county AAAs should abide with their respective county protocol regarding the use of their county seals on any publication and marketing materials.

The ADRC project is supported by many community organizations and public agencies at the state and county levels. The primary partners in the initial ADRC development are the State Executive Office on Aging/Department of Health, Department of Human Services, Hawaii County Office of Aging and Honolulu's Elderly Affairs Division. Subsequent and further development will include Maui County Office on Aging and the County of Kauai Agency on Elderly Affairs. Each group has its own agency/department logo. While the ADRC is a collaborative effort, it is not necessary to use all the participating agency logos on the marketing materials. A reference that identifies the partners may be sufficient. Another option is to list the primary partners or participating agencies (i.e. co-tenants in the Hawaii County pilot site in Hilo) on the ADRC print materials or letterhead.

Logo Users

The ADRC logo may only be used by EOA and officially recognized ADRC pilot sites. *(Note: EOA authorizes the establishment of all future ADRC sites)*. Other public and private groups may be allowed to use the logo only upon **written approval by both EOA and the local ADRC site.** The entity requesting for approval must provide detailed explanation of the intended use and a sample illustration of the logo placement on the intended materials, and if approved, the entity will agree to adhere to the ADRC Logo standards. The use of the ADRC logo by other aging and disability service providers should be limited to minimize public confusion. It is recommended that such allowance should only be reserved for agencies and providers physically located in the ADRC site (i.e. Hawaii County ADRC in Hilo) or Kupuna Care contracted providers requesting to use the logo.

ADRC Hawaii Logo

VII. Evaluation of the ADRC

Ongoing evaluation of the ADRC is necessary to assure that the center is accomplishing its intended goals, serving the intended populations and achieving the intended outcomes.

Evaluation should be done from the perspective of all consumers of the ADRC: older adults, adults with physical disabilities, caregivers of these populations, and professionals who use the ADRC on behalf of their clients. An evaluation handbook was developed by the University of Hawaii (UH) School of Social Work (SSW). It includes samples of customer satisfaction survey, baseline assessment on community awareness of available services and places to seek for help. Focus groups are an additional way of gaining insight into how consumers view the ADRC. See Appendix I – the Evaluation handbook and sample tools developed by the SSW for obtaining feedback from partners and other stakeholders in the process.

Regular review of data from Hawaii ADRC is extremely important and should be assigned to a specific staff person. Data from this system should be analyzed to determine who is being served (or not served), what information or assistance is being requested, the efficiency of the ADRC in responding to those requests, what agencies are making referrals, what referrals are being made by the ADRC, etc.

Taken together, the data from these sources provide important management information to guide the ADRC in its operation. Ongoing evaluation allows the ADRC to make mid-course corrections as needed and provides valuable information to planners and policymakers.

Quality Review Process

Quality Assurance (QA) covers all activities from design to implementation to customer feedback. Being able to measure a program is an effective method to identify areas of improvement, to increase the productivity of your employees, and to improve the overall quality of goods and services. In short, having quality assurance measures from the beginning will help to ensure that the development and services offered by the ADRC are "done right the first time."

Measurement is necessary to prove the effectiveness of an organization and to increase quality and productivity. Measurement can be used to monitor activities, to change activities, and as an early warning indicator of problems. Measurement is also a

management tool to ensure that positive progress is made toward achieving goals and objectives. (See Appendix I - Evaluation Handbook for samples)

VIII. Lessons Learned

The following are the lessons learned from Hawaii's pilot sites that new ADRCs can benefit from. Also included are findings and lessons learned from other ADRCs across the nation that the Lewin Group compiled as common themes about what facilitate a successful ADRC.

Leadership

- Ensure state and county leadership is briefed, on board and regularly informed.
- Work with the leadership to breakdown barriers and let them know that key areas of support are required - including the Governor and Mayors, leaders from all partner state agencies, leaders from pilot sites and members of the state legislature.
- Have letter of support from Governor's office (on file at the EOA).
- In the first year, dedicate at least one staff member to the project and ensure a project manager is in place at the very beginning of the grant.
- Find a local champion with influential authority to passionately advocate and support the ADRC. (Mayor Kim was instrumental in pushing the Hilo physical site)

Planning and Evaluation

- Understand the current environment, strengths, weaknesses and gaps including detailed analysis of current eligibility requirements across targeted programs (try to chart them out if possible).
- Develop specific and measurable milestones for at least three years, especially for year 1.
- Hire an external evaluator.
- Use evaluation data to inform decision-makers, track performance and enable continuous quality improvement.
- Analyze and pre-plan for technology needs.
- Have a focus and plan for sustainability.
- Expect timelines to be revised – It usually takes longer to accomplish tasks.

Partnerships

- Develop and model values of collaboration, communication, inclusion and teamwork.
- Ensure significant involvement and buy-in between EOA, Medicaid and disability agencies – have all signoff on ADRC work plan.
- Encourage development of memorandums of agreement or understanding.
- Have comprehensive letters of support or commitment from all stakeholders providing services.
- Leverage other grants and state programs.
- Adopt state and local civic engagement and ensure involvement of all key public, private, consumer and community service provider groups – engage and train to serve as stakeholders on committees.
- Solicit key stakeholder feedback on various aspects of the project such as website design/content, marketing/outreach, streamlining access and referrals, etc.

- Be open to non-traditional partners who may have special resources or expertise (i.e. University of Hawaii Travel Industry Management School).

Investments in People and Information Technology

- Develop and use information technology tools including websites, case management software, integrated databases and report generators.
- Train staff on customer satisfaction, private pay, cross-cultural competence, cross-train aging, Medicaid and disability serving staff.
- Have succession planning for key staff and utilize knowledge management processes. Budget for unexpected or additional IT costs (e.g., new software licenses, increase in vendor fees, need for outside consultant services)
- Dedicate adequate staff time and resources for maintaining and updating the ADRC website and resource directory. More time and effort is needed during the planning and start-up phases, especially when learning a new system or piece of software.
- Involve a dedicated IT staff person in planning and developing systems change and in training front line staff on the use of new IT – often times there is a steep learning curve for direct service/I&A staff to fully understand and become competent in using new IT. Additionally, there is sometimes a disconnect between direct service/I&A staff and IT personnel in understanding each others needs, which leads to frustration and loss of confidence in the new system. An outside vendor or consultant may be needed to facilitate the adoption and understanding of new IT.
- Train staff on ADRC goals, values and philosophy, customer satisfaction, private pay resources, Medicaid and Medicare programs and eligibility, disability programs/services/philosophies and cross-cultural competence.
- Involve front line staff in the development and implementation of planned improvements to ensure greater buy-in and to adequately address concerns as they arise. Successful change is most likely when there has been staff involvement in all stages of development.
- Provide cross-training to other aging, Medicaid and disability partners about the ADRC vision, goals and core functions/services.
- Getting staff buy-in, learning about new resources/networks and needs of a younger population, changing operational flows, revamping systems and forms take time, funds, training and perseverance.

Marketing

- Develop outreach and public information dissemination plan.
- Plan well publicized ribbon-cutting ceremonies to open new sites.
- Create taglines, logos and messages that are relevant, acceptable and understandable to the community (use Hawaii ADRC logo).
- Target outreach through multiple channels including word of mouth, mass venues (radio, TV, print media) and critical pathways (hospitals, discharge planners, pharmacies, physicians, independent living centers).
- Use a consumer's lens in all things.
- Utilize existing media outlets and community partners to maximize marketing efforts and resources.

Enhanced Service Provision

- Re-align instead of create more new services.

- Collaborate with gatekeepers and critical pathways.
- Leverage private pay side.
- Focus on streamlining eligibility determination (e-forms, electronic referrals, sharing of client data, Medicaid Intake Worker on-site).
- Understand HIPAA compliance issues.
- Treat I&R/A and case management as a process, not an event.
- Use no wrong door and integrated access models.
- Reduce inefficiencies and duplicative services.
- Develop standard service definitions for options counseling, benefits counseling, futures planning, and other ADRC services/activities for consistency in data collection and service provision.

IX. Resources

Because the development of ADRCs is a major initiative of the federal and state Aging offices, considerable resources have been made available to assist local and regional entities in implementation of these new centers. The adage that "you don't have to re-invent the wheel" certainly applies here and sponsors of new centers would be well advised to avail themselves of these resources.

National Resources

The ADRC Technical Assistance Exchange (TAE) supports Aging and Disability Resource Center program grantees. The ADRC TAE provides technical assistance through one-on-one support, semi-annual ADRC national meetings, weekly newsletters, monthly webcasts, and a variety of other ways. AoA/CMS have funded The Lewin Group to provide technical assistance to their grantees.

A major mechanism for doing this is through a website, www.adrc-tae.org. This website contains historical information about the ADRC initiative, technical assistance briefs of specific topics, tools and documents developed by ADRC grantees, presentations at grantee meetings and conferences, etc. It simply is a treasure trove of information and should be researched frequently. To have access to the full site, users must be registered. The Executive Office on Aging should be notified to grant access to local users. Users are usually limited to the ADRC or designated AAA staff. Others will be considered based on the reasons. Authorized users can access past Semi Annual reports on this site.

State Resources

The Executive Office on Aging has dedicated considerable resources to the initial piloting of the ADRC in Hawaii and Honolulu counties, and subsequent locations in Maui and Kauai counties. EOA staff are available to provide both ongoing technical assistance and training.

County Resources

Hawaii County and Honolulu have or have nearly implemented the ADRCs on their respective islands. Their specificity to their counties fully reflects the history and

environment of their long term care services and may be useful in providing technical assistance and support. Numerous samples drawn from their experiences can be found in the appendices of this manual.

X. Appendices

- Appendix A - Memorandum of Agreement
- Appendix B - Work Plans (Hawaii County and Honolulu)
- Appendix C - Confidentiality Policy
- Appendix D - Customer Service/Communications Curriculum (UH/TIM)
- Appendix E - Information Flow Within an ADRC
- Appendix F - Exclusion/Inclusion Policy
- Appendix G - Website Contents Selection Policy
- Appendix H - Management Information Systems Plan
- Appendix I - Evaluation Handbook
- Appendix J - Miscellaneous (Intake Form, Medicaid Screening, Service Excellence Survey)

Appendix A - Memorandum of Agreement

Appendix A

MEMORANDUM OF AGREEMENT
BETWEEN
HAWAI'I COUNTY OFFICE OF AGING
AGING AND DISABILITY RESOURCE CENTER
AND
[A COMMUNITY PARTNER]

This Memorandum of Agreement (MOA) is entered by and between the Hawai'i County Office of Aging, Aging and Disability Resource Center (hereinafter referred to as 'ADRC"), and the [Community Partner].

PURPOSE: The purpose of this MOA is to clearly define partner roles and responsibilities related to services provided by the ADRC and [Community Group].

This MOA may be terminated by either party upon at least 30 days written notice or immediately upon notice for cause. If mutually agreed upon, the scope and/or terms of the MOA may be amended.

BACKGROUND: The ADRC is a collaboration of government and private agencies offering a one-stop shop for information and access to resources on long term care options. The ADRC offers information, counseling, linkage, referral, and screening for assessment and eligibility for both publicly and privately funded services. The ADRC provides options counseling to help understand choices for community long term care. The target groups for the ADRC are: 1) Individuals age 60 and over, and 2) Individuals with physical disabilities.

SERVICE AREA: The service area for this MOA is the County Of Hawai'i, State of Hawai'i. The ADRC physical site is 1055 Kino'ole Street, Hilo, Hawai'i. Access will also be provided by telephone and electronic means.

ROLES AND RESPONSIBILITIES / SCOPE OF AGREEMENT:
ADRC agrees to:

1. Provide Information and Assistance services for the target groups by trained personnel.
2. Provide access to training and meeting facilities of the ADRC for aging and disability related activities.
3. Provide a Resource Library for the target population to access aging and disability resources.
4. Provide opportunity for training on community resources and programs addressing aging and disability issues.
5. Provide Options Counseling to individuals and families planning for long term care needs.

6. Provide access for use of ADRC Training, Inter Agency Office and Conference Room facilities as may be appropriate.
7. Staff in the ADRC respect the privacy and confidential nature of clients' and care givers' presence in the facility.

[Community Partner] agrees to:
1. Be open for participation by individuals in the community with [specific disability/condition], their families and individuals providing supports.
2. Collaborate with the ADRC personnel on meeting needs of individuals.
3. Participate in quality assurance activities including consumer satisfaction surveys.
4. Be available to provide informational training on [specific disability/condition], and issues and support needs of individuals with [specific disability/condition] and their support network.
6. Collaborate in community education and outreach activities.

CONFIDENTIALITY:
Both parties shall protect the confidentiality of information received in the implementation of this MOA. Client information must be protected in accordance with applicable state and federal laws. A consent for release of confidential information signed by the individual or an authorized representative will be executed prior to sharing of confidential information.

This Agreement is in effect from the date of signing until revoked by either party.

Approved:
Hawai'i County Office of Aging

By:_____
Alan R. Parker, Executive on Aging

Date:_____

Approved:
[Community Partner[

By:_____
Executive Director

Date:_____

Appendix B - Work Plans (Hawaii County and Honolulu)

CITY AND COUNTY OF HONOLULU AGING AND DISABILITY RESOURCE CENTER (ADRC) APPENDIX B
WORK PLAN (2007 – 2009)

Overall Goal: *Work jointly with City and County staff, State Executive Office on Aging, ADRC Advisory Board and sub-committee members and other key stakeholders to plan, develop, implement and sustain a virtual ADRC that meets the respective needs of the State, City and County of Honolulu and its residents.*

1. Develop Work Plan for completing key tasks and activities related to the City and County of Honolulu's virtual ADRC	Develop draft Work Plan for review. Update and modify Work Plan based on input from staff, other stakeholders and new activities and developments	Sara	Sept. 1, 2007	Draft plan completed in Sept. Work Plan is a living document and is periodically modified and updated.
2. Continue to participate in State ADRC sub-committee and Advisory Group meetings and other relevant meetings, phone calls, etc., to continue progress towards meeting ADRC goals and objectives	Attend sub-committee and Advisory Group meetings on a regular basis to provide input and ensure continuity of planning with the State and other pilot sites	Sara and assigned staff	On-going throughout grant period	• ADRC Advisory Group: 7/19/07, 10/11/07, 1/15/08, 6/26/08, 1/20/09, 6/30/09 • Evaluation Subcommittee: 1/31/07, 3/15/07, 9/12/07, 10/25/07 • Marketing/Comm: 9/20/07, 10/17/07, 7/2/08, 8/28/08, 2/25/09 • Staff Training: 9/20/07, 10/17/07, 11/20/07 • MIS: 10/25/07, 2/13/08 (MIS RFQ Eval), 10/08 (Website RFQ Eval) • Ad hoc: 12/17/07 mtg w/ Audrey, Sara, Karen to discuss work plan and next steps. • Website (new). First meeting to be convened in Aug. 2009
	Participate in other related meetings, conference calls, webinars and/or research activity to stay current on local, state and federal ADRC issues, increase knowledge and understanding of local aging and disability network providers and their clients, and to discover opportunities for enhancing ADRC program	Sara and assigned staff	On-going throughout grant period	NEW TASK added Nov. 2007 to capture on-going research, information gathering and coordination/collaboration efforts. AoA/CMS/Lewin grantee phone calls/webinars: quarterly updates - 9/30/07, 2/28/08, 7/1/08; streamlining access survey - 11/14/07; monthly grantee calls/workgroups - 12/6/07,(Aging in Place); 12/13/07

				(Multiple Agency Wrkgrp-entry points), 2/7/08 (resource databases), 2/28/08 (Synergy/Harmony), 3/6/08 (ADRC readiness), 3/20/08 (Alzheimer's Center), 6/4/08 (ADRC-CMS), 6/5/08 (private pay consumers), 9/4/08 (5yr look back), 4/29/09 (options counseling). NCOA webinars: 10/23/07 (Aging in Place/Reverse Mortgage Counseling), 11/15/07 (Accessible Web sites) ADRC updates at EAD Service Provider's meetings: 9/19/07, 11/21/07, 1/23/08, 3/12/08, 5/28/08, 7/23/08, 9/24/08, 11/26/08, 1/28/09, 3/25/09, 5/27/09 HCOA meetings: 11/16/07, 3/14/08, 7/18/08, 9/19/08 Site observation visits: 11/15/07 (Olaloa CDSMP), 12/11/07 (KKV CDSMP), 1/14/08 (CC Housing Prg), 2/21/08 (Project Dana, Attendant Care) DCS: 1/23/08 -overview and update to DCS executive staff Other: 6/4/08 overview and update to student intern and 2 new DCS staff, 9/15/08 ADRC presentation with EOA and Hilo at HPGS conference. National ADRC meeting Oct. 1-2, 2008 in Boston, MA. Hilo grand opening 11/14/08. Presentation to OASIS mental

				health group 3/12/09. 4/21/09 meeting with Dr. Goetz re: mental health network of care. Attended launch of MH NOC site 4/22/09.
	Establish internal feedback loop for sharing information, ideas and responding to requests re: sub-committee and Advisory Group activity	Sara	Sept. 30, 2007	Updates are provided and input is solicited from staff at weekly Planner's meetings, Staff meetings and/or ad hoc meetings/discussions. Started weekly meetings with I&A staff in May 2008 to discuss data collection and reporting processes, use of BeaconIR, transition to SAMS, development of website content and other related issues. See item #5.
3. Increase participation and involvement of disability community in planning and developing ADRC	Establish partnership with at least one key disability agency to explore options for joint collaboration	Sara and Karen	March 31, 2008	10/22/07: Sara, Pat attended Emergency Preparedness conference for persons with disabilities and special health needs to learn more about the local disability provider network, the state's plan in meeting the needs of these target populations and potential roles and responsibilities of EAD/ADRC. 1/9/08: Karen, Sara, Lei met with DCAB staff (Debbie Jackson, Judy Paik, and Charlotte Townsend), to provide ADRC update and discuss collaboration opportunities. DCAB agreed to share their resource listings, which are available in an online printable format and a Filemaker database. DCAB informed EAD in April 08 that resources have been updated and are on website for our use. 1/17/08: Sara, Karen presented ADRC

				overview and update to DCAB Advisory Board. Presentation was well-received, although some questions and concerns were raised about possible duplication between the ADRC and Real Choices websites since RC was designed to be a single entry point for LTC. Target population was also clarified. One board member expressed desire to include resources for younger persons with developmental disabilities. 2/13/08: ILC Director, Pat Lockwood, met with Noemi Pendleton, EOA, to discuss role of ILC in the ADRC project and opportunities for collaboration. EOA formally invited ILC to participate on State ADRC Advisory Board (already a member of HCOA ADRC Advisory Board) and suggested a joint meeting with EAD and EOA staff to explore partnership possibilities for the Honolulu pilot site. 3/28/08: Sara attended state-wide Language Access Conference to learn more about accessibility issues and obligations of EAD in this area. Although not specific to disabilities, the conference introduced important concepts and information that can be extended to include blind/low vision and deaf/hard of hearing persons. Staff discussed development of language access plan to assess internal and service provider capacity/capabilities to provide language access and strategies

				for making improvements. 3/31/08: DCAB staff provided in-service training for EAD/ADRC community service aides and other I&A staff. 6/08: EOA met with Cheryl Mizusawa, Interim Executive Director of Hawaii CIL. Added to State Advisory Board and attended 6/26 meeting. 8/6/08: Sara and Lei met with CIL ED, Cheryl Mizusawa, and Board President, Charles Herrmann, to provide an update and overview of Honolulu's progress and discuss ways to collaborate. Met separately with IL Specialist, Hiroko Kobira, and was introduced to other staff. 9/12/08: IL Specialist from CIL provided in-service training to all EAD I&A staff. 9/08-10/08: Sara communicated via email and phone with Hiroko about re: disability links and resources to include on website. 7/09: HCIL will be targeted for live demo presentation. IL Specialist noted above is no longer with HCIL.
4. Coordinate completion of required grant reports and other evaluation activity, as necessary	Work with State to complete required grant reports in a timely manner	Sara and other staff as necessary	On-going throughout grant period	Excel SART report completed and emailed to EOA on 10/19/07. Final report was submitted to Lewin on 10/31/07.

				Excel SART report completed and emailed to EOA on 4/21/08. Narrative section email on 4/23/08. Final report due to Lewin on 4/30/08 (for reporting period Oct. 1, 2007 – March 31, 2008). 6/19/08: Forwarded copy of CSA Survey P&P manual and written results, as requested by the Lewin group (Barbara Ettner). 10/27/08: Emailed excel SART and narrative for reporting period April 1, 2008 – September 30, 2008. EOA submitted final report to Lewin on 10/31/08 4/23/09: Forwarded SART and narrative to EOA for reporting period Oct. 1, 2008 – March 31, 2009. EOA submitted to feds on 4/29/09.
	Work with State evaluator to coordinate completion of surveys and other evaluation activity	Sara and assigned staff		NEW TASK added Nov. 2007 to reflect additional evaluation activity. 9/07: Sara drafted two needs assessment/satisfaction surveys for seniors and caregivers based on template provided by Evaluator (Pam Arnsberger). I&A staff facilitated completion of 189 surveys at annual Senior Fair on 9/21, 9/22 and 9/23/07. Evaluator provided overview of preliminary results at 10/25/07 Evaluation Sub-committee mtg. Will draft final report to summarize findings. 4/1/08: EAD student intern completed

				survey project that measured client satisfaction with I&A services provided by EAD's community service aides during outreach home visits. Clients were asked to fill out a survey form (10 questions) that rated the quality of information and/or service(s) provided. Initial results (covering approximately the last 6 months and 300 surveys) revealed that a majority of clients felt the service they received was "above average" or "outstanding." Over the course of the project, however, several bias factors were identified that may have influenced the validity and reliability of the results. The survey tool and methodology were modified to account for some of these factors, but others (such as confidentiality /anonymity of respondent) still present a potential bias and should be taken into consideration when analyzing the results. A policy and procedure manual was created so that future staff and interns can continue to administer the survey and make modifications to the survey tool or process, as needed. 6/19/08: Lewin (Barbara Ettner) requested copy of CSA Survey P&P manual and written results. 6/08: Staff created and administered language access survey to assess language capacity of EAD contracted providers.

				6/09: Staff modified website evaluation tool created by IT consultant and distributed to EAD CSAs. Similar survey will be distributed to EAD office staff.
5. Assess and analyze EAD's existing IT systems and key business processes (I&A, outreach, screening, assessment) to identify what works well and what needs improvement	Develop before and after flow charts that show how consumers access information and services now and how that will be improved in the envisioned new system (at the County level)	Sara, MIS consultant, other staff as necessary	March 31, 2008	Draft charts were developed by EAD staff (Joel) in 2006. 3/08 – modified flow charts and discussed with I&A as part of weekly meeting agenda. 4/29/08 - MIS Consultant developed updated flow charts based on staff discussions and analyses of EAD's current processes. Incorporated into MIS Development Plan describing current processes, identifying opportunities for improvements and proposing a plan to transition process to new and improved system. Plan has been used to guide staff in transitioning to new MIS and modifying current intake and data collection processes.
	Document strengths and weaknesses and brainstorm ideas for improving I&A and data collection processes	Sara, MIS consultant	March 31, 2008	Meetings/discussion listed below led to decision to transition from in-house IR tracker system to BeaconIR/SAMSIR. Also moved EAD's management information system (SAMS) from local network to web-based system hosted by Harmony on agingnetwork.com. EAD meetings with MIS consultant (Shawn) to document key processes

				and identify areas for process improvements: 3/4/08 (kick-off), 3/5/08 (process), 3/6/08 (process), 3/11/08 (process), 3/13/08 (process), 3/17/08 (process, DIT), 3/19/08 (Synergy Demo), 3/20/08 (HIC), 4/1/08 (Synergy Demo, 4/3/08 (website features). <u>I&A and Data Processing Meetings:</u> Regular meetings with Sara, Carlton, Lei and other key staff to discuss issues with using Beacon, moving to SAMS on the web, transitioning to SAMSIR and customizing, refining and trouble shooting problems related to caller intake screen, assessment form, service provider database and reports. 11/27/08 and 11/28/07 - SAMS demo for Sara, Lei provided by Carlton, Melanie, Kelly. 1/22/08 -Conference call with Jan N, Cowabunga, State EOA staff, other counties; 1/10/08 - Cowabunga consultant met with Carlton, Kelly, Melanie, Sara to review service provider intake and data collection process. Consultant is evaluating each AAA to determine feasibility of implementing a statewide data system); 2/4/08 – Sara, Lei, Susan (intern), Ryan, Tony discussed modifications to EAD's intake and assessment process

				and forms. Susan is assisting in developing a more comprehensive intake form. Shared example intake form from ADRC Intake-Assessment Committee (Ohio). 2/25/08 – Sara participated on Outreach observation visit with CSA. 2/27/08 - Fup mtg with staff to continue discussion on I&A processes and areas for improvement. 5/08 - install of new Beacon/SAMS integrated tool on Sara's and all I&A staff computers. I&A to begin testing system by inputting 4-5 calls/day into Beacon, with the goal of eventually phasing out old tracking system. Discussion of transition, next steps. Started weekly meeting schedule in May 2008. I&A and data processing staff represented. List of meeting dates below. Agendas stored on shared drive. 5/7/08, 5/20/08, 5/27/08, 6/10/08, 6/17/08, 6/24/08, 7/15/08, 7/22/08, 7/29/08, 8/5/08, 8/12/08, 8/26/08, 9/23/08, 9/29/08, 10/7/08, 10/14/08, 10/21/08, 10/28/08, 11/5/08, 11/12/08,11/25/08, 12/2/08, 12/9/08, 12/17/08, 1/6/09, 1/20/09, 2/3/09, 2/10/09, 2/24/09, 3/10/09, 3/17/09, 3/31/09, 4/7/09, 4/17/09, 4/21/09, 5/5/09, 5/12/09, 5/19/09, 6/2/09, 6/9/09, 6/24/09, 7/7/09.

6. Research and document application and eligibility processes for key aging and long term care programs (i.e., Medicaid) and assess the potential for streamlining with the ADRC	Develop flow chart and narrative description of current Medicaid eligibility processes (financial and functional) for aged, blind and disabled consumers	Sara (with support from I&A staff)	June 2008. Pushed back to Sept. 2009	New Task added as of 12/07 based on 11/14/08 conference call with Lewin. 11/8/08: Preparation for streamlining Medicaid Access conference call (Sara, Karen, Lei) 11/14/08: Lewin-AoA-CMS Streamlining Medicaid Access conference call. Reviewed survey form with Lewin, Audrey and Hilo staff. 1/17/08: State Med-Quest division (Lois Lee) contacted. 3/4/08: Staff (Karen, Sara, Lei) met with Alan Takahashi, Med-Quest, to gain a better understanding of Medicaid application and eligibility processes and explore options of working more closely. Staff was informed of reorganization efforts underway to address impending changes to the Medicaid program with the transition of ABDs from FFS Medicaid to managed care. Rita Ching, health Plan representative from Ohana Family Care scheduled to present to EAD staff on 5/27/08 re: new expanded Med-Quest program and role of health plans (CANCELLED due to pending lawsuit filed by a health plan that was not selected). Suzanne Danielson, ACS, presented to EAD CSAs on 7/18/08 and EAD Service Providers on 7/23/08 to re: the new Medicaid managed care program and

				ACS's role in the enrollment and transition process. This information will help EAD/ADRC staff understand changes to the Medicaid program and eligibility processes and explore potential collaboration opportunities. 6/30/09 – presentation to EAD CSAs by Scott Garnder & Co. about private consultation services for Medicaid LTC application assistance. Q&A session followed about necessary verifications and application process. 7/09 - Will refocus on this effort now that new Medicaid managed care program is underway. Currently, EAD/ADRC outreach workers and I&A office staff are available to assist individuals in completing Medicaid applications. IL Specialist noted in item #3 is no longer with HCIL, but is now working as a care coordinator for one of the new Medicaid managed care health plans.
7. Determine the virtual structure, critical system requirements, desired functions, capabilities and content of ADRC	Determine how the virtual ADRC will be structured and coordinated at the County and State levels	State MIS committee (with input from EAD)	Dec. 31, 2007	Following the 10/25/07 MIS sub-committee meeting, it was decided that EAD should ultimately issue its own RFP for an IT vendor as opposed to the State for creation of database and website. At this time, it is not the intent of the State to have one statewide database for service provider information, so each county will be responsible for developing and maintaining their own. State plans to

				build a basic ADRC home page on an existing website/server that will provide links to each individual county ADRC website. Each county would have discretion to use its existing data collection system or decide to purchase/upgrade to a new system. However, given that the state recently hired an IT consultant to explore the feasibility of developing and implementing a statewide data collection system, it might be counterproductive to use something other than SAMS and the Synergy Suite of products since that is the common software system used by all counties. 2/13/08 Update: RFQ issued/awarded to provide technical assistance in exploring ADRC website options, developing cost estimates, providing input into RFP for IT/website vendor, assisting EAD in analyzing current IT/MIS systems and key business processes and developing MIS Plan. In addition to hiring MIS consultant, EOA said they would issue RFP for IT vendor using available funds in their budget. 6/08: Updated plan is for EOA, EAD and Kauai to collaborate in building county/state specific ADRC websites on a common platform instead of going out to bid for an off-the-shelf product from an outside vendor. Will use Kauai's content management system (dotnetnuke), Kauai IT staff person and

				supplemental contractors (project manager and web designer) hired by the State to build sites. EOA will purchase servers and other necessary hardware. DOH IT will host the sites on these servers. An MOA will need to be developed among the state and counties to specify responsibilities and commitments re: regular website maintenance, content management, etc. Nov. 08: State contracted with Matainet (Shawn O'Donnell) to design and build websites. Kick-off mtg with staff on 11/18/08. Shawn presented first draft of template on 12/4/08. Revised templates were made available for review in January. 2/26/09 meeting with Shawn, Sara, Karen, Joel to discuss features and content. On-going review, content identification, development & vetting through 6/09. Website training on 7/1 and 7/2/09.
	Determine if and how the virtual ADRC will interface with current State and City/County IT systems (e.g., SAMS 3.0, SAMS 2000, I&R Tracking, EAD web site, EOA web site)		March 31, 2008	See also item #5. Website will eventually be linked to SAMS IR-Web, which will allow public to find local programs and services in a searchable database.
	Identify and assess local databases for potential of being integrated into ADRC web site, in whole or in part.		March 31, 2008	4/29/08: State ADRC coordinator met with 211 to brief them on project and discuss collaboration possibilities (eg., providing data on referrals to each

				other's agencies). They use Hawaiian Telcom for their call center telephone system and also contract with tele-interpreters (mainland based company) to provide live bilingual translation. State will follow up with this group, which can provide translators for 150 languages. 211 found them more accessible than our local bilingual access. Sara researched AIRS for human services taxonomy (scaled down version appropriate for ADRCs), AIRS membership and staff certification processes and related costs. State willing to pay for initial costs. Staff certification on hold until transition is made to new resource database and it is determined that AIRS certification is necessary. DCAB informed EAD in April 08 that their resources have been updated and are on website for our use. (online text/html-only and Mac Filemaker database file) 6/18/08 update: Synergy not able to electronically import Senior Handbook excel file into Beacon, so staff will have to manually update database. Have started the initial steps. State offered EAD $10,000 to hire a part-time database assistant through UH. Half-time Database Assistant started

				8/26/08. Inputted Senior Handbook resources and additional programs and agencies into EAD's Beacon database, verified program information, etc. Contract expired end of Feb. 2009. 6/09: clean-up and maintenance of Beacon (now SAMSIR) database continues. A bug was discovered in SAMSIR migration process where previously deactivated provider data was migrated over to new system. Vendor is aware of problem and working on a fix. In the meantime, EAD has initiated a manual process for fixing/restoring service provider database.
	Develop database inclusion and exclusion criteria	Sara	April 30, 2008	Completed draft Inclusion/Exclusion Policy and solicited feedback from staff (Karen, Joel, Lei). Made changes based on input. Policy updated in Jan 08 and again in June 09. In the process of developing additional database guidelines and forms re: organization/coding, on-going management and maintenance, staff responsibilities, etc. Will be modified and changed overtime as needs evolve.
	Research and assess existing web sites to generate a list of desired content and system requirements, including a searchable and easy-to-use database. Identify existing resources and content that would be useful to include on	Sara	Jan .31, 2008 Oct 31., 2008	Completed review of MIS workgroup's list of web site features. Created list of potential features and requirements and shared with MIS consultant. Developed and organized internal teams to assist in identifying and

	ADRC website. Make recommendations for creation or development of additional tools or resources (checklists, fact sheets, decision trees, etc).		On-going	collecting initial website content (FAQs, Glossary/Acronyms, Useful Links). Drafted "About Us" and "Contact Us" page. Meetings held 5/27/08, 6/3, 6/9, 6/23, 7/0, 7/30, 8/13, 9/10, 9/25/08. This information will be given to project mgr and web design consultants to assist in designing EAD's site. 12/08 to present: Working with web design team to provide input on template design, identify and vet educational content to include on website and develop new content.
	Prioritize list of requirements and content and make final determination of essential and desired ("nice to have") elements to be incorporated into IT vendor RFQ.	Sara, MIS consultant	April 30, 2008	MIS consultant created website features list and ranking system. EAD staff completed ranking exercise and discussed results with consultant on 4/3/08.
8. Select IT vendor to create ADRC web site and database according to specified requirements and timelines	Establish evaluation criteria for IT vendor based on identified system requirements; develop evaluation matrix to document vendor capabilities and differences	State	April 30, 2008	MIS Consultant drafted evaluation criteria for IT vendor. Also provided expertise and assistance in identifying and contacting potential local vendors (State and City/County IT Departments) to explore options of developing an "in-house" website. Honolulu DIT not able to offer support for ADRC website due to changes in county platform and other priorities.
	Develop and finalize Request for Proposal (RFP) based on evaluation criteria		May 9, 2008	MIS Consultant developed a Project Overview (for State IT Depts) and provided an outline for a more formal RFP for outside/mainland vendors with input from EAD staff.

				Request for Quotation (RFQ) used instead of a formal RFP. Issued the end of Sept. 08. Sara, Carlton assisted in evaluating responses in Oct. Contractor began work in Nov. 08.
9. Establish continuous quality improvement process for updating, maintaining and enhancing the ADRC web site and database on an on-going basis.	Establish systematic process for communication and follow-up with IT vendor re: development, maintenance, trouble shooting and making enhancements and improvements to web site	Sara and assigned staff	July 30, 2008 Revised -- Sept 2009	10/08: MOU developed between EAD, EOA and DOH IT re: responsibilities for website maintenance, hardware and software purchase. Additional detail about work flow and actual processes to be finalized as part of state website advisory committee and internal EAD discussion. Matrix of website responsibilities for EAD staff has been drafted.
	Track and monitor ADRC website usage and consumer and provider satisfaction through pre and post surveys, staff feedback, web trend reports and/or other statistical measures	EAD staff with assistance from State evaluator or IT contractor	On-going, once website has been developed	Will be available through Google analytics reports.
10. Collaborate with the State and IT vendor to test ADRC web site prior to launch	Test site made available for review and testing	Web developer	Feb. 2009	Development site made available beginning of April 2009
	Test website capacity, accuracy and responsiveness prior to launch with City and County staff, ADRC Advisory Group and sub-committee members, State staff and other key stakeholders. Work with vendor to make any necessary fixes or improvements prior to launch	Sara, assigned staff	April – June 2009	Review and testing has occurred. Recommendations for fixes, additional content have been made.

				Providers continue to be brought in on a monthly basis to train and educate EAD staff on industry-specific services, skills and LTC issues. List of training topics and dates maintained in separate file.
12. Raise community visibility of ADRC through media and outreach activities	Develop draft marketing plan that identifies internal and external audiences, primary secondary audiences, specific messages for each group, dissemination methods and time frames	Sara	January 2008	Draft plan developed. Will be periodically reviewed and modified based on new developments, changes in timelines, etc.
	Implement Marketing plan		Website launch date and beyond	See marketing plan for planned activities. Will piggyback on regular EAD marketing efforts to raise awareness of new ADRC website. Will also work with EOA to maximize resources.
13. Develop sustainability plan to maintain the ADRC post grant period	Develop plan that outlines shared staff responsibilities and possible funding sources for how ADRC web site and backend MIS system will be monitored, maintained and continually improved once system is up and running	Karen, Sara	Sept. 30, 2009	EAD is committed to funding and sustaining ADRC activities. Cost of MIS system factored into MIS Development Plan and other internal documents. Website maintenance and Database maintenance procedures and guidelines in the process of being developed. State Website/MIS committee to be convened in Aug. to define roles and responsibilities of administrators, content editors, DOH IT and IT/website consultant, making change requests that affect shared data, reporting/fixing problems, and other necessary protocols.

				State EOA ADRC funds include $300,000 (SFY'07-'08). $230,000 available for SFY08-09 not released by governor. EAD funds for Aug 07-Sept 08 = $128,797. Contract for ADRC Coordinator has been extended until June 2010. Executive is position requests for additional I&A personnel. Other funding sources: Recent grants awarded to EOA with ADRC components (MIPPA, Hospital Discharge); new grants that EOA will be applying for (Community Living Program, ADRC); Lanikai monies (EAD funding acquired through sale of home that was bequeathed to EAD in a will).

Hawaii County Office of Aging
Eight Months Action Plan (November 2007- June 2008) – Amended in May 2009
Revisions: Jan. 22, 2008 March 3, 2008 March 10, 2008 March 17, 2008 March 24, 2008 March 31, 2008 April 21, 2008 May 12, 2008, May 27, 2008, June 9, 2008, June 16, 2008, July 7, 2008

I. HCOA Role/Identity Under ADRC	Tasks	Lead Person(s) – first name listed is lead	Time frame and target deadline	Comments/Status
[redacted]	[redacted]	Alan	Mid-November 2007	Completed 11/04/07 part of staff manual – standards book.
[redacted]	[redacted]	Alan	**Completed**	**HCOA as the AAA is the lead in coordinating the ADRC. HCOA is the funding source/contractor for elder services** in the ADRC.
[redacted]	[redacted]	Alan Audrey	Completed	-Completed. State will follow the County's lead on timing marketing activities.
1.4	Identify/clarify impact on I and A Component, on planners, how to implement	Alan		**Based on the developed ADRC client flow, the I&A component will be in-house and will involve further activity for linkage compared to I&R. Planners, on rotation, are the fourth level coverage for the ADRC I&A function. Planners will also need**

				AIRS certification.
[redacted]	[redacted]	**Vicki**/Sally/Debbie/ Woody	**Completed 3/3/08**	**Intake form will be used for both care givers and care recipients. Whoever initiates the contact is the client. We will reassess this protocol and determine if it meets our intake requirements.**
[redacted]	[redacted]	**Woody** (MOU with Co-tenants and selective outside agencies (DOH-AMHD, contracted providers)	**First MOA signed 09/2008. Additional are ongoing.**	**Templates for MOAs developed; Tenant, Community Partner (Agency & Support Group)**

II. Assessment, Intake, Case Management	Tasks	Lead Person(s) – first name listed is lead	Time frame and target deadline	Comments/Status
[redacted]	[redacted]	**Vicki**/Woody/Debbie/ Pauline/Sally/Alan Deidre	**Completed 2/29/08**	**-Intake flow draft completed for phone/walk-in/letter-electronic contact. Protocols need finalization then field testing.** **- Website visits; State is lead on website development.**
[redacted]	[redacted]	**Woody**/Horace (minimum data requirements	**Completed**	**-Intake form drafted and to be implemented in house. Deidre to develop Options Counseling and benefits counseling tools.** **-HOLD on sharing with stakeholders.**
[redacted]	[redacted]	**Alan**/Debbie/Sally	**Completed**	**Short term = up to 3 months. (SFS has the contract)** **Long term = over 3 months. (SFS, CMCP, CG)** **Case Management definition defined in the SFS contract – Debbie will provide a copy.** **CMCP – "labor intensive", more involved/complex.**

				Vendor pool accessed by SFS and CMCP.
[redacted]	[redacted]	**Vicki**/Woody/Sally/ Horace	**Completed**	**-Deidre and Woody drafted a Medicaid and waiver screening tool. -Deidre is able to complete the DHS 1147 – Prior Authorization for Nursing Care Services.**
2.5	Define Referrals Process (In-house and outside agencies)	**Vicki**/Woody/ **I&A staff person** Woody / Alan	**Completed (except for Medicaid referral needing clarification)**	**For DHS Medicaid referral, follow up with DHS to Clarify services to be provided at the ADRC site.**
[redacted]	[redacted]	**Woody**/All Planners	**Completed Mar. 17 , 2008**	**HCOA planners brainstormed a list of scenarios.**
2.7	Disability community – how do we interface	**Woody**/Vicki/Sally Deidre	**Keep open with plans to address all disabilities**	**Arc of Hilo identified as the disability agency. CIL still a potential. Have Arc review our intake form. Deidre/Woody to follow up with Vicki Linter. Invitation for training. Request training from. ADRC – Outreach and ask how we can interface with you. Mayor's Disabilities committee a resource. DCAB. HATS. Data person for database. Other agencies come to**

				the ADRC to provide services? Acceptance of information provided by the ADRC.
2.8	Confirm whether we streamlined the process: - reduce duplication - reduce assessment process - reduce paperwork - reduce the # of referrals	Woody	**"Work in progress"**	**Take into consideration when designing operations or procedures. Pending DHS lease formalized and the shift to managed care settling.**
[redacted]	[redacted]	Alan/All Planners	**Completed**	
[redacted]	[redacted]	See marketing	**Completed**	**-State developed a "template" ADRC card customized tfor the county.**
[redacted]	[redacted]	Woody	**Completed**	**-Partial completion: Per Woody, SAMS software meets HIPAA compliance.** **HIPAA article off the internet reviewed. Per the guide, HCOA does not meet any of the criteria to be a covered entity.**
2.12	Delineation of in-home and center ADRC staff's roles and functions, protocols	Alan	**Revisit 6 months after move into the ADRC.**	**Regarding I&A: Short term = CSE and SFS will only receive**

				referrals (HCOA to do I&A) Long term = To be determined if some I&A responsibilities to shift out of HCOA.;
[redacted]	[redacted]	Alan	**Completed**	**-Articles posted on Free4all.**

III. Management Information System	Tasks	Lead Person(s)	Time frame and target deadline	Comments/Status
[redacted]	[redacted]	Woody /Horace	**Comp leted June 2008**	**Horace placed Beacon in live mode Woody, Deidre and Sally's computers.**
[redacted]	[redacted]	Woody	**Completed June 2008**	**Decision by HCOA staff: database will not be shared**
3.3	Decision – will State issue RFP for one vendor for all counties, or just for portal with linkages with other county websites	Audrey	**Feb 2008 completed**	**State issued RFP and selected vendor**
[redacted]	[redacted]	Vicki/Sally/Horace	Completed	**Completed**
3.5	How do we ensure that people don't fall through the cracks	Woody /Horace	Completed	**Need clarification on type of follow up. Beacon default = 1 week follow up – change default to 2 weeks?**
3.6	Follow up with DHS – identify protocol to follow up when a client is referred to Medicaid	Woody /Audrey	Completed	**Will be captured on the 2 week follow up with client.**Deidre to do follow up.
3.7	Design MIS flow for online, self directed web user, in-	Woody /Horace	End of December 2007	**Completed for telephone, drop in visit,**

	person/phone intake.			**written. Need to consult Shawn ODonnell regarding web based. [3/25/08 meeting with Shawn: web design and functions still in exploration phase]** HCOA (Horace) plans to add an ADRC page in our current website. State is creating a State ADRC site. Includes pages for Counties.

IV. Telephone System	Tasks	Lead Person(s)	Time frame and target deadline	Comments/Status
4.1	Develop one single number (Statewide) -work on transfer mechanisms Between counties, agencies (county and outside) - Cell phone users - automatic call distribution system to track calls, waiting time	Audrey/Alan	Still pending June 16, 2008	**Awaiting state level decision.**
[redacted]	[redacted]	Same as 2.1	End of December 2007	**Completed.**
4.3	Identify staff to man phones - training -volunteer back ups - hours of phone service -after hour coverage	Alan/Vicki/Deidre	June 16, 2008 completed except for after hours coverage which will be a future consideration.	**ADRC telephone call forwarded to 961-8600 if it is not picked up (programmed to do this). Training on new system when it is selected and installed** Stagger lunch hours. Have a good voicemail message. We are not a crisis service. After hours – future consideration.
[redacted]	[redacted]	Alan/Deidre	End of December 2007	**Completed.**
4.5	How do we ensure that people don't fall through the cracks – follow up calls.	Alan/Planners/ Deidre	End of December 2007	**Will be captured on the 2 week follow up with client.**

IV. Telephone System (Continue)	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
4.6	Identify telephone lines in new facility, automatic rollover when lines are busy	Alan	End of January 2008	**Current HCOA telephone system is being taken to the ADRC as an interim system until Voice over IP is available. Be sure to include a rollover function in the new system.**
[redacted]	[redacted]	Alan, Deidre Horace	**Completed**	**Revisited once in the ADRC; HCIL present w/ alternative to use Relay System. Public telephone with TDD.**
[redacted]	[redacted]	Woody	Completed	**Language translators are available by telephone. Have a poster like the one currently next to the elevator in HCOA.** County contract for non-English speakers. Sally has an extra poster (pe above).
[redacted]	[redacted]	Vicki/Deidre	Target mid-July 2008 for ADRC planning group and other HCOA staff.	**-For abuse issues (domestic, adult), refer to appropriate agency: police or APS. Note: APS will work only**

				with dependent adults. -Woody will distribute Just1Call protocol on suicide for discussion at the July 7, 2008 meeting. Vicki completed SLAP training (Specificity, Lethality, Accessibility Plan) 7/7/08.

V. Evaluation	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
[redacted]	[redacted]	Horace, Woody, Pam Arnberger	November 2007	ADRC grant contracted UH, CDS (Pam Arnsberger)
5.2	Develop satisfaction surveys	Pam /Woody	Pending	Post grant, look at sample Satisfaction County Survey. Review and adjust to ADRC. Deidre does a client survey after 2 weeks. Ongoing, place in Resource Library area so they can be picked up. See Bill Takaba's set up description.
5.3	Identify mechanisms to document diversions from Institutional care or discharge from Institutional care	Pam/Woody		Review grant requirements re: LTC. Kupuna Care has data for this question. Consult Pam Arnsberger. Short term mechanism. Long term mechanism.
5.4	Monitor cost effectiveness of	Pam/Woody/Audrey	Pending	Ditto above

	ADRC			
5.5	Develop Quality Assurance Plan	Pam/Woody/Audrey	Pending	Ditto above
5.6	Training for Staff (collecting data) and outside agencies as needed	Woody/Pam/Audrey	Pending	Ditto above

VI. Marketing Plan	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
6.1	Develop marketing plan for HCOA- Soft opening Positioning statement Critical Pathways – strategies Coordinate with State Translation for non English speaking populations	Woody and Deidre	**Nov 2008 Grand Opening Ceremony**	**-Critical pathways: Pe Woody, strategies. Usually describes starting point to where to come to the ADRC. How do you market to services that will refer/route to ADRC? Suggestion to use the Marketing subcommittee.** **-Marketing to non-English speaking populations: use organizations such as ethnic/cultural related e.g. Marshallese, Micronesian.** **-Translate key things needed to access the service. Have one brochure but have key points in various languages.**
6.2	Develop marketing materials-Brochures, handouts, posters, Flyers, Translation into multi-languages	Alan/Deidre/Woody	Review after language Access Workshop June 20, 2008. Use information from this.	Deidre is developing a brochure for the ADRC. – due after 6/23. Use also as an insert to State ADRC brochure. Translation into multiple languages. Decision needed on: 1) what languages. 2) whole brochure vs. essence of service and contact information

VII. Staff Training	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
[redacted]	[redacted]	Alan	**Completed**	ADRC Staff – completed **Volunteer PD drafted y Deidre**
7.2	AIRS Certification Protocol	Woody	**April 2008**	**Deidre will email website access directions to staff. Add to Mar. 31 meeting agenda.**
[redacted]	[redacted]	Alan/Vicki	**Completed**	**Training done April 2008 by UH.**
[redacted]	[redacted]	Alan/Vicki	**Completed**	**Ditto above**
7.5	Protocols for training co-tenants and volunteers	Alan/Vicki	Start when physically in ADRC including setting process and procedures.	**Later task: Cross training on agency services by tenant agencies, disaster preparedness, First Aid/CPR, SLAP assessment (Suicide risk), Medicaid D, etc. IDT model of training. Network partners included in training. Develop protocols.**

VIII. Financing/ Sustainability	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
[redacted]	[redacted]	Alan	Completed	Needs revision / updating.

IX. Future ADRC sites	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
[redacted]	[redacted]	Alan	**Draft Completed 11/07**	**Community Focal Points established by the HCOA in early 80's will be designated satellite sites. The Hamakua Partners in Elder Care project will be the next ADRC site.**

X. Facility Construction (pre-construction)	Tasks	Lead Person(s)	Time Frame and Targeted Deadline	Comments/Status
[redacted]	[redacted]	Alan	Completed Nov 2009	
[redacted]	[redacted]	Woody and Deidre are developing.	**Completed**	**MOAs templates developed. P&P for facility use and tenant guides done**
[redacted]	[redacted]	Alan	Completed	Visitor stalls to be marked. Other stalls marked "reserved"- paid stalls for employees. Bicycle racks? **Office vans not move to site until additional parking made. Alan to send a memo to EAD.**
10.4				

Appendix C - Confidentiality Policy

Appendix C

CONFIDENTIALITY (draft – to be updated)

The following procedures apply to ADRC staff and/or volunteers, advisory board members and AAA contractors. All confidentiality laws and regulations shall be followed.

- All personal or other sensitive information about any client, staff, board member or other volunteers shall be kept confidential.
- Personal data about clients may be discussed among staff while conducting normal tasks. However, staff shall not discuss cases with others not involved with the case.
- Limit access to confidential information to persons demonstrating a need to know.
- Personal information should not be left open on one's desk. If one is working on a document and leaving one's desk for a very brief period, it should be put away, or at the very least turned over so others passing cannot see the information.
- Computer systems shall be secured against entry by unauthorized persons with passwords. Do not post your password anywhere in your work area. Do not store personal information on laptops. Lock office doors before and after normal business hours or when no one is in the office.
- Safeguards to and secure storage of confidential records shall be maintained, e.g. locked files. This includes paper records, drives, diskettes, CDs, DVDs, and flash drives.
- Hand carry or transmit information in sealed envelopes to avoid opening by unauthorized persons. When transmitting by e-mail, send only necessary information and be careful when sending to avoid sending to the wrong persons. Do not email Social Security numbers.
- The identity of individuals cited in any report or other documents shall be protected. Written consent of the individual involved must be on file to release any information.
- Shred personal information if not needed.
- Notify CEOA of any receipt of court orders for any records prior to the release of information.
- Under HRS 487J, the collection, use, or release of Social Security numbers is prohibited unless acquisition is for a legitimate purpose, e.g. employment purposes, EUTF forms. If there is a security breach, contact the Department's ASO. Under the law, the person whose information was released must be notified. See below plan completed 12/1/08 regarding compliance.

Purpose

The purpose of this plan is to ensure that personal data maintained by the ADRC and is not released to the public without legal authorization.

"Personal information" means an individual's first name or first initial and last name in combination with the individual's redacted Social Security number, when either the name or the Social Security number are not encrypted.

"Redacted" means the rendering of data so that it is unreadable or is truncated so that no more than the last four digits of the identification number are accessible as part of the data.

Data Collection History

The 1992 reauthorization of the Older Americans Act (OAA) directed the Federal Administration on Aging to improve performance reporting on programs and services funded by the OAA.

In 1997, ADRC adopted the SAMS database system by Synergy Software (now Harmony Information Systems) to collect NAPIS data. Part of the minimum dataset to be collected was the client's Social Security number. Data was collected and stored both as computer files and paper documents.

After July 2007, ADRC stopped collecting complete Social Security numbers to comply with HRS 487.

Data Collection

Unless otherwise noted, all data collection and storage policies and procedures have been in place since July 2007.

ADRC site collects data on persons directly from ADRC Information and Assistance Section staff interacting with the public and through contractors. Prior to July 2007, this data sometimes included the person's full name and their complete Social Security number. AAA has informed contractors who collect data for AAA and AAA/ADRC staff not to collect the full Social Security number beginning July 2007. Beginning July 2007, complete Social Security numbers submitted to ADRC's Data Processing Unit were redacted to include only the last-four digits of the Social Security number.

Data Storage and Destruction

Paper

ADRC's Data Processing Unit retains data collection forms submitted by contractors for five (5) years. These forms are stored in file cabinets that are locked after office hours. These file cabinets are stored in an office suite which is locked after office hours. Access to the office suite is restricted by building security measures after office hours.

Data collected by ADRC's Information and Assistance Unit are similarly stored in a locked file cabinet in a secure suite and building.

Data collection forms more than five years old are shredded.

Electronic

Electronic data exists as electronic data collection documents in Microsoft Word format, Microsoft Access database format and Microsoft SQL Server format.

Documents in Microsoft Word format are stored on the City's servers. Access to these documents requires a City employee user login name and password.

Databases in Microsoft Access and SQL Server are stored on a server located in the Data Processing Unit's area. The server is located in the same office as are the ADRC's Data Processing paper documents.

Electronic databases used the ADRC's Information and Assistance Unit are kept on the City's servers.

Persons whose database records have been inactive for more than five (5) years are purged from the database.

ADRC is migrating its electronic databases to a private vendor located in Vermont. The electronic databases will thereafter be available over the internet. Access to the databases will be available only with a password. This process should be complete by July 2009.

Data Release and Sharing Procedures

Government

ADRC does not make its data available to other government agencies. Requests for data by AAA's State funding agency are only in the form of summary data and contain no records on individuals.

Contractors

ADRC/AAA does not communicate personal data to contractors since only redacted Social Security numbers are collected by the contractors.

Software Vendor

The software vendor (Harmony Information Systems) has been informed of the requirements of HRS 487.

Public

Requests for information on persons in ADRC's databases are referred to DCS Administration for action.

Appendix D - Customer Service/Communications Curriculum (UH/TIM)

Appendix D

University of Hawai`i at Mānoa
School of Travel Industry Management

Preliminary Objectives and Outlines for Training

Hawai'i Aging and Disability Resource Center

Customer Service Skills, Communications Skills, and Interviewing Skills Training

Contact: Rachel Soma
Assistant Director of Training
Professional Programs
2560 Campus Road, George Hall
Honolulu, HI 96813
PH: (808) 956-4902, FAX (808) 956-5378, EMAIL: rsoma@hawaii.edu

ADRC Interpersonal, Intercultural, Communication, Sequence of Service and Interviewing Training Objectives Proposed training date: Mid to Late October 2007

Training	Instructional hours	Training Objectives
Customer Services Skills Training Instructor: Pat Kramm	6	Understand why customer service is important to the desired outcomes of ADRC Define what is good customer service Identify the skill set needed for good customer service Staff defines ADRC customer service standards; what core values we want to have, who we are, what we do, what outcomes we want to achieve in the services we provide Practice good customer service skills

Communication Skills Training Instructor: Rachel Soma	6	Effective interpersonal skills Understanding cultural perception and values (stereotyping, prejudices) • How to listen across cultures • Relationship Development Nonverbal communication
Sequence of Service Standard Skills Training Instructor: Pat Kramm	8	Design a customer sequence of service standard for ADRC with the end result in mind Understand first person contact dos & don'ts Develop excellent greeting skills Learn to answer the telephone correctly, provide service information and saying goodbye Learn to provide helpful information by listening to the customer's needs Follow up and follow through, logging your service actions Contacting the vendor and executing services Reconfirming the services Practice sequence of services
Interviewing Skills Training Instructor: Chuck Wilson	6	Learn the importance of understanding two populations (Elderly & Disabled) Develop how to skills in questioning and assessing your client and family Learn how to communicate effectively with the Elderly & Disabled Learn the current resources available on the Island

Code	Subject Areas of Training	Outcome	Training Method
BK/IP/COM	• Define customer service for elder care • Define empathy • Define compassion • Appropriate and inappropriate interpersonal & communication skills • Intercultural and communication skills • Sensory challenges and communication • Define ADRC Standards of Services and service quality		Learn from best practices in health care and from health care providers examples
	1. Opening	Ensure area is properly lighted and clean Fill vendor brochure and information racks	
IP/COM	2. Make eye contact	Present a nonverbal welcome	Lecture, discussion, role playing, practice,
IP/COM	3. Offer inviting and warm welcome 4. Do self introduction using your first and last name	Understand appropriate and inappropriate welcomes Break down communication barriers and create an interpersonal rapport with the client Understanding communication gaps and strong suits	

		Be attentive to family members	
BK	5. Give brief overview of ADRC services & offer appropriate brochure and literature	Be able to clearly state who the ADRC agency is and what services ADRC offers?	
	6. Escort client to interview area	Provide escort or wheel chair assistance to client to specified area	
	7. Make client comfortable and prepare client for interview and discussion	How can this be done? Need to get employee input and feedback.	
IP/COM	1. Make eye contact 2. Offer inviting and warm welcome 3. Do self introduction using your first and last name	Present a nonverbal welcome Understand appropriate and inappropriate welcomes Break down communication barriers and create an interpersonal rapport with the client Understanding communication gaps and strong suits Be attentive to family members	Lecture, discussion, role playing, practice,
IP/COM /INTV	4. Appraise client's needs through the interview process	Understand the interview process Define effective interviewing skills? Establish elder care needs, what they are and what vendor can provide the services	
	5. Prepare and provide a response	Question: during this time, does the	

		ADRC staff leave the client to determine what kind of services are needed, and return with a contact list? Does the ADRC staff make the call / appointment for the client?	
	6. Assess your success	Did we address your concerns?	
	7. Provide information on ADRC follow up services	Define what the follow up services are Inform client of what the follow up services will be	Open for discussion with staff
IP/COM	8. End session with invitation for client to return and or to call in for more ADRC services	Develop closing steps Offer contact information Use your name Remind them of your hours of operations	
	Communication Skills Training Using Verbal & Nonverbal communication effectively <u>Rationale for communications skills training:</u> There is growing research evidence linking provider-patient communication and relationship with a range of measurable indices of patient outcome. Health service providers need to manifest high levels of skills in dealing with associates at an interpersonal level. Health Services Commissioner's Annual Report identifies poor or inadequate communication between patients and health professionals as a source of many of the grievances dealt with.		

	Empathic communication is closely associated with patient-centered care. Attention to choice of words is important both to expansion of the capabilities attributed to older people and to perceptions of society in general		
	<u>Communication Skills Training objectives:</u> Develop effective interpersonal communication skills Develop effective interpersonal communication skills Develop relational and relationship building skills	1. ADRC skilled elder-care centered staff 2. ADRC staff develop unhindered two-way communication flow with elder associates for information gathering	
	Customer service skill training **A good customer service provider fully understands what duties, tasks and services they provide in order to meet and exceed their customer's expectation. ADRC training subcommittee needs to identify the following:** **What kind of services will ADRC provide?** **What are the volunteer duties?** **What are the hired staff duties?** **Customer Service Training** 1. Volunteer staff need to understand and learn what their duties and daily task are 2. Regular and hired staff will need to obtain and deduct information from associates (elder community) 3. Regular and hired staff needs to learn all services available to the elder community		

	• Who are the vendors • What services do vendors provide 4. Regular and hired staff will need to be detailed oriented and efficient in making contacts with appropriate vendors, confirming time and services 5. Regular and hired staff will need to log and regulate suggested vendor services 6. Regular and hired staff will need do follow up and follow through services on the vendor services they refer associates to.		

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CODES

(Bowlby, 1958) Interpersonal & Communication Skills, (BK) Basic Knowledge, (INTV) Interview Skills

Aging and Disability Resource Center
Staff Training – Introduction to ADRC Model (rev 9/27/07)

Code	Subject Areas of Training	Outcome	Training Method
	• Define ADRC vision and goals (national and local) • Define key ADRC function • Define target population • Compare ADRC versus Information and Assistance Services (similarities and differences) • Define ADRC Standards of Services and Quality • Describe different ADRC models • Future of ADRC	Understand the Vision and Goals Of ADRC (national and local) Identify target populations Identify and provide key functions	Lecture, discussion, questions and answers (power-point presentation)
	1. Overview of ADRC	Understand the Vision and Goals Of ADRC (national and local) Identify target populations Identify and provide key functions	Lecture, discussion
	2. Give brief overview of ADRC services & offer appropriate brochure and literature	Be able to clearly state who the ADRC agency is and what services ADRC offers?	

Aging and Disability Resource Center
Staff Training – Introduction to ADRC Model (rev 9/27/07)

	1. Overview of ADRC	Understand the Vision and Goals Of ADRC (national and local) Identify target populations Identify and provide key functions	Lecture, discussion
	2. Give brief overview of ADRC services & offer appropriate brochure and literature.	Be able to clearly state who the ADRC agency is and what services ADRC offers?	Lecture, discussion
	3. Explain referral and linkages process	Understand the referral, assessment, linkages. Understand the scope of ADRC case management. Does the service provider understand their role and the ADRC's role?	Lecture, discussion
	3. Provide information on ADRC follow up services	Define what the follow up services are. Discuss scenarios where client needs to be referred again.	Open for discussion with staff, role playing

Aging and Disability Resource Center
Staff Training – Introduction to ADRC Model (rev 9/27/07)

Detailed Curriculum for ADRC Orientation

Code	Subject Areas of Training	Outcome	Training Method
	I. Official Name (State) "Aging and Disability Resource Center Hawaii" **Hawaii County** "Aging and Disability Resource Center Hawaii – Kahi Malama (Place of Care)" **Honolulu County** Aging and Disability Resource Center Hawaii – Tag-line pending **II. National and State of Hawaii Vision** "ADRC is a highly trusted, unbiased source of information for public and private paying individuals. It is a one stop source of information that offers a full range of long term care support options and services". **III. National Goal** Empower individuals to make informed choices and streamline access to long term support	Recognize the Official Name Understand the Vision and Goals Of ADRC (national and local)	Lecture, discussion, questions and answers (power-point presentation)

	IV. State of Hawaii Goals 1. Establish the ADRC to be a one-stop source of information to long term care programs, services and benefits. 2. Have two pilot sites initially in Hawaii and Honolulu Counties, and to be followed by Maui and Kauai thereafter. 3. Streamline process for screening, intake, assessment and eligibility determination		
	V. Philosophy Establish a highly trusted and unbiased source for long term car information and where people can obtain assistance to make informed decisions about their long term care. **VI. Core Values** • Respect • Warm, Comforting • Trustworthiness • Courtesy • Customer-oriented • Responsive • Accessible • Unbiased • Caring	Understand Philosophy, Core Values, And Culture of ADRC.	

	VII. Key ADRC functions Intake and Screening Assessment and Eligibility Determination Information and Referrals Case Management and follow up **Compare ADRC versus Information and Assistance Services (similarities and differences)** • Show AAA and ADRC Intake Flow Sheet Pre-ADRC and Post-ADRC	Identify key functions Understand the referral, assessment, linkages. Understand the scope of ADRC case management. Does the service provider understand their role and the ADRC's role?	Lecture, discussion
	Seniors 60 y.o. and older Adults 18 y.o. and older with physical disabilities Informal and Formal Caregivers People Planning for future Long Term Care Needs	Identify Target Population/Primary Users of Services	
	Reflect Core Values and Standards of Customer Service	Understand Standards of Services	

	Hawaii County ***Physical Site in Hilo*** ***Lead Agency: Hawaii County Office of Aging*** • Co-location of Aging and Disability Service Providers and Agencies (DHS, Nutrition Program, Legal Aid Society, Transportation, Coordinate Services for Seniors) • Plus Telephone and Website Systems **City and County of Honolulu** ***Virtual Site on Oahu*** ***Lead Agency: City and County of Honolulu Elderly Affairs Division*** • Website and Telephone System • Future Physical Site **Other Models** • Satellite and Kiosks in Public Library • Mobile Units	Recognize different models	
	Maui and Kauai Counties Start Up ADRC and Housing Partnerships Financing and Sustainability	Understand future Developments	

Appendix E - Information Flow Within an ADRC

Appendix E

ADRC Client Flow
Mar. 3, 2008
Telephone Call

1. Call is received at the (808) 961-8626 ADRC number. A call center within HCOA area may be set up [other possibility to have calls directed to a specific telephone(s) of assigned staff?].

2. Assigned staff will pick up the call in the following priority order:
   1. ADRC Specialist
   2. ADRC Coordinator
   3. Care giver ADRC Specialist
   4. HCOA Planners – rotation
   5. Clerk

[Need to understand telephone system on how this can be set up for simultaneous calls. Look at a forwarding feature for the telephone so calls can be directed to other numbers or instruments and ring on those instruments. Also will need to set up alternative staff to accept simultaneous calls or walk ins.]

3. Staff greets the caller. [script will be developed]

   Staff will listen to caller and begin to document information on the ADRC Intake form while carefully timing questions so they will not significantly interrupt the callers flow of conversation.

   There may be two general types of contacts:
   1) Requests for general information on services and resources not related to care giver, long term care issues, immediate service needs or needs to support community living without imminent long term care issues.

   2) Requests for information and services related to care giver and other long term care issues, or related to more immediate service needs or needs to support community living without imminent long term care issues.

   For type 1) requests, general service and contact information will be provided to the caller for follow up. For other callers, the following process will be followed.

[If the situation permits, staff may query the SAMS database during the call to determine if individual is known to HCOA. Staff covering intakes may log into SAMS and stay in while on coverage to enable quicker access.]

5. Based on staff's assessment, potential resources may be identified from the assessment. Staff will provide information on the resources and offer assistance in making connection with the provider(s) by telephone or mail. Depending on telephone system capability, staff may offer to transfer the call to the agency identified as most appropriate to start.

6. Staff offers to do a printout of the information to be mailed or picked up by caller [to prevent needing to repeat information] or to come in to sign **or mail out* (a) consent form(s) to authorize ADRC to release information to agencies referred to. [Form to be developed]

Appendix E

ADRC Client Flow
Mar. 3, 2008
Telephone Call

**Note: Need to clear with Corporation Counsel attorney, Brooks Bancroft if mailing is OK = no witness.*

Important to determine individual's legal status to authorize consent for release of information. Staff must believe the individual has capacity to understand what consent they are authorizing. For anyone else, individual must produce documentation (copy of order) of court appointed guardianship or other legal court determined status that authorizes their release of confidential information. Notarized Power of Attorney (POA) document is also acceptable if the individual is present and staff determines their capacity to give POA the authority. Notarized Durable Power of Attorney (DPOA) is acceptable if staff believes it has not been revoked. A copy of the document should be made and attached to individual's file.

7. At the termination of the call, staff will inquire if there are any other questions or concerns and address these. If none, staff will thank the caller for using ADRC services, invite future use and to get verbal permission to do contact the caller within 2 weeks to determine progress on acquisition of services, and to do a short satisfaction survey.

8. ADRC Specialist, ADRC Coordinator and Care Giver Specialist makes the data entry of the intake into Beacon and flags the follow up. All completed intake forms are routed to ADRC Specialist.

   HCOA Planners will route intake forms to the ADRC Specialist for data entry of the intake form into Beacon.

9.. ADRC Specialist will do the 2 week follow up contact and the Satisfaction Survey. If linkage was not completed for any reason, ADRC Specialist will further assist with the linkage.

ADRC Client Flow
August 11, 2008
Walk in

References to 'individuals' in this process will also apply to a group of 2 or more individuals.

[Need to identify process for dealing with more than one "customer" at a time when this occurs]

1. Volunteer greeter located inside ADRC reception area close to the entryway

2. Greeter greets individual, asks their name and writes it on a slip of paper as well as the time of day, then offers assistance. [script to be developed]

   Greeter will have an ADRC staff directory in case it's a visitor wanting to see a specific staff member in the ADRC. If so, greeter calls the staff to come and meet individual. I&A staff member will then query SAMS and printout information if the individual is known. (Staff covering intakes may log into SAMS and stay in while on coverage to enable quicker access.)

3. If services or information are requested, the greeter will seat the individual in the reception area. The greeter will then go to the I&A staff's area, give them the slip of paper and alert them of the walk in visitor.

   Greeter will attempt to contact ADRC Specialist first, ADRC Coordinator second, Caregiver Specialist third then Luana fourth (who will then identify and call to the front area the planner covering on rotation).

4. Staff will come and meet with the individual in the reception area; both the staff member and the individual have the option to move to an interview room or conference room if privacy is wanted. Staff can offer the availability of the more private setting – should be a client need vs. staff need. Staff will inform HCOA clerical staff (Luana) whenever moving an interview into a interview room or other private area.

5. Staff will begin filling in the ADRC intake form (will have a clipboard with the form) while interviewing.

There may be two general types of contacts:

1) Requests for general information on services and resources not related to caregiving, long term care issues, immediate service needs or needs to support community living without imminent long term care issues.

2) Requests for information and services related to caregiving and other long term care issues, or related to more immediate service needs or needs to support community living without imminent long term care issues.

For type 1) requests, general service and contact information will be provided to the visitor for follow up. For other visitors, the following process will be followed.

ADRC Client Flow
August 11, 2008
Walk in

6. Staff begins an assessment [as part of the interview process] -> identify need(s) -> identify service options and present this information to the individual and document.

7. If any service(s) selected, staff will assist individual to make linkage to the service(s). E.g. Initiate call to service, assist in making an appointment, transportation (check on CSE availability, available Share ride coupons?), etc. Provide printout of data or copy of the intake form to take to service agency when contacted. Get consent form *signed so agency can access data online in SAMS and any other sharing of information.

Important to determine individual's legal status to authorize consent for release of information. Staff must believe the individual has capacity to understand what consent they are authorizing. For anyone else, individual must produce documentation (copy of order) of court appointed guardianship or other legal court determined status that authorizes their release of confidential information. Notarized Power of Attorney (POA) document is also acceptable if the individual is present and staff determines their capacity to give POA the authority. Notarized Durable Power of Attorney (DPOA) is acceptable if staff believes it has not been revoked. A copy of the document should be made and attached to individual's file.

8. If Long Term Care services or questions arise, staff will link the individual to the ADRC Specialist for an appointment for Options Counseling.

9. Staff begins to close the interview by informing individual they are welcomed to contact the ADRC for questions or future needs. Staff offers individual the ADRC business card to facilitate return contact. If the service referral is to an ADRC based agency and they have been contacted and able to interview the individual, staff accompanies them to the agency office in the ADRC. If not, staff thanks the individuals and accompanies them to the door or offers them to browse in the resource area before leaving.

10. Staff informs individual that a follow up contact within 2 weeks will be made to determine progress on acquisition of services, and to do a short satisfaction survey.

11. ADRC Specialist, ADRC Coordinator and Care Giver Specialist makes the data entry of the intake into Beacon and flags the follow up. All completed intake forms are routed to ADRC Specialist.

    HCOA Planners will route the intake forms to the ADRC Specialist for data entry of the intake form into Beacon.

ADRC Client Flow
August 11, 2008
Walk in

12. ADRC Specialist will do the 2 week follow up contact and the Satisfaction Survey. If linkage was not completed for any reason, ADRC Specialist will assist with the linkage.

ADRC Client Flow
Mar. 3, 2008
Letter or Technology

1. Letter or other contact (fax, email, website) received at the ADRC and routed to the ADRC Specialist. If the ADRC Specialist is on leave for more than one day, the request will be routed to other staff in the following priority order:
   1. ADRC Coordinator
   2. Care giver I&A Specialist
   3. HCOA Planners – rotation

   Response time target: Within one work day. The individual may indicate the urgency within their communication.

2. Staff checks the SAMS database to determine if individual is known to HCOA.

3. Staff will fill the ADRC intake form based on information provided.

4. Staff assesses the information provided and determines if further information is needed to respond or a response can be made without further information. A telephone call or other response (letter, email, etc) may be made to gather further information if appropriate.

5. Based on staff's assessment, potential resources may be identified from the assessment. Staff will provide information on the resources and offer assistance in making connection with the provider(s) by telephone or mail.

6. Staff offers for the individual to come in to sign *or *mail out* (a) consent form(s) to authorize ADRC to release information to agencies referred to. [Form to be developed]

   Note: Need to clear with Brooks Bancroft if mailing is OK = no witness.

   Important to determine individual's legal status to authorize consent for release of information. Staff must believe the individual has capacity to understand what consent they are authorizing. For anyone else, individual must produce documentation (copy of order) of court appointed guardianship or other legal court determined status that authorizes their release of confidential information. Notarized Power of Attorney (POA) document is also acceptable if the individual is present and staff determines their capacity to give POA the authority. Notarized Durable Power of Attorney (DPOA) is acceptable if staff believes it has not been revoked. A copy of the document should be made and attached to individual's file.

7. In the closing of the response, staff will thank the individual for using ADRC services and invite future contacts if needed. Staff will also include in the response, as appropriate, that a follow up contact within 2 weeks will be made to determine progress on acquisition of services, and to do a short satisfaction survey.

ADRC Client Flow
Mar. 3, 2008
Letter or Technology

8. ADRC Specialist, ADRC Coordinator and Care Giver Specialist makes the data entry of the intake into Beacon and flags the follow up. All completed intake forms are routed to ADRC Specialist.

   HCOA Planners will route the intake forms to the ADRC Specialist for data entry of the intake form into Beacon.

9. ADRC Specialist will do the 2 week follow up contact and the Satisfaction Survey. If linkage was not completed for any reason, ADRC Specialist will assist with the linkage.

Aging and Disability Resource Center
Kahi Mālama

P&P for Telephone Call or Walk in with Suicide Risk

ACCESS: Hawaii Suicide and Crisis Line 1-800 -753-6879

Available 24/7. Based on Oahu but has contracts with Care Hawaii and local MH Centers for Crisis Mobile Outreach Teams that can send a staff in the field to meet with the individual. [confirmed via telephone call 7/21/08]

In the event that a caller or walk in client threatens harm to self, the worker will not immediately refer the caller or walk in client to the Behavioral Health Call Center; the caller or walk in client may be actively engaged in suicidal ideation and interpret that attempt as rejection, commentary on his/her meaninglessness, or further evidence of the hopelessness of his/her plight. The worker will attempt to guide the caller or walk in client to the Behavioral Health Call Center if and when the caller or walk in client is agreeable. If the Behavioral Health Call Center is not a viable option, the worker will get a co-worker to contact 911 while the worker remains on the call. If the worker can not obtain the caller or walk in client's address or location, the worker will use the caller or walk in client identification function of their phone as identifying information to transfer to 911. The worker will obtain as much information from the caller or walk in client as possible in order to be able to dispatch emergency services to the caller or walk in client, but the worker will be careful not to alienate the caller or walk in client by avoiding the purpose of the call or by moving faster than the caller or walk in client wants to.

The worker will ask the caller or walk in client's name and interject it frequently during conversation. The worker will attend specifically to the caller or walk in client's concerns.

The worker must be in firm control of the conversation. The worker will be directive to minimize imminent potential for harm (I want you to place the gun on the table on the other side of the room; I'll wait here while you do that, and I want you to come directly back to the phone.)

The worker will also take control of the conversation by asking questions related to the present suicidal crisis. The worker must be prepared to direct each successive action of the caller or walk in client.

The worker will stay on the call as long as is required to ameliorate the current crisis, and will enlist the aid of co-workers for collateral phone calls or other assistance.

Points to remember:

- **Talking about suicide to a troubled person will not give him/her the idea. The ideas are already there. Almost all suicidal types feel relieved to discuss it.**

- **A "garden variety" depression triggers most suicide attempts, not psychosis. The worker must endeavor to look for and emphasize the individualized reason(s) a person may have to live.**
- **Typical suicides are not impulsive actions; they are preceded by long deliberation. Suicide is often a choice that is contemplated for months, if not years.**
- **The caller or walk in client who only talks vaguely or threateningly about suicide or makes feeble "gestures" is not interested only in manipulation, and should be taken seriously. This person requires attention, without which the next suicide attempt may be lethal.**

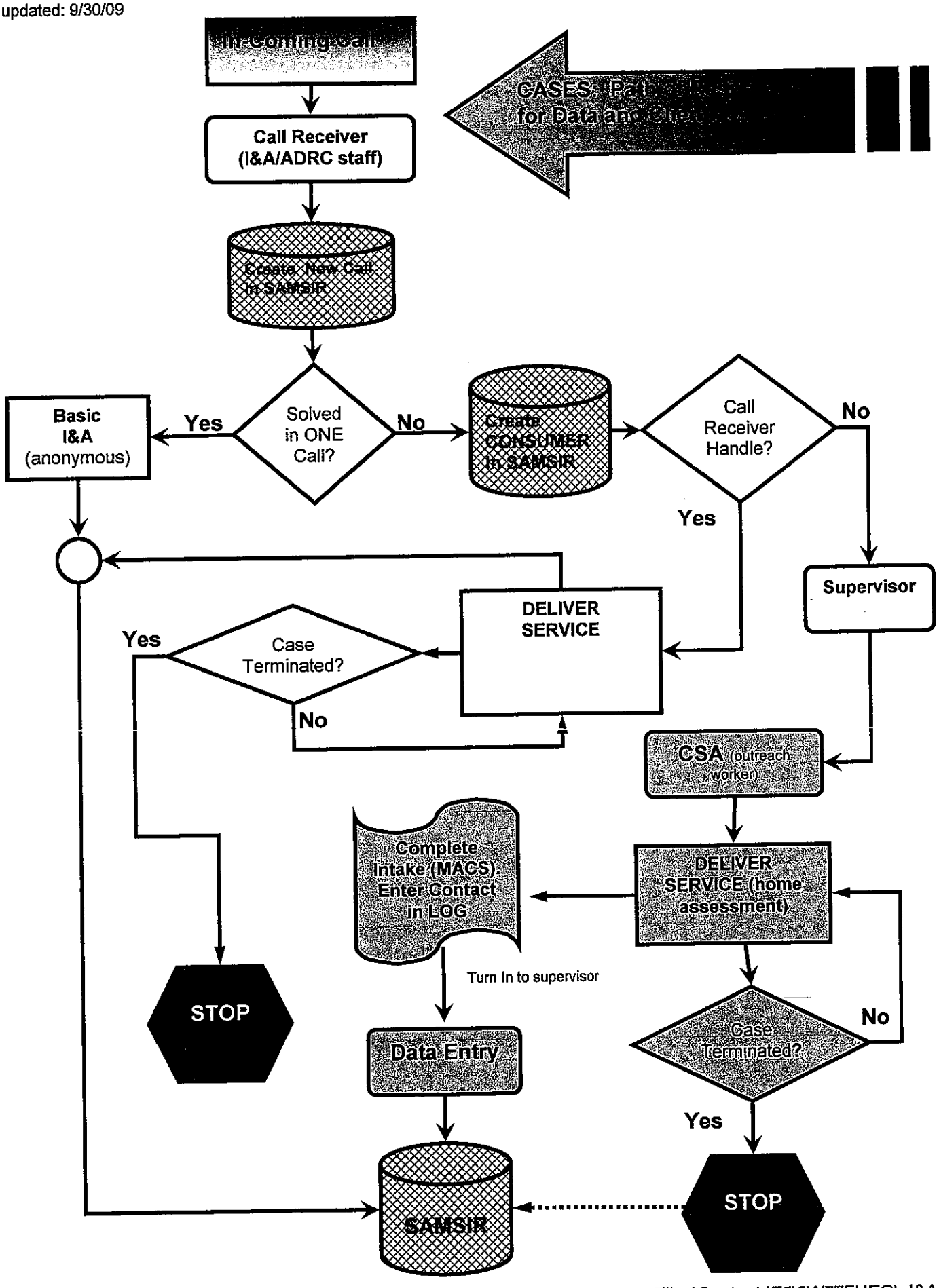
The worker may assess the risk of suicide by using the following interview guide (adapted from Behavioral Health Call Center Policy and Procedure). This instrument is a guide to assessing risk; it is not intended to provide a score that will determine a decision. It is not intended to be a substitute for sound clinical judgement.

A. CHARACTERISTICS OF THE SUICIDAL CRISIS

1. Is this person thinking about killing himself/herself?
2. What event(s) or situation precipitated the crisis this time? (What , when, who is involved?)
3. What does the event(s) or situation *mean* to this person?
4. What has been this person's reaction (behavior, feelings, and thoughts) to the precipitating event(s)?
5. How are significant others responding, and/or how does this person *believe* they are responding?
6. Will available significant others be helpful, or will they contribute to this person's suicidal preoccupations?
7. What "secondary motivations" and affects are expressed on the surface? (Vindictiveness, self-hatred, hopelessness)

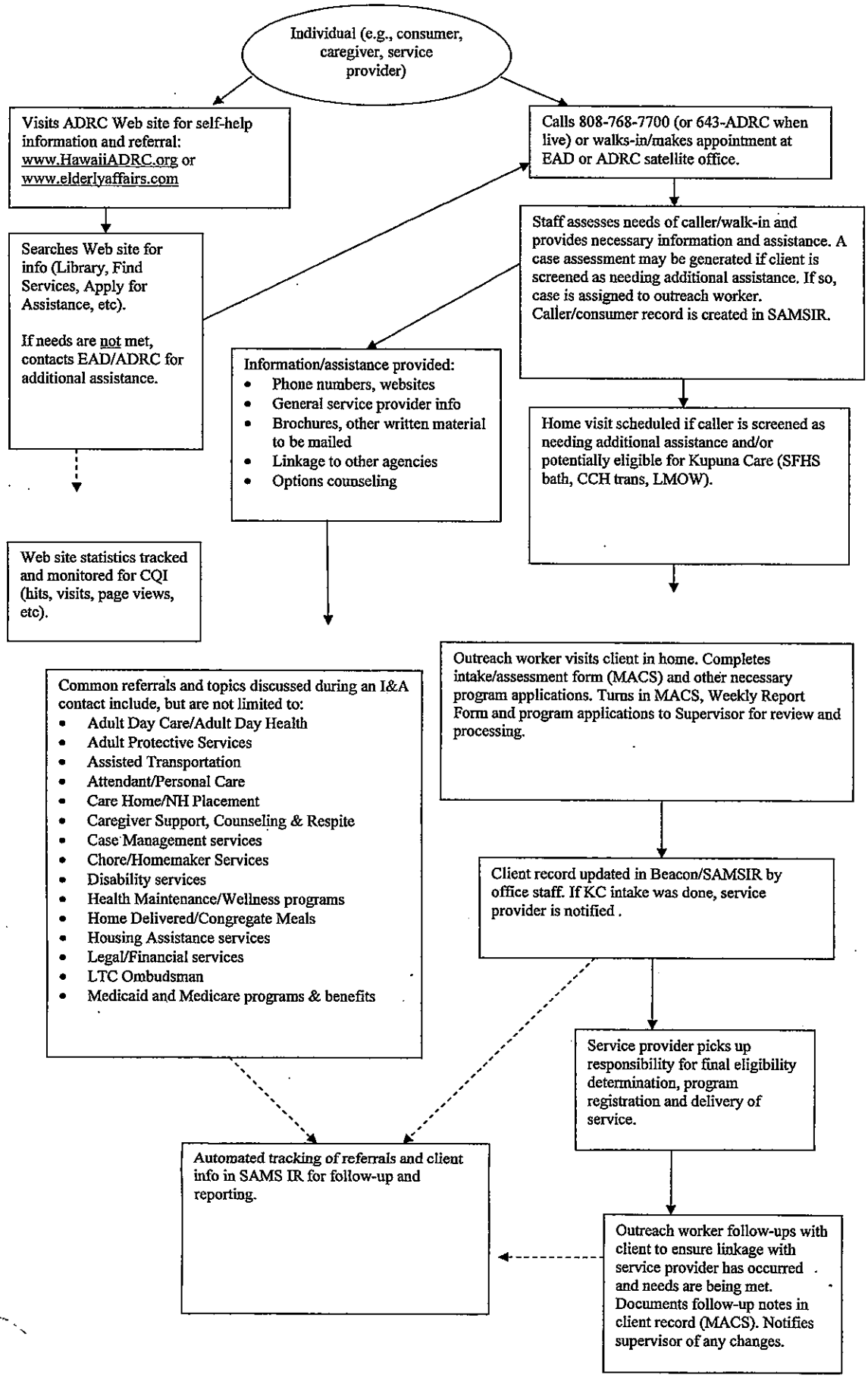
B. CHARACTERISTICS OF THE CONTEMPLATED ATTEMPT	**RISK INTENSITY**		
	LOW	MODERATE	HIGH
1. How lethal is the planned method? (Pills, especially antidepressants and acetominophen, driving into a tree, jumping from a height, a shotgun in the mouth)			
2. Does the planned method match the personality type?	No	Maybe	Yes
3. How specific is the plan?	No plan	No details worked	Well

Last updated: 9/30/09



HONOLULU ADRC: Flow of Information

Updated: 3/3/08, 7/1/09, 9/30/09



Appendix F - Exclusion/Inclusion Policy

AGING AND DISABILITY RESOURCE CENTER HAWAII
RESOURCE DATABASE POLICIES AND PROCEDURES

PURPOSE: The purpose of this policy is to establish a set of standards for including agencies in the Hawaii Aging & Disability Resource Center ("ADRC") database on its website or in other publications, for use by the public, including those who need financial assistance as well as those who have personal resources to pay for services.

POLICY: Qualified service providers that empower older adults, disabled adults, and/or family caregivers to make personal decisions, plans, and connections that allow them to live as independently and fully as possible shall be included in the ADRC resource database. Each Area Agency on Aging ("AAA") shall establish and maintain the resource database for services in its planning and service area, according to the criteria and procedures on the following pages.

BACKGROUND: The ADRC is a one-stop source for long term care information and services for older adults, people with disabilities and caregivers who need help in caring for a family member or loved ones. The ADRC is a collaborative project funded in part by the U.S. Administration on Aging, Centers of Medicare and Medicaid Services, State of Hawai'i and the Counties of Kaua'i, Maui, Hawai'i, and the City and County of Honolulu. The sponsoring agency for each county's ADRC is its respective Area Agency on Aging:

- Hawai'i County Office of Aging of the Big Island
- City and County of Honolulu Elderly Affairs Division on O'ahu
- Kaua'i County Agency on Elderly Affairs, and
- Maui County Office on Aging (includes Molokai and Lanai)

Each county publishes an Information & Assistance Handbook and is in the process of developing an electronic searchable resource database. The database will assist staff, consumers, caregivers, providers and others in the community in finding local long term care programs and services. The information in the database will be accessible on Hawaii's new Aging & Disability Resource Center website (www.HawaiiADRC.org) and may be used to create printed material, including the Information & Assistance Handbook and other resource guides.

ADRC RESOURCE DATABASE INCLUSION/EXCLUSION CRITERIA

DISCLAIMER:

- **Although this policy indicates what agencies and services are eligible for inclusion in the database, the AAA/ADRCs reserve the right to prioritize and limit entry;**
- **A listing in either the Handbook or online directory does not constitute an endorsement of or liability for any agency, program or service and omission does not indicate disapproval;**
- **An organization will be on probationary exclusion (inactive status) if they have not provided service for at least 6 months;**
- **Non-compliance with the inclusion process is grounds for exclusion;**
- **AAA/ADRCs reserve the right to edit information to meet format, guideline, space and taxonomy requirements;**
- **AAA/ADRC will make every effort to provide complete and accurate information, but it neither guarantees nor makes any representation as to the accuracy or completeness of the information contained in its resource database. The user takes full responsibility to further research the services and information listed in the resource directory and on the website.**

AGING AND DISABILITY RESOURCE CENTER HAWAII
RESOURCE DATABASE POLICIES AND PROCEDURES

INCLUSION: The resource database will include services and programs that adequately address the needs of those 60 and older, 18 and older with a physical disability and/or their caregivers. Overtime, the goal is to expand content to include relevant long term care programs and services regardless age, income or disability requirements. Inclusion criteria are as follows:

1. Government and non-profit agencies and programs that provide assistance for the targeted populations (e.g., federal, state, city/county government, 501c3 designated non-profits, crisis lines, help lines, etc). No attempt will be made to list all government agencies and departments.
2. Agencies that are certified, licensed, or accredited by the appropriate levels of government, as applicable (e.g., adult day care, nursing homes, assisted living facilities, home health services, hospitals, etc);
3. Agencies and programs that are tax-exempt or do not charge fees.
4. Self-help support groups that do not charge a fee or charge a nominal fee.
5. Senior and disability advocacy groups and community coalitions.
6. Agencies, including for-profit, proprietary and non-profit, that provide State, City or County contracted services.
7. For-profit, commercial or private organizations may be considered on an individual basis. Evaluation of inclusion is based on the following:
    - Uniqueness of service (e.g., specially targeted services or services that are otherwise difficult to access);
    - Financial eligibility (agency also offers free service, scholarship, reduced fees, sliding fee scale or accepts Medicaid);
    - Lack of comparable services in the public, non-profit sector;
    - Demonstrated community need for services.

EXCLUSION: The AAA/ADRC reserves the right to make the final determination to include or exclude any agency from the resource database. Exclusion criteria are as follows:

1. In general, private practitioners or group practices in the following areas are excluded, except as may be necessary under inclusion criteria: i.e. medical doctors, legal/paralegal providers, mental health practitioners, insurance agents, investment or banking lenders, nutritionists, physical therapists, chiropractors, dentists.
2. Any agency that knowingly or unknowingly discriminates or violates local, state or federal discrimination laws and regulations.
3. Any agency or person that misrepresents their services in any way or provides misleading or fraudulent information to the public.
4. Have been in existence less than one year, except for government agencies.
5. Do not respond in a timely manner when asked to update agency/program information.
6. Programs where standards of service quality are regulated and for which there exists an entity that adequately maintains current data (e.g., Department of Health, Office of Health Care Assurance, maintains vacancy list for adult residential care homes).
7. Elected government officials.
8. Churches, service groups (e.g., Rotary) and other organizations that offer no special service to the target populations.

Regarding Exclusion or Elimination from the Database

- If an organization/agency submits an application and is determined to be ineligible to be listed within the database, the AAA/ADRC will respond with a letter of explanation.

AGING AND DISABILITY RESOURCE CENTER HAWAII
RESOURCE DATABASE POLICIES AND PROCEDURES

- AAA/ADRC has the right to refuse or discontinue listing organizations that have had complaints filed with AAA/ADRC, other aging and disability network programs, the Better Business Bureau or a regulatory entity.
- AAA/ADRC has the right to eliminate a program/organization for failing to update their record annually.
- AAA/ADRC has the right to eliminate a program/organization when it is determined that the program is not in compliance with federal, state, or local laws.
- Organizations wanting to be removed from the database or resource directory should contact their local AAA/ADRC by phone or email. See contact information on pages 3-4.
- If the organization has been denied database inclusion for the following reasons, please do not reapply for admittance as we will not be able to include your program:
  - If your organization is denied database entry based on a severe complaint file with AAA/ADRC, a regulatory board, or the Better Business Bureau;
  - If your organization is involved in illegal practices;
  - Agencies that misrepresent their services in any way;
  - If your agency has been removed from the database for any of the "Not Eligible to be Included" reasons listed above.

PROCEDURES FOR PROSPECTIVE AGENCIES:

1. Organizations wanting to be included in the database shall submit an application and full documentation as requested (see Attachment 1: "ADRC Resource Database Application Form")
2. Complete the application form and return it to the appropriate Area Agency on Aging by mail, fax or email:

City & County of Honolulu	**Hawai'i County**
Elderly Affairs Division Department of Community Services ATTN: Information & Assistance Unit 715 South King St., Rm 200 Honolulu, Hawaii 96813 Phone: 808-768-7700 Fax: 808-527-6895 Email: elderlyaffairs@honolulu.gov	Hawaii County Office of Aging Kahi Malama (A Place of Caring) 1055 Kino'ole Street, Suite 101 Hilo, Hawaii 96720 Phone: 808-961-8626 Fax: 808-961-8603 Email: hcoa@hawaiiantel.net

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Kaua'i County	Maui County
Kauai County Agency on Elderly Affairs 4444 Rice Street,Suite 330 Lihue, Hawaii 96766 Phone: 808-241-4470 Fax: 808 241-5113 Email: elderlyaffairs@kauai.gov	Maui County Office on Aging Department of Housing and Human Concerns 2200 Main Street, Suite 547 Wailuku, Hawaii 96793 Phone: 808-270-7774 o Fax: 808-270-7935 Email: aging@co.maui.hi.us

3. Completed applications will be reviewed by AAA/ADRC staff for accuracy, completeness and consistency with database taxonomy and other guidelines. Staff may request additional information or clarification of applicant agency.
4. Prospective agencies will receive notification regarding the status of their application within 7-10 business days.
5. Following review and acceptance, the agency and program information will be added to the database in accordance with internal guidelines.
6. Agencies that do not meet the criteria for inclusion and wish to challenge the decision should follow the Complaint/Grievance Procedure outlined below.
7. Organizations with incomplete applications will not be considered – all applications and any necessary addendum forms must be complete; all required documentation must be submitted to each respective ADRC/AAA.
8. All applicants must meet the criteria of being in operation and providing the listed service for at least one year prior to being added to the database.
9. Services that are subject to licensure or regulation must provide appropriate documentation of compliance. (i.e. professional license number and type of license, etc.)
10. The AAA/ADRC staff reserves the right to request for a site visit at the agency's place of business or additional documentation or records of business compliance status (i.e. Certificate of Good Standing with the Hawaii Department of Commerce and Consumer Affairs, proof of 501 (c) 3 status, etc.).

COMPLAINT/GRIEVANCE PROCEDURE:

1. Contact the AAA/ADRC by phone to clarify concerns. Refer to contact information on pages 3 and 4.
2. If concerns are not resolved by step one, submit a written statement to the appropriate sponsoring agency.
3. The ADRC Coordinator, I&A Coordinator, County Executive on Aging and/or other staff as necessary will review the appeal and make a final decision.
4. The appealing organization will be informed in writing within 30 calendar days.

QUALITY CONTROL: In order to provide the community with accurate and useful information, the AAA/ADRC will follow a systematic and timely process for maintaining and updating the resource listings and will review the Inclusion/Exclusion Policy on an annual basis. AAA/ADRC staff will collect, verify and update information about providers through a variety of methods, including existing resource guides, handbooks and databases as well as surveys, phone calls,

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email and other communication. Survey updates will be performed annually, at a minimum, and may be performed in increments on a revolving basis.

UPDATING AGENCY/PROGRAM INFORMATION:
Each AAA/ADRC will update their respective database information on an on-going basis. Agencies will be asked to respond to a formal agency update survey at least once a year. Unresponsive service providers risk being excluded or dropped from the database. Agencies are relied upon to keep each AAA/ADRC site informed of any new programs or if they are getting inappropriate referrals. Please use the contact information on pages 3-4 to notify the appropriate AAA/ADRC of any changes, updates or inappropriate referrals. Eventually agencies will be able to update their information online. A description of this process will be included in this document once the feature is made available.

COMMENCEMENT DATE
The implementation of the specified policies and procedures will begin January 3, 2010. Each AAA/ADRC will review the Resource Database Policies and Procedures on an annual basis and modify as necessary.

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ATTACHMENTS

1. ADRC Resource Database Application Form
2. Resource Database Inclusion Criteria Checklist (internal)

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Attachment 1: ADRC Resource Database Application Form

Thank you for your interest in the Hawaii ADRC Resource Database. If you have not read the Inclusion/Exclusion Policy, we strongly suggest you do so before proceeding.

AGENCY/PROGRAM INFORMATION Please fill out one application per agency/program. Make copies as needed.
AGENCY NAME (Legal):
AKA (Also Known As):
AGENCY STREET ADDRESS (Physical Location): **CITY/TOWN:** **COUNTY:** **STATE:** **ZIP:** Is the physical address confidential? __Yes __No
MAILING ADDRESS (if different from above): **CITY/TOWN:** **COUNTY:** **STATE:** **ZIP:**
AGENCY PHONE NUMBERS (main, fax, administration, TTY, other):
WEBSITE URL:
PRIMARY CONTACT NAME: **PHONE NUMBER:** **EMAIL:** **SECONDARY CONTACT NAME:** **PHONE NUMBER:** **EMAIL:**
AGENCY TYPE: _ Nonprofit. If yes, are you a 501©3? _ YES _ NO _ Government/Public _ For Profit/Proprietary _ Other. Please specify _____

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BRIEF AGENCY/PROGRAM DESCRIPTION (use language that the general public would understand):

WHAT TYPE OF SERVICE(S) DO YOU OFFER? CHECK ALL THAT APPLY.

_ Health/Medical Care _ Social Service _Financial Assistance _Legal Assistance

_ Housing Assistance _ Recreation _ Advocacy _Care/Case Management _Employment

_ Assisted Transportation _ Food/Nutrition/Meals _Caregiver Support/Respite

_Volunteer Opportunities _Homemaker/Chore _ Personal Care _Disaster/Emergency

_Advocacy _Counseling _Education _Mental Health _ Other:_____

WHAT POPULATION DOES YOUR PROGRAM SERVE? CHECK ALL THAT APPLY.

__Elderly. Specify age group, if applicable (e.g., 55 & older, 60+, 62+, 65+) _____

__Caregivers. Specify age restrictions, if applicable _____

__Clients with a Physically Disability. Specify age group, if applicable (e.g., all ages, 18+)_____

__Clients with a Developmentally Disability. Specify age group, if applicable _____

__Clients with Multiple Disabilities. Specify age group, if applicable _____

__Clients with a Mental Illness. Specify age group, if applicable _____

__Other. Please specify _____

SERVICE AREA COVERED (island wide, by zip code, city/town, etc):

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PROGRAM FEES. Please list hourly rates, minimum hours required and any other relevant fee information (e.g., sliding scale, fee-for-service, fixed, membership, no fees, donation requested):

ELIGIBILITY REQUIREMENTS. Please specify any requirements clients must fulfill to receive services from your program (e.g., age, low income, Medicare/Medicaid eligible, etc):

HOURS OF OPERATION (day/hours):

LANGUAGES SPOKEN OTHER THAN ENGLISH:

INSURANCE ACCEPTED __yes ___no

If yes, please indicate: ___Medicaid ___Medicare ___Private ___Military

___other: _____

ACCESSIBILITY INFORMATION (e.g., ramp, wheelchair lift, elevator, interpreter, translator, etc):

HAS YOUR AGENCY EXISTED IN HAWAII FOR AT LEAST ONE YEAR? __ Yes __ No

IS YOUR AGENCY LICENSED OR CERTIFIED BY THE STATE OR ANOTHER REGULATING BODY? If yes, identify type of license and license # if applicable.

__Yes License #_____ Type of License_____

Regulating Agency Name:_____

__No

Is your agency part of a community collaboration, coalition, task force or professional association related to the oversight or provision of your service(s)? If yes, please state:

__ Yes Name of Organization/Affiliation(s):_____

__ No

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ADDITIONAL INFORMATION: Include any additional information you wish to make known about your organization.
HOW DID YOU LEARN ABOUT THE AGING & DISABILITY RESOURCE CENTER (ADRC)?

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ATTACHMENT 2: Resource Database Inclusion Criteria Checklist

Name of Applicant Organization _____

Date of Application Review _____ Reviewed by (print)_____

Check all descriptions that apply.

1. Inclusion category (agency type) – To allow inclusion, one or more of these must apply
   This applicant is a:
   - ❑ Non-profit organization (501(c)(3) which provides, coordinates and/or advocates for a health or human service
   - ❑ Government health or human service program offered by
     - ❑ State
     - ❑ County
     - ❑ Federal
   - ❑ For-profit company offering support services to older and/or disabled adults that are scarce or not easily accessible in the public or non-profit sectors

     List the scarce service: _____
   - ❑ Self-help support group of interest to older and/or disabled adults or family caregivers
   - ❑ Agency based outside of Hawaii that meets a critical need for older adults and/or disabled adults in Hawaii. (List the need _____)
     - ❑ and is the local chapter for a national organization
   - ❑ Professional organization in the health and human service field that provide a public service
   - ❑ Social or fraternal organization of interest to the target population, which **serves non-members**
   - ❑ Professional regulatory agency in a health or human service industry
   - ❑ Information and referral service
   - ❑ Licensed adult day care program
   - ❑ Licensed and regulated nursing home, care home, assisted living facility, home health service, or hospital

2. Inclusion category (population served) – To allow inclusion, one or more of these must apply
   This applicant serves:

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- ❑ older adults (60+)
- ❑ disabled adults (18+)
- ❑ family caregivers of older and/or disabled adults
- ❑ the general public including older and/or disabled adults

3. Not Eligible Category – exclude if any one of these apply
   This applicant is a:
   - ❑ Organization that offers a service **to their members only** (e.g. some churches or social clubs)
   - ❑ Employment agency that charges a fee to applicants
   - ❑ Private lawyer, or insurance agent, or investment or banking firm, or lender, or building or home repair company, or doctor, or medical group, or private therapist, or other entity offering services which do not meet the specific inclusion criteria listed in 1 and 2 above.

4. Compliance – to be included, the agency must meet a; and if b applies, must also meet c.
   This applicant:
   - ❑ a. has been in existence in Hawaii for at least one year.
   - ❑ b. is subject to licensure or regulation by _____(regulating entity)
     - ❑ c. and has provided documentation of current licensure or regulatory compliance (i.e. license number and type of license)

5. Background check (look up on both websites):

   This applicant's name:

   ❑ has been located through the BBB website http://hawaii.bbb.org and its status is

_____

[Exclude and print out the report if BBB status is "complaint not settled" or "unable to pursue complaint" or "does not meet standard" or "unable to verify standards." Read the report as posted on the website to identify specific problems.]

   ❑ has been checked through the RICO database at http://pahoehoe.ehawaii.gov/cms/app and
   - ❑ a. there is no match (i.e., no complaints on file)
   - ❑ b. there is a complaint on file that has not been adjudicated, or has been adjudicated with no finding against this applicant (attach print-out of record on the RICO website)
   - ❑ c, there is a complaint on file that has been adjudicated with a sanction or other adverse action against this applicant (attach print-out of record on the RICO website) ***[Exclude if c applies]***

6. Determination
   - ❑ This applicant meets the criteria for inclusion in the ADRC Resource Database
   - ❑ This applicant does not meet the criteria for inclusion because
     _____ (list exclusion)

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Signature/Title of the Reviewer _____

❑ The determination letter was sent to this applicant on _____ (date)

Appendix G - Website Contents Selection Policy

Aging and Disability Resource Center Hawaii
Website Content Selection Process

Background: A core requirement of an Aging & Disability Resource Center (ADRC) is to raise awareness about aging, disability and caregiving topics. Website content provides a primary method to increase the knowledge of ADRC visitors by offering relevant information that is simple to find and easy to understand. Content may be of several forms including: educational articles, calendar events, announcements, glossary terms, guides and publications, links to external website pages and lists of frequently asked questions (FAQs).

In order to establish a consistent and quality technique for including various sources of content on the ADRC website, a selection process must be developed. The approach should be followed when considering any new content source, throughout the life of the ADRC.

Purpose: To establish a set of standard guidelines for determining appropriateness or relevancy of content to be included in ADRC Hawaii's website. This policy covers content for various sections of the website including Quick Links & News, Announcements, Calendar, Browse Library, Apply for Assistance and Frequently Asked Questions (Access Our Services). A separate inclusion/exclusion policy exists for the service provider database (Find Services).

Process:

1. Identify available sources of informative content.
2. Categorize suitable content for most effective placement. Indicate the primary/secondary locations (e.g., Library, Apply for Assistance, FAQs, Glossary, Calendar, Announcements, Quick Links & News). Library and Apply for Assistance sections have secondary locations (e.g., "Browse Library- Housing– Long Term Care Facilities" or "Apply for Assistance-Financial Assistance Programs)
3. Add new content to appropriate section(s) of website. Archive old content.
4. Review, edit, update content on a regular basis (see "ADRC Website Maintenance Responsibilities" for description and schedule of activities)

Consider the following criteria when determining suitability of content:

A. Does the content increase awareness of a designated ADRC population? (Seniors 60 years or older, adults (18+) with disabilities, caregivers of any age)
B. Is the content concise and easy to understand?
C. If not currently concise, can it be re-written without violating copyright laws?
D. Is the content not a duplicate?
E. Is the content source authoritative?
F. Is the content relevant TODAY? (i.e. versus 10 years ago)

Consider the following criteria when categorizing each content element:

A. What primary/secondary section should the content be located? For example, a user can drill down several levels in the Library and Apply for Assistance sections ("Library- Housing– Long Term Care Facilities" or "Apply for Assistance-Financial Assistance Programs)
B. Does the content provide information that will be of significant relevance to an issue commonly faced by an elder person?
C. Does the content provide information that will be of significant relevance to an issue commonly faced by a person with a disability?
D. Does the content provide information that will be of significant relevance to an issue commonly faced by a caregiver?

General Usage Guidelines:

- Be selective in the information that is included. Examples of suitable sources of authoritative content include federal, state and local government agencies (e.g., Administration on Aging, Centers for Medicare and Medicaid Service, State Units on Aging, AAAs), national associations and organizations (e.g., AARP, Alzheimer's Association, American Cancer Society, National Council on Aging), well-known and respected academic institutions and centers (e.g., UH Center on Aging) and local, state or national media outlets (Honolulu Advertiser/Star Bulletin, NY Times, CNN, etc).
- Present information in a way that is easy to use and highly relevant to an individual's needs (i.e., organize the content so that it can be browsed efficiently).

Specific Inclusion/Exclusion Criteria for Calendar Events and Announcements:

The Calendar and Announcements sections shall only include events and announcements intended for ADRC target audiences (those 60 and older, 18 and older with a physical disability, caregivers).

Inclusion criteria are as follows:

1. Events sponsored by government and non-profit agencies that provide assistance for the targeted populations. No attempt will be made to list all events sponsored by government and non-profit agencies.
2. Sponsoring agencies are certified, licensed or accredited by the appropriate levels of government, as applicable;
3. Sponsoring agency, community coalition or advocacy group does not charge fees or charges a nominal fee or discounted rates.
4. Self-help support groups do not charge a fee or charge a nominal fee.
5. Events sponsored by for-profit, commercial or private organizations will be considered on an individual basis. Evaluation of inclusion is based on the following:
    - Uniqueness of service (e.g., specially targeted services or services that are otherwise difficult to access);
    - Financial eligibility (event is free or offers scholarships, reduced fees, sliding fee scale);
    - Lack of comparable services in the public, non-profit sector;
    - Demonstrated need for services.

Exclusion: The AAA/ADRC reserves the right to exclude any event/announcement. **Exclusion criteria are as follows:**

1. Any agency or group that knowingly or unknowingly discriminates or denies services that violates local, state or federal laws and regulations.

2. Any agency, group or person that misrepresents their services in any way or provides misleading or fraudulent information to the public.
3. Churches, service groups (e.g., Rotary), elected officials, individuals or other organizations that offer no special service to the target populations.
4. Support groups offered by private practitioners for which there is a fee to pay the leader for his/her time.

Definitions:

A. **Aging/Elderly/Older Adult/Senior** – content as it relates to a situation or issue commonly faced by an older adult. Examples include articles, website links, publications or FAQs about long term care planning (e.g., living wills, trusts, advance directives, LTC insurance), reverse mortgages, care options in the home/community or a facility (e.g., adult day care, chore/homemaker services, home health, assisted living, skilled nursing, etc), understanding health insurance (Medicaid, Medicare, private insurance -HMO, PPO, etc), general health or how to maintain one's physical and mental health (nutrition, exercise, CDSMP, recognizing depression), how to stay connected to the community (e.g., employment, volunteerism, education/life long learning).

B. **Disability** – content as it relates to a situation or issue commonly faced by a person with a disability. Examples include articles, website links, publications or FAQs about the Americans with Disabilities Act, disability housing laws, universal design, assistive technologies, peer counseling, etc. Initial content should focus on adults (18 years or older) with a physical disability. Overtime, the goal is to expand ADRC content to include other types of disabilities. The definition of "physical disability" varies under federal and state statute and across community programs. Since the definition of disability in the Social Security Act (SSA) is the most stringent, it can be used as a default guideline: "The inability to engage in substantial gainful activity because of a medically determinable physical or mental impairment, which can be expected to result in death or last for a continuous period of at least 12 months." An example of a less stringent definition is, "a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such impairment." (Department of Housing and Urban Development).

C. **Caregiving** – content should be categorized as "Caregiving" if it is a potentially relevant "caregiver" topic that would either:
    a. Offer information that directly improves the welfare or wellness of the caregiver, or
    b. Provide caregiving advice on aging and or disability issues, when written from the perspective of the caregiver.

    Examples include articles/links about coping, how to be a better caregiver and self care/stress relief options such as support groups, exercise/meditation techniques, etc)

Purpose of Website Sections and Examples of Suitable Content

- Access Our Services
- Quick Links & News

- Browse Library
    - Glossary
- Find Services
- Apply for Assistance
- About Us
    - Newsletters
    - Contact Us
    - Announcements
    - Calendar

Appendix H - Management Information Systems Plan

Appendix I - Evaluation Handbook

Appendix I

ADRC

Evaluation Handbook

ADRC Evaluation Handbook

Table of Contents

Steps to completing your own evaluation

Setting up a committee It is difficult to evaluate yourself. For your own sanity as well as a degree of objectivity set up an evaluation committee and develop a plan for your evaluation with their assistance. Faculty from your local college may be able to help or perhaps a graduate student might be willing to undertake a portion as a research project. We have attached the evaluation plan drafted plan for Oahu and Hawaii as a guide; yours will not be as elaborate but some parts of it may be useful. In addition the Lewin group has provided guidelines and priorities for program evaluation which can found on the national ADRC website; some of the less lengthy documents are also attached here. Following are the basic steps from that plan that you may wish to undertake in completing an evolution of your ADRC. The evaluation of the two existing ADRC's contained two components : (a) a process evaluation and (b) an impact evaluation.

Process Evaluation The process evaluation consists of your own assessment of the process in getting the ADRC set up as well as a counts of your accomplishments (How many people did you serve? What were their characteristics? What services did you provide etc etc.) This part of the evaluation of the ADRC's for HCOA and EOA had three parts, any or all of which you may find useful:

(1) An assessment of whether or not the project met its own goals
(2) Collection of client and caregiver information and
(3) Summary of services provided.

(1) Meeting Project Goals Overall These are questions to address yourself in order to determine if you are satisfied with the process you used to implement the ADRC in your county. Questions could include:

- Did the project manage to establish a unified or at least compatible method of establishing a process for screening, intake, assessment and eligibility determination of the clients eligible for long term care services?
- Were Medicaid, AAA, physical disability service providers and other stakeholders represented in this process?
- Were resources from these stakeholders committed to the process of reorganization of services?
- Was the objective of streamlining the paper work of eligibility and more effectively meeting client needs achieved?

(2) Client information – Unduplicated counts of the characteristics of elders served and caregiver data can be collected through a process of extracting information from the SAMS2k and NAPIS data bases. These data are to be collected under the minimum data set specifications provided by Lewin et al (see "ADRC Priority levels for minimum data set" document following this). A subset of these fields is used to complete the semi-annual report (SART) which in on-line in an excel format.

(3) Service Units and Types Again the SAMS and NAPIS data bases contain this information and you will need to develop a method to extract it from those data bases ; however it should be noted that all three of the core data bases are needed

to provide all the information requested in the minimum data set specifications. In addition it cannot be automatically generated; if for instance you wish to know how many Japanese clients had case managers you may need to go crops tab between two modules.

Impact Evaluation The impact evaluation should address the impact of the ADRC program on the consumers and their caregivers. The impact portion of the evaluation could include: (1) outcome measures in the MDS; (2 a and b) a measure of satisfaction with the ADRC (3) a measure of change in the experience of service providers and (4) web-based measures.

1. MDS Data Collection Following a review of all the data collection systems a grid has been devised summarizing the MDS fields and comparing then with local NAPIS and SAMS data fields (see attached). This initial review found that approximately 50% of the data are currently available from these sources.
2. Consumer and caregiver satisfaction survey

(a) Either a randomly selected subset of existing consumers taken from your intake information can be surveyed pre and post implementation of your ADRC (see specific instructions for surveys) you can distribute this same survey to potential long term care consumers as well as potential or actual spousal caregivers.

(b) The second portion of this part of the evaluation can involve the use of focus groups of selected consumers. These groups will provide a baseline measure of potential or actual consumer of knowledge of the long term care system and (if they have used it) their experiences with accessing and utilizing services. Follow-up focus groups can then be run to compare change over time in access to services. (See attached for sample focus group script and blinded results of one group).

3. A county wide service provider survey can also be undertaken. The evaluation team developed a phone survey of service providers to assess baseline (pre ADRC) provider knowledge of the service referral process as well as number of clients served annually and the current length of agency waiting lists, if any (see attached). This along with questions assessing the service providers perceptions of access and quality of services currently offered in their region will provide you with additional information on the impact of the ADRC from a providers rather than a consumer perspective.
4. Items should be developed that make use of web technology. Although we assume that few elders will use this method and we would not recommend this as the sole method of evaluation, focus groups indicated that a wider number than might be expected use the internet to search for service. When they do the search you can automatically record the number of hits to the website and create a pop-up encouraging them to provide some brief demographic information (age, ethnicity, gender, elder /disabled or caregiver) as well as the reason for accessing the site (need information, need a specific service(name) etc) and whether or not they got what they needed). Web based items that should be collected at a minimum would include:
    a. the number of web site hits
    b. basic demographics on the user
    c. reason for accessing the site
    d. a measure of satisfaction

Closing the loop The final step in completing the evaluation process is closing the loop; that is using the information you have obtained for program improvement purposes. For instance in the consumer satisfaction survey undertaken in Hawaii County, the one service that clearly emerged as a problem was transportation. Virtually all other services consumer were satisfied with as well as the responsiveness of the office itself. Thus it created a clear priority for Hawaii County to examine their transportation services and see if improvements could be made. Feedback sessions led by the evaluator or the evaluation team should be held at least twice a year to update programs on evaluation findings and these finding should then be used to adjust, improve or modify program services. Examples of findings form the baseline consumer satisfaction, focus group and service provider surveys for Oahu and Hilo are included in this packet to give you an idea of how the results of these surveys might look in your own county. In addition it gives you the opportunity to compare your results with theirs

Areas required for the semi-annual report: ADRC project

All answers should reflect the last six months of service

1. Consumer contacts – average number of times by same person _____

2. Consumer characteristics – (#s in each category)

Gender m__ f__,
Average age_____,
Urban/rural _____
Poverty or not_____,
Live alone or not_____
Ethnicity

- O Native Hawaiian_____
- O Samoan_____
- O Tongan
- O Fijian
- O Japanese
- O Chinese
- O Korean
- O Hispanic
- O African-American
- O Other (specify)_____

3. Average Number of ADL impairments (bathing, eating, transferring, mobility, toileting)

1 impairment_____2 impairments_____ 3 impairments_____ 4 impairments_____

4. Number Elderly_____

5. Number Physically disabled _____

6. Caregiver contacts – average number of times by same person_____

7. Caregiver characteristics – (#s in each category)

Gender m__ f__,
Average age_____,
Urban___rural___
Ethnicity

- O Native Hawaiian_____
- O Samoan_____
- O Tongan_____
- O Fijian_____
- O Japanese_____
- O Chinese_____
- O Korean_____
- O Hispanic_____

O African-American_____
O Other (specify)_____

Grandparents caring for grandchild_____
Relationship to care recipient
Spouse_____
Adult child_____
Sibling_____
Other relative_____
Non relative_____

5. New contacts (people contacting the ADRC for the first time)_____

6. Repeat contacts (people contacting this ADRC for the second time or more)_____

7. . Provider or professional contacts - both telephone and in person _____

8.. Total contacts (and total contacts by number of full time staff)_____ _____

9.. Unduplicated individuals contacting ADRC_____

10. Who referred them to ADRC?
Self_____
Family member_____
Friend or neighbor_____
Health care or social service professional_____
Other_____

11. Reasons for seeking help
No knowledge of available services_____
Physical or mental frailty_____
Burdened caregiver_____
Needed placement in long term care facility_____
Help to remain in community_____
Other *please specify* (1)_____

Other *please specify* (2)_____

12. Type of help sought
Information only_____
Service eligibility_____
Needed community services_____
Needed services in the home_____
Long term care question_____
Financial or legal assistance_____
Case management _____
Other *please specify* (1)_____

Other *please specify* (2)_____

Note: Types of help available

- Standard categories include congregate meals, nutrition counseling, assisted transportation, case management, personal care, home delivered meals, homemaker chore, adult day health, legal assistance, information and referral, outreach)
- Optional categories include escort (w/out transportation), health screening and maintenance, exercise physical fitness, health education and promotion, recreation, friendly visiting, telephone reassurance, literacy language assistance, education/training, counseling, housing assistance, attendant care
- Caregiver categories also include counseling, support groups, caregiver training, respite care , access services, information services and supplemental services
- Possible new series under ADRC include benefits counseling (for SSI food stamps etc) futures planning (long term finances) intensive I and R with one to one face to face contact with care recipient or caregiver, advocacy intervention, crisis intervention, follow-up, options counseling (assisting with applications , advocacy for needed services etc)

13. Number and types of referrals made (select from list of service types above)

Type 1_____	#_____	Type 10_____	#_____
Type 2_____	#_____	Type 11_____	#_____
Type 3_____	#_____	Type 12_____	#_____
Type 4_____	#_____	Type 13_____	#_____
Type 5_____	#_____	Type 14_____	#_____
Type 6_____	#_____	Type 15_____	#_____
Type 7_____	#_____	Type 16_____	#_____
Type 8_____	#_____	Type 17_____	#_____
Type 9_____	#_____	Type 18_____	#_____

14. Service units of each type of help provided (hours, meals, trips, etc)

Type 1_____	# units_____	Type 10_____	#units_____
Type 2_____	# units _____	Type 11_____	#units_____
Type 3_____	# units _____	Type 12_____	# units_____
Type 4_____	# units _____	Type 13_____	# units_____
Type 5_____	# units _____	Type 14_____	# units_____
Type 6_____	# units_____	Type 15_____	# units_____
Type 7_____	# units _____	Type 16_____	# units_____
Type 8_____	# units _____	Type 17_____	# units_____
Type 9_____	# units _____	Type 18_____	#units_____

(Any follow-up done? Did they receive the help they needed?)

15. Total number of hits made to internet website and average number per month_____

_____

(any online applications available? if so how many were filled out?_____)

16. Number of level of care assessments made (to assess an individual's need for long term care services) Include reasons and outcome

LOC Assessment 1

_____

_____

_____

LOC Assessment 2

_____

_____

_____

LOC Assessment 3

_____

_____

_____

LOC Assessment 4

_____

_____

_____

LOC Assessment 5

_____

_____

_____

(use more sheets if necessary)

17. Number of financial determinations of eligibility made_____

ADRC Priority Levels for Minimum Data Set

This document and table was prepared by Lewin in response to several requests from grantees for more guidance regarding the data they need to collect and report to AoA/CMS through the Semi-annual Reporting Tool (SART). The table below presents the ADRC Minimum Data Set (MDS) Elements as they were outlined in the *2004 Evaluation Guidelines for Assessing ADRC Project Progress and Accomplishments* side-by-side with the SART question or questions designed to capture these data.

In the last column of the table, each data element is assigned a priority ranking of *Highest, Medium* or *Low*. These priority rankings are designed to assist grantees in focusing their data collection efforts on the elements of the Minimum Data Set that are of the highest priority for AoA/CMS, and to assist grantees in prioritizing enhancements they might make to their information technology systems. Underneath the priority rankings in the last column, we have included additional guidance and explanation of these data elements and further instruction on how to report these data on the SART.

#	MDS Element	SART Section	SART Question(s)	Priority Level
1	# of contacts (telephone, web inquiries)	**BASELINE DATA**	Total # of Contacts Made to this Entity during this period.	**HIGHEST PRIORITY** This question is designed to provide a point of comparison between contact volume before and after ADRC implementation. Ideally, baseline data should be collected and reported for a period of time prior to ADRC implementation. This may involve putting together data from reporting systems for other programs or using historical service records. If you do not have access to any pre-ADRC data from your pilot sites' operating organization(s), you should report data for a period of time immediately after ADRC implementation using the OUTCOMES DATA section of the SART.
2		**BASELINE DATA**	Total # of Unduplicated Individuals Served in this period.	**LOW PRIORITY** This question was not part of the 2004 MDS, but was added to the SART at the request of several grantees who routinely collect this information and want to report it.
3		**BASELINE DATA**	What types of services were available to these Contacts (for example, Information and Referral, Benefits Counseling, Case Management)?	**LOW PRIORITY** This question was not part of the 2004 MDS, but was added to the SART to provide an additional point of comparison with pre- and post-ADRC service activities.

#	MDS Element	SART Section	SART Question(s)	Priority Level
4	# and types of outreach activities	**BASELINE DATA**	Describe the number and types of consumer outreach activities undertaken by this Entity. For example, brochures, direct mailings, website development, outreach to providers and other critical pathways, public service announcements, newspaper advertisements, and public forums.	**MEDIUM PRIORITY** This question is designed to provide a point of comparison between the types and intensity level of outreach activities before and after ADRC implementation.
[redacted]	Avenues & steps to apply for public programs (flow chart of steps – organizations, staff, methods of information exchange, time) • clinical eligibility determination • financial eligibility determination	**BASELINE DATA**	Upload your flow chart, description or diagram depicting the avenues and steps to apply for public programs, BEFORE and AFTER ADRC implementation.	**HIGHEST PRIORITY** This flow chart will demonstrate how your ADRC will improve or streamline access to public programs from the perspective of ADRC clients.
[redacted]	# of contacts by new versus repeat-- based on response to standard question of all contacts -- "Have you contacted us before?"	**OUTCOMES DATA – Basic Contacts**	# of New Contacts including Consumers, Caregivers, Professionals, and Others. ("New Contacts" are made by individuals whom, to your knowledge, have not contacted the ADRC before.) # of Repeat Contacts including Consumers, Caregivers, Professionals, and Others. ("Repeat Contacts" are made by individuals known to have contacted the ADRC before.)	**HIGHEST PRIORITY** Adding the number of new and repeat contacts together will provide the total number of contacts made to the ADRC. If you do not ask callers whether they have contacted you before, you should record anonymous or unknown callers as "new" contacts. Please keep in mind that this may make your marketing/outreach efforts appear to be more effective than they are (to the extent that you consider "new" contacts a proxy for successful marketing efforts).

#	MDS Element	SART Section	SART Question(s)	Priority Level
7	# of contacts by type of caller -- based on response to standard question of all contacts -- "Are you a consumer, caregiver or provider/ professional?": • Consumer • Caregiver • Professional	**OUTCOMES DATA – Basic Contacts**	# of Contacts made to the ADRC by Providers or Professionals.	**HIGHEST PRIORITY** This question is designed to capture the extent to which your ADRC is visible and trusted by providers and professionals. It may also speak to the effectiveness of your marketing/ outreach activities along "critical pathways."
		OUTCOMES DATA – Consumer Contacts	Adding all the "Main Age and Disability Category" contacts (including Unknown contacts) on the Consumer Contacts page should provide the total number of contacts known to have been made by consumers.	**HIGHEST PRIORITY** These questions are designed to capture the extent to which your ADRC is serving consumers in your target groups. They may also speak to your ADRC's levels of visibility and trust among your target groups.
		OUTCOMES DATA – Caregiver Contacts	Adding all the "Main Age and Disability Category" contacts (including Unknown contacts) on the Caregiver Contacts page should provide the total number of contacts known to have been made by caregivers on behalf of consumers in these main categories.	**HIGHEST PRIORITY** Although these questions ask about *caregivers*, they are also designed to capture the extent to which your ADRC is serving *consumers* in your target groups. They will help you determine whether your calls are coming primarily from caregivers of older adults or from caregivers of younger people with physical disabilities, for example. They may also speak to your ADRC's levels of visibility and trust among your target groups and their families.

#	MDS Element	SART Section	SART Question(s)	Priority Level
8	For the measures above, reports would be generated by target group (age 60+, physical disability, developmental disability, mental disorder and other disability) and NAPIS groupings of low income, minority and frail.[1]	**OUTCOMES DATA – Consumer Contacts and Caregiver Contacts** (Please apply the same priority ranking to the set of almost identical questions in the Consumer Contacts section and Caregiver Contacts section.)	**Main Age and Disability Categories:** Total # of Contacts Made by Consumers Over Age 60 Total # of Contacts Made by Consumers with No Disability and Under Age 60 Total # of Contacts Made by PD Consumers Under Age 60 Total # of Contacts Made by MR-DD Consumers Under Age 60 Total # of Contacts Made by MI Consumers Under Age 60 Total # of Contacts Made by Consumers with Other Disability Under Age 60 Total # of Contacts Made by "Unknown" Consumers. (Contacts made by Consumers about whom no demographic information is known.)	**HIGHEST PRIORITY** The "Main Age and Disability Categories" for contacts should be reported ONLY to the extent that this information is provided spontaneously by callers or asked for as part of your standard I&R protocol. I&R callers/walk-ins DO NOT need to be asked to provide this information specifically, unless asking for it is otherwise part of your standard I&R protocol, or is appropriate or necessary for service delivery. If you know a caller was a consumer, but they did not provide any additional demographic data you should report them as an "unknown" consumer. Similarly, if you know a caller was a caregiver, but they did not provide any demographic data about the consumer they care for, you should report them as an "unknown" caregiver.
		OUTCOMES DATA – Consumer Contacts and Caregiver Contacts	For all the Main Age and Disability Categories above, the following sub-categories from NAPIS are listed: • Minority • Low-income • Frail	**MEDIUM PRIORITY** Characteristics beyond target population (the main age and disability categories) should be reported ONLY to the extent that this information is provided spontaneously by callers or asked for as part of your standard I&R protocol. I&R callers/walk-ins DO NOT need to be asked to provide this information specifically, unless asking for it is otherwise part of your standard I&R protocol, or is appropriate or necessary for service delivery.

1 The SART only asks grantees to break down consumer and caregiver contacts by target group. It does not ask grantees to break down the number of professional contacts by target group.

#	MDS Element	SART Section	SART Question(s)	Priority Level
		OUTCOMES DATA – Consumer Contacts and Caregiver Contacts	For all the Main Age and Disability Categories above, the following sub-category is listed: • Unduplicated # of Individual Consumers	**LOW PRIORITY** This question was not part of the 2004 MDS, but was added to the SART at the request of several grantees who routinely collect this information and want to report it. Comparing the number of unduplicated individuals served with the number of contacts may speak to how many "contacts" become "cases," and how many contacts an ADRC receives, on average, per individual served.
9	# of contacts by source of referral -- based on response to standard question of all contacts -- "How did you hear about us?":	**OUTCOMES DATA – Source of Referral**	For each of the following Sources of Referral, enter the number of Contacts made directly to the ADRC by Consumers, Caregivers and Professionals who heard about the ADRC from that source. Enter the total number of Contacts who were referred by or from these sources during the reporting period you specified (Newspaper, HCBS or Social Organization, Brochure, etc.)	**HIGHEST PRIORITY** You might collect this information on the day of contact or through a consumer satisfaction survey that follows service provision. This question is asked in order to determine the relative effectiveness of the various marketing/outreach activities used by grantees. If you only ask this question of a sample of your total contacts, you should use the open entry field at the bottom of this page on the SART to specify what size sample you used.
10	# of contacts per FTE providing I&R, assistance, intake & eligibility	**ACTIVE AND PLANNED PILOTS**	Please provide the number of Full Time Equivalents (FTEs) currently working in each job category at this Pilot Site.	**HIGHEST PRIORITY** This element of the 2004 MDS is not asked for separately in the SART because it can be calculated using answers from three other questions in two sections of the SART. This ratio (# of contacts/# of FTE) is designed to illustrate how many staff members each ADRC devotes to meeting consumer demand for services. In calculating the # of FTEs, you should count all employees who fulfill ADRC functions regardless of who pays them and regardless of when they started working (pre- or post-ADRC grant award). If this Pilot Site is being operated by different organizations in different physical locations, please add together the number of FTEs in all locations.
		OUTCOMES DATA – Basic Contacts	# of New Contacts including Consumers, Caregivers, Professionals, and Others. ("New Contacts" are made by individuals whom, to your knowledge, have not contacted the ADRC before.) # of Repeat Contacts including Consumers, Caregivers, Professionals, and Others. ("Repeat Contacts" are made by individuals known to have contacted the ADRC before.)	

#	MDS Element	SART Section	SART Question(s)	Priority Level
11	# of contacts/1,000 service area population	**ACTIVE AND PLANNED PILOTS**	Total Population in Service Area of Pilot Site	**HIGHEST PRIORITY** This element of the 2004 MDS is not asked for separately in the SART because it can be calculated using answers from these two sets of existing questions. This ratio (# of contacts/ population) is meant to illustrate the extent to which the ADRC is known about and used by residents in the service area.
		OUTCOMES DATA – Basic Contacts	# of New Contacts including Consumers, Caregivers, Professionals, and Others. ("New Contacts" are made by individuals whom, to your knowledge, have not contacted the ADRC before.) # of Repeat Contacts including Consumers, Caregivers, Professionals, and Others. ("Repeat Contacts" are made by individuals known to have contacted the ADRC before.)	
12	# of contacts by type of assistance provided	**OUTCOMES DATA – Type of Assistance**	For each of the following Types of Assistance provided by the ADRC, enter the number of Contacts made to the ADRC by Consumers, Caregivers, or Professionals that resulted in this Type of Assistance being provided. More than one Type of Assistance may be selected for one Contact if more than one distinct type of service was provided on one occasion.	**HIGHEST PRIORITY** You should be able to answer this question about every contact made to the ADRC. The categories are designed to be mutually exclusive so that most contacts will fit in one category of assistance type alone. However, if more than one type of assistance was provided at the time of contact, you should count that contact in more than one category. Please keep in mind that *referrals* are distinguished from giving people *information*, in that the resource center refers the caller to other services or resources, or is actively involved in obtaining a service or resource for a caller.
13	Website Activity – average hits per month; number of online applications (if applicable)	**OUTCOMES DATA – Basic Contacts**	Average # of Internet Contacts or "hits" on your ADRC website per month (if applicable).	**HIGHEST PRIORITY (BUT ONLY IF APPLICABLE)**

#	MDS Element	SART Section	SART Question(s)	Priority Level
14	# of institutional Level of Care determinations among individuals that contacted the ADRC and in the ADRC service area by target group and reason for conducing LOC (initial, change in condition, annual recertification)	**OUTCOMES DATA – Long-term Outcomes**	# of institutional Level of Care (LOC) determinations among individuals age 60 and over by reason for conducting the LOC # of institutional Level of Care (LOC) determinations among individuals in your second target population (or all consumers under age 60) by reason for conducting the LOC	**HIGHEST PRIORITY** For the SART, this element of the MDS has been changed to an either/or question. You should report the totals **EITHER** for individuals who contacted the ADRC, **OR** for all individuals living in the ADRC service area. Please keep in mind that tracking ADRC clients through the long term care support and service system is a goal of the ADRC grant. In moving toward meeting this "client tracking" goal, these outcomes should be included in the data elements you plan to track. The Long-term Outcomes questions are designed to capture information about the usage of institutional and HCBS services in a service area after the implementation of the ADRC.
15	# of institutional LOC determinations among individuals that contacted the ADRC and in the ADRC service area by setting (home, hospital, assisted living, other residential alternative, nursing facility)	**OUTCOMES DATA – Long-term Outcomes**	# of institutional Level of Care determinations among individuals age 60 and over by setting # of institutional Level of Care determinations among individuals in your second target population (or all consumers under age 60) by setting	**HIGHEST PRIORITY** You should report these outcomes **EITHER** for individuals who contacted the ADRC, **OR** for all individuals living in the ADRC service area. Please keep in mind that tracking ADRC clients through the long term care support and service system is a goal of the ADRC grant. In moving toward meeting this "client tracking" goal, these outcomes should be included in the data elements you plan to track. The Long-term Outcomes questions are designed to capture information about the usage of institutional and HCBS services in a service area after the implementation of the ADRC.

#	MDS Element	SART Section	SART Question(s)	Priority Level
16	# of financial eligibility determinations among individuals that contacted the ADRC and in the ADRC service area	**OUTCOMES DATA – Long-term Outcomes**	# of Financial Eligibility determinations made (including those that resulted in approval and denial of eligibility)	**HIGHEST PRIORITY** You should report the totals **EITHER** for individuals who contacted the ADRC, **OR** for all individuals living in the ADRC service area. Please keep in mind that tracking ADRC clients through the long term care support and service system is a goal of the ADRC grant. In moving toward meeting this "client tracking" goal, these outcomes should be included in the data elements you plan to track. The Long-term Outcomes questions are designed to capture information about the usage of institutional and HCBS services in a service area after the implementation of the ADRC.
17	# enrolled in Medicaid or other programs among individuals that contacted the ADRC and in the ADRC service area	**OUTCOMES DATA – Long-term Outcomes**	HCBS Waiver Enrollment -- average monthly number of individuals in the total target population in waivers and receiving services during the reporting period. Institutional Care Use -- average monthly number of Individuals in nursing facilities, ICF-MR or IMD in the total target population receiving services during the reporting period. Other Program Enrollment -- average monthly number of Individuals in the total target population receiving OAA or state funded services during the reporting period.	**HIGHEST PRIORITY** You should report these outcomes **EITHER** for individuals who contacted the ADRC, **OR** for all individuals in the target population living in the ADRC service area. Please keep in mind that tracking ADRC clients through the long term care support and service system is a goal of the ADRC grant. In moving toward meeting this "client tracking" goal, these outcomes should be included in the data elements you plan to track. The Long-term Outcomes questions are designed to capture information about the usage of institutional and HCBS services in a service area after the implementation of the ADRC.

#	MDS Element	SART Section	SART Question(s)	Priority Level
18	Customer satisfaction with the objectivity, reliability, comprehen-siveness, currency & usefulness of information, focusing on: • responsive to needs • preferences & unique circumstances, • information being simple & clear • simplicity of applying for services • reduced frustration & confusion • interaction with ADRC staff	**CONSUMER SATIS-FACTION**	How many Consumer Satisfaction surveys were distributed or conducted during this reporting period? What percentage of those distributed surveys were completed and returned? Please describe, in general, what you have learned about your ADRC program from the completed surveys? In other words, what are consumers telling you about their experiences with the ADRC? Please include both negative and positive feedback. Please describe any changes you have made or will make to procedures, policies, staff training, and outreach efforts based on consumer feedback.	**HIGHEST PRIORITY** While the *2004 Evaluation Guidelines* includes a recommended set of questions to use for ADRC consumer satisfaction surveys, you are free to decide what strategy you will use to collect data and what measures you will use to determine the level of satisfaction among those who contact your ADRC. The SART questions are general so you can report on whatever strategy or measures you use.
19	Testimonials	**CONSUMER SATIS-FACTION**	Please use this space to share quotes or testimonials from consumers.	**LOW PRIORITY** Consumer testimonials may give you new information about your ADRC, or they may confirm what is already known. They may be particularly useful in making a case to the public and policy makers about the value of the ADRC.

Measuring consumer satisfaction

Consumer Satisfaction Survey

Instructions:
Please check the appropriate answer for the following questions. RETURN THE SURVEY IN THE ENCLOSED ENVELOPE. A research assistant will check with you on the phone in a few weeks to answer any questions you may have.

1. Did you contact us for services for yourself or are you a caregiver? (check one)

   a. Self ____
   b. Caregiver ____
   c. Other ____

***If your answer is 'CAREGIVER' complete ALL questions for ALL sections.**
****If your answer is 'SELF' skip ahead to "Section II: Care Recipient" section.**

Section I: Caregivers

1. What is your gender? (check one)

   Male ____ Female ____

2. What age category do you fall into: (check one)

   ____ 18-30
   ____ 31-40
   ____ 41-50
   ____ 51-60
   ____ 61-70
   ____ 71-80
   ____ 81-90
   ____ 91 plus

3. What is your ethnicity? _____

4. What is your relationship to the care recipient? (check one)

   ____ Spouse
   ____ Adult child
   ____ Other relative
   ____ Friend/ Neighbor
   ____ Paid caregiver
   ____ Other

5. How long have you been a care provider for the care recipient? ___ (years) ___ (months)

6. Does the care recipient live with you? Yes ____ No ____

7. Are you employed? (check one)
   ____ Full time
   ____ Part time
   ____ Unemployed
   ____ Retired

8. Does the person you care for need assistance with:
   Managing finances? Yes ____ No ____
   Transportation? Yes ____ No ____
   Cooking or meal preparation? Yes ____ No ____
   Arranging for medical care? Yes ____ No ____

9. Does the person you care for need assistance with:
   Eating? Yes ____ No ____
   Dressing? Yes ____ No ____
   Bathing? Yes ____ No ____
   Getting to the bathroom? Yes ____ No ____
   Walking? Yes ____ No ____

<u>Section II: Care Recipient</u> (To be completed by those who contacted HCOA for themselves or Caregivers please complete for care recipient)

1. What is the gender of the care recipient? Male ____ Female ____ (check one)

2. What is the care recipient's country of birth? _____

   3a. If not the U.S. what year did he/she or you move here? ____ (please use 4-digit year)

3. What age category does the care recipient fall into:
   ____ 18-30
   ____ 31-40
   ____ 41-50
   ____ 51-60
   ____ 61-70
   ____ 71-80
   ____ 81-90
   ____ 91 plus

4. What is the care recipient's primary ethnicity? _____ (please provide primary only)

   4a. What is the care recipient's preferred language?
   _____

5. Does the care recipient live alone? Yes ____ No ____

5a. If no, whom does the care recipient live with?

_____

6. What type of housing does the care recipient live in? (check one)

____ Own home
____ Care giver's home
____ Foster care RCFE or assisted living facility
____ Nursing Home
____ Other

7. What is the care recipient's marital status: (check one)

____ Married /partnered
____ Divorced /Single /Widowed
____ Other: _____

Section III: Satisfaction with Hawaii County Office of Aging Questions (To be completed by ALL survey participants)

1. How did you hear about Hawaii County Office of Aging?

_____

2. How many times have you called or gone into the Hawaii County Office of Aging within the past six months? ____ (number of times)

3. How quickly was your call answered; in how many rings? (circle one)

0	1	2	3	4	5
Not answered	One ring	two rings	three rings	four rings	five or more

4. If you left a message, when did a person call you back? (check one)

____ Within the hour
____ Within the day
____ Within a week
____ Within two weeks
____ Not sure/don't remember

5. If you came into the Hawaii County Office of Aging how long did you have to wait to see someone? (check one)

____ Less than five minutes
____ Under half an hour

____ About half an hour
____ An hour or so
____ More than an hour

6. When you called or came to the Hawaii County Office of Aging what was the reason?

_____
_____
_____
_____

7. On a scale from one to five was the information provided to you about our services clear? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

8. On a scale from one to five how helpful was the person you spoke to? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

9. On a scale from one to five how courteous was the staff who gave you information about the services? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

10. On a scale from one to five how knowledgeable was the person who provided you with information about services? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

11. Overall how would you rate your satisfaction with Hawaii County Office of Aging? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

12. Would you say that the Hawaii County Office of Aging staff understood and respected your culture? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

13. Would you recommend the Hawaii County Office of Aging to a friend or member of your family?

Yes ____ No _____ Other answer: _____

14. After you spoke to the Hawaii County Office of Aging were you able to get services from another agency? Yes ___ No ___

***If your answer is 'YES' Continue**

****If your answer is 'NO' Skip ahead to "Section IV: Closing"**

15. If yes, what agency or service was it? (Check all that apply)

____ Meals on Wheels
____ Hospice
____ Home health care
____ Transportation
____ Nursing Home Ombudsman
____ Mental Health services
____ Other: _____
____ Medicaid
____ Nursing Home Without Walls
____ Legal Services
____ In home support services
____ Adult Day Health Care
____ Caregiver support group

16. If you were qualified for services, how long did it take from when you first applied for services until you began receiving them? (check one)

____ Under a week
____ 2-3 months
____ Don't know/can't remember
____ About a month
____ More than 3 months
____ Never got them

17. On a scale from 1 to five, if you received services from an agency, how difficult was the process of obtaining them? (circle one)

1	2	3	4	5
not at all	a little	somewhat	very	extremely

18. What were some of the things that the Hawaii County Office of Aging could have done to make the process easier or the services better? (Check all that apply)

____ Clearer financial guidelines
____ Longer hours/weekend hours/evening hours
____ Easier application procedures
____ Multi-cultural/multi-lingual staff
____ Someone to keep an eye on care recipient for you
____ Better quality of service provided
____ More services
____ Timeliness of service provided
____ More knowledgeable staff
____ More courteous staff
____ Improve physical environment (cleaner, less hectic, more pleasant, etc.)
____ Billing issues
____ Other: _____

Section IV: Closing (To be completed by ALL survey participants)

Thank you for taking the time to answer this survey. We will use your answers to help improve the way services for elders are delivered in the future. Are there any last comments you would like to make?

_____

_____

_____

_____

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STATE OF HAWAI'I ADRC PROJECT
INFORMED CONSENT FORM

A. PURPOSE AND BACKGROUND OF STUDY

The purpose of this study is to understand how the State of Hawai'i may better serve its older adults by helping people to more easily find needed long term care services. The Principal Investigator for the study is Pam Arnsberger, Ph.D. at the University of Hawaii (arnsburg @ Hawaii.edu or (808) 956-9892). You are being asked to participate in the study because you contacted the Hawai'i County Office of Aging for information or assistance in the last year for yourself or for the person you care for.

B. WHAT YOU ARE ASKED TO DO IF YOU PARTICIPATE IN THE STUDY:

You are asked to fill out the enclosed survey. There is one section for the person receiving care and one for the caregiver. You only need to fill out part(s) that apply to you. It should take about 15 minutes to do. If you do not wish to fill it out yourself, our research assistant will call you and ask the questions to you over the phone. That will take about 20 minutes

C. RISKS AND BENEFITS

Although there is no direct benefit to you for participating in the study, you will have contributed to work that may improve the long term care system in Hawai'i. If any of the questions on the survey or in the interview make you uncomfortable, you may refuse to answer them. You may also end the interview at any time. If you don't want to answer the survey, you will still get the same services you need.

D. CONFIDENTIALITY

No individual identities will be used in any reports or publications resulting from this study. This information will be pooled with information from other subjects to produce overall statistics on your experiences. Your records will be kept as confidential as is possible; however absolute confidentiality cannot be guaranteed, since research documents are not protected from subpoena.

My signature, below, will indicate that I have read the information above.

Date:_____ Signature: _____

Date:_____ Signature of person obtaining consents: _____

If you are a caregiver:

1. What is your gender? Male _____ Female _____

2. Please check the age category you belong in:
   18-30 _____
   31-40 _____
   41-50 _____
   51-60 _____
   61-70 _____
   71-80 _____
   81-90 _____
   91 plus_____

3. With what ethnic group do you most strongly identify?

   _____

4. What is your relationship to care recipient?
   Spouse_____
   Adult child_____
   Other relative_____
   Friend/ Neighbor_____
   Paid caregiver_____
   Other_____

5. How long have you been providing care? _____(yrs)_____(mo's)

6. Does the care recipient live with you? Yes_____ No_____

If you are an older adult:

1. **What is your gender? Male _____ Female _____**

2. **Please check the age category you belong in:**
   a. **61-70** _____
   b. **71-80** _____
   c. **81-90** _____
   d. **90 and over** _____

3. **With what ethnic group do you most strongly identify?**

4. **Do you live alone? Yes_____ No_____**

   a. **If no, who do you live with?_____**

5. **Please check the type of housing you live in**
   1. **Own home** _____
   2. **Family's home** _____
   3. **Foster care RCFE or ass't living** _____
   4. **Nursing Home** _____
   5. **Other** _____

6. **Please check your marital status**
   1. **Married** _____
   1. **Divorced /Single /Widowed** _____
   2. **Other** _____

ADRC Baseline consumer satisfaction survey results
(Hawaii county)
5/1/07
N=40

Item	Percent
Contact for yourself or are you caregiver?	
Self	66.7%
Caregiver	25.0%
Other	2.0%
The following items were asked of caregivers	
Gender of respondent	
Female	75.0%
Male	25.0%
Age category	
Under 50 or missing	62.5%
51-60	8.3%
61-70	20.8%
71-80	8.3%
Ethnicity	
Caucasian	37.5%
Japanese	25.0%
Hawaiian	37.5%
Relationship to care recipient	
Adult child	83.3%
Other relative	16.7%
How long have you provided care?	
3yrs	16.7%
5 yrs	16.7%
7yrs	16.7%
12 yrs	33.3%
18 yrs	16.7%
Does care recipient live with you?	
No	50%
Yes	50%
Are you employed?	
Fulltime	14.3%
Part time	0%
Unemployed	14.3%
Retired	71.4%
Care recipient needs assistance with:	
Finances	83.3%
Transportation	100%
Cooking or meal prep	100%
Arranging for medical care	100%

Eating Dressing Bathing Getting to bathroom Walking	33.3% 33.3% 50% 50% 50%

Focus group methodology

Focus Group Methodology

Attached is the report (which also shows the questions) of the focus groups that were run. However there are some considerations that might assist you in organizing, setting up and running focus groups for older folks and their caregivers.

(1) First note that homogeneous groups are a good idea. If you can run at least three groups: one for elders, one for people with disabilities and one for caregivers. Each will have different concerns and issues as can be seen from our report.

(2) The sessions should be run by two people ; one to run the group , the second to take notes, preferably on a laptop so they can be electronically analyzed later on.

(3) The session also needs to be taped. It is preferable to get a non-directional microphone that can be set in the middle of a round table so that everyone's voice can be heard. Make sure you have enough tape for the whole session!

(4) Groups should be small (8-10 people). Make certain every can hear everyone else before you start.

(5) Use your group work skills when running the group! Don't let one person dominate; make sure you hear from everyone in the group. Use prompts, cues and follow-up questions to get the information you need.

(6) For these groups, provide transportation if needed and serve lunch or at least refreshments.

(7) Choose your room carefully. The room you use needs to be quiet; the tape will pick up background noise you do not even notice.

(8) Be conscious of confidentiality issues; you cannot guarantee confidentiality in a focus groups; therefore do not bring up issues that may be too personal.

(9) Be sure to get at least basic demographic information. If you are reporting the findings people want to know generally at least age, gender and ethnicity of the participants (see attached)

Introduction

Five focus groups were held throughout the Island of Oahu. It was determined that each focus group should be relatively homogeneous in make-up in order to maximize the potential for shared experiences. An effort was made to have reasonable representation of varying genders, ages and ethnicities and this diversity is reflected in the responses. The following categories of groups were run:

- Active Seniors
- Caregivers
- Underserved minority group (seniors and caregivers)
- Younger adults with Physical Disabilities
- Long Term Care Service Providers

Total Number of Participants: 49
Average Group Size: 3- 12
Timeframe of Focus Group Interviews: January - June 2007
Sites: Various throughout Honolulu, Hawaii

Methods

The script was developed by Wesley Lum and was modified and pre-tested with the assistance of students in a sociology Ph.D. seminar on survey research. Each group was asked the same questions in the same order, although prompts and probes varied by group. Each session lasted from an hour to an hour and a half and was conducted at a site that was familiar to the participants. Each focus group had one facilitator from the executive office on aging and at least one recorder. With the permission of the participants, Ph.D. students from the University of Hawai'i were allowed to observe and assist as part of their learning experience. The sessions were also audiotaped. The data were analyzed using a combination of recordings and notes. Due to audio difficulties some recordings were not possible to use and notes only were used.

Summary of Findings

Question 1 (Self introduction; sharing of caregiving experience)

1. Those who mentioned who they were caring for said:
   - Husband (4 times) girlfriend's husband (once)
   - Wife mentioned twice
   - Dad/ father mentioned six times; one father-in-law
   - Four people mentioned mother; one mother –in-law
   - Two people mentioned in-laws as a couple

- Three people mentioned caring for both aged parents; one for a husband and wife together where the relationship to the caregiver was not established
- One person mentioned aunt
- Two mentioned sister
- Two people mentioned son or grandson
- Several were professionals/ professional volunteers in addition to their own personal caregiving experience

2. Among those who mentioned a reason for care, the following was said:

- Elderly
- Stroke (mentioned twice)
- Lung cancer
- Dementia
- Disability
- Sprained shoulder,
- Cannot be left alone
- Heart problems
- Blindness
- MS

3. Among those who mentioned the type of care they provide, the following was said:

- General assistance with ADL's,
- Assistance with dressing
- Assistance with transportation
- Exercise needs
- Companionship for a person who lives alone
- Making /getting to appointments
- Managing care
- Hiring help
- Getting information on /applying for needed benefits
- Several participants discussed the fact that their care recipient had already been institutionalized in a group home or nursing home and that they had handled the placement

Other themes not in direct response to question reflected:

- Length of care
- Multiple caregiving experiences
- The burden of care (financial, physical)
- Inability to provide 24 hr care as reason for institutionalization
- Confusion about finding resources to help
- Personal exhaustion
- Hard to find personal care attendants.
- Affordable housing is a big issue

- Doctors have been helpful.
- Family support crucial

Question 2 (When did you realize that you had become a caregiver (or became disabled yourself) how did you access help? Who did you turn to for information? Any negative experiences?)

- Hospital social worker or discharge planner/ case managers
- Doctors
- Friend
- Salvation Army
- Called 911
- Lifeline
- VA/military
- Social security SSI
- Medicaid /DOH
- HGP
- Got senior handbook
- Foster care home/other care homes
- American lung Association
- KKV
- Caregiver conferences
- Service organizations
- Family/especially health care professionals in family
- Websites/Internet
- Called 211
- Media (newspaper, TV ads)
- In-patient case manager
- 211 online services.

Negative experiences mentioned many times no matter which system was accessed for help. Among the comments were:

- Social workers/ discharge planner and case managers left a great deal on the caregiver to figure out/ find out
- Private case managers? Too expensive
- VA benefit process was confusing; conflicted in the end with SSI benefits some of which then had to be returned
- Service organizations were too paperwork oriented, not client oriented enough
- Medicaid was mentioned at least twice as being very busy
- Raised issues of confidentiality and not honoring of powers of attorney by many caregivers who were seeking benefits/ eligibility establishment for a care recipient
- Had to call many times; referred around; hard to find time to follow-up if employed
- "Kept hitting my head against the wall"

- Insurance 'hard to get for younger people who are non medicaid eligible and doesn't cover personal care anyway
- Bad experience with 211 phone line
- Only time you receive services is during hospital discharges; otherwise on your own

Questions 3-5 (on phone number vs website vs physical site)

Phone comments:

- Must speak my language
- Don't want phone menus
- Don't want to get answering machine
- Want to talk to a person who is very knowledgeable
- Should be 24 hours
- Should be a toll free number
- Don't want to be denied information (confidentiality issues)
- Need person to person help; what about help completing forms?
- Number should be well advertised on the media at time when seniors watch on channels they watch
- Seniors may have problems calling: selecting numbers, menu (confusing), want to talk to person
- Want a live person
- Don't want to be put on hold.

Website comments

- Might be ok for younger people
- Would be good for younger caregivers
- Not everyone has computers
- Again, what about language problems?
- Website is good for younger family members.
- Has lots of information access with useful information.
- More likely to have current information and all available information.
- Also alternatives. Example was choices of case managers, and care homes
- All people would use website (comment from MS group)
- Must be easy to navigate.
- Have FAQ's; Q and A; links to other websites
- Should be like one stop shopping, only on line
- Have wi-fi at the ADRC.

One stop physical site comments

- Good for person to person help
- Would go if I knew I could get help there
- Needs eves and weekends for working people
- Especially needed for Medicaid /forms

(6) The current 'referral' method is difficult for both the elderly and younger disabled adults, where minimal information is supplied and then they are on their own to get services. Preliminary calls to verify information and eligibility /appointments and perhaps even care arrangements should be made whenever possible by professional 'brokers' who know how to 'work the system'.

(7) In terms of phone vs physical site, vs website, a phone number was slightly preferred, although there were many stipulations about using it. A general feeling that a website would be good for younger (read: more sophisticated, educated) caregivers and family members. This feeling among older adults and caregivers was reinforced by the responses of younger disabled adults who said 'everyone" would use a website. It was accurately perceived that websites would probably provide a broader range of current choices. A few people strongly supported a physical site where people would talk to them face to face and be accountable for the results. These often sounded like people who had been frequently passed from place to place for information or help; however there were concerns about too many people using it and waiting time. There was a strong preference that a place like this should be 'walk-in' without appointments necessarily required.

Hawaii Aging and Disability Resource Center
Access and Linkage Subcommittee

Focus Group Questions for Healthy and Active Seniors, At-risk Seniors, Caregivers, Persons with Disabilities, and Service Providers

Introductions

- Thank you for coming to this group. My name is _____, and together with _____, we will be facilitating the group today. We are with ____. We have been selected by the Executive Office on Aging, Access and Linkage Subcommittee of the Aging and Disability Resource Center Advisory Board to complete this project.
- Our purpose today is to better understand how the public accesses, or would prefer to access, information for aging and disability services and resources.
- Before we start, we want to assure you that:
  - We are VERY interested in what you have to say;
  - There are no right or wrong answers, so tell us whatever you really think or feel;
  - Because we want to hear from each of you, I may call on you if you are quiet. And if you are talkative, I might ask you to "hold that thought" while we hear from some of the quiet ones.
  - Everything you say is confidential; in other words, what you say will not be attached to your name in our report.
  - But from the answers from this group and others, we will learn how the State can improve access to our long-term care system.

Questions

Q1 (Icebreaker): Please tell us your name and a funny story about your dealings with an older adult.

Q2: We sometimes become family caregivers instantaneously. For instance, we get a call in the middle of the day from the hospital emergency room. Dad had a stroke. When released, he can't live independently anymore. Who would you contact to get information? What type of information would you need?

Comment [WL1]: Change scenario based on the group that is meeting.

Q3: At other times, we become family caregivers gradually and over time. For instance, you begin by providing light housework, and then you're taking mom to the doctor's office, and then you're picking up her medications, and then you preparing her meals, and then you're doing her financial paperwork, and then, and then, and then. At what point do you say "I need help?" Who would you contact to get information? What type of information would you need?

Comment [WL2]: Change scenario based on the group that is meeting.

Q4: What prevents you from accessing information and resources?

Q5: If you have had an experience in your effort to obtain help and information, please tell us about it.

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Q6: We are considering the development of a website that would assist the public in navigating the long-term care system. Would you use such a website to access information? What was your experience?

Q7: We are also considering the development of a single telephone number that would connect you to a live person. Would you call this number to access information? What was your experience?

Q8: We are also considering the development of a physical walk-in site where you could meet with a counselor, pick up brochures, complete paperwork, and attend educational seminars. What is the likelihood that you would visit a physical site?

Q9: If you had to choose between a website, single telephone number, or walk-in site, how would you rank your preferences?

Q10: Please tell us what suggestions you have to improve access to information and services.

Wrap-up

- Thank you for your participation today. We learned a lot from you, and we appreciate your help.
- We will also be listening to other groups with seniors and caregivers. Our findings will be provided to the State's Executive Office on Aging and will help the State to better understand how the public accesses aging and disability resources.
- If you think of anything else that you want to tell us, please call me at ____.
- Thanks again.

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Service provider survey methodology

Senior Service Provider Survey Methodology

A graduate methods course in sociology was petitioned to include this survey as their class project in February of 2007. A list of Oahu service providers for the elderly was generated and 30 providers were randomly selected from the list. These were divided up and each student was assigned to do a specific number of phone interviews. Each student was told to read the following statement as an introduction to the survey.

The ADRC Evaluation Committee is measuring collaborative attitudes about working in a health and social services consortium. This self-assessment offers us the opportunity to get the service provider's current perceptions of access and quality of services currently offered in your region. Along with the information we get from the phone survey, we will be reviewing how referrals are received and made across service providers. This will provide us with additional information on the impact of the ADRC from a provider, rather than a consumer, perspective.

Witnessed oral consent was obtained over the phone (although the project was technically exempt as it was class project conducted in an educational setting; it was felt this was a satisfactory compromise). The survey questions were developed by the evaluation committee except for an adaptation of a validated scale used with a network of childrens' service providers in Southern California

Data were collected, coded entered in SPSS and analyzed as to the frequency of responses. Comments and answers to open question were analyzed and reported separately (see report).

A follow-up senior service provider survey is planned in order to assess whether or not the EOA ADRC has altered the way in which service providers connect as well as changed their assessment of the availability of information and ease of obtaining services.

Senior service provider survey comments

- MOW – waiting list is too long; no new services to anyone
- ADC – cost of service prohibitive – even if families knowledgeable about services they cannot afford them
- Everything too expensive, service branch pulling out , assisted living facilities too expensive for average retiree, many people will have to go to nursing homes soon private care homes asked to do too much for too little
- Hospital – doesn't apply to targeted population
- ADC - should focus on caregivers
- Senior center what about disability services?
- More services needed for adults that fall between children and elderly who need health care services especially those who are disabled but not too disabled
- Nonprofit medical and social services agencies struggle year after year to provided services needed by community for adequate funding and other resources
- Be a blessing wherever you can ; maybe its just comfort they need
- Every island is different with their service systems, culture needs to be considered need similar assessment (tools) and single point of access
- Seniors and disabled need assistance to get the services; they do not ask for help they do not have anyone to help them get to services
- Whole committee submitted to legislature plan to make a single entry
- Great program
- SNF - Good idea hopefully get finding used to have a lot of people calling not knowing where to go now have a brochure, people often not brave enough to reach out
- ADC - mostly word of mouth; most referrals through physicians
- ADRC needs to work with people who speak different languages
- State agencies should receive funding from state and government to have better access to services
- ADRC a wonderful direction for State of Hawaii
- Transportation – need more workers for shifts they can assist a little bit of aloha because it's not being practiced anymore
- Not too well informed; major focus is not this population
- Need funding for the ADRC for better coordination of services

Table 2

Service Provider Survey Results
Oahu

Summary:

- 37 surveys completed
- 7(20%) had heard about ADRC; 26 (74.3%) had not
- Those who had heard about it did so in ways others than media or word of mouth
- Agencies responding served from 9 to 13,000 clients
- 15 (42.9%) had waiting lists for their services
- Waiting time varied from 0 to 156 weeks; average waiting period was 4 months (16.3 weeks)

Service provider opinions on how well they worked together as a network varied (see below). On the low end, service providers indicated that services are not very easily accessed, they did not really feel that the elderly and disabled get what they need, and they themselves met together only infrequently to plan services.

Furthermore, they are only somewhat knowledgeable about each other's services, they make and receive referrals from each other frequently (but not all the time) and that the elderly wait a long time to get what they need.

Finally, service providers strongly endorsed items that said with more community based services the elderly and disabled could remain longer in the community and could benefit from streamlining services.

These findings indicate that from the point of view of service providers, the professional community could benefit (as could consumers) form a more integrated approach to service delivery.

Networking Scale Results*

As part of the network for aged and disabled services:	Min value	Max value	Mean	Std. Dev
You feel services are easily accessed	1	4	2.97	1.02
You are connected and know about each other's services	1	5	3.03	1.02
Your services are known to others	1	5	3.03	1.13
You frequently receive referrals	1	5	3.45	1.18
You frequently make referrals	1	5	3.55	1.20
The referrals you receive from other are appropriate	1	5	3.61	0.93
You have adequate resources	1	5	3.36	1.34
You feel that the elderly and disabled get what they need	1	5	2.61	1.06
You feel that the elderly and disabled wait a long time for services	1	5	3.52	1.03
You feel that the elderly and disabled could remain in the community w/ more services	2	5	4.09	0.77
You feel that the elderly and disabled could benefit from streamlining services	2	5	4.12	0.86
You meet with other service providers to plan coordinated efforts	1	5	2.91	1.26

* Five point scale answers range from 1 (strongly disagree) to 5 (strongly agree)

Appendices

Selected Measures of Streamlining

Streamlining Process ↓	Selected Indicators of Streamlining Italicized Text = measure specified in Minimum Data Set (MDS) or Evaluation Guidelines (EG) Regular Text = measure described in the document: Evaluation Plan Highlights 2003 & 2004 Grantees; not specified in MDS or Evaluation Guidelines. States listing the measure are provided in parentheses)			
	Ease	***Timeliness***	***Facilitation of Consumer Choice***	***Reliability***
Initial Call to ADRC	*--Track #Contacts, telephone, web inquiries (MDS)* --Hours of operation accommodate easy access (WI). --Minimized the need for client travel (CA). --Track # abandoned calls (CA, MN, NM). --Determine increase in percentage of calls that are smoothly transferred through the telephone system to counselors (NM).	*--# Contacts per FTE (MDS).* --Speed with which calls are answered (CA, NM). --Decreased time for callbacks to messages left on voice mail (NC).	--Use of web-based information system developed with consumer and service provider input. *--Intake screens initiate access to diverse types of client services and information (EG).* *--Disposition of initial call matches caller need (EG).*	*--Track # Contacts by type of caller (MDS).* *--Track # Contacts by source of referral (MDS).* *--Frequency/method for updating resource information (EG).* *--Frequency/level of staff training & experience (EG).* *--Assess cultural competency of staff (EG).*
Basic Information	--Reduction in # times consumers must provide the same information (NC).	--Decreased average length of time for consumers to receive needed information (IN).	*--Average # web site hits per month. (MDS)*	*# Contacts/1,000 service area population. (MDS)*
Comprehensive Needs Assessment	*--# On-line application forms (MDS).* --Reduction in # times consumers must provide the same information (NC).	--Reduced waiting time to see a professional (NC).	*--# times "other" service-related needs have been identified (mental health, nutrition, etc.)*	
Providing Assistance: Options Counseling; Care Planning; Benefits Assistance; Referrals; Futures Planning; Crisis Intervention; Employment Options,	--Reduction in # consumer contacts required to access multiple services (MN). --Consumer satisfaction survey results (ease of understanding information, usefulness, responsiveness). --Provider survey results	--Decreased average length of time for consumers to receive needed information (IN). --# individuals accessing/receiving services over time.	--Assess consumer usage of information and subsequent satisfaction with choices. --# and type of referrals to programs that facilitate consumer choice (direct pay, cash & counseling, etc.)	--Conduct baseline & followup interviews on consumers' perceptions about access to services (ME)

other				
Eligibility Determination				
Financial	*--Flowchart of avenue and steps needed to apply for public programs – pre and post-ADRC (MDS)* --Reduced # of contacts, applications or steps required between initial contact and determination (MD, NM, NC). --Reduced time required for eligibility determination to be made (MD, CNMI, NM, NC, WI).	*--Flowchart of avenue and steps needed to apply for public programs – pre and post-ADRC (MDS)* --Develop/monitor process map and track time for determinations for public program eligibility. *--Decrease in time to determine financial eligibility (EG)*		*--# of Financial Determinations of eligibility including outcome data. (MDS) Track data over time.*
Functional	--Reduced # of contacts, applications or steps required between initial contact and determination. --Reduced amount of time for determination to be made (MD, CNMI, NM, NC, WI).	--Develop/monitor process map and track time for determinations for public program eligibility (IN).		*--# of Institutional LOC Determinations by target group and secondary target group. (MDS; Include reason and outcome regarding LOC determinations. (MDS) Track data over time.*
Service Access	--Reduced # calls to other agencies before reaching ADRC (NC, GA). --Use of survey of ADRC staff satisfaction to determine if web-based information system facilitates data collection and information sharing for such services as eligibility determination and short-term case management coordination (IN).	--Reduced # calls to other agencies before reaching ADRC (CA, MN, MN). *----Consumer/Service Provider/Critical Pathway Partner feedback on ADRC performance (EG).* *--Case studies; testimonials;focus group findings (EG).*		--Use a "Systems Change Checklist" to capture change in desired system level outcomes (SC).

Ongoing Monitoring	--Consumer satisfaction survey to assess # calls made by consumers to other agencies before reaching ADRC (CA, NM, MN)		--Develop checklist to monitor partner involvement in all aspects of ADRC	--Survey staff regarding ADRC MIS and web-based info systems to manage data (IN). --Determine whether the ADRC is providing accurate and useful information about placement options (NC).

State of Hawai'i
ADRC Evaluation Plan

March 1, 2007

Contents

State of Hawai'i
ADRC Evaluation Plan

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Evaluation Design

The evaluation design is quasi–experimental, examining change over time utilizing pre and post tests. It is a mixed, multi-method approach using both quantitative (surveys and phone interviews) and qualitative (focus groups) methods,We also plan to collect certain secondary data for analysis including Medicaid data to make an assessment of level of care determinations changes that may have occurred as a result of the ADRC. The overarching goal of the evaluation is to be able to assess the consumer and system level changes in the State of Hawaii brought about by the ADRC. Indicators will include some measure of the characteristics of the target population, a baseline and posttest measure of knowledge about long term care options of the target population(s) and a measure of appropriate utilization of long term care services by the consumers (and their caregivers). Because of the rolling entry of each island into the study, the evaluation results will be separated by county. Hawai'i County will be the first to be evaluated followed by Oahu. The design will also incorporate process and impact measures.

(1) The *process* portion of the evaluation will include at a minimum the number and type of services provided, as well as a description of the population to whom the service are provided and will assess whether or not the program has achieved (or made progress towards achieving) its own stated goals and objectives. Several of the required items in the MDS reflect these process measures such as the number of contacts, types of services available and an unduplicated count of the consumers served.

(2) The *impact* portion of the evaluation will measure the effect of the ADRC on both the target population and the programs' actual consumers. Again, selected measures from the minimum data set such as the number of institutional level of care determinations made and consumer satisfaction will be considered outcome measures. Additional impact measures (see below) will also help to assess ADRC outcomes.

Evaluation methodology

Process evaluation: This portion of the evaluation will proceed in three parts.

(1) An assessment of whether or not the project met its own goals
(2) Collection of client and caregiver information and
(3) Summary of services provided.

(1) Meeting Project Goals We will assess whether a single point of entry system was established on Hawai'i Island and which agencies and services were included in this effort. When Oahu enters the study, a description on of the virtual model established in Honolulu will be also assessed. Questions to be addressed as part of the process include: Did the project manage to establish a unified or at least compatible method of establishing a process for screening, intake, assessment and eligibility determination of the clients eligible for long term care services? Were Medicaid, AAA, physical disability service providers and other stakeholders represented in this process? Were resources from these stakeholders committed to the process of reorganization of services? This portion of the evaluation will be conducted through on site interviews of the staff of the ADRC and long term care service agencies, in addition to meeting minutes for the ADRC advisory committees. Their assessment of the success of the project in streamlining the paper work of eligibility and more effectively meeting client needs will be included here. A semi-structured interview process will be utilized for this portion of the evaluation and the results will be qualitatively analyzed utilizing a qualitative software package (QSR 6).

(2) Client information Unduplicated counts of the characteristics of elders served and caregiver data will be collected through a process of extracting information from the SAMS2k and NAPIS data bases. On the advice of current providers, additional information not on these data bases will be collected utilizing a form (see below) to be developed by the evaluation subcommittee and staff. These data will be collected quarterly and entered into an SPSS data base for analysis

(3) Service Units and Types The final portion of the process evaluation will also assess the units and types of services provided. For this we will establish with the service providers a method of collection of utilization and claims data, both baseline and at least on a quarterly basis. Again the SAMS and NAPIS data bases have some of this information and we are developing a method to extract it from those data bases ourselves. However for additional data not currently collected (such as the source of referrals) we will also establish a simple standard form (see above) that can be utilized by service providers to convey any additional data to the evaluator.

Impact Evaluation The impact evaluation will address the impact of the ADRC program on the consumers and their caregivers. The impact portion of the evaluation will include: (1) outcome measures in the MDS; (2 a and b) a measure of satisfaction with the ADRC including a measure of whether referred services are actually utilized; (3) a measure of change in the experience of service providers pre and post ADRC; (4) a measure of impact on the target population; (5) comparison of single point of entry system with a virtual model of service delivery and (6) an assessment of the success of sustainability efforts.

1. MDS Data Collection Following a review of all the data collection systems a grid has been devised summarizing the MDS fields and comparing them with local NAPIS and SAMS data fields. This initial review found that almost 50% of the MDS data fields are currently available from these sources. However on onsite visit verified that there is a great deal of missing data in many of these fields. The evaluation team will work with providers in stressing the need for the collection of data in those fields as well as the above noted additional data collection form for the fields currently uncovered. As noted above, we plan to collect these data quarterly.

2. Consumer and caregiver satisfaction survey A randomly selected subset of elders has been identified for a baseline measure of consumer satisfaction prior to implementation of the ADRC in Hawai'i County. The survey will be largely a mailed survey with follow-up reminder phone calls. If the survey is not returned and it is determined that during the follow-up phone contact the individual did not respond because of language barriers, interviewers will do phone interviews in Japanese and Ilocano, the most prevalent languages other than English spoken by elders on the Island of Hawai'i. The instrument we used for this survey was based on the format recommended by the Lewin group (*Recommended consumer measures for surveys*) and carefully reviewed and revised by the evaluation subcommittee and the staff of the Hawai'i County ADRC for a multi-cultural population and alignment with the services offered there. The consent form and phone version of the survey is attached. We have mailed out 140 surveys and our target goal is for a sample size of 100 completed surveys. (Hawai'i County has a potential target population of about 3,300 consumers.) This satisfaction survey will be repeated in one year with a randomly selected set of consumers.

   (a) A plan is being developed to distribute this same survey on Oahu to potential long term care consumers as well as potential or actual spousal caregivers at a senior fair in the fall of 2007. While this sampling method has drawbacks in terms of external validity (the sample will not be random) it is an excellent opportunity to get responses from a very large number of potential consumers. The Executive Office on Aging will make these surveys available at their booth to be filled out and returned on site in exchange for a token incentive. There is essentially no cost associated with this method of data collection and we anticipate getting hundreds of responses. Because services are more available on Oahu than the other Islands we will also add several questions focusing on non-utilization of available services.

   (b) The second portion of this part of the evaluation will involve the use of focus groups of selected consumers. At this point in time the focus groups are being coordinated with the Access and Linkage subcommittee. Three focus groups will take place in the next month and one the following month. Information from these groups will provide a baseline measure of potential or actual consumer of knowledge of the long term care system and (if they have used it) their experiences with accessing and utilizing services.

3. On an annual basis, a statewide service provider survey will also be undertaken. The evaluation has developed a phone survey of service providers to assess baseline (pre ADRC) provider knowledge of the service referral process as well as number of clients served annually and the current length of agency waiting lists, if any. This, along with questions assessing the service providers perceptions of access and quality of services currently offered in their region, will provide us with additional information on the impact of the ADRC from a provider, rather than a consumer, perspective.

4. Working with the stakeholders, we will establish an objective regarding the percentage of the target population that the project wishes to impact. A count of actual consumers (to be measured by MDS data or through website hit counts) will be compared with the targeted population of elders and disabled adults who could be potential consumers of ADRC. We are in the process of determining a baseline count for Oahu and Hawai'i County. Population estimates of the State Executive Office on Aging as well as the University of Hawai'i Center for Disability Studies data are available for this purpose.

5. As the State of Hawaii is utilizing several models of ADRC implementation. we have a unique opportunity to compare outcomes across a single point of entry system as compared to a virtual system of service delivery. This will be done one time only at the end of funding period utilizing the MDS outcome measure fields.

6. The staff and advisory committees of the ADRC have undertaken several activities to insure sustainability of the project and these will be evaluated. Current efforts include utilizing a non–profit umbrella to launch grants and increase flexibility in lobbying the legislature of ongoing funding.

State of Hawaii: Streamlined Access Work Plan (With Evaluation components included)

Goal/Objective: The ADRC's intake, assessment, screening and eligibility determination process will be streamlined and coordinated to be consumer-friendly and accessible.

Measurable Outcome(s): 1) High Consumer Satisfaction 2) High Provider Satisfaction with appropriateness of referrals 3) Reduced amount of time to complete intake and referral process 4) Reduced number of contacts, application or steps required between initial contact and determination to appropriate LTC programs, Medicaid and other public and private services 5) Reduced number of times consumers must provide the same information, 6) Increase in public awareness of the ADRC services

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
1. Identify and establish a baseline assessment of current access processes and systems.	***Assessment, Intake and Forms*** 1. Review consumer intake and assessment work flow in current Area Agencies (AAA), Medicaid programs, and Disability systems. 2. Review current intake and assessment tools, forms, and screening and referral questions and processes. 3. Identify staffing roles and functions and workload. 4. Work closely with pilot sites and other partners.	A.Suga-Nakagawa (State Proj. Coordinator) Assessment and Intake Subcommittee	X	X	X									
	Management Information System/Telecommunications 1. Review MIS work flow in current system. 2. Identify and review data and information being collected and systems, software products being utilized by the AAAs and other major networks. 3. Identify hardware and software needs, training and costs to meet the ADRC MIS requirements and functions. 4. Explore statewide toll free telephone system for ADRC. 5. Explore resource database systems, websites and linkages to other network data base systems. 6. Work closely with pilot sites and other partners.	A. Suga-Nakagawa MIS/Website/ Telecomm. Subcommittee	X	X	X	X	X	X						

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
(continued) 1. Identify and establish a baseline assessment of current access processes and systems.	***Evaluation*** 1. We have developed and are implementing a pre-ADRC assessment survey with service providers to conduct a pre-test and assessment of their awareness of current resources and the AAAs prior to implementing ADRC. 2.We are in the process of reviewing current data collection methodologies and process in Hawai'i County.	P. Arnsberger (Proj. Evaluator) Evaluation Subcommittee	X	X	X	X	X							
	Communications/Consumer Education 1. Conduct a baseline survey to assess consumer's perceptions of aging, network resources and needs. Identify current public awareness.	W. Lum (UH) Communication Subcommitee	X	X										
2. A flow plan will be designed for the ADRC intake, assessment, screening and eligibility determination process .	***Access and Linkages*** 1. Identify and design a critical pathway for public access to ADRC for information, referrals, linkages to appropriate information services and resources. 2. Identify focus groups for feedback and input in critical pathway design. 3. Conduct Pre-test and Post-test with focus groups.	W. Lum Access and Linkages Subcommittee/ Evaluation subcommittee	X	X	X	X	X	X						

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
(continued) 2. A flow plan will be designed for the ADRC intake, assessment, screening and eligibility determination process.	***Assessment, Intake and Forms*** 1. Design intake, screening, assessment and eligib ility determination work flow for ADRC. 2. Identify trigger questions for screening and providing linkages to Medicaid, public funded programs, aging and disability service providers.	W. Lum Access and Linkages Subcommittee	X	X	X	X								
	Management Information System 1. MIS Development plan will be designed which includes website and telephone systems.	A. Suga-Nakagawa MIS Subcommittee			X	X	X	X	X					

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
To evaluate the success of the ADRC in achieving: Ease, Timeliness, Facilitation of Consumer Ch., Reliability	***Evaluation***To measure the effectiveness and outcomes of the ADRC operations, focus groups, pre and post test surveys of consumers and service providers, secondary data analysis of Medicaid data and extraction of data from the NAPIS and SAMS 2K data bases will all be used.	P. Arnsberger Evaluation Subcommittee	X	X	X	X	X	X						
To develop an evaluation plan covering evaluation objectives a-h	***Evaluation***An ongoing evaluation plan has been developed to incorporate data collection tools, surveys, etc. to obtain the necessary information and data for measurable outcomes. The plan includes the objective and activities of the program evaluator and the evaluation committee as follows:	P. Arnsberger Evaluation Subcommittee	X	X	X	X	X	X						
a. To understand and collect the minimum data set reporting requirements	***Evaluation***1. In meetings with the evaluation committee, to review AoA Reporting requirements utilizing Lewin's MDS grid 2. A data collection form will be developed to collect data not currently available in the NAPIS and SAMS. 3. Quarterly data collection will occur	Eval committee/ evaluator	X	X	X		X	X	X			X		
b. To determine the best method(s) of collecting data on coordination efforts	***Evaluation***Keeping meeting minutes and recording efforts of all committees charged with this objective	All committee staff	X	X	X	X	X							

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct. 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
c. To collect data on consumer demographics and their knowledge of service and service utilization patterns at baseline in Hawai'i county	***Evaluation***1. Utilizing current fields in the SAMS and NAPIS retrieve consumer and caregiver demographic information 2. Through a combination phone and mailed survey collect baseline data as required in the MDS in order to measure change over time in levels and types of service utilization and service satisfaction. Hawaii Island Oahu	Evaluator			X	X X	X X				X	X	X	X
d. To track the activities required to implement the ADRC in Hawai'i county, (single point of entry approach)	***Evaluation***1. Keeping meeting minutes and recording steps towards achieving this objective 2. Site visits and interviews with Hawaii Island ADRC staff	Project Evaluator ADRC staff	X	X	X	X	X	X	X					
e. To track the activities required to implement the ADRC on Oahu (virtual reproach)	***Evaluation***1. Keeping meeting minutes and recording steps towards achieving this objective 2. Site visits and interviews with Hawaii Island ADRC staff	Project Evaluator ADRC staff							X	X	X	X		
f. To collect data on the impact of the ADRC on service use and appropriate referrals	***Evaluation***A baseline phone survey of randomly selected service providers is being undertaken. The survey covers knowledge of ADRC, the ease of making and receiving referrals, the appropriateness of these referrals and their agencies waiting list time (if any). It will be replicated in a year.	Project Evaluator/ ADRC staff and Assessment streamlining committee					X							

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct. 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
g. To evaluate the effectiveness of sustainability efforts	***Evaluation***All efforts to establish sustainability will be tracked including (1) the establishment of a private non-profit (2) funds raised for the thru grantwriting and (3) and additional legislative awareness efforts.	Project Evaluator/ ADRC staff and Assessment												
h. To analyze and report our findings to the Administration on Aging	***Evaluation***The report will include MDS data and additional selected outcome measures as noted in the narrative with emphasis on a comparison of the process of implementation and impact of a single point of entry system (Hawai'i County) as compared to a virtual system (Oahu) of service delivery.	Project valuator												

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct. 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
A flow plan will be designed for the ADRC intake, assessment, screening and eligibility determination process.	***Communications and Consumer Education (marketing)*** 1. A marketing plan will be developed to identify the primary and secondary target groups for marketing, promotion and outreach. The plan includes the message, dissemination plan, positioning of the ADRC. Marketing plan will be closely interfacing with the Access and Linkages Critical Pathway plan to ensure that the public will be aware of the ADRC, its role and functions and how to access the services.	W. Lum Communication & Consumer Education Subcommittee	X	X	X	X	X	X						
	Staff Training 1. Develop ADRC Staff job descriptions and training curriculum. 2. Plan and develop cross training programs for staff on different resources and eligibility screening for Medicaid, public funded programs, aging and disability services. Work closely with pilot sites and other partners.	A. Suga-Nakagawa M. Kim (Pilot site Proj. Coord) Staff Training Subcommittee	X	X	X	X	X	X						
	Financing and Sustainability 1. Explore different funding resources to support the ADRC access development plan which includes staff training, marketing, and MIS support. Develop a fund development plan.	A. Suga-Nakagawa Finance/Replication Subcommittee	X	X	X	X	X	X						

Major Objectives	Key Tasks/Action Steps	Lead Person/ Work Group	Timeframe (Oct. 2006 – Sept. 2007)											
			10	11	12	1	2	3	4	5	6	7	8	9
4. The screening, intake, eligibility process will be evaluated to measure the ADRC's ability to streamline access, minimize redundancy and maximize efficiency and effectiveness.	***Management Information System*** 1. To support and streamline the application and intake process, the MIS system will be enhanced to include on-line application, information/data sharing. Explore means for the MIS system to be accessible or able to interface with other programs. Establish a website & monitor the number of hits/visits to measure public's knowledge and awareness of the ADRC website.	A. Suga-Nakagawa MIS/Telecommunication Subcommittee	X	X	X	X	X	X	X	X	X	X	X	X

Appendix J - Miscellaneous

- Intake Form
- Medicaid Screening
- Service Excellence Survey

AGING & DISABILITY RESOURCE CENTER

INTAKE FORM

SECTION I. Senior Disability CONTACT TYPE: MAIL WALK-IN PHONE EMAIL

DATE: _____ TIME:_____ SOC. SEC. _____

CLIENT LAST NAME: _____FIRST _____MI____

MAILING ADDRESS: _____

RESIDENCE ADDRESS: _____

PHONE NO. _____DATE OF BIRTH: _____ MARITAL STATUS M W D NM

SENIOR ID CARD: Y N NUMBER:_____ U.S CITIZEN? Y N LEGAL RESIDENT ALIEN? Y N

SEX M F ETHNICITY:_____ NATIONALITY: _____

IN YOUR OWN WORDS HOW WE CAN HELP YOU/REASON YOU'RE HERE: VETERAN: Y N

REQUEST: INFO SERVICE BOTH CAREGIVER NEEDS LONG TERM/OPTIONS

Language Needs: Yes No If yes, what language(s) do you speak?

VERBAL PERMISSION RECEIVED TO MAKE REFERRAL Y N WRITTEN: SEE BACK

STAFF TO COMPLETE BELOW: Staff Name: _____ Date:_____

ACTION:

REFERRAL(S) :

FOLLOWUP:

SECTION II.

Person assisting in filling out form: _____

Relationship to client: _____Phone No. _____

Client lives alone? Y N If no, what is the name and relationship of the person they live with? _____

Who is considered clients primary caregiver? _____

Phone: _____ Address: _____

Medicaid Yes No Number_____ Worker: _____

Medicare Yes No Number_____ Part A _____ Part B _____

Other Insurance Number & Policy : _____

DISABILITY: _____

MEDICAL DIAGNOSIS: _____

OTHER SERVICES BEING UTILIZED_____

LEGAL GUARDIAN/POA: _____

LEGAL FORMS OBTAINED: YES NO DPOA LIVING WILL POA

FINANCIAL INFO: SOC SEC_____ SSI _____ OTHER_____

ADLS: Y or N or S	IADLS: Y N or S	
EATING ____	Preparing meals _____	Doing heavy housework _____
DRESSING____	Using Telephone _____	Doing light housework _____
BATHING____	Medication Management_____	Transportation Ability _____
TOILETING____	Managing Money_____	
TRANSFERRING____	Shopping for Personal Items _____	
ADLS# Y____ N____ S____	IADLS# Y____ N____ S____	

SECTION III.

OPTIONS COUNSELING ASSESSMENT TOOL OR CAREGIVER SPECIALIST TOOL

AGING AND DISABILITY RESOURCE CENTER

HAWAI'I COUNTY OFFICE OF AGING

County of Hawai'i • 1055 Kino'ole Street Suite 101 • Hilo, HI 96720 • Phone: (808) 961-8626

SERVICE EXCELLENCE SURVEY

Employees of the Aging and Disability Resource Center and the Office of Aging provide information and assistance for aging, disability and care giving related needs. As we do this, we strive to provide each individual with courteous, knowledgeable, and efficient, service. Please rate us in each of these areas.

Date(s) of Visit or Call: _____ **Time of Visit or Call:** _____

Purpose of Visit or Call: _____

_____

_____

A. COURTESY

1. Were you satisfied with the time that it took to be acknowledged or served?

Yes No

Comments/suggestions: _____

_____

_____

2. How would you rate our *overall courtesy*?

Excellent Good Satisfactory Poor

Comments/suggestions: _____

_____

_____

B. JOB KNOWLEDGE

1. Did you receive the information you requested?

Yes No

Comments/suggestions: _____

_____

_____

(MORE QUESTIONS ON BACK)

2. **How would you rate our ability to answer your questions?**

Excellent **Good** **Satisfactory** **Poor**

Comments/suggestions: _____

_____

_____

C. EFFICIENCY

1. **Do you feel that your request could have been handled more efficiently?**

Yes **No**

Comments/suggestions: _____

_____

_____

2. **How would you rate our *overall efficiency* in responding to your concern?**

Excellent **Good** **Satisfactory** **Poor**

Comments/suggestions: _____

_____

_____

GENERAL COMMENTS

_____

_____

_____

_____

_____

HOW MAY WE CONTACT YOU?

Name: _____ **Phone Number:** _____

Address: _____ **E-Mail Address:** _____

_____

Upon completion, please mail or deliver to: **Aging and Disability Resource Center, Hawai'i County Office of Aging, 1055 Kino'ole St. Suite 101, Hilo, HI 96720.** A self-addressed envelope is furnished for your convenience. Thank you for participating in this survey.

Adult Medicaid and SSI Screening Tool ***DRAFT 02/23/2009***
Aged and Disabled

Disclaimer: This is a screening tool only and should be used to determine what may be potential factors affecting eligibility. True eligibility would require an application with the Department of Human services, MedQuest Division, for Medicaid eligibility and the Social Security Administration for Supplemental Security Income (SSI) eligibility.

Instructions: Unless needing to specify, each blank line should be filled with a Y = Yes, N = No, or ? = unknown. Start with the criteria column. A Yes, No or ? in this column would translate to a similar answer in the Screen column.
A Yes in all 3 screen column = good potential eligibility.
A Yes or ? in all 3 columns = potential eligibility but factors with a ? are potential barriers to eligibility.
A No in any column = potentially ineligible due to factor with the No response.

SSI

Screen factor	Criteria	Appears to meet criteria	Comments
___ Category	___ Aged (Age 65 or older) **OR** ___ Disabled (Disability identified by potential applicant) specify:_____ _____	Yes = Meets aged criteria ? = May meet disability criteria.	If does not meet the aged criteria, there is an assessment process to determine disability. This is arranged by SSA as part of the eligibility determination process. Children or spouses who receive SSB based on a disability generally have already met the disability criteria.
___ Income (monthly)	___ Single $674.00 (2009) ___ Couple $1011.00 (2009)	Yes = Gross income is below the criteria level ? = Income is difficult to clearly determine	Includes all income. There may be special treatment of certain types of income such as earnings.
___ Assets	___ Single $2,000.00 or lower ___ Couple $3,000.00 or lower	Yes = Assets are below the criteria level	Assets generally include anything of value that the individual has. Examples: bank accounts, CDs, Christmas savings, cash, checks, trusts, stocks, bonds, other investments, etc.

Medicaid

Note: Unless needing to specify, each blank line should be filled with a Y = Yes, N = No, or ? = unknown.

Screen factor	Criteria	Appears to meet criteria	Comments
___ Category	___ Aged (Age 65 or older) **OR** ___ Disabled (Disability identified by potential applicant) specify:_____ _____	Yes = Meets aged criteria ? = May meet disability criteria.	If does not meet the aged criteria, there is an assessment process to determine disability. This is arranged by SSA as part of the eligibility determination process. Adults who receive SSB or SSI based on a disability generally have already met the disability criteria.
___ Income (monthly)	___ Single $1038.00 (2009) ___ Couple $1397.00 (2009)	Yes = Gross income is below the criteria level. ? = Income is difficult to clearly determine	Includes all income. There may be special treatment of certain types of income such as earnings. Most adults who receive SSI meet the income.
___ Assets	___ Single $2,000.00 or lower ___ Couple $3,000.00 or lower	Yes = Assets are below the criteria level	Assets generally include anything of value that the individual has. Examples: bank accounts, CDs, Christmas savings, cash, checks, trusts, stocks, bonds, other investments, etc.

Appendix B

ADRC Streamlining and Access Focus Groups

Attachment B

ADRC Streamlining and Access Focus Groups

Introduction

Five focus groups were held throughout the Island of Oahu. It was determined that each focus group should be relatively homogeneous in make-up in order to maximize the potential for shared experiences. An effort was made to have reasonable representation of varying genders, ages and ethnicities and this diversity is reflected in the responses. The following categories of groups were run:

- Active Seniors
- Caregivers
- Underserved minority group (seniors and caregivers)
- Younger adults with Physical Disabilities
- Long Term Care Service Providers

Total Number of Participants: 49
Average Group Size: 3- 12
Timeframe of Focus Group Interviews: January - June 2007
Sites: Various throughout Honolulu, Hawaii

Methods

The script was developed by Wesley Lum and was modified and pre-tested with the assistance of students in a sociology Ph.D. seminar on survey research. Each group was asked the same questions in the same order, although prompts and probes varied by group. Each session lasted from an hour to an hour and a half and was conducted at a site that was familiar to the participants. Each focus group had one facilitator from the executive office on aging and at least one recorder. With the permission of the participants, Ph.D. students from the University of Hawai'i were allowed to observe and assist as part of their learning experience. The sessions were also audiotaped. The data were analyzed using a combination of recordings and notes. Due to audio difficulties some recordings were not possible to use and notes only were used.

Summary of Findings

Question 1 (Self introduction; sharing of caregiving experience)

1. Those who mentioned who they were caring for said:
   - Husband (4 times) girlfriend's husband (once)
   - Wife mentioned twice
   - Dad/ father mentioned six times; one father-in-law
   - Four people mentioned mother; one mother –in-law
   - Two people mentioned in-laws as a couple

- Three people mentioned caring for both aged parents; one for a husband and wife together where the relationship to the caregiver was not established
- One person mentioned aunt
- Two mentioned sister
- Two people mentioned son or grandson
- Several were professionals/ professional volunteers in addition to their own personal caregiving experience

2. Among those who mentioned a reason for care, the following was said:

- Elderly
- Stroke (mentioned twice)
- Lung cancer
- Dementia
- Disability
- Sprained shoulder,
- Cannot be left alone
- Heart problems
- Blindness
- MS

3. Among those who mentioned the type of care they provide, the following was said:

- General assistance with ADL's,
- Assistance with dressing
- Assistance with transportation
- Exercise needs
- Companionship for a person who lives alone
- Making /getting to appointments
- Managing care
- Hiring help
- Getting information on /applying for needed benefits
- Several participants discussed the fact that their care recipient had already been institutionalized in a group home or nursing home and that they had handled the placement

Other themes not in direct response to question reflected:

- Length of care
- Multiple caregiving experiences
- The burden of care (financial, physical)
- Inability to provide 24 hr care as reason for institutionalization
- Confusion about finding resources to help
- Personal exhaustion
- Hard to find personal care attendants.
- Affordable housing is a big issue

- Doctors have been helpful.
- Family support crucial

Question 2 (When did you realize that you had become a caregiver (or became disabled yourself) how did you access help? Who did you turn to for information? Any negative experiences?)

- Hospital social worker or discharge planner/ case managers
- Doctors
- Friend
- Salvation Army
- Called 911
- Lifeline
- VA/military
- Social security SSI
- Medicaid /DOH
- HGP
- Got senior handbook
- Foster care home/other care homes
- American lung Association
- KKV
- Caregiver conferences
- Service organizations
- Family/especially health care professionals in family
- Websites/Internet
- Called 211
- Media (newspaper, TV ads)
- In-patient case manager
- 211 online services.

Negative experiences mentioned many times no matter which system was accessed for help. Among the comments were:

- Social workers/ discharge planner and case managers left a great deal on the caregiver to figure out/ find out
- Private case managers? Too expensive
- VA benefit process was confusing; conflicted in the end with SSI benefits some of which then had to be returned
- Service organizations were too paperwork oriented, not client oriented enough
- Medicaid was mentioned at least twice as being very busy
- Raised issues of confidentiality and not honoring of powers of attorney by many caregivers who were seeking benefits/ eligibility establishment for a care recipient
- Had to call many times; referred around; hard to find time to follow-up if employed
- "Kept hitting my head against the wall"

- Insurance 'hard to get for younger people who are non medicaid eligible and doesn't cover personal care anyway
- Bad experience with 211 phone line
- Only time you receive services is during hospital discharges; otherwise on your own

Questions 3-5 (on phone number vs website vs physical site)

Phone comments:

- Must speak my language
- Don't want phone menus
- Don't want to get answering machine
- Want to talk to a person who is very knowledgeable
- Should be 24 hours
- Should be a toll free number
- Don't want to be denied information (confidentiality issues)
- Need person to person help; what about help completing forms?
- Number should be well advertised on the media at time when seniors watch on channels they watch
- Seniors may have problems calling: selecting numbers, menu (confusing), want to talk to person
- Want a live person
- Don't want to be put on hold.

Website comments

- Might be ok for younger people
- Would be good for younger caregivers
- Not everyone has computers
- Again, what about language problems?
- Website is good for younger family members.
- Has lots of information access with useful information.
- More likely to have current information and all available information.
- Also alternatives. Example was choices of case managers, and care homes
- All people would use website (comment from MS group)
- Must be easy to navigate.
- Have FAQ's; Q and A; links to other websites
- Should be like one stop shopping, only on line
- Have wi-fi at the ADRC.

One stop physical site comments

- Good for person to person help
- Would go if I knew I could get help there
- Needs eves and weekends for working people
- Especially needed for Medicaid /forms

- Buses would help/transportation is needed
- Want it to be customer relations oriented, not like social security
- Want people to speak my language /dialect and know about my culture there
- Precaution of one-stop resource: may break down existing line of communication between agencies
- Waiting is an issue.
- If need care and help, you can't be running around. Getting confused.
- Don't want building. Save $$. Put resources in people
- Tracking system for clients
- Structure/physical facility with a person held accountable would be good.
- Faster service. One building would be convenient for workers (employed caregivers?).
- Would be good but what about waiting time?
- So many people in need, walk-in site would be overbooked. Will need to schedule an appointment.
- Good place for an education center.

How could services be improved?

- Consolidate services for younger people with disabilities..
- Like Social Security, have $$ come out of paycheck to pay for the future.

Final Questions: (Type of publicity? Name? Logo? Further comments?)

Publicity methods

- Publicity/ information should be disseminated thru sites where seniors go
- Videos in doctor's offices
- Documentary for Sundays (reporter ½ hour?).
- Morning news, specific time or on evening news. Many caregiversleave for work early.
- Classes/meetings/ other face to face opportunities
- Training professionals on info to give to others

Names

- Some appreciation of 'first call' and 'senior care link' names
    - Discussion of inclusive nature of name
- Some suggestions (I didn't know which) had negative connotation suggest mental health?
- Another reminded people of Kahi mohala (Kahi Malama?)
- Hawaiian names seen as possibly only serving Hawaiians
- On first call - someone said it reminded them of Bank of Hawaii
- Name shouldn't be an abbreviation or too long
- Shouldn't sound like any existing agency

Other suggestions included:

- Aging and Disability – all ages included
- Community Elderly Resource Center
- Elderly Community (can add younger people later)
- Community Resource Center for Elderly and Disabled
- First Call for Information
- Hawaii Aging and Disability Information Resource Center
- Caregiver Link
- Resource Hawaii
- Senior Care Link Hawaii.

Logo suggestions:
Lots of suggestions involving hands:

- Helping hands
- Pointing/joining hands (helping hands)
- Shaking hands with elder
- Welcoming/extending hands
- Helping hands like food bank.

Other

- Angel (guardian angel).
- Petroglif
- Elderly pushing wheelchair and disabled son through park
- Golden retriever
- Cane/wheelchair

Conclusions

Several overall conclusions emerged from this analysis.

(1) There is a need for consolidation and organization of information on long term care. People rely on a variety of methods to get information – from family to health care professionals to the media – without any rhyme or reason. There is absolutely no guarantee that any two people will get the same answer to the same question.

(2) Negative experiences with the system far outweigh positive ones.

(3) Younger disabled adults have different needs than elders and their families. Insurance availability and coverage, affordable and accessible housing, help finding personal care attendants, employment conflicts - are big issues.

(4) While younger caregivers and younger disabled adults will use the internet and websites older adult will be less inclined to do so and would prefer a phone line, but only one answered by a human being without menus and it needs to be available 24 hours a day.

(5) A physical site should have arrangements for walk-ins.

(6) The current 'referral' method is difficult for both the elderly and younger disabled adults, where minimal information is supplied and then they are on their own to get services. Preliminary calls to verify information and eligibility /appointments and perhaps even care arrangements should be made whenever possible by professional 'brokers' who know how to 'work the system'.

(7) In terms of phone vs physical site, vs website, a phone number was slightly preferred, although there were many stipulations about using it. A general feeling that a website would be good for younger (read: more sophisticated, educated) caregivers and family members. This feeling among older adults and caregivers was reinforced by the responses of younger disabled adults who said 'everyone" would use a website. It was accurately perceived that websites would probably provide a broader range of current choices. A few people strongly supported a physical site where people would talk to them face to face and be accountable for the results. These often sounded like people who had been frequently passed from place to place for information or help; however there were concerns about too many people using it and waiting time. There was a strong preference that a place like this should be 'walk-in' without appointments necessarily required.

Appendix C

Management Information System/Information Technology Development Plan – City and County of Honolulu Elderly Affairs Division

Appendix C

MIS/IT Development Plan for Honolulu Elderly Affairs Division

Table of Contents

MIS/IT Development Plan for Honolulu Elderly Affairs Division

1. Overview

This document describes the Honolulu Elderly Affairs Division (EAD) plan for development of its MIS/IT infrastructure. This plan was devised from a review of EAD's current processes (as of early 2008) and with consideration of process improvements that could result in higher organizational efficiencies.

The EAD MIS/IT Development Plan was created with support and assistance of Hawaii Executive Office on Aging (EOA), and to the extent possible coordination with the three other Area Agencies on Aging (Hawaii, Kauai, and Maui). The EOA and AAAs desire to establish the appropriate level of standardization that can benefit our State and the constituents we serve. Therefore this plan may serve as a reference source for other AAAs.

2. Influences and Scope

The health and human services industry is experiencing significant growth in demand, largely as a result of a disproportionate increase in the aged population. (Baby Boomers are now reaching the age of 60 at a rate of NN per day.) Unfortunately, it is very challenging to fund these increases. Several thrusts and initiatives are moving forward to help.

- First is a general recognition that health in old age is achievable with good basic practices, such as nutrition and exercise. The healthier we can make our aged population through education and select programs, the less will enter expensive chronic situations.
- Another major thrust is in home and community based services rather than institutions. Studies have proven there are benefits to the individual in remaining in home and community based settings, and importantly that such care is less expensive than institutions. (A true win-win.)
- Finally, trial and demonstration programs have also proven that the human services network can benefit by modernizing processes and through increased use of Web-based systems for constituents. In recent years the Federal government, including CMS, AoA, and NIH have sponsored various programs to encourage such advancements at the State and local levels. This includes merging service networks for the elderly and for populations with disabilities seeking long term care supports.

Hawaii has already seen the affects of the above trends. Both DOH and DHS have received grants in the past five years that promote adoption of related practices. One of the most recent was the award of the Aging and Disability Resource Center (ADRC) grant to EOA, with pilot sites designated for Hawaii County Office on Aging and Honolulu EAD. This plan includes the development and use of the ADRC.

Hawaii, including Honolulu EAD is embracing these industry thrusts. Under tight budgets and dynamic conditions, EAD has sustained operations with less-than-ideal systems and processes. EAD recognizes that room for process improvement exists. This document describes a plan to institute those improvements as quickly as reasonably possible.

The scope of this plan includes consideration of improvements to any potential resource, process, or system that could generate an attractive return on investment. (This is not to suggest a formal ROI analysis was always practical. However, potential costs and benefits were considered. Even in the case where they may be intangible, our objective has been to adopt improvements that could be justified.) Primary operations were examined, including those involving coordination or interaction with other agencies and providers. The resulting plan, therefore will not only improve efficiencies and quality of service within EAD, but also promote those characteristics across other organizations in the Honolulu region.

Because of its proven ability to make a positive impact, our evaluation and planning effort addressed in detail the potential of automation systems to assist EAD in improving service. EAD has had sparse use of computer software in recent years. Capabilities of software EAD has used to-date have been improved, and this plan takes advantage of these advances. As the plan reflects, these new software features will take EAD to the next level of efficiency and customer service with relatively minor financial costs and training. Personnel will be allowed to expand their skills accordingly.

3. Highlights

As part of the ADRC initiative, EAD, with support from EOA and consideration of AAAs from other Counties, has endeavored to examine its processes and identify opportunities for improvement. Our goal was an honest appraisal so that we can improve our ability to respond to client requests and fulfill our responsibilities to State and Federal agencies.

3.1. Current process highlights

I&A staff are dedicated to their customer service mission and work diligently to accomplish it

The important activity of providing information and assistance to EAD clients is currently being performed with less-than-efficient processes and virtually no automation. Similar, but not to the same scale as the U.S. nursing crisis that is compounded by more time spent with paperwork than with patients, at times EAD I&A must be a frustrating profession. From anecdotal evidence, the staff is open to the additional training that will be required to incorporate computer systems in their processes, if the benefits of improved access to information and reduced 'administrative' activities can be realized.

DP staff endeavor to accommodate a diverse provider network successfully

EAD's charter includes referring clients to the broad provider network that exists in the City and County of Honolulu, and the tracking and reporting of performance by those providers. The EAD Data Processing staff is primarily responsible for that tracking and reporting function. DP has established

numerous customized processes to accommodate the providers. The staff are continuously involved in the collection, re-formatting, and incorporation/distribution of information from the providers.

Under-reporting of accomplishments is likely

While examples of innovation in process design is evident, it remains likely that EAD is not completely aware of the services provided after being referred. The burden of such tracking under a primarily paper-based and disconnected process is too severe. As a result, Hawaii may not be securing its full-share of funding from Federal sources (e.g. Older Americans Act).

Extensive use of paper-based resource information and forms

Computer software is used by EAD only in isolated processes, and primarily for the generation of reports from re-formatted or manually entered information. While this is representative of many of the Area Agencies on Aging across the U.S., more and more organizations are upgrading to comprehensive and integrated software tools to assist in information and assistance, case management, and reporting.

Inability to access prior client information efficiently

As a result of client information being held in paper files or offsite within providers' records, EAD I&A staff cannot take advantage of historical knowledge of clients by the aging services network. This makes it very challenging for the staff to make informed decisions when rendering assistance.

Significant data entry required for provider information

In order to attempt to track provider services, EAD must collect information and enter into its own tool for that purpose. This is a time-consuming and error-prone process.

Manually intensive data re-formatting

As mentioned above, EAD DP has collaborated with providers to offer a reasonable data interchange protocol for report data collection. As a result, the staff must re-format information received from the providers before it can be imported into the EAD tool. This activity is executed as carefully and quickly as possible, but remains a significant drain on resources and results in delays in report distribution.

Minimal opportunity for service improvement due to paper processing

In the presence of manual and paper-based processes, EAD is doing well to satisfy client need. Any significant improvement in service efficiency requires more wide-spread incorporation of computer automation. While it is not necessary to completely eliminate paper, the largest benefits will be a result of minimizing or eliminating its use in specific activities.

Unable to respond effectively to increases in service demand

Under the current processes, the only potential reaction to an increase in service demand would be the growth of staff. Given the cost repercussions of such a strategy, it is clearly unacceptable to maintain the status quo.

Unable to fulfill requested mission as centralized Kupuna Care Intake agent

In YYYY, the State (?) designated that EAD would serve as Oahu's centralized point for Kupuna Care intake. To-date, this request has largely gone unfulfilled, due primarily to a lack of resources exacerbated by the aforementioned process inefficiencies.

Comment [MO1]: Ask EAD how they would like this stated.

3.2. Process improvement highlights

Historic familiarity with Synergy tools aides in the migration to broader use

For more than 5 years, EAD and other County AAAs have had exposure to limited use of Synergy case management, NAPIS reporting, and I&R/A tools. Synergy has recently upgraded its suite of tools to work seamlessly, offer more efficiencies, and operate over an out-sourced IT configuration (i.e. the "AgingNetwork" service). The enclosed plan incorporates the new Synergy capabilities and by so-doing leverages EAD's prior, albeit limited exposure.

Recent Synergy tool enhancements integrate I&A and consumer-facing portal with case management and reporting

Chief among recent advances to the Synergy suite are two major enhancements. The I&A functionality (referred to as "BeaconIR") has been re-architected to work within the "SAMS" tool. This has two primary benefits. First the user is exposed to a single user-interface that increases situational awareness, and therefore the ability to serve clients better. Second, as a result of a single database, versus two separate databases with import/export functions, the systems will be more stable and less apt to introduce duplicate records. The second major enhancement involves the introduction of consumer-facing website features such as a replication of the I&A directory (referred to as "BeaconWEB") and submitting of electronic forms information into SAMS. These features allow the client to access the EAD resources even while EAD is closed for the day, and to leave useful information for efficient follow-up. These are the sort of advances that the Federal ADRC initiative encourages to promote maximum service quality.

Great advances in efficiency can be achieved

The planned improvements will result in significant increases in efficiencies, with relatively modest effort or investment. As the "current" versus "planned" process charts will demonstrate below, the improvements will result in current staff being able to provide better guidance to clients, with less effort, increased accuracy, and superior consistency. A side effect is an inherent ability to meet increased demands for service without proportional increases in staff.

Paper sub-processes can be eliminated or reduced to only exception cases

Where possible, the plan eliminates manual and paper-based activities with computer-assisted. In select areas, consistent with industry best-practices, paper-based activities will remain in place. Those that remain however, are better integrated into the information tools with defined coordination processes.

I&A can be better informed in real-time while working with client

As a result of the plan's use of an integrated I&A, case management and NAPIS reporting toolset, EAD staff will be better informed when working with clients. (This will also be true of providers using the same tools.)

DP can focus more on pro-active data monitoring and less on wasteful data re-entry and conversion processes

The legacy process requires the DP staff to spend most of its time manipulating paper forms or non-standard data files. Under the plan for improvements using a single toolset – and to the extent practical

inclusion of providers on the toolset – DP staff will be re-tasked to provide services that inherently produce more value to the organization. This improves EAD's responsiveness and quality by ensuring that the most informed decisions are being made and that coordinating organizations are complying with guidance.

Management will be better able to fulfill fiscal responsibilities in a time of increasing demand for services and limited potential funding

The comprehensive effect of the plan is to equip EAD to develop into a best-in-class organization. At this time of increasing demand for services, to some extent exacerbated by some of the less appealing aspects of "the Aloha State" such as disproportionately high instances of diabetes and heart disease, these steps will serve to enhance our ability to serve our clients.

Consumers will be able to directly access EAD resources "24 – 7" via the ADRC

By incorporating the ADRC as a virtual resource center, EAD ensures that consumers can receive support any time from any place, so long as they have Internet access. The ADRC services, with content maintained by EAD staff, will play an important role in providing service to a growing demand by consumers without additional personnel.

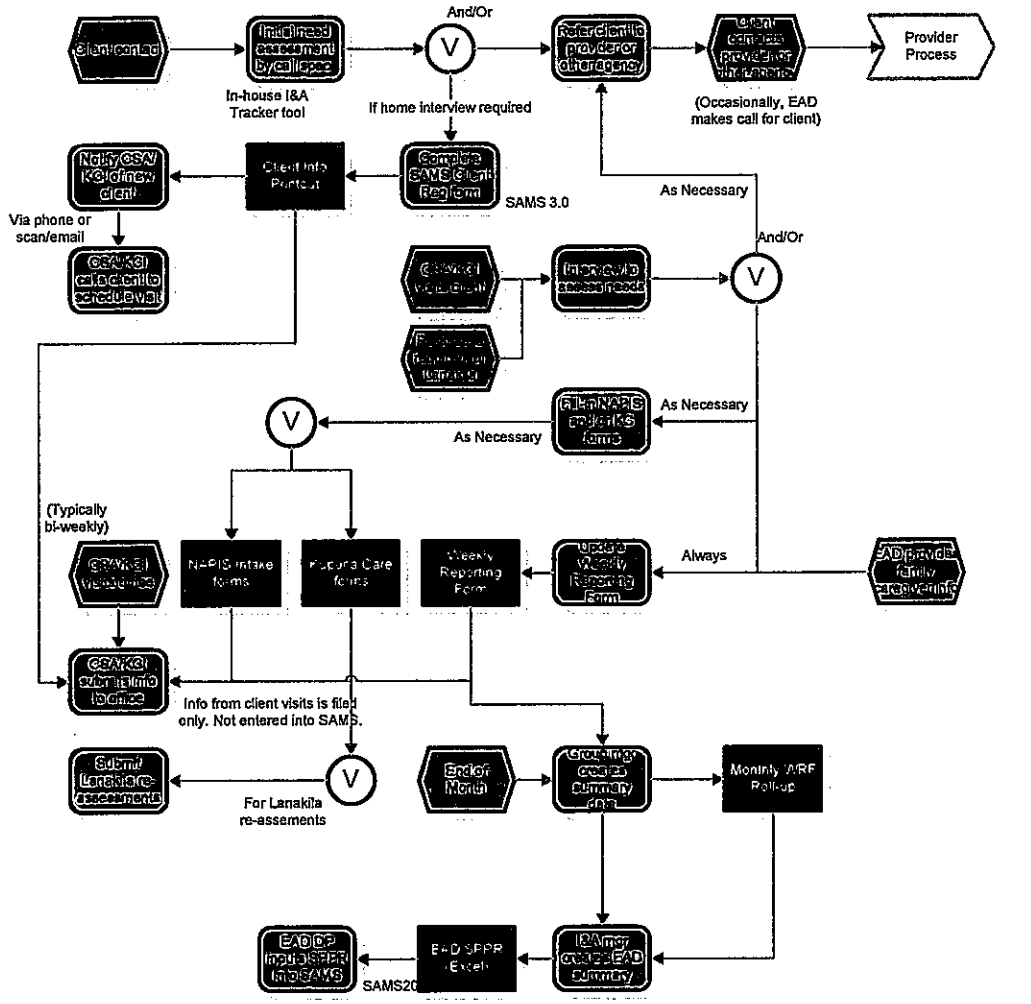
4. EAD Current Process

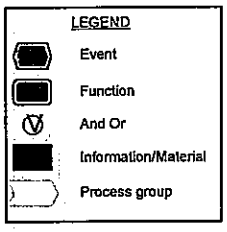
As highlighted above, EAD currently relies on a combination of manual and paper-based process with isolated use of in-house and vendor software tools. The tools are used primarily to assist in generating reports. The dependence on manually captured information to populate the database is inefficient and prone to error, but EAD is able to sustain the process with diligent effort.

4.1. I&A Process

For information and assistance (I&A) EAD relies on the familiarity of the staff with provider services for referring clients. It is challenging to keep up with changes to the provider network with this approach. Referrals to providers are made by giving the client contact information, and on rare occasion the I&A staff calls the provider on behalf of the client. There is little chance under this approach that referrals to providers are traceable to actual follow-up with the client – a desirable performance metric. (A pro-active client and provider survey could be instituted to evaluate this case, requiring however additional resources.) When follow-ups by CSA/KCI are determined to be required, the initial staff relays this information via phone or email. A client record is created in a legacy version of SAMS apparently for the sole purpose of printing a client registration worksheet. This information is not used for other purposes. When (or whether) the CSA/KCI makes the follow-up call is not easy to evaluate, due to the manual processes involved. During the follow-up visit, the CSA/KCI completes the paper assessment form(s) and eventually submits them to the office along with a log of weekly activities. Managers manually tally information from the logs into monthly reports, from which the department creates the monthly SPPR (Excel spreadsheet). EAD DP imports the SPPR information into its SAMS2000 database for report generation.

EAD I&A Process



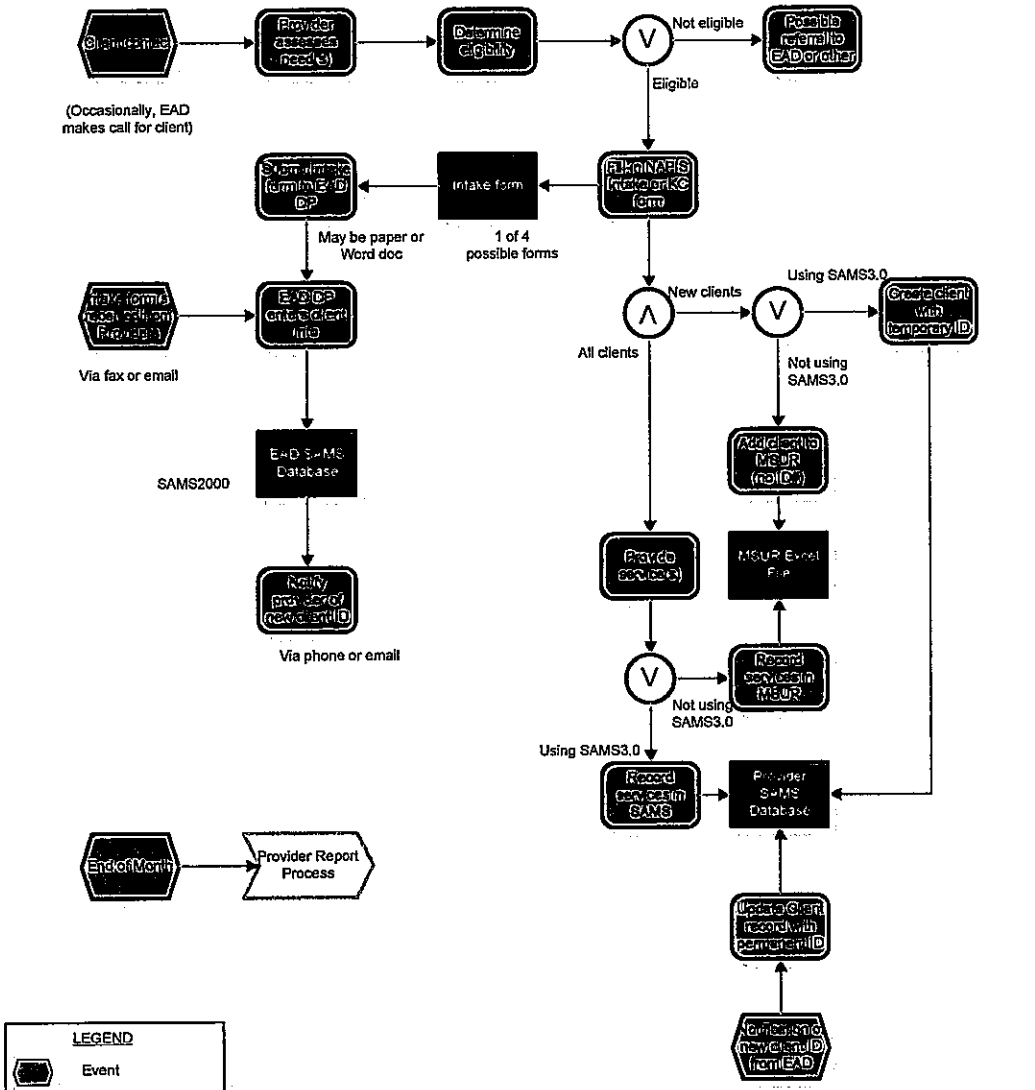


Revision: 3/12/2008

4.2. Provider Process

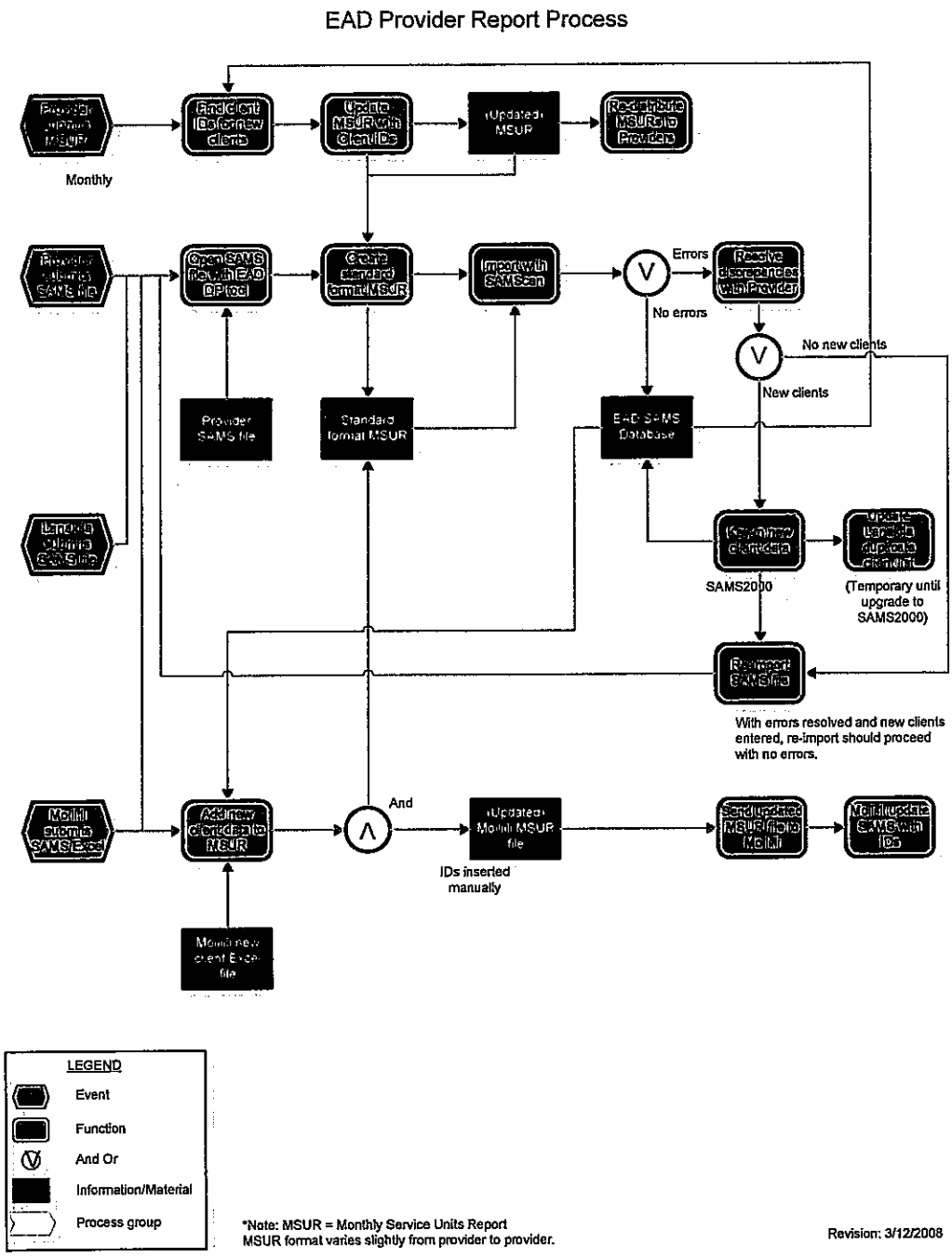
For the purposes of this analysis, there are two major types of providers – those using SAMS3.0 and those not using SAMS3.0. In either case, once a client contacts the provider, an intake form will be completed for clients that will be served. These intake forms are submitted as hand-written or type (via MS Word) paper to EAD DP. EAD DP enters the data from these paper forms into the SAMS2000 database so that the client record is created. EAD subsequently notifies the provider via phone or email of the client identification number (ID) so that future reports of service units can be reconciled to the proper client record. As the provider serves the client, service unit information is recorded so that it may later be submitted to EAD. If the provider uses SAMS3.0, service unit information is entered into the tool, otherwise the provider records the data into an MS Excel document designed for that purpose called the Monthly Service Unit Report (MSUR). EAD has agreed to support multiple layouts of the MSUR to accommodate differences in provider program/service recording schemes. When EAD notifies the provider of new client IDs, the provider updates its SAMS database or MSUR file to reflect the ID for future reference.

EAD Provider Process



4.3. Provider Reporting

EAD DP must aggregate provider service unit information into its SAMS2000 database so that reports can be generated. This is a moderately complex process, although EAD DP can achieve a consistent level of quality by exercising care. When MSUR files are received, they must first be scanned for client IDs that do not match the EAD SAMS2000 database. This can occur when for example, a new client was recently intake by the provider and EAD DP has not yet created a SAMS2000 record. Once these issues are resolved, EAD DP updates the MSUR to reflect the client ID, transmitting a copy of the updated MSUR back to the provider for use next month, and continues with the processing of the MSUR. The various MSUR formats are first converted into a standard EAD format by the DP staff using Excel features such as Copy and Paste. A Synergy product known as "SAMScan" can then read the standard format MSUR and import the service unit information into the EAD SAMS2000 database. Providers that use SAMS3.0 create an export file containing service unit information that is submitted to EAD DP. An in-house tool was created by EAD DP to assist in processing this information. The in-house tool is used to re-format the provider-exported data file into the standard format MSUR file, which can then be imported just like an MSUR using SAMScan. Some providers, such as Lanakila and Moiliili follow slightly different service unit reporting processes, which EAD DP adapts to with manual modifications to the above.



4.4. Report Generation

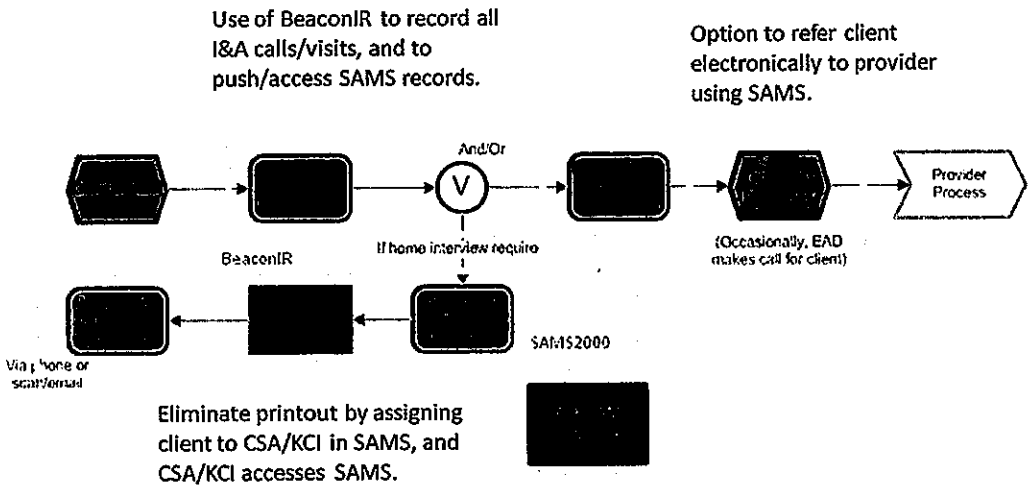
5. Opportunities for Process Improvement

This section identifies potential process improvements and describes the potential benefit of each. The main four process of I&A, Provder intake, Provider reporting, and report generation are sub-divided within this section into logical sub-processes for ease of discussion. Most of the opportunities for process improvement emanate from the deployment of SAMS (with BeaconIR) throughout the EAD staff and to the extent possible throughout the provider network. The staff can receive relatively minor procedural training to become proficient with the tools.

5.1. I&A Process

5.1.1. Basic client call process handling and initial referral

Basic client call process handling and initial referral



Use of SAMS (BeaconIR) to record all I&A calls/visits, and to push/access SAMS records

The I&A capabilities of BeaconIR (now integrated with SAMS) are much improved over versions originally considered for use by Hawaii several years ago. By using one system from initial call through assessment, intake, and provision of service, the State and individual Counties will all operate more efficiently.

Benefits:

- Discontinue use of legacy in-house tool for much improved, feature-rich SAMS/BeaconIR will eliminate maintenance concerns.
- Out-sourced information services provides high-value to agencies.

Option to refer client electronically to provider using SAMS

While on a call, the I&A specialist can decide that a referral is warranted. If the client is willing to provide basic information such as name, contact, status/needs then the specialist can quickly select the provider and service program to receive a referral. The specialist can request that the provider perform an activity, such as contacting the client by a specified date, or the client referral can remain "queued" until the client chooses to contact the provider.

Benefits:

- Eliminates need for EAD staff to call/email/fax provider for direct referrals (only done in emergency cases).
- By using the EAD I&A created client record, the potential for duplicated records is minimized.
- Any information collected by EAD during I&A is available within the single client record for review/use by the provider.
- All NAPIS information related to the I&A activity and subsequent actions are automatically rolled-up into the proper report(s).
- Subsequent provider actions are automatically recorded and can be viewed by the EAD staff for a complete and accurate client history on future potential calls.

Eliminate printout by assigning client to CSA/KCI in SAMS, and CSA/KCI accesses SAMS

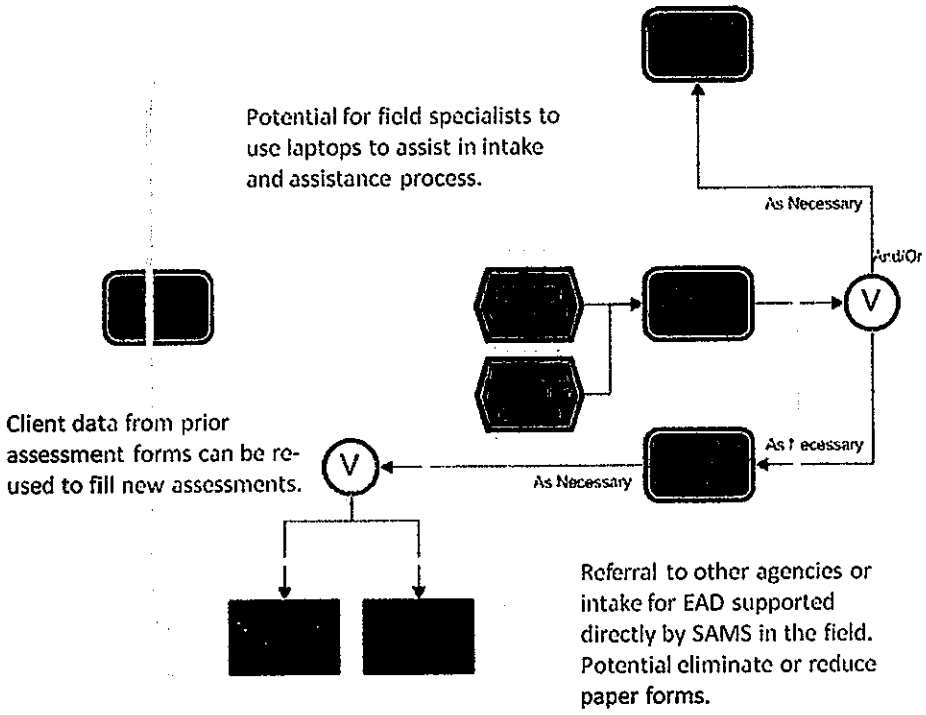
The current practice of creating a printed "client record" form (using SAMS 3.0) as means to assign the client to a CSA/KCI for follow-up visit can be converted into a totally electronic assignment. When the I&A call handler determines that a visit is required for detailed assessment and intake, they can use the SAMS "Activity & Referral" action to make the proper assignment. This action places an activity reminder in the SAMS dashboard used by the CSA/KCI's to list their queue of pending requests.

Benefits:

- Elimination of use of legacy SAMS3.0 system being used solely for the creation of a paper form.
- Eliminate phone call/email/fax by I&A staff to CSA/KCI to notify of assignment, and associated errors that may occur during translation of the information.
- Quick and fool-proof means of activity assignment using the same tool that is used for I&A call handling, during the call itself.
- Permits CSA/KCI to manage client activity requests without shuffling papers.
- Actions are captured within the database, and rolled-up to proper reports with no manual intervention.

5.1.2. Client follow-up assessment and intake

Client follow-up assessment and intake



Potential for field specialists to use laptops to assist in intake and assistance process

CSA/KCIs currently use paper forms during client visits to record intake information. They also must rely on their own knowledge supplemented by paper directories and program descriptions to inform the client. Using SAMS it is feasible to equip the CSA/KCI staff with laptops or PDAs to eliminate paper forms and include a complete electronic library of providers, programs and relevant information. SAMS permits the staff to download the day's client records so that while they are visiting the client they may access pertinent information. (Alternatively, the laptop can be equipped with a wireless Internet access so that real-time information is accessed.)

If the laptop/PDA option is not chosen, the SAMS system will promote process improvements over existing approach by permitting real-time use of information after it has been entered. It could be entered either by the CSA/KCI staff themselves from their home office, or the paper intake forms could be forwarded to a data entry staff. The former has maximum efficiency because the individual is more likely to accurately interpret their hand-writing, and can immediately enter referral information, etc.

Benefits:

- Eliminates mistakes and re-work if forms are lost or not available.

- Provides better informed decision support.
- Eliminates data re-entry (i.e. from paper form into MIS system) if using laptop/PDA.

Client data from prior assessment forms can be re-used to fill new assessments

The current process requires the CSA/KCI to fill-in the paper intake form completely. If demographic or partial intake information was collected during the initial I&A call, the CSA/KCI has no way to view or re-use it. With SAMS (including BeaconIR) the CSA/KCI can view any information previously collected. Furthermore, they can use this information to partially fill an intake form. This re-use is maximized if the CSA/KCI has a laptop since they can then choose any form(s) to fill and prior data will be automatically populated.

Benefits:

- Reduces time and effort required to fill an intake form(s) during client visit.
- Assessment forms can include formulas to ensure that CSA/KCI is notified when certain risk factors exist (such as nutrition, ADL/IADL).
- Any assessment form completed by the CSA/KCI is immediately available for other personnel, agencies, providers (in the SAMS network).

Referral to other agencies or intake for EAD supported directly by SAMS in the field

Once intake and assessment information is populated in SAMS as a result of the CSA/KCI data entry, it can be very easily referred to a provider (or another EAD person).

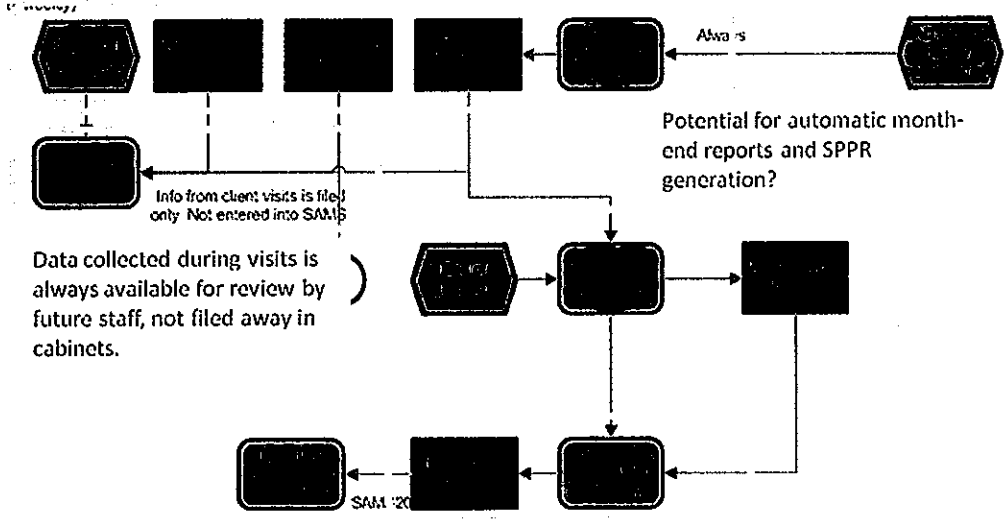
Benefits:

- Eliminates mistakes caused potentially by lost or misplaced paper forms.
- Eliminates need to call/fax/email provider to refer client.
- Reduces errors and duplicate clients caused by a client contacting a referred provider if the provider does not already have the record within their SAMS information.

5.1.3. Report data collection from EAD I&A process

Assessments performed and other notes from visits are automatically incorporated in SAMS data for reporting.

Report data collection from EAD I&A process



SPPR information can be collected without paper for EAD processes using SAMS and BeaconIR reducing work for DP.

Assessments performed and other notes from visits automatically incorporated into SAMS data for reporting

The paper-based process for assessment and intake is not only inefficient, but it also creates barriers for re-using of data. By using SAMS throughout the process, all information entered is immediately available to other personnel. This includes personnel within EAD and personnel at other agencies/providers. (Personally identifiable health information can be restricted from access to only those authorized to view it.) Data collected is also available for ad hoc and structured reports with no manual effort.

Benefits:

- Minimizes time for data entry.
- Promotes better decision making and information as a result of a complete view of client history.
- Eliminates manual report data collection activities.

Data collected during visits is always available for review by future staff, not filed away in cabinets

Potential for automatic month-end reports and SPPR generation

The current process requires CSA/KCI staff to complete a "Weekly Reporting Form" to tally specific information about their clients separate from the intake forms they may also fill. On a monthly basis, the department managers must then collect these forms and aggregate the information before end of month reports can be generated. This is a time-consuming and error-prone process. Due to the aforementioned process improvements using SAMS to collect intake and assessment information, the reporting process requires virtually no human intervention (other than the click of a report selection button). The SAMS tool permits the mapping of client-level information to NAPIS (or other) reporting schemes, and the report tool uses this information to generate the data.

Benefits:

- Eliminates filling of "Weekly Reporting Forms" by CSA/KCI.
- Eliminates filling of "Monthly Reporting Form" by department managers.
- Eliminates manual process to create SPPR.
- Improves accuracy of reports with standardized mapping patterns.

SPPR information can be collected without paper for EAD processes using SAMS and BeaconIR reducing work for DP

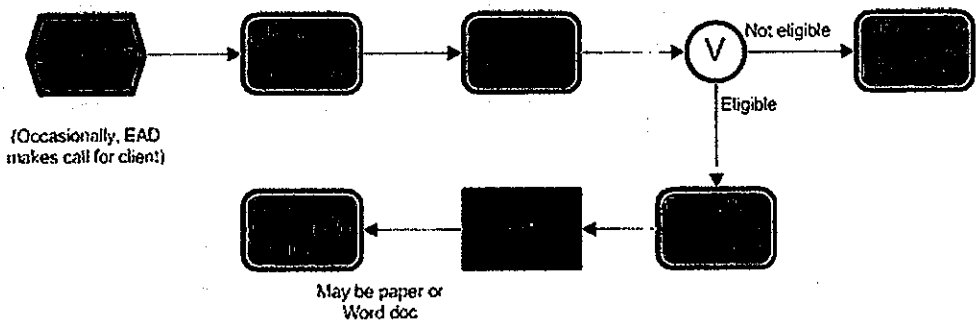
5.2. Provider Process

5.2.1. Provider client assessment and intake

Provider client assessment and intake

For providers in EAD SAMS network, referral assignments can be paperless, and results of assessments can be available for review.

Post-assessment activities can be entered directly into SAMS, reducing or eliminating paper. (If using laptops.)



Intake/assessment forms can be performed within SAMS, reducing paper handling and data re-entry by EAD DP.

For providers in EAD SAMS network, referral assignments can be paperless, and results of assessments can be available for review

A referral is currently made by giving the provider contact information to the client verbally. It is then up to the client to contact the provider, and the provider has no awareness of the referral and no history on the client. (On some occasions, EAD I&A staff will contact the provider on behalf of the client.) Without an electronic referral from EAD, the provider must "start from scratch" in intaking the client and assessing their needs. With EAD and providers sharing SAMS information, the provider finds the client in the SAMS database during initial contact, and is able to view any information EAD collected, as well as client history. This more informed intake process is efficient and leads to better decision making.

Benefits:

- Reduces duplicated clients.
- Reduces intake and assessment time by provider.
- Promotes client confidence by not requiring client to give information already provided to EAD.
- Improves quality of provider decision making by being able to access client history.

Post-assessment activities can be entered directly into SAMS, reducing or eliminating paper

When a provider assesses a client's needs, it may lead to referral to another agency/provider, and or intake for a service offered by the provider. Currently, EAD has no awareness of the results of their referral, except as is rolled-up in total service unit reports. Under a unified SAMS network, EAD will be

able to track down to an individual client from referral(s) to subsequent service provision and additional referrals. The provider is able to better manage the client through the coordinated use of SAMS features including intake and assessment forms and additional activities and referrals.

Benefits:

- Eliminates paper handling.
- Increased tracking of EAD and provider activities on a client-basis.
- Reduces effort required to administer a client.

Intake/assessment forms can be performed within SAMS, reducing paper handling and data re-entry by EAD DP

The current process requires EAD DP to enter intake information received from providers into the EAD SAMS system from paper intake forms. This is time-consuming and error prone. Under the proposed process, providers will enter information into SAMS assessment and intake forms. This information is immediately accessible by EAD, and the DP staff is not required to enter information from paper forms. The provider is also able to complete intake and assessment processes more efficiently by re-using information already collected on previous intakes.

Benefits:

- Eliminates need by EAD DP to enter provider data from paper forms.
- Reduces errors caused by misinterpretation of data on paper forms.
- Reduces time by providers to fill intake and assessment forms.
- Information entered by providers is immediately available for access.

5.2.2. Processing of provider intake information

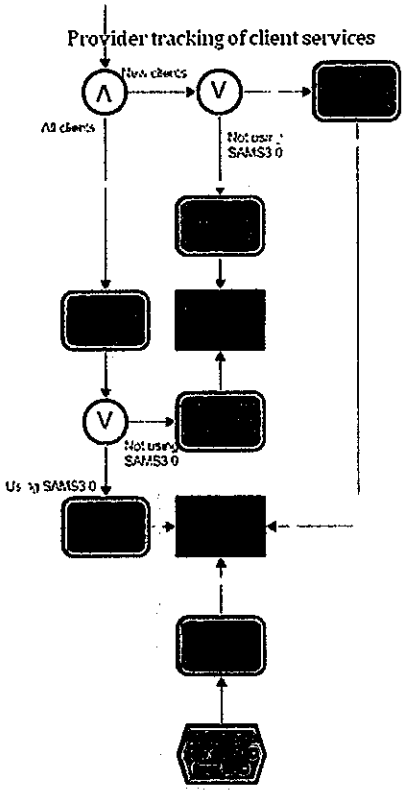
This is complicated by the fact that the client databases are not synchronized electronically. Therefore, currently providers must notify EAD of a potential new client, EAD must confirm this and enter the client information into EAD SAMS, and then notify the provider via phone or email of the master client ID. Under the proposed process improvements, client ID management is automatically achieved by the SAMS system. (EAD and providers must adopt a policy and procedure to ensure that they use reasonable means to identify the existence of a client before creating them as new.)

Benefits:

- Eliminates need for EAD DP to enter new client information when client contacts provider.
- Eliminates need for EAD DP to contact provider to advise of new client IDs.
- Reduces errors and minimizes duplicated clients.

5.2.3. Provider tracking of client services

Potential for reduction of some use of MSUR reports by including more providers in EAD SAMS network.



Client ID management tasks are eliminated for providers in EAD SAMS network.

Potential for reduction of some use of MSUR reports by including more providers in EAD SAMS network

Providers currently track and report service units by filling the "Monthly Service Unit Report" form. EAD has worked with providers to permit them to record this information in the manner most suited to their operations. This reduces the total effort by the provider, but requires more work by EAD to process the various MSUR formats. In addition, since the MSUR reporting is separate from the primary means used to manage clients, errors can be introduced by the provider. Providers that are upgraded to the EAD SAMS network will no longer need to record service units separately, nor will they need to submit MSUR reports manually.

Benefits:

- Decrease or eliminate use of MSUR reporting.
- Eliminate errors introduced as part of MSUR report collection process.
- Eliminate time and effort required to submit MSUR reports to EAD DP.

Client ID management tasks are eliminated for providers in EAD SAMS network

As mentioned previously, the current process requires manual and error-prone activities to manage new client IDs. These are eliminated in the proposed system to the extent that providers are included in the SAMS network.

Comment [S2]: Consider proposing an improved method for client management for any providers not included in network.

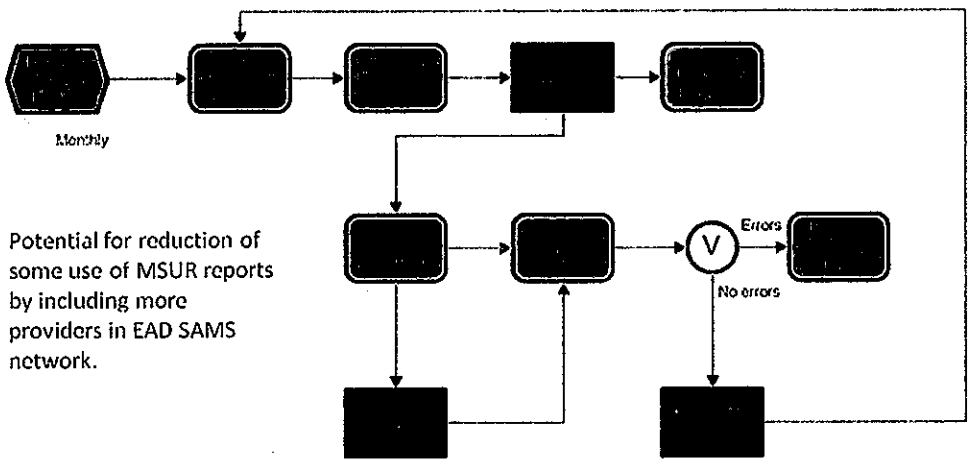
Benefits:

- Eliminates need for EAD DP to enter new client information when client contacts provider.
- Eliminates need for EAD DP to contact provider to advise of new client IDs.
- Reduces errors and minimizes duplicated clients.

5.3. Provider Reporting

5.3.1. Processing of provider client service unit information – basic MSUR handling

Processing of provider client service unit information – basic MSUR handling



Potential for reduction of some use of MSUR reports by including more providers in EAD SAMS network

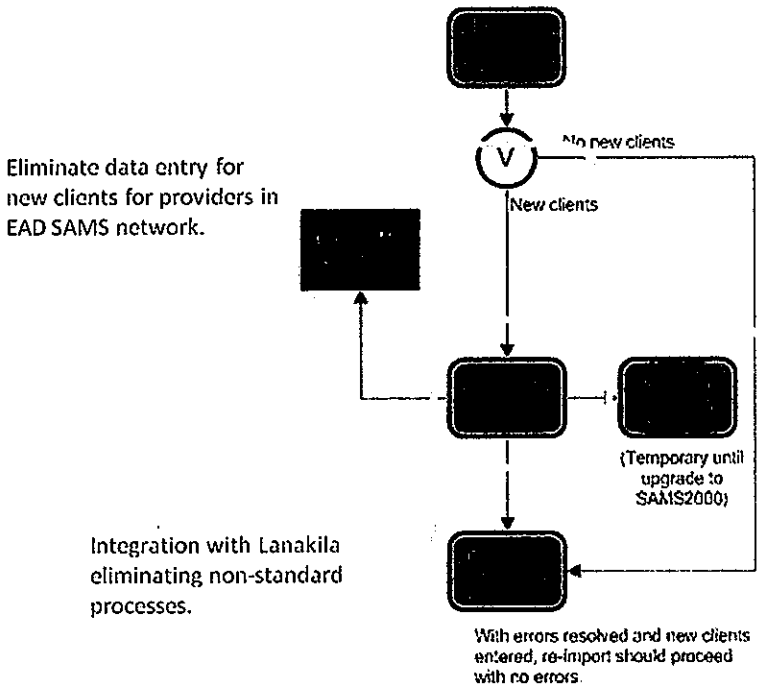
As shown by the process diagram above, the processing of MSUR reports by EAD DP is composed of many steps. The EAD DP team works hard to minimize the time required for this process. Unfortunately it relies on time-consuming manual tasks working with various file formats. The proposed approach completely eliminates the above process (and associated delays) for service unit reporting. (The exception is if providers are not within the EAD SAMS network. Such providers will continue to use some sort of MSUR reporting process.)

Benefits:

- Elimination of a time-consuming and potentially error-prone process.
- Accurate service unit data is immediately available for monthly and other reports.
- Eliminate need to send updated MSUR files to providers.

5.3.2. Processing of provider client service unit information – loading of new client data

Processing of provider client service unit information – loading of new client data



Eliminate data entry for new clients for providers in EAD SAMS network

EAD and providers have agreed on a set of practices that attempt to minimize duplicated clients. Unfortunately, these practices lend themselves to human error and are inherently inefficient. Under the proposed system, any client will be entered only once by the first organization that the client contacts (be it EAD or a provider). This information is immediately available as soon as a client is created. When that client enters another door at a later time, SAMS will assist the organization in determining that the client was already previously created.

Benefits:

- Minimizes duplicated clients.
- Promotes accurate reporting.
- Eliminates inefficient specialized handling of new client IDs.

Integration with Lanakila eliminating non-standard processes

EAD and Lanakila maintain a special process for managing new clients. Lanakila plans to transition to SAMS2000 from SAMS3.0. Until this move is accomplished, EAD and Lanakila maintain a new clients exception list to resolve mis-matched client IDs in the EAD and Lanakila systems. This is inefficient and

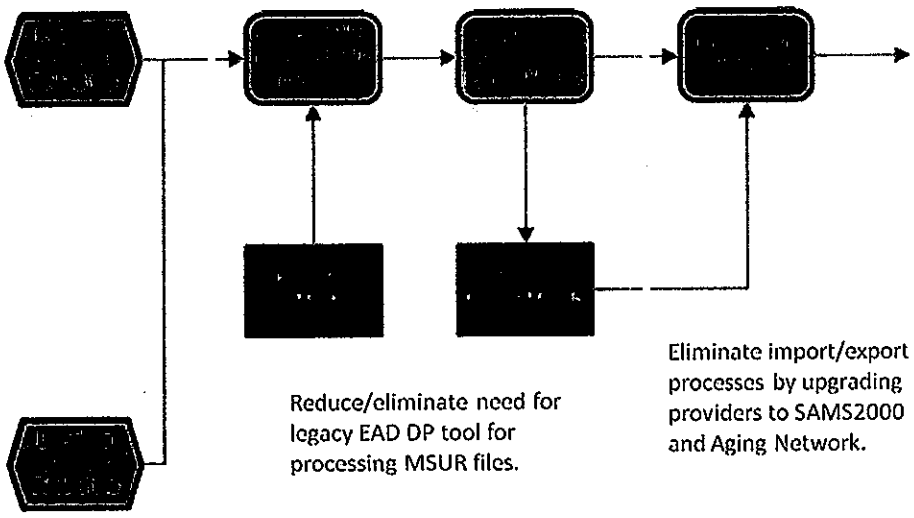
prone to error. Eliminating this process with a single SAMS database will promote accuracy and efficiency.

Benefits:

- Eliminates a non-standard process.
- Improves efficiency.
- Promotes accuracy.

5.3.3. Processing of provider client service unit information – handling of SAMS import files

Processing of provider client service unit information – handling of SAMS import files



Reduce/eliminate need for legacy EAD DP tool for processing MSUR files

In some cases, providers in the City and County of Honolulu are using SAMS3.0. This tool is similar to the EAD SAMS system, but is not integrated. EAD DP has developed an in-house tool that assists staff in processing service unit information exported from the provider SAMS3.0 systems. The EAD DP team is accustomed to using this tool, however it is a time-consuming process to import the SAMS data. Once providers and EAD are using the same tool and same database, the need for the legacy tool is eliminated.

Benefits:

- Discontinue use of legacy EAD DP tool.

Eliminate import/export processes by upgrading providers to SAMS2000 and Aging Network

A common system and shared database maximizes efficiency. No import/export processes will be required. As mentioned previously, the associated client ID processes are also eliminated.

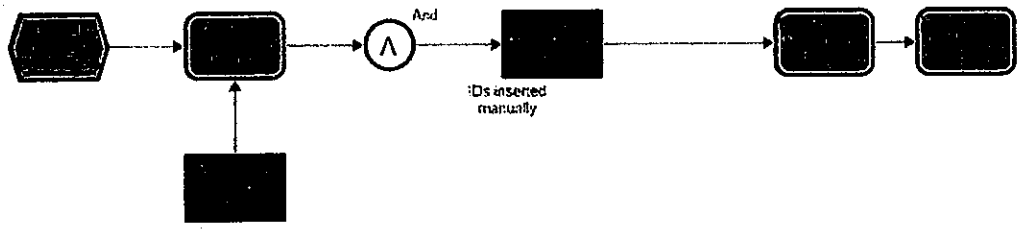
Benefits:

- Upgrade all organizations to current SAMS system for vendor support. (SAMS3.0 is not supported.)
- Eliminate import/export processes.

5.3.4. Processing of provider client service unit information – Moiliili processing

Processing of provider client service unit information – Moiliili processing

Eliminate special Moiliili processing by including in EAD SAMS network.



Eliminate special Moiliili processing by including in EAD SAMS network

EAD has agreed to support a non-standard process with Moiliili for reporting service unit information. As with Lanakila, EAD DP works hard to ensure that Moiliili data is processed in a timely manner. Under the proposed system, this non-standard process is eliminated and service unit information becomes immediately available as a result of the provider's everyday activities.

Benefits:

- Eliminate processing of Moiliili service unit information.
- Eliminate need to send updated MSUR file to Moiliili.

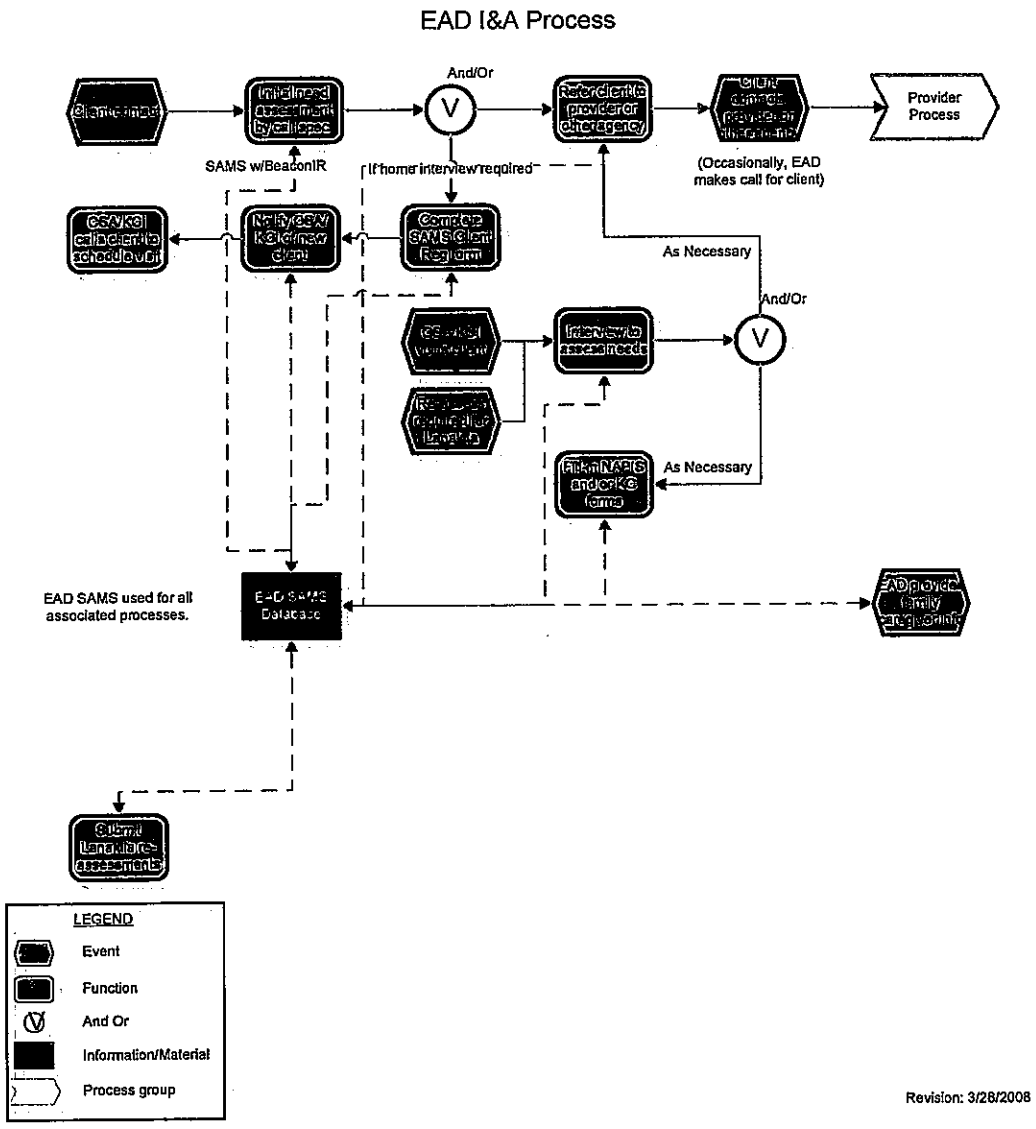
5.4. Report Generation

6. EAD Planned Process

The process descriptions below reflect the EAD processes that will exist after the planned improvements. The core enabler for these improvements is the organization-wide use of the Synergy "SAMS" suite (with BeaconIR, Omnia, and other modules as required for each personnel). As the diagrams clearly demonstrate, use of paper has been reduced to a minimum and access to client information is increased substantially.

6.1. I&A Process

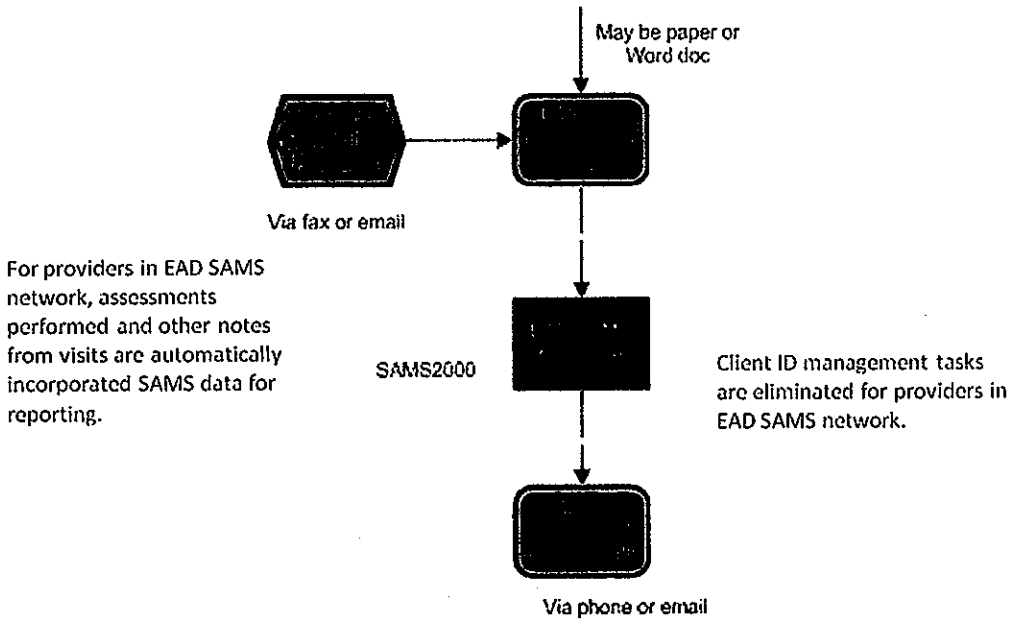
Isolated use of legacy tools, including the DP "IA Tracker" and Synergy SAMS3.0, will be discontinued in favor of access to the currently supported version of Synergy SAMS via Aging Network. For I&A, the staff relies chiefly on BeaconIR (for information and assistance) and Omnia (for intake and assessment) modules within SAMS. EAD provides minimal "case management" services, and unless deemed useful to some staff such as group leaders, the SAMS case management features will not be required. (This results in a less expensive license.) Referrals to provider and notification of follow-up by CSA/KCI will be performed by I&A staff with these tools efficiently, and subsequent actions will be tracked seamlessly. Additionally, information collected from prior steps are available for re-use in subsequent steps. For example, an abbreviated intake during initial call with I&A is available for use by the CSA/KCI during follow-up, and a more extensive assessment by CSA/KCI is available for use by providers. This approach eliminates paper (intake forms and Kupuna Care forms) saves time, and promotes improved decision-making by sharing information already provided by the consumer.



6.2. Provider Process

Providers will receive referrals electronically via SAMS. During client intake, the provider can easily check if a referral was provided and associate the client to the referred record. This increases the accuracy of reporting. New clients are automatically checked by SAMS against existing clients to minimize duplicate entries. All subsequent activities performed by the provider are also associated with the client, ensuring an accurate record of all support for a client across all providers and EAD.

Processing of provider intake information



For providers in EAD SAMS network, assessments performed and other notes from visits are automatically incorporated into SAMS data for reporting

Under the current processes, information collected by providers is largely not accessible by EAD (or other providers). Once the proposed improvements are in place, EAD and providers can share information without any re-entry of information. SAMS supports a very granular permissions assignment capability so that only those organizations and individuals that should be able to see or edit information can. So for example, private health information on clients will only be viewable by those with authority to access. Reports will reflect accurate information without entry of additional data.

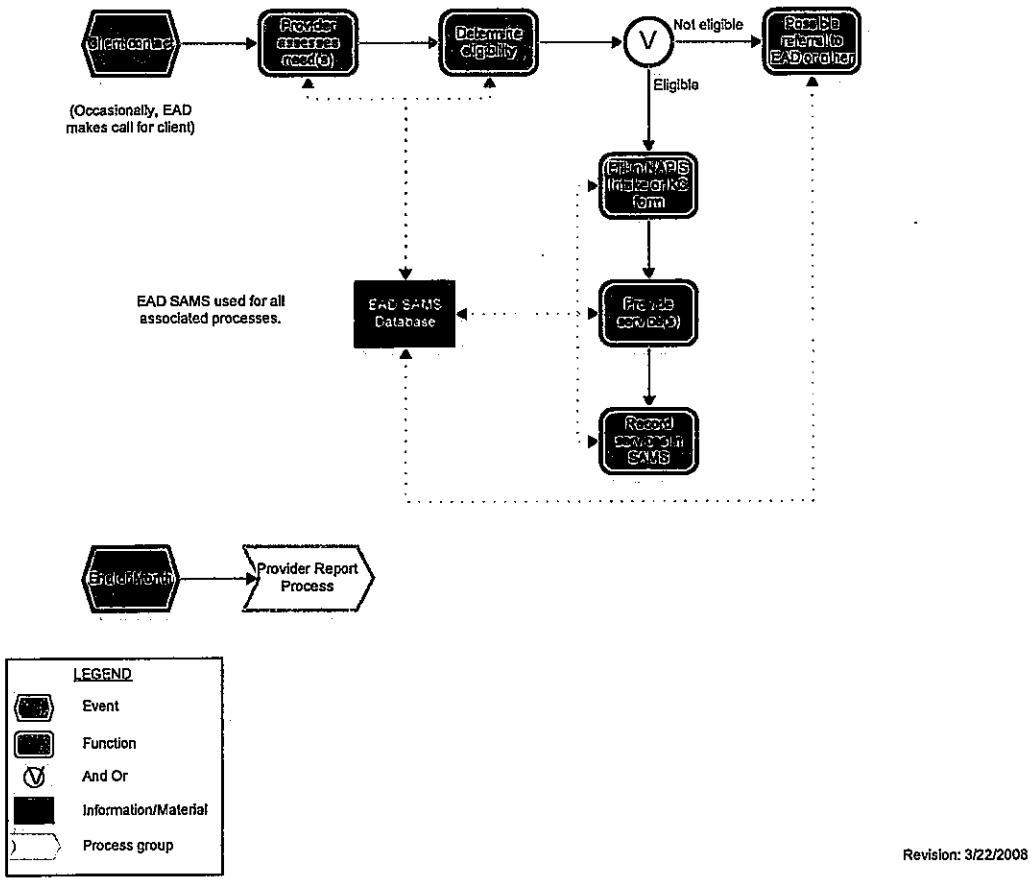
Benefits:

- Information is immediately available for viewing by agencies and providers.
- Reports are generated without re-entry of data.

Client ID management tasks are eliminated for providers in EAD SAMS network

One of the most time-consuming and inefficient processes currently adopted by EAD and the aging services network in Honolulu involves management of "new" clients. Any time a client contacts EAD or a provider, it is desirable to determine if the client is already in the system or is actually new. If new, it is important that a unique ID be assigned to the client by EAD so that accurate reporting can be generated.

EAD Provider Process



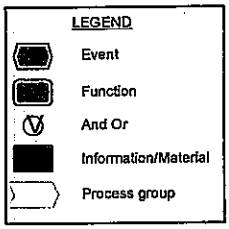
Revision: 3/22/2008

6.3. Provider Reporting

In the planned improvements, the process of reporting by providers is automated. All services and other activities associated with a client are recorded in the EAD SAMS database and therefore are immediately available for query and reporting. This eliminates time-consuming data entry and re-formatting processes.

EAD Provider Report Process

The associated activities with this process are eliminated for all providers that participate in the EAD SAMS network. Provider reporting of services occurs as an automatic result of the provider process. No additional effort is required.

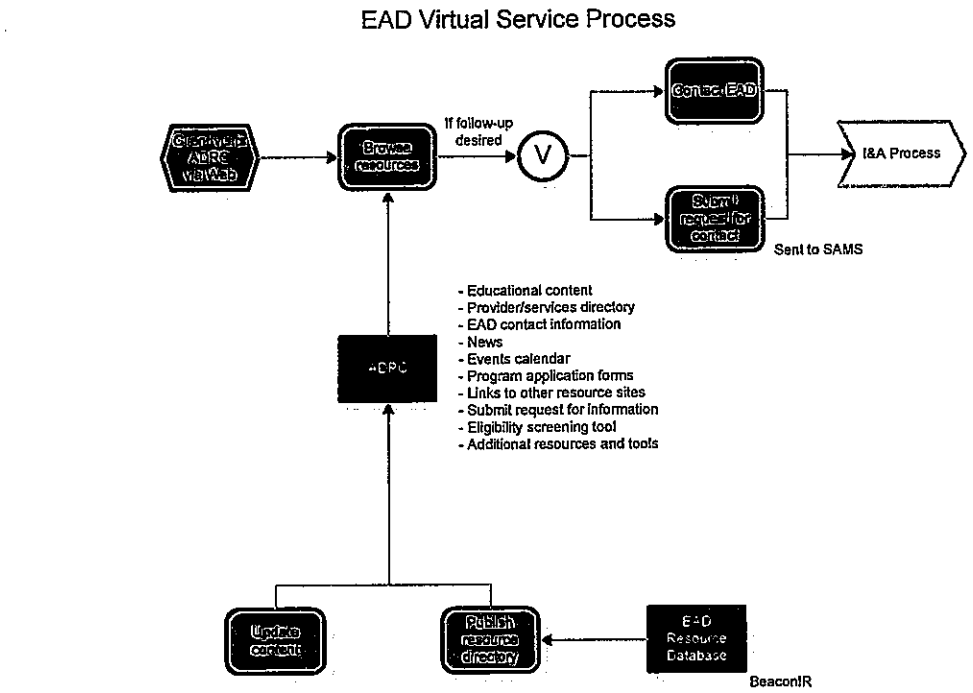


Revision: 3/22/2008

6.4. Report Generation

6.5. Virtual Service Process (new)

With the development of an ADRC, consumers will be able to interact with resources provided by EAD without face-to-face or phone interaction. In some cases, access to the ADRC will be all that a consumer needs to satisfy their need. At other times, the consumer receives some useful information from the ADRC but determines that direct interaction with EAD is required. In this latter case, the ADRC can provide tools to assist the consumer in informing EAD about their needs, which can lead to better "initial contact" results.



Comment [MO3]: EAD should review this section carefully for sensitivity to statements, and to ensure that any role enhancements that are not mentioned are identified for inclusion.

7. Organizational Role Enhancements/Outlook

Under current processes, EAD staff is hard-pressed to improve quality of service due to the burden of administrative (paper) activities and limited access to online client and provider information. The planned approach opens the door to enhancements in organizational roles by decreasing such burdens and increasing access to real-time information. As a consequence, personnel can be more fulfilled from being able to provide better quality service to more clients.

7.1. I&A Role

Armed with an electronic resource directory of providers and services, the I&A staff can present the broadest set of options to clients, confident that changes are kept up to date. Being able to quickly

assign actions to their clients using the BeaconIR capabilities of the SAMS toolset, further instills confidence that those actions will be performed in a timely manner. Finally, by being able to view a client's history not only with EAD directly but across the entire provider network (if desired) permits the I&A to offer better decision support to the client, approaching that of a case manager, although without the associated formal designation and obligations. As a result, the I&A staff are likely to be more energized in their role and clients will be better served.

CSA/KCI personnel should appreciate being able to review a list of assignments from within the SAMS tool, rather than needing to copy information from a telephone call or shuffling through emails. When the CSA/KCI completes an action, or fills an intake form, this information will be entered once. A separate paper log of activities is not required to be maintained. These advances free the CSA/KCI to focus on their clients, and to serve more clients without the burden of excessive paperwork.

The collective result of the planned approach may permit EAD to support its mission of acting as the centralized Kupuna Care Intake agent. The extent to which this may be achieved (in absence of additional staff) depends upon the demand for the services. Nevertheless, it is clear that the planned approach permits the staff to complete more of this mission than previously possible.

Another future advantage of the planned approach is to equip EAD to handle the anticipated expansion of their mission to include more clients with disabilities, and initiatives such as reverse mortgages and additional long term care home and community based services. With a shared database and toolset, information can be distributed quickly, and services tracked efficiently.

7.2. DP Role

The DP staff will similarly be given an opportunity to increase their contribution to the improvement of EAD quality, versus currently being limited to fulfilling a day-to-day burden of conversion of paper and data files for purposes of reporting. DP will remain the "keeper" of the data, however their focus can shift from the elementary activity of data entry to more analysis and monitoring.

DP will assume responsibility for maintaining the configuration of the City and County of Honolulu SAMS system database, which will be accessed not only be EAD but also providers. This includes management of the provider database information – i.e. BeaconIR data. They will lead a State of Hawaii (or at least Oahu) SAMS user group to set guidelines for use and to identify best practices, and pro-actively monitor all organizations for compliance. (Some training will be required for designated DP staff to increase their expertise in configuration and management of SAMS systems.)

Security is an important consideration for EAD, especially concerning providers sharing access to the SAMS database. DP will manage and ensure compliance with configuration settings to control access to client information that may be sensitive. SAMS provides a comprehensive tool for managing security rights. One provider may be able to view a client, but not access an assessment containing sensitive health information for the client. Another provider has full access to the client information as a result of a decision based on the provider's need and training.

The integrated database provided by the planned approach permits EAD (and the State for that matter) to be more pro-active in its analysis of the condition of the aging and disability population, programs and services in Hawaii. DP can assist in this analysis by creating reports using SAMS and or the Crystal Reports tool. While in the past DP did not have time to support such requests, it is foreseeable that they will be able to help management in this area given the efficiencies that will be gained.

7.3. Grants Management

8. EAD Systems

8.1. Current

(Insert a diagram of current systems.)

I&A Tracker

EAD DP created this MS Access application to permit I&A staff to record call activity and to assist in basic activity counting to support reporting. The tool has limited functionality and is not competitive to vendor-supplied products.

DP Import Tool

EAD DP created an MS Access application that reads files exported by providers with SAMS3.0 and assists the staff in creating files suitable for import into SAMS2000. SAMS3.0 is an un-supported version of the Synergy SAMS case management tool and its use is not recommended. All agencies and providers should use a common platform such as SAMS2000 so that conversion of files is not required. Use of a single SAMS database within the State and or Counties further mitigates errors, reduces effort, and increases efficiencies.

SAMS 3.0

This is a legacy version of the Synergy SAMS case management tool used by EAD to print new client information for I&A follow-up. Its use should be discontinued as it is no longer supported by Synergy, and likely does not support NAPIS fully.

SAMS 2000

This is the supported version of the Synergy SAMS case management tool used by EAD to collect client and service information for reporting.

8.2. Planned

(Insert a diagram of planned systems.)

ADRC

The Aging and Disability Resource Center is a consumer-facing online system for the distribution of resources including educational content, provider/service directory, news, events, and other decision support information.

Aging Network

The Aging Network service is an online delivery platform for the other Synergy functions. It alleviates the necessity for management of servers, software, and communication by EAD, County, or State IT departments to host the Synergy software. Each user requires only a PC with Internet connectivity.

BeaconIR

This is the Synergy module that provides information and referral capabilities. A forth-coming version expected to be released Q2 2008 integrates BeaconIR and SAMS under one SAMS user interface.

BeaconWEB

This is an optional service provided by Synergy that can "push" provider/service information from a BeaconIR database to a website that includes a resource directory search tool suitable for use by consumers.

SAMS (formerly SAMS2000)

This is the supported version of the Synergy SAMS case management tool.

SAMS-BCU?

This is an optional module permitting NCOA's Benefits CheckUp capabilities to be integrated with SAMS systems. A SAMS user can then automatically assess eligibility from SAMS for BCU programs. (Currently limited to Medicare Part D Low Income Subsidy program.)

SAMScdi

This is an optional SAMS module that permits a website to include an electronic form that may be used by a consumer to submit needs information into SAMS as a client request. The SAMS staff may then review this information and be better prepared to follow-up with the client.

SAMSapp?

This is an optional service provided for SAMS systems that permits users to complete electronic program application forms on behalf of clients. Forms will be automatically populated with any information from prior data that was collected.

Document scan/management tool?

This tool is being considered for value to store electronic (scanned) images of paper forms and attach to client records in SAMS. This would permit SAMS staff to review information (such as assessments, notes) without needing to enter via keyboard into SAMS. Another version of the tool could perform optical character recognition on the forms so that information could become part of the SAMS database.

9. Program Plan

This section describes the program plan to advance EAD systems and processes. An overview of the plan is shown below.

(Insert high-level diagram of plan.)

9.1. Objectives

1. A comprehensive electronic I&A database and tracking tool across EAD
2. Minimal paper-based processes, and where required optimized to integrate with EAD database
3. Shared access to the EAD database by providers for referral and case management
4. A virtual resource center to serve consumers and increase EAD efficiency
5. Enhanced policies and procedures to improve EAD's ability to meet increasing demands
6. Continuous quality improvement

9.2. Approach

EAD will build on experience to establish a low-risk, efficient approach to achieving its objectives.

1. Leverage knowledge of the aging services space and City and County of Honolulu specific needs to ensure process improvements produce expected benefits
2. Upgrade and extend the Synergy suite of aging services tools consistent with national state of the practice techniques
3. Define enhancements to personnel roles that boost their contribution to the organization's mission and lead to greater individual fulfillment
4. Involve the provider network in advances and secure to the extent possible a uniform platform within the network for information sharing, promoting superior decision-making
5. Construct a virtual resource center that permits consumers to self-serve and to interact with EAD more efficiently
6. Collaborate and coordinate with EOA and other Hawaii AAAs to identify and adopt best practices
7. Seek continuous quality improvement with on-going measurement and pro-active data analysis

9.3. Major Activities

(This section will contain the specifics of our final plan. The following are placeholders for possible activities. I want to facilitate the formation of the plan with several phone calls. Mark up this section to suggest activities that you believe should be considered. I will accumulate and present for discussion.)

9.3.1. Policy development and coordination

(This perhaps is saved for the later document "Protocols and Standards". But if some policy related information belongs in this document, please insert here.)

9.3.2. New EAD/provider platform roll-out

Acquire licenses for Synergy services upgrade as necessary (Aging Network, BeaconIR, SAMS, BeaconWEB, SAMScdi, SAMSapp)

Stage and configure Synergy upgrades for initial data migration

Train and roll-out systems to personnel

Phase-out legacy processes and systems while phasing-in providers and personnel on new platform

9.3.3. Consumer ADRC development

Content management system for presenting regionally relevant information and decision aides

Common platform for EOA and all four AAAs, with tailoring to appear as five "sites" for local appeal

Either purchased as "solution" from commercial vendor, or developed locally, with purchased specialty modules as necessary

Publish EAD I&R database to ADRC

Integrate with MIS platform (SAMS including Beacon)

Content maintained by each agency

9.3.4. Process monitoring

9.3.5. Future advances

SAMScdi

Assess needs

Eligibility screening

Online application forms

9.4. Budget?

9.5. Outcomes?

9.6. Required Policies/Mandates/Agreements

11.1. To record service provided by EAD staff to community groups, etc., create custom user groups in SAMS, create custom program, and record service delivery record for each event.

11.2. When needing to assign a client to CSA/KCI for home visit, create an Activity during the I&A call and optionally set a date. The Activity can point to an "agency" that is actually a department or staff person such as "EAD Customer Service Agent".

11.3. When referring to providers that are not in the SAMS network, use SAMS to create a PDF of the referral information, and email or fax it to the provider.

11.4. Use the call Outcomes feature to record outcomes that can be rolled-up into ADRC report.

11.5. Implement recommendations from EOA "Federal and State Reporting Requirements 2005" (see appendices)

11.6. For CSA/KCI not using laptops, use SAMS paper "re-assessment" feature to printout form to take to client home, then enter changed data into SAMS/Beacon from home office.

Appendix D

ADRC Hawaii Evaluation Update Report
(Excerpt only)

Appendix D

ADRC HAWAII EVALUATION UPDATE REPORT

September 2009

Prepared by:
Pam Arnsberger, PhD
Professor and Evaluation Coordinator
University of Hawaii School of Social Work

ADRC Evaluation Update

2006-2009

2006-7

The evaluation team developed an evaluation work plan to meet the goals of the overall ADRC work plan. It was submitted to the Administration on Aging and Lewin Associates in March, 2007. One of the major goals of the 2006-2007 year was to establish pre-implementation measures for both consumers and providers in order to have a baseline against which to compare the effects of the ADRC. The following activities were undertaken in order to meet this goal:

- The committee administered a baseline consumer satisfaction survey utilizing a list of consumers from Hawai`i County Office on Aging. One hundred and forty surveys were sent; twelve were returned as undeliverable. Thirty one (31) surveys were eventually completed for a response rate of 24% - slightly better than consumer satisfaction surveys conducted in other states. The results indicated that most older adults were very satisfied with their contact with HCOA. Their service was seen as prompt, informative, courteous and culturally sensitive. However several interesting areas emerged. One was that caregivers used the HCOA less frequently than expected and while most people saw HCOA as a source of information, fewer people used it for assistance with care. Of the entire sample less than 15% used HCOA as a beginning source for referral to other agencies where they obtained services. Transportation emerged as one of the main service problems.
- The committee also completed a service provider survey in the spring of 2007 on Oahu. A standardized networking assessment tool was adapted that measured the extent to which agencies are aware of each other's services and cooperate in service delivery. Additional questions were added for use in Hawai`i and the survey was administered to randomly selected service agencies by phone in the spring of 2007. Thirty-five (35) surveys were completed. Service provider opinions on how well they worked together varied. The findings were analyzed, summarized and presented to the evaluation committee.

- In cooperation with the access and streamlining committee, the results of the findings from five focus groups were analyzed. These five groups were composed of active seniors, caregivers, underserved minority groups, younger adults with physical disabilities and long term care service providers on Oahu. Overall 49 people participated in the focus groups and the finding were analyzed and prepared in a report which was submitted to both the evaluation and access and streamlining committees in September, 2007.
- At the end of September the Honolulu Elderly Affairs Division adapted the baseline consumer satisfaction instrument used in HCOA for distribution at the annual seniors fair. They divided the instrument into two, one for caregivers and one for elders. Together they collected 189 responses. These data were analyzed and provided a baseline measure as well as a needs assessment for Oahu. The results of this assessment are detailed in the Summary of Findings from the Oahu Senior Health Fair Survey.

2008-9

The evaluation team worked in cooperation with ADRC staff to include and coordinate evaluation components in the ongoing evaluation work plan to meet the goals of the overall ADRC work plan.

- In spring of 2008 a consumer satisfaction follow-up survey for the HCOA ADRC site was undertaken utilizing the same methodology as in the previous survey (see Evaluation Handbook for survey methods discussion). Baseline and follow-up data were then compared and report compiled (see Summary of Findings ADRC HCOA baseline and follow-up surveys compared). However a caveat to this survey is that most consumers were still not aware of the transition of the Area Agency on Aging to an ADRC and full awareness of the transition did not take place until November 2008 when the launch of the new site was accomplished. Please note that demographic statistics are used for comparison only; they were not subject to any statistical tests.
- In spring of 2009, an Evaluation Handbook was developed which covered the survey methodology for each of the surveys undertaken including the two for

change in service utilization and consumer satisfaction over time once the ADRC is fully in operation.

- The first follow-up survey of the EAD ADRC website will be undertaken in September to assess consumer utilization and satisfaction. A web based survey methodology (utilizing the final version of the web-based survey tool) will be used to conduct this survey with the possible addition of a phone based supplement.

- A follow-up survey of Oahu service providers will be conducted in September 2010 which will be 12 months after the launch of the OAHU website. The same questions that were originally in the survey, which included the possibility of waiting list reduction and increased cooperation between service providers in term of making and receiving referrals and streamlining application procedures, will be repeated in order to determine if ADRC produced change over time in these areas.

Summary of findings
ADRC HCOA baseline and follow-up surveys compared
Pam Arnsberger
Program Evaluator

Demographics /caregivers

The surveys were conducted in April of 2007 and the follow-up survey in April of 2008. Response rates for both surveys were similar in that 25-30% of the respondents for whom we had correct contact information responded to the survey at time 1 and again at time 2 to the mailed survey and /or the follow-up phone contact (N = 48 respondents overall). These were not the same respondents; a random sample of services user in the past year was the basis for each of the surveys (see the Evaluation Handbook for a complete description of survey methods).

Respondents on the follow-up survey for Hawaii County Office on Aging (HCOA) ADRC differed somewhat from respondents on the baseline data. At baseline there were more respondents (69%) answering for themselves; at follow-up there were more caregivers (52.6%). The percentage of males at time one was 25%; at time two it was 38.9%. The follow-up sample was slightly younger. In terms of ethnicity a higher percentage (52.9%) were Japanese at follow-up then baseline. There was a higher percentage of spousal caregivers (35.3%) at follow-up. There was little difference in terms of care recipients living with caregiver (about half each time), but among caregivers more were employed full time at follow-up (33%) than at baseline (14.3%).

Functional status

Over 80% of those answering that they had ADL impairments required assistance with finances, transportation, meal prep or cooking, and arranging for medical care at both baseline and follow-up. Far fewer needed assistance with eating both times (20-30%) and dressing (also around one third both times). Bathing and getting to the bathroom were both at about 50% of those needing assistance. A higher proportion at follow-up needed assistance walking (73.3%) than at baseline (50%).

Seniors and/or care recipients

Follow-up had more females than at baseline (59% vs. 43.5%). Both times almost all were born in the U.S. (including Hawaii). There were a higher percentage of Caucasian and a lower percentage of Japanese at baseline than at follow-up. Nearly all at both times listed their preferred language as English and both times around 75% said they lived alone. If they did reside with someone, half lived with spouses with daughters next followed by sons. The percentage living in their own home was higher at baseline (78%) than at follow-up (60%). About half were married and half all other marital statuses both times.

Satisfaction questions.

There were few differences between baseline and follow-up on many of the satisfaction questions. There was not a statistically significant difference between baseline and follow-up on using any of the services and whether or not they would recommend HCOA ADRC to a friend or family member. There were also no differences between time one and time two on the response time for return calls and the knowledgability and clarity of the information provided . There was a notable (although not statistically significant) difference in the number of contacts (from a mean of .9 to 1.4) which approached significance ($p<.14$) and the overall satisfaction rating which increased from 3.9 at time 1 to 4.2 at time 2. However there were a few differences on the items about what would make things easier. More courteous staff were seen as an issue at baseline by 38% of respondents; at follow-up this had been reduced to 0%. That service should be timelier was seen as an issue at baseline by 33% of the respondents; at follow-up 0% endorsed this item. Service quality was an issue at baseline by 33% of the respondents and 0% endorsed this item at follow-up. In terms of where they heard about HCOA there was a significant difference between baseline and follow-up. Upon closer examination of the data, a greater percentage at follow-up had heard from Information and Referral and fewer by word of mouth. Finally there was a significant increase in those who said they got services from another agency after contacting HCOA ADRC. Only 14.3% did at baseline but 58.8% did at follow-up.

Summary

Overall more caregivers were contacting the HCOA at follow-up than at baseline. They were more satisfied with the ease of service use and indeed were far more likely to go ahead and get services from another agency. More people were also hearing about the ADRC from I and R sources rather than just word of mouth. All of these indicators are in the positive direction indicating that the HCOA ADRC is improving in its ability to satisfactorily meet the needs of more needy seniors and their caregivers as it moved towards implementation of the ADRC.

ADRC Consumer Satisfaction Survey

The ADRC Consumer Satisfaction Survey was developed in 2007 in order to determine if there was change over time in the level of satisfaction consumers experienced when they went to the new ADRC model of service delivery. The survey questions and methodologies were based on several other consumer satisfaction surveys used by ADRC sites throughout the country and followed the Lewin Associates suggested model. The evaluation team in Hawaii also added several questions about language, culture, and ethnicity categories unique to the area. In addition, a section was added for caregivers with a skip pattern for them to answer only the questions relevant to them.

A baseline assessment was conducted in April 2007 and an annual follow-up assessment was conducted in April 2008. The following methodologies were used in administering the follow-up survey in Hawaii County:

1. HCOA was contacted and asked to prepare a list of consumers (for whom they had contact information) who had used their services within the past year. From that list 120 potential respondents were randomly selected.
2. HCOA prepared a contact list (including names, addresses, and phone numbers) for all randomly selected individuals from which mailing labels were created.
3. A letter was generated from HOCA explaining why the consumers were being contacted.
4. An exemption from the university IRB which handles the protection of human subjects was obtained since UH was handling the evaluation.
5. Within two weeks of the HCOA letter going out, the surveys were mailed to consumers. A brief cover letter was included explaining the purpose of the survey and to inform the consumers that their responses would be confidential. Each letter contained a self addressed stamped envelope for the return of the survey.
6. Within two weeks of the survey being mailed, a research assistant began the process of reminder phone calls. These calls were simply to remind people who had not yet responded to return the survey and to answer any questions they might have. Additionally, this phone call was used to determine if there were language difficulties and if so they were referred to the HCOA office where an interpreter was available.
7. An effort was made to find new addresses or phone numbers for returned mail.
8. At the end of six weeks it was determined that we had our final sample size (N=30) and the data were coded and entered into a master database in SPSS.
9. Frequencies were calculated by the program and open ended responses were post coded and added to the data base.
10. For each variable the data were then compared in order to determine if the implementation of the ADRC had improved consumer satisfaction and the speed and ease of service delivery.

The comparison of baseline data to follow up survey data indicated the following for Hawaii County:

1. More people heard about HCOA via word of mouth contacts, media sources, and Information and Referral. Less people found out about HCOA through health or social care providers.
2. There was an increase in the frequency of contacts with HCOA, with many more people reporting 2 or more contacts within the past 6 months.
3. Follow up survey indicated that HCOA improved in their operations re: how many times the phone rang before someone answered the call and how long a person had to wait before being seen by someone.
4. More people contacted HCOA for information, assistance with care, and for senior services on follow-up survey. Primary reason for contact on baseline was for senior ID cards. Data could potentially be a reflection on method and timing of data collection.

5. Satisfaction with HCOA services and staff improved in all areas. 0 "not at all" satisfaction ratings were received in areas of clarity of information, helpfulness, courteousness, and staff knowledge on follow-up survey. Ratings of "extremely satisfied" increased in all areas including overall satisfaction with HCOA.
6. When asked about getting services from another agency after speaking to HCOA, there was a notable increase in access from 6% baseline to 61.9% of follow up responses. Although there was a significant increase in respondents getting services from another agency, there was an overall decrease in access to services indicated on survey (i.e. MOW, hospice, home health care, transportation, NHWW, etc.) possibly due to limited funding and longer wait lists.