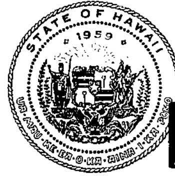
DAVID Y. IGE
GOVERNOR OF HAWAII



VIRGINIAPRESSLER, M.D.
DIRECTOR OF HEALTH

DEPT. COMM. NO. 358

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:

April 26, 2017

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Twenty-Ninth State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Joseph Souki, Speaker
and Members of the House of
Representatives
Twenty-Ninth State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Souki, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of an Annual Report regarding "The Executive Office on Aging to provide an Annual Evaluation Report on Elder Programs for the Governor the Legislature" pursuant to Section349-5(b)(2). In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

http://health.hawaii.gov/opppd/department-of-health-reports-to-2017-legislature/

Sincerely,

Virginia Pressler

VIRGINIA PRESSLER

Director of Health

Enc.

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REPORT TO THE TWENTY-NINTH LEGISLATURE
STATE OF HAWAII
2017

PURSUANT TO HB 1878, ACT 138 REQUIRING THE EXECUTIVE OFFICE ON AGING TO EVALUATE THE EFFECTIVENESS OF THE AGING AND DISABILITY RESOURCE CENTERS IN EACH COUNTY AND TO REPORT ON THE IMPLEMENTATION OF THE FEDERAL NO WRONG DOOR/AGING AND DISABILITY RESOURCE CENTER NETWORK IMPLEMENTATION GRANT

"E Loa Ke Ola"
May Life Be Long

Prepared by
Executive Office on Aging
Department of Health
State of Hawaii
November 2016

REPORTS

An Assessment on the Effectiveness of the Hawaii Aging and Disability Resource Centers

Implementation of the No Wrong Door System for All Populations and All Payers

AN ASSESSMENT ON THE EFFECTIVENESS
OF THE
HAWAII AGING AND DISABILITY RESOURCE CENTERS

"E Loa Ke Ola"
May Life Be Long

Prepared by
Executive Office on Aging
Department of Health
State of Hawaii
November 2016

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I. Hawaii's ADRC System

A. Background – History of ADRC

The Aging and Disability Resource Center (ADRC) is a system that provides older adults and their caregivers, and persons with disabilities with a single access point to information on the full range of long-term support options and benefits (LTSS). It operates using specific standardized tools and processes. The Administration for Community (ACL) and the Centers for Medicare and Medicaid Services (CMS) envisioned the ADRC to be a mechanism to improve access to and utilization of community supports and to the development of partnerships to enable the availability and accessibility of all LTSS services.

The ADRC in Hawaii began in 2006 when the Executive Office on Aging (EOA) received a grant from the Administration on Community Living to pilot the system. This was followed with an ADRC Expansion award grant in 2009 that allowed EOA to expand the ADRC system statewide and to prepare a 5-year plan, with an accompanying budget, to transform the Aging Network into a statewide ADRC system. In 2013, the State legislature promoted the adoption of the ADRC by codifying it into the Hawaii Revised Statutes Sections 349-31 and 32.

EOA has delegated the responsibility for implementing and operating the ADRC system to the Area Agencies on Aging (AAA). The operation of the ADRC meant that the AAAs needed to expand their roles to not only address the needs of older adults but to provide the necessary supports and referral for persons with disabilities.

In Hawaii, the ADRC will be the means through which the State intends to meet new federal guidance and regulations. The new federal guidance and rules require the State to ensure home and community based services respond to participant's needs and choices, provide strategies to maximize independence, and provide support and coordination necessary for community living. Hawaii will meet these federal requirements by enhancing the ADRC's ability to respond to the needs and preferences of participants.

B. Key Elements of a Fully Functional ADRC

The ACL and CMS use the federal ADRC Readiness Assessment, a tool designed to evaluate the functioning status of the ADRC. The Readiness Assessment measures the degree to which an ADRC meets the fully-functioning criteria. It evaluates the ADRC in the following 10 areas:

- **Organization & Governance.** Do the ADRC sites have a compliant philosophy and organizational structure, including staffing, budgeting, and sustainability, and include and receive advisement from the community?

- **Personnel Management & Training.** Do the staff at the ADRC sites meet the qualifications for serving populations with LTSS needs, and operations include new staff and ongoing training as well as cross training within the organization and with other partnering agencies?
- **Service Delivery & Operations.** This category is broken down into four key areas:
    - **Point of Contact.** Do the ADRC sites' operations allow for positive access and consumer interaction, regardless of day or time?
    - **Assistance, Counseling, and Assessment.** Do the ADRC sites provide staff with resources and training to assist consumers in the following three areas:
        - **Information & Referral Assistance.**
        - **Long Term Care (LTC) Decision Support & Options Counseling.**
        - **Coordinated Access & Assessment.**
- **Outreach & Marketing.** What is the ability of the ADRC sites to target publically funded and private-pay consumers and evaluate their targeting effectiveness?
- **IT & Management Information Systems (MIS) Capacity & Support.** Have the ADRC sites IT and MIS system(s) been coordinated through written policies and procedures and have appropriate data sharing and electronic record capabilities.
- **Partnerships.** Have the ADRC sites developed partnerships with other state and local agencies, and actively recruits and involves these agencies in organizational updates?
- **Evaluation & Monitoring.** Are the ADRC sites able to evaluate data to improve the quality of services and consumer satisfaction.

C. Status of Implementation of Hawaii's ADRC

EOA is using a phase-in approach to implement the ADRC system in Hawaii. The phase-in approach enables each county to customize their operations to meet the needs of their communities while holding true to the fully functional criteria and the universal elements that the EOA and ADRC sites agreed upon. In addition, staggering the implementation allows for learning opportunities and best practices to arise from the implementation.

A recent assessment showed the phase-in approach may be paying dividends. EOA requested HCBS Strategies to conduct the Readiness Assessments of the AAA's ADRC systems in Hawaii. HCBS Strategies was selected because their staff have been working with the AAAs to refine their operations to incorporate Hawaii's statewide approach for building a fully-functioning

ADRC. This work allowed them to assess each of the counties' operations without needing to conduct extensive additional reviews. HCBS Strategies reviewed the preliminary findings with staff from EOA and each of the counties to ensure that the analysis was complete and accurate. EOA will verify the readiness scores during their monitoring site visit. Their findings are summarized in the table below.

Readiness Review Assessment Category	Maui County	Kauai County	City and County of Honolulu	Hawai'i County
Organization & Governance	*	*	*	*
Personnel Management & Training	*	*	*	+
Point of Contact	*	*	*	*
Information & Referral Assistance	*	*	*	+
LTC Decision Support & Options Counseling	*	*	*	*
Coordinated Access & Assessment	*	*	*	*
Outreach & Marketing	*	*	+	+
IT/MIS Capacity & Support	*	*	*	*
Partnerships	*	*	*	*
Program Evaluation	*	*	*	+

The asterisk (*) denotes that the readiness assessment category has been met.
The plus symbol (+) denotes that progress is being made to meet the readiness threshold.

As the results in the table show, Maui and Kauai Counties, which began phasing in the ADRC system in 2012 met the readiness threshold in all ten areas. The City and County of Honolulu AAA, which began phasing in their ADRC system in July of 2015, met nine of the ten criteria and the Hawaii County AAA, which is preparing to incorporate the new operations, met six of the ten criteria.

To learn more about the implementation and operation of the ADRC in Hawaii, in 2016, the State Legislature passed Act 138, which directed EOA to assess the effectiveness of the ADRC

system in all four counties. This report examines the ADRC system's responsiveness to inquiries for services, their success in linking consumers to services, and the consumers' satisfaction with the services they received from the ADRC.

II. Methods

To examine the quality of the ADRC services, EOA looked at the timeliness of the ADRC response to inquiries, the linkage of ADRC consumers to services, and the consumers' satisfaction with their experience. To measure the timeliness of response, EOA reviewed the time it took ADRC consumers to receive an assessment, a service plan, and a service authorization after requesting for Kupuna Care services. To assess the ADRC ability to link consumers to service, EOA examined the length of time it took for the service to be delivered to the consumer and the number of services authorized to ADRC consumers.

Finally, to assess the consumers' satisfaction with their experience with the ADRC, EOA solicited the assistance of the University of Hawaii Center on Disability Studies to develop a client satisfaction survey. The survey sought consumer feedback on their experience with ADRC or contracted staff who perform intake and/or referrals. Specifically, the 9-item instrument solicited consumer input on staff or contracted personnel performance in the following: (1) listening carefully, (2) understanding what the client wanted, (3) explaining clearly, (4) being courteous, (5) respectful, (6) knowledgeable, (7) caring, (8) assisting the client in taking care of their needs, and (9) providing a support plan, referrals, connections that were helpful. For each item, clients were asked to mark the category best representing their impression: Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree, or Not Applicable.

A. Sample

EOA restricted the study to persons who were referred for or received Kupuna Care services for the first time between August 15 and October 25, 2016. Thus, the study included persons who may have previously registered but did not have an LTSS need. However, because one of the ADRCs had been registering persons applying for senior cards when they turned 65, restricting the sample to those registering and receiving services for the first time would have excluded a large number of individuals at that ADRC. The reason for restricting the sample to first-time Kupuna Care service recipients was to avoid the possibility that the response time would be affected by the mix of first-time and previous service users, since it is possible that, having already gone through the assessment and service referral process, persons who had already received services from the ADRC would be processed faster than those new to the ADRC.

During our study period, the ADRC received a total of 11,453 contacts. (See Table 1.) These include walk-ins, and inquiries by telephone and website. More than half of the contacts (6,137) and nearly a third (3,551) were received by the Honolulu and Maui ADRCs, respectively. Slightly more than a tenth of the contacts (1,397) were received by the Kauai ADRC and the rest (368) were received by the ADRC in Hawaii County. A total of 626 consumers were assessed as

needing a Kupuna Care service(s) for the first time, nearly two-thirds of them were new to the ADRC.

Table 1. Number of ADRC Consumers in the Study Sample Relative to Total Number of Contacts

ADRC CONSUMERS	COUNTY				State
	Hawaii	Honolulu	Kauai	Maui	
Total contacts[1]	368	6,137	1,397	3,551	11,453
Total in Study	20	488	20	98	626
Newly registered	8	326	10	51	395
Previously registered	12	162	10	47	231

[1]Includes telephone calls, walk-ins, and website inquiries from August 15, 2016 to October 25, 2016.

The demographic characteristics of the consumers in the study sample in each county are presented in Table 2. The table shows that consumers in the Hawaii County sample tended to be older, while those in the Maui County sample tended to be much younger. The table also shows that Maui and Honolulu Counties had a larger proportion of females in their sample than did either Hawaii or Kauai Counties. The Kauai and Honolulu consumers were found to be less likely to be living alone. Consumers in the Kauai sample appeared to have higher risk factors than those from the other counties. Three-quarters of Kauai's sample were considered to be at high-risk nutritionally and had a median of 5 ADLs and 7 IADLs. Only Maui County had nearly the same proportion of consumers with high nutritional risks.

Table 2. Demographic Characteristics of the Consumers in the Study Sample by County

Demographic Characteristics	COUNTY			
	Hawaii (n=20)	Honolulu (n=488)	Kauai (n=20)	Maui (n=98)
Median Age	87 (n=20)	82 (n=486)	85 (n=20)	76 (n=76)
Sex				
Male	40.0% (8)	34.2% (167)	45.0% (9)	30.6% (30)
Female	60.0% (12)	65.8% (321)	55.0% (11)	67.3% (66)
Missing	0.0% (0)	0.0% (0)	0.0% (0)	2.0% (2)
Living Alone				
Yes	45.0% (9)	29.9% (146)	25.0% (5)	37.8% (37)
No	20.0% (4)	55.9% (273)	75.0% (15)	54.1% (53)
Don't know/Missing	35.0% (7)	14.1% (69)	0.0% (0)	8.2% (8)
Nutrition High Risk				
Yes	25.0% (5)	42.0% (205)	75.0% (15)	70.4% (69)
No	30.0% (6)	41.6% (203)	25.0% (5)	19.4% (19)
Don't know/Missing	45.0% (9)	16.4% (80)	0% (0)	10.2% (10)
Median number of ADLs	1.5 (14)	2.0 (411)	5.0 (19)	2.0 (88)
Median number of IADLs	6.0 (13)	5.0 (412)	7.0 (19)	6.0 (88)

B. Data Collection

Data for the quality assessment were collected between August 15, 2016 and October 25, 2016. A tracking form was embedded in the ADRC consolidated consumer database for ADRC staff to record the completion dates for the following activities: (1) initial service request, (2) initial intake, (3) in-home assessment, (4) ADRC support plan, (5) authorization of first service, and (6) delivery of Kupuna Care services. The Kupuna Care services are: adult day care, assisted

transportation, attendant care, case management, chore, home delivered meals, homemaker, personal care, and transportation.

The data collection for the consumer satisfaction survey utilized the methods similar to the ones the ADRCs were already using to capture client feedback. In three ADRC sites, staff provided each first-time Kupuna Care consumer with a hard copy survey packet. The survey packet was given to the consumer after an in-person intake or either mailed immediately following a phone intake or two weeks after the completion of the consumer's intake. In all cases, the client was asked to complete the survey form and mail it to EOA using the enclosed self-addressed stamped envelope. These procedures ensured consumers that their responses would be anonymous to EOA and the ADRCs.

At the ADRC site in Hawaii County, the activities of intake, assessment, and support plan development are done with a subcontractor. The ADRC site delayed data collection to give the subcontractor time to work with the consumers and administered the survey over the telephone to ensure a quick response. Thus, in this case, the consumers' responses were not anonymous.

The response rate to the ADRC Consumer Satisfaction survey is reported in Table 3. Overall, slightly more than a fifth of the consumers in our study returned their satisfaction survey. The table shows that the response rates for ADRCs with fewer new Kupuna Care consumers were significantly higher than those with more consumers.

Table 3. Response Rate for the ADRC Consumer Satisfaction Survey by County

	COUNTY				
	Hawaii	**Honolulu**	**Kauai**	**Maui**	**State**
Number of new Kupuna Care Consumers	20	488	20	98	626
Number of survey forms returned	12	90	11	23	138
Percent returned	60.%	18.4%	55.0%	23.5%	22.0%

EOA processed incoming surveys weekly by (1) entering the survey data into an electronic database, (2) performing quality control checks on the data, to make sure the electronic entries accurately represented the paper survey responses, and (3) sharing updated survey summary results with the ADRCs.

C. Data Analysis

For the analysis on the ADRC's responsiveness to consumer inquiries, we calculated the number of days it took the ADRC to process the consumers in the sample from the initial date of request for help through key transition points in the ADRC system. Then for each of the transition points, we divided the sample into quartiles based on the number of days it took the ADRC to process the consumers from the initial contact to the transition point. The results provide the approximate time it took the ADRC in each county to process 25%, 50%, 75% of their consumers through each transition point.

In addition to the duration from initial intake to delivery of the first service, for the service linkage study, we looked at the number of services the ADRC authorized and delivered to their consumers. We also looked at the types of services the ADRC authorized for their consumers based on the support plans.

Because this study uses recent data over a short period, the results for service delivery may be a bit misleading since, for some of the consumers, there was simply not enough time for the system to deliver the service. It is also possible that the service may have been delivered, but the vendor did not have enough time to report the delivery. Our analysis also did not exclude consumers who withdrew from the ADRC.

In the consumer satisfaction study, for each of the 9 items, we report the percentage of consumers who indicated that they were either agreed or strongly agreed with statement on staff performance.

III. Findings

A. The ADRC Response to Requests for Assistance

This section presents the findings on the timeliness of the ADRC response to the consumer's request for assistance. EOA examined the time it took the ADRCs to process consumers from the day they received the request to each of the key transition points in the ADRC system. As Table 4 shows, most of the consumers who contacted their ADRC with an LTSS need (for this report we limited to first-time Kupuna Care service users) received a service authorization. Statewide, 74 percent were authorized to receive a service. At least 80% of the consumers received an assessment from their ADRC and, with the exception of the Maui ADRC, similar proportion received a support plan. It is possible that some of those who did not receive a service authorization may have contacted their ADRC close to the end of the study period and, therefore, were still moving through the system. Others may have withdrawn their request for assistance.

Table 4. ADRC Transition Points Reached by Consumers in the Time Study

ADRC Transition Points Reached	COUNTY				State
	Hawaii	Honolulu	Kauai	Maui	
Number of First-Time Consumers with an LTSS Need	20	488	20	98	626
Assessment	100.0% (20)	79.3% (387)	80.0% (16)	84.7% (83)	80.8% (506)
Support Plan	80.0% (16)	79.3% (387)	80.0% (16)	58.2% (57)	76.0% (476)
First Service Authorized	70.0% (14)	74.0% (361)	65.0% (13)	79.6% (78)	74.4% (466)
First Service Delivered	50.0% (10)	5.7% (28)	35.0% (7)	45.9% (45)	14.4% (90)
Consumer Case Closed	0.0% (0)	16.8% (82)	10.0% (2)	5.1% (5)	14.2% (89)

To examine the ADRCs' timeliness in processing their consumers, for each ADRC, we divided the consumers they served into quartiles based on the number of days from the initial request for service to the completion of each of the key ADRC transition points. Thus, the time study includes only the consumers who reached the transition point being studied. The results are shown in Tables 5 and 6.

Table 5. Number of Days from Initial Request that It Took a Quarter, Half, and Three-Quarters of the Customers to Receive an Assessment and a Support Plan, by County

PERCENT OF NEW KUPUNA CARE CONSUMERS	DAYS FROM INITIAL REQUEST TO ASSESSMENT AND SUPPORT PLAN, BY COUNTY							
	Hawaii		Honolulu		Kauai		Maui	
	Assessment	Support Plan	Assessment	Support Plan	Assessment	Support Plan	Assessment	Support Plan
25 percent	0.0	14.5	1.0	1.0	0.0	0.0	1.0	6.0
50 percent	0.0	22.5	6.0	6.0	0.0	0.0	4.0	9.0
75 percent	6.3	31.0	11.0	11.0	0.0	0.3	6.0	14.0
100 percent	27.0	41.0	45.0	45.0	2.0	13.0	16.0	32.0
Total Consumers	20	16	387	387	16	16	83	57

Table 6. Number of Days from Initial Service Request that It Took a Quarter, Half, and Three-Quarters of the Customers to Be Authorized and to Receive Services, by County

PERCENT OF NEW KUPUNA CARE CONSUMERS	DAYS FROM INITIAL REQUEST TO SERVICE AUTHORIZATION AND DELIVERY, BY COUNTY							
	Hawaii		Honolulu		Kauai		Maui	
	Authorization	Delivery	Authorization	Delivery	Authorization	Delivery	Authorization	Delivery
25 percent	0.3	13.0	4.0	16.8	3.0	18.5	2.0	5.0
50 percent	11.0	20.0	10.0	23.5	5.0	20.5	4.0	10.0
75 percent	16.0	23.0	16.0	34.0	6.0	20.5	8.0	16.0
100 percent	25.0	37.0	45.0	42.0	13.0	37.0	21.0	46.0
Total Consumers[1]	14	9	357	28	13	7	70	45

[1]Customers with a negative number of days between initial request and authorization or delivery date were excluded from the analysis. As a result, the number of customers may not match the numbers reported in Table 4.

Table 5 shows the results for the completion of the assessment and support plan. The table shows that half of the consumers who received an assessment received it within a week of their contacting their ADRC for assistance and three-fourths received it about 1.5 weeks from the initial request. In the case of the Hawaii and Kauai County ADRCs, 50 percent of the consumers received their assessment on the day they contacted the ADRC. The Kauai ADRC also assessed three-fourths of their consumers on the day they made their request. The Honolulu County ADRC, which handles a larger volume of inquiries, assessed half of their consumers requesting assistance for the first time within 6 calendar days of the request and three-quarters within 11 calendar days.

The results in Table 5 also show that, for the most part, in the Kauai and Honolulu Counties, the number of days from initial service request until the completion of the support plan mirrored the number of days it took to complete the assessment. This was not the case in Maui and Hawaii Counties. The Maui ADRC completed half of their support plans 9 days after the service request and three-quarters within two weeks. In the case of the ADRC in Hawaii County, it took them slightly more than 3 weeks to complete half of their consumers' service plan and 31 days to complete three-quarters of their consumers' support plan. Statewide, half of the consumers who received a service received it within 16 days of their request. (Not shown in table.)

Table 6 reports the quartile points for number of days it took the ADRCs to authorize services and the vendors to deliver services. (The results for the service deliver is discussed in the "Linkage to Service" section below.) The table shows that by the middle of the third week after receiving the service request, all of the ADRCs had authorized services to three-quarters of their consumers.

B. Linkage to Services

As Table 4 above showed, by the end of the study period, the ADRCs, combined, had authorized services to three-quarters of consumers contacting them for the first time with a LTSS need. However, the table also shows that only 14% had a service delivered to them by the end of the study period. Half of the 20 people in Hawaii County who requested assistance for the first time and nearly half of the 98 people in Maui County had their LTSS needs met by receiving a Kupuna Care service by the end to the study period. The percentage falls to 35 and 6 percent for Kauai and Honolulu Counties, respectively. Also, as Table 6 shows, most of the consumers received their first service approximately three weeks after their initial request.

There may be several reasons for the drop in the proportion and the length of time it took to deliver services. For consumers who contacted the ADRC close to the end of data collection, there simply may not have been enough time to process the request and deliver the service. Some of them may have received the service, but the vendor may not have reported the

delivery of the service. For some, they may have been authorized for services such as transportation. In these cases, the transportation is not actually provided until which time the consumer has a need for the transportation. The number of services the ADRC authorized for a consumer were found to vary by ADRC sites. (See Table 7.) About 7 in 10 consumers at the ADRCs in Kauai and Honolulu Counties were authorized to received one service. In contrast, about 6 in 10 consumers at the ADRCs in Maui and Hawaii Counties were authorized for 2 or more services.

The type of services authorized for consumers differed among the ADRCs which we would expect with a person-centered process where needs vary among individuals. (See Table 8.) It is important to note that a larger proportion of the services authorized in Honolulu and Kauai Counties were for home-delivered meals and transportation. Approximately 4 out of 10 and 3 out of 10 services authorized in Honolulu County were for transportation and home-delivered meals, respectively. Two-thirds of the services authorized by the Kauai County ADRC were for home-delivered meals and a fifth were for transportation. In contrast, the ADRCs in Hawaii and Maui Counties authorized more case management services than any other services. To the extent, case management is a more accessible service, this may have partially accounted for the larger proportion of services that were reported to have been delivered in Hawaii and Maui Counties.

Table 7. Number of Services Authorized and Delivered Per Customer by County.

Services Per Consumer	SERVICES AUTHORIZED AND DELIVERED, BY COUNTY							
	Hawaii County		Honolulu County		Kauai County		Maui County	
	Authorized	Delivered	Authorized	Delivered	Authorized	Delivered	Authorized	Delivered
1	30.8% (4)	70% (7)	68.1% (246)	100.0% (28)	84.6% (11)	71.4% (5)	43.2% (32)	77.8% (35)
2	30.8% (4)	30% (3)	22.4% (81)	0.0% (0)	15.4% (2)	28.6% (2)	24.3% (18)	22.2% (10)
3	7.7% (1)	0.0% (0)	8.0% (29)	0.0% (0)	0.0% (0)	0.0% (0)	17.6% (13)	0.0% (0)
4	30.8% (4)	0.0% (0)	1.1% (4)	0.0% (0)	0.0% (0)	0.0% (0)	9.5% (7)	0.0% (0)
5	0.0% (0)	0.0% (0)	0.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	5.4% (4)	0.0% (0)
Total[1]	100.1% (13)	100% (10)	99.9% (361)	100.0% (28)	100.0% (13)	100.0% (7)	100.0% (74)	100.0% (45)

[1]Percentage may not total to 100.0% because of rounding.

Table 8. Distribution of All Kupuna Care Services Authorized and Delivered to First-Time Users by ADRC

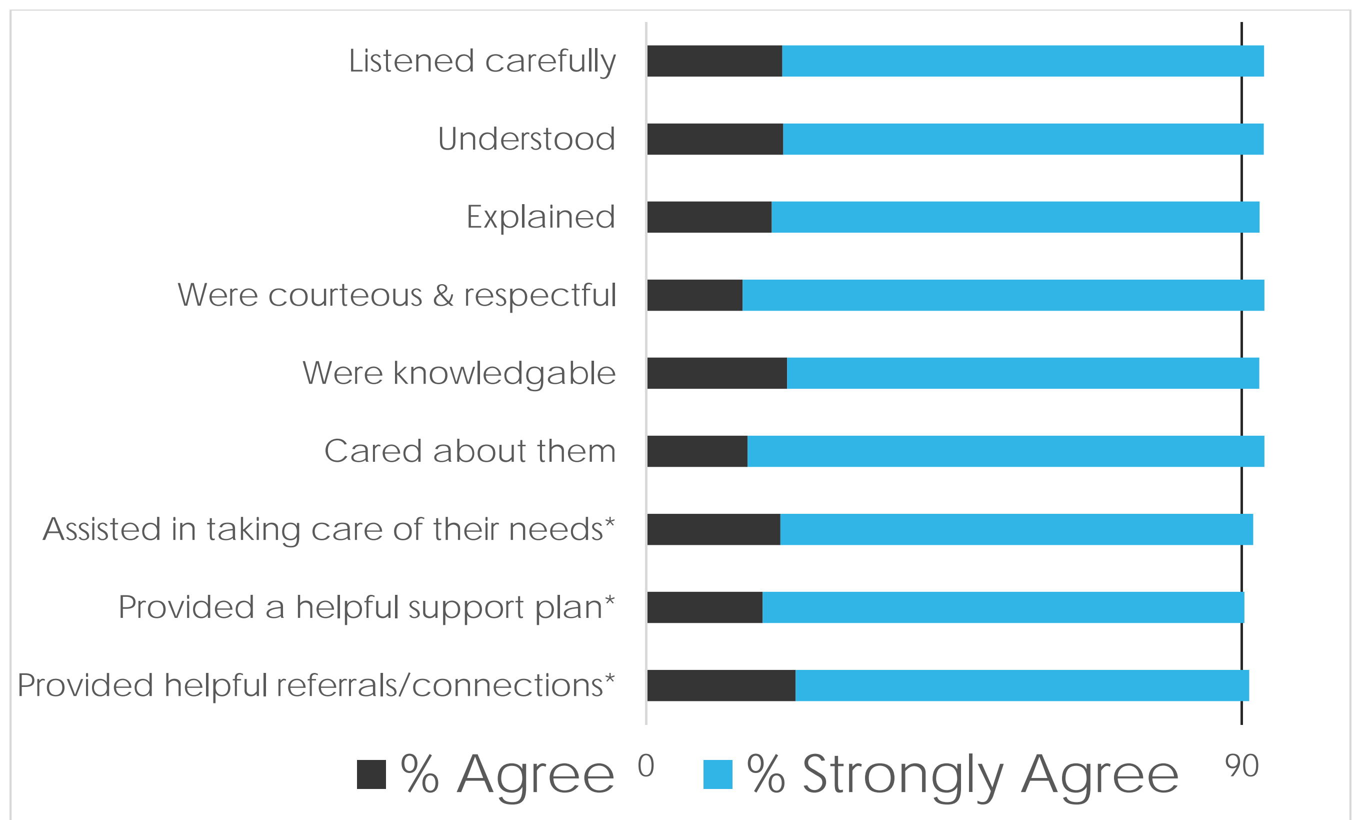
Kupuna Care Service[1]	SERVICES AUTHORIZED AND DELIVERED BY COUNTY									
	Hawaii County		Honolulu County		Kauai County		Maui County		TOTAL	
	Authorized	Delivered	Authorized	Delivered	Authorized	Delivered	Authorized	Delivered	Authorized	Delivered
Adult Day Care	2.8% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	4.5% (7)	0.0% (0)	1.1% (8)	0.0% (0)
Assisted Transportation	13.9% (5)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	5.8% (9)	0.0% (0)	1.9% (14)	0.0% (0)
Attendant Care	0.0% (0)	0.0 (0)	7.9% (41)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	5.7% (41)	0.0% (0)
Case Management	36.1% (13)	76.9% (10)	4.8% (25)	3.6% (1)	13.3% (2)	0.0% (0)	39.4% (61)	57.6% (34)	14.0% (101)	42.1% (45)
Chore	5.1% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	4.5% (7)	1.7% (1)	1.2% (9)	0.9% (1)
Home-Delivered Meals	8.3% (3)	23.1% (0)	32.6% (168)	53.6% (15)	66.7% (10)	71.4% (5)	16.1% (25)	32.2% (19)	28.5% (206)	39.3% (42)
Homemaker	19.4% (7)	0.0% (0)	6.0% (31)	0.0% (0)	0.0% (0)	0.0% (0)	15.5% (24)	3.4% (2)	8.6% (62)	1.9% (2)
Personal Care	13.9% (5)	0.0% (0)	10.1% (52)	25.0% (7)	0.0% (0)	0.0% (0)	3.9% (6)	0.0% (0)	8.7% (63)	6.5% (7)
Transportation	0.0% (0)	0.0% (0)	38.6% (199)	17.9% (5)	20.0% (3)	28.6% (2)	10.3% (16)	5.1% (3)	30.2% (218)	9.3% (10)
Total Number	100.0% (36)	100.0% (13)	100.0% (516)	100.0% (28)	100.0% (15)	100.0% (7)	100.0% (155)	100.0% (59)	100.0% (722)	100.0% (107)

[1]Client may receive multiple services

C. Consumer Satisfaction

The overall pulse of the consumers regarding the ADRC Feedback Surveys is a favorable one. *Over ninety percent* of ADRC consumers agreed or strongly agreed that they were satisfied with their ADRC experience. Exhibit 1 shows the ADRC Consumer Satisfaction Survey responding consumers' satisfaction with their ADRC experience.

Exhibit 1: Percent of ADRC Consumers who agreed that ADRC or Other Staff Assisting Them……



IV. Conclusions

In summary, EOA was charged to determine the effectiveness of the ADRCs in each county to ensure alignment with federal guidelines on criteria for a full-functioning ADRC. As demonstrated EOA's measures included timeliness of response by the ADRC, caller satisfaction, and number and percentage of kupuna and caregivers who were linked to a service or resource as a result of contact with an ADRC.

Most of the Hawaii's ADRCs were found to have met the federal criteria for a fully functioning ADRC. The ADRCs in Maui and Kauai Counties were found to have met the thresholds for all 10 criteria. The City and County of Honolulu met 9 of the 10 readiness criteria, and Hawaii County met 6 of the 10 readiness thresholds. This was the outcome of the staggered start approach adopted by EOA and the AAAs, which resulted in Maui launching its ADRC in April of 2012, Kauai in October of 2012, Honolulu in July of 2015, and Hawaii County in January of 2016. EOA will work with Honolulu to address the unmet category of outreach and marketing. In addition, EOA will continue to work with Hawaii County to address the thresholds for personnel management and training, information and assistance, outreach and marketing, and program evaluation.

The study on the ADRC's response to consumer service request showed them to be responsive to their consumers. The ADRC sites were able to authorize services at least two-thirds of the consumers during the study period and to three-quarters of their consumers within 2.5 weeks of their request.   Statewide, half of the consumers who received a service received it within 16 days of the initial request. In addition, of 138 consumers who responded to the Consumer Satisfaction Survey, 90 percent indicated they were satisfied or strongly satisfied with their ADRC experience.

The results also showed that of the 626 consumers during this time period, 466 (75 percent) were authorized services, but only 90 (14.4 percent) actually received a service. There may be several factors that contributed to the small number of individuals who received a service during the ten (10) week pilot study. These include the shortness of the pilot study, types of services authorized and rendered, and an overall workforce issue.

It is likely that there was simply not enough time to process, deliver services, or to report service delivery for consumers who contacted their ADRC during the last several weeks of the study. Because of the shortness of the study, this affected a larger proportion of the consumers than it would for a longer study. Completing the delivery of an authorized services within the study's time frame may be more difficult for services that are triggered by the consumers' need. For example, transportation was one of the more frequently authorized services.

However, transportation is delivered only when the consumer needs it and, thus, some consumers may have been authorized the service, but did not use it in the study period.

Finally, even if the ADRC authorize services within a reasonable timeframe, the actual delivery of services may problematic because of service provider staffing. The following two factors may contribute service providers' difficulty to retain and increase staffing:

a) *Type of work.* Homemaker, chore, personal assistance, and other similar types of occupations are not inviting areas to work in and, therefore, more difficult to fill, especially in a tight labor market. The providers are competing with businesses that offer more appealing jobs, such as those in the hospitality and retail industries.
b) *Funding uncertainty.* The uncertainty of the year-to-year supplemental funding may have resulted in providers' hesitance to increase their staff for fear of having to discharge staff should the funding drop the following year. As a result, it would take the vendor longer to respond to service requests from the ADRCs.

Implementation of the No Wrong Door System for All Populations and All Payers

Hawaiʻi

Executive Office on Aging

Semi-annual Progress Report
October 2016

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INTRODUCTION

The Executive Office on Aging (EOA) was awarded a three-year grant to implement a plan to establish the No Wrong Door (NWD) system for all populations and all payers in Hawaiʻi to access long term services and supports (LTSS). Core access points for publicly funded long term services and supports are called “Doors” and include: the four county Area Agencies on Aging (AAAs) that operate the Aging and Disability Resource Center (ADRC), Med-QUEST (MQD) the state Medicaid agency, Developmental Disabilities Division (DDD), Adult Mental Health division (AMHD), Division of Vocational Rehabilitation (DVR), Office of Veterans’ Services (OVS)/Veteran’s Health Administration (VHA), Children with Special Health Needs Branch (CSHNB), and the Centers for Independent Living (Aloha Independent Living Hawaiʻi and Access to Independence).

The **goals** of this three-year project are to: 1) expand the ADRC effort into a NWD network that includes all access points for publicly funded LTSS and 2) build an infrastructure to offer person-centered (PC) counseling to all individuals. The **objectives** are to establish: 1) a governance structure, coordination protocols, and universal PC counseling standards across the NWD network; 2) a sustainable PC training infrastructure; 3) capacity to provide MLTSS beneficiary supports required in CMS’ proposed rules for managed care; 4) agreements and infrastructure for Medicaid administrative federal financial participation (FFP); and 5) a business case for expanded State funding for the NWD network. Anticipated **outcomes** are: 1) implementation of the integrated NWD network that streamlines access to LTSS; 2) train all NWD network staff to use a PC approach; 3) offer PC counseling for all populations; and 4) establish sustainable funding. Expected **products** include: 1) written agreements (e.g., MoUs) among the

NWD partners; 2) a Hawaiʻi-based PC training institute; and 3) a managed care rule compliance strategy that includes a central role for agencies with established, conflict-free relationships with the older adult and disability communities.

This is a semi-annual report for year one of the three-year grant period. It discusses accomplishments, challenges, outcomes and products produced so far.

ACCOMPLISHMENTS

What did you accomplish during this reporting period and how did these accomplishments help you reach your stated project goal(s) and objective(s)? Please note any significant project partners and their role in project activities.

Our major goals are: 1) to develop a network of agencies into a single statewide system of access to long term services and supports and 2) build an infrastructure for person-centered counseling. To accomplish our goals, we identified nine tasks:

Project Management

This task ensures that the work on these initiatives proceeds smoothly; stakeholders have ample opportunities for input; and the work complies with Federal rules, guidance and requirements of the NWD grant. The work over the past year included:

- Established an Infrastructure team (IST) including the Executive Office on Aging, University of Hawaiʻi Center for Disability Studies, Hilopa'a and HCBS Strategies.
- Conducted bi-weekly web-enabled conference calls to manage the project work.
- Tracked and updated all tasks on Asana, our web-enabled project management tool.

NWD Network Development

The tasks in this area formally establishes the structure of NWD Network and the approaches for providing counseling to individuals in need of LTSS. Major achievements over the past year included:

- Established an Advisory Committee including 12 Doors, 7 Referral partners and 9 stakeholders and met six times between August 2015- August 2016. The Advisory Committee has very active participation by people with disabilities including self-advocates and individuals with physical and sensory impairments. To ensure the meetings are accessible to all individuals we translated materials into large print and braille, provided sign

language interpreters at all meetings, and had coaches review materials with self-advocates in advance of the meetings.

- Drafted protocols to guide who should be referred to each Door. The processes for those referrals were developed and are being reviewed by the Doors. To achieve this, we developed a crosswalk that summarized: 1) who should be referred; 2) process for referral; 3) training information; 4) process for agency staff training; and 5) willingness to work towards standardizing tools and adopting person-centered standards. This information will be also used for systems navigation training.
- Agreed upon Person-centered standards based on CMS rules and NWD Advisory Committee recommendations. We went through an extensive process with each of the Doors to identify their ability to comply with the standards and changes they would have to make to incorporate the standards into policies and practices. The standards are already impacting efforts by the individual Doors to restructure their access processes.

Enhancing the Capacity of the Network

These tasks build capacity within the NWD Network to support all populations with disabilities. The grant application discussed developing protocols for supporting adults under age 60 who are not served by another source and working with the Medicaid agency to explore providing Choice Counseling to individuals enrolling in QUEST Integration (QI). In addition, we are exploring the feasibility of developing Veteran Focused Person-Centered Counseling (VF-PCC) for veterans with long term services and support needs. Work accomplished in this area in the past year included:

- Developed an outline of a VF-PCC innovation project. We vetted this effort with the Advisory Committee, the local VAMC staff and leadership. They are all supportive of further exploring this option. If the national VA and/or ACL can locate a funding stream, we are prepared to move forward with the development of the initiative.
- Began work on a pilot project on Maui for individuals under 60 yrs old with a disability. Meetings are being scheduled with Maui County on Aging staff to establish a framework for the approach to providing person-centered counseling to individuals under 60. We will also review this framework with disability stakeholders.
- Reviewed CMS' final Managed Care rules and reported on the implications for the NWD Network and the provision of Choice Counseling. We have had several meetings with MQD as they develop their plans for responding to the new rules.

Administrative FFP Claiming

This portion of the work plan will build infrastructure to support Medicaid administrative claiming that will provide a sustainable funding stream for the NWD Network. Major tasks completed over the past year included:

- Developed a coding system for administrative claiming and received feedback from all ADRC leadership and workers.
- Conducted two pilot FFP random moment time studies with ADRCs (see attached report on "Results from Hawai'i's Time Study Pilot to Support Medicaid Administrative FFP Claiming", July 12, 2016).
- Developed a spreadsheet for capturing information to be included in the cost pool and worked with each of the counties to complete the spreadsheets. Based on the pilot time study and the calculations on the cost pool spreadsheet, it is estimated that the state may be able to claim $1.3 million Medicaid funds to reimburse the ADRCs for Medicaid related work.
- Presented our work at the 2016 HCBS conference.

Support Planning Tools

The tasks in this area improve integration of intake, assessment, and support planning tools across the ADRC Doors to minimize the need for participants to tell their stories multiple times in order to access services. Major tasks accomplished in the past year included:

- Common referral form: Interviewed the Doors and obtained their intake, assessment, and support planning tools. Based on the information collected, we developed a crosswalk identifying common data domains. This effort is being used to develop a common referral form.
- Common consent form: We developed a draft consent form that can be used by all Doors and will allow participants to only have to complete the form once. We are currently reviewing the form with the Doors. After their approval, we will submit it to the Attorney General's office for their review.

Person-centered and Systems Navigation Training

These tasks will build Hawai'i-based training that has ongoing funding. Work in this area in the past year included:

- Approximately 30 staff members from various agencies participated in the ACL Elsevier PCC training program. An initial review and pilot of the ACL curriculum was completed and decided that the ACL curriculum would not resonate with the Hawai'i staff. However, the training effort identified several components of the ACL training that will be incorporated into the Hawai'i specific training.
- Began development of a Person-centered curriculum more culturally appealing for Hawai'i. We have begun compiling tools that can be incorporated into this training.
- Developed the following tools that will serve as the basis of this training:

- LTSS Crosswalk: Developed an inventory of all publicly-funded LTSS programs in Hawaiʻi. This crosswalk will serve as a core element of the training.
- Access processes workflows: Started development of charts that summarize the key steps and decisions made in determining who can access LTSS at each of the Doors. This information will be a central component of training.
- Support planning tools: The common consent and referral forms described in the preceding section will be integrated into the training model. Doors have provided initial input, and some indicated they are willing to pilot the forms as the next step in development and also to inform future training and the development of guiding instructions regarding how to use the forms.

CHALLENGES

What, if any, challenges did you face during this reporting period and what actions did you take to address these challenges? Please note in your response changes, if any, to your project goal(s), objective(s), or activities that were made as a result of challenges faced.

Administrative FFP Claiming

- The plan for FFP claiming was put on hold due to a change in leadership at Med-QUEST. While the time studies and cost projections were completed at the AAA level, Med-QUEST is not ready to complete the Cost Allocation Plan (CAP) for FFP claiming to CMS.
- Additionally, Med-QUEST was not ready to support an additional staff person who would liaise with the ADRCs. As a result, the MQD ADRC Liaison position is not being filled. The Executive Office on Aging ADRC Network Lead and ADRC Network Developer positions will assume the duties of the MQD ADRC Liaison position.
- We met with the new Med-QUEST leadership and will continue to work with them on the CMS application.

Person-centered Training

- A group of 30 staff participated in the ACL PCC online training, however, it was the consensus of the group that the curriculum was not relevant to our local culture.

- Hilopa'a will be reviewing curriculum from other states and programs and developing a new curriculum for the NWD project. Training will be delayed to year 2 of the grant.

Delayed contract execution

- Initially our Year 1 budget included limited funds to contract with the University of Hawaiʻi at Mānoa Center on Disability Studies (UH) for evaluation of only the training aspects of the NWD project (Measurable Outcomes #3 and #6).
- In addition, our contract with UH was delayed due to a back log of contracts to review at the State of Hawaiʻi Attorney General's office. This resulted in limited evaluation activity during Year 1 of the project.
- We addressed these challenges and accomplished the following:
  - UH continued their commitment to the NWD project and participated in a variety of planning and committee meetings, including IST and other project leadership meetings. This contributed to the team work and working relationships the NWD project established during Year 1. This also resulted in providing time for UH to develop a collaborative and participatory evaluation approach that aligns with the core values of NWD and the person-centered philosophy.
  - Due to a delay in contract implementation, UH will likely have cost savings to support the evaluation of additional NWD project components.

Veterans

- Adoption of the person-centered standards by our local VHA has been hampered because some of the forms and protocols could not be changed without approval on the Federal level.
- We requested federal guidance and assistance in locating a funding stream for the proposed Veterans-focused person-centered counseling effort.

MEASURABLE OUTCOMES

How have the activities conducted during this project period helped you to achieve the measurable outcomes identified in your project proposal?

1) Minimum of 12,500 people per year across the network will receive Person-Centered Counseling

- Review and pilot of the ACL curriculum helped us determine that we needed to develop our own curriculum for Hawaiʻi. The curriculum is currently being developed by Hilopa'a and training will begin in 2017. We are building the infrastructure to track the amount of person-centered counseling provided across the Doors, starting with the ADRCs.
- Our Year 1 IST meetings resulted in a more accurate understanding of the number of individuals who would potentially receive Person-Centered Counseling across the network each year. Currently, we feel we are on track to meeting the minimum of 12,500 people per year goal.

2) Implementation of the integrated NWD Network that streamlines access to LTSS

- Discussions with the Doors and the NWD Advisory Committee have been helpful in reaching consensus on PC standards and common support planning tools. We will continue these discussions to develop referral tools that will help to streamline access to LTSS.
- Under the collaborative and participatory approach adopted by the project, several Doors are field testing the common consent and referral forms mentioned previously and listed in the Products section below.
- Please note that streamlined access and system navigation will be folded into training as we recognize that training and technical assistance is an integral part of supporting Doors committed to implementing new practices in their work environments.

3) At least 100 NWD Network staff trained to use a person-centered approach and systems integration with 300 affiliate partner personnel trained in ADRC

- Because of the pilot training the staff participated in, we were able to better determine the type of training curriculum we wanted. Training curriculum is currently being developed. Periodic feedback for trainers and other assessment protocols and strategies to measure knowledge gain and impact will be integrated into the training model.
- A fidelity checklist described under #7 will be discussed with Doors as a resource or tool for the Doors to use as they monitor and assess the quality, and extent of PCC implementation. If found to be of interest, it may become part of the training model in the CQI activities which could occur in each Door.
- We have also observed that PCC and systems navigation capacity building appears to be ongoing during meetings. The cross-Door

information sharing and collaborative and participatory strategies used to facilitate the development of common forms, tools, and resources is at times an informal learning platform which has the potential to be sustained beyond the NWD grant period. This is an example of the team work and community of practice occurring under the Hawaiʻi NWD initiative.

4) Development of FFP claiming infrastructure that is projected to produce at least $500,000 per year in administrative FFP

- As a result of the time study and cost pool calculations, as estimated $1.3 million may be received from administrative FFP. The data gathered in the pilot study will be used in discussions with Med-QUEST and preparing the application for CMS.

5) Agreement of the NWD Network to provide MLTSS Choice Counseling

- Discussions with Med-QUEST continue. Agreement has not been reached.

6) Sustainability of Hawaii-based training infrastructure that results in participants believing that NWD Network staff are competent

- We will continue to involve stakeholders and the general public in the development of the NWD Network and training curriculum so they will gain confidence in the NWD Network staff's competence. Our evaluation team will inform us of our progress.
- Regarding the participant's perspective, and motivated by legislation passed during the 2016 Legislative Session (effective July 1, 2016) an evaluation of Hawaiʻi ADRCs, between August 15 and October 31, 2016 was piloted. A statewide consumer satisfaction survey via the county-based ADRCs was implemented. The aim of the survey was to learn what new clients thought about the HCBS intake process and ultimately to improve service quality. We learned a lot about piloting a survey and to date have preliminary results from three of four counties demonstrating that the overwhelming majority of clients responding reported having a positive experience with the HCBS intake process they experienced under the Hawaiʻi ADRC umbrella. Many survey items overlapped with person-centered approaches, and over 90% of responding clients agreed that the staff who did their intake:
  - Listened carefully to what the client wanted
  - Understood what the client wanted
  - Explained things in a way the client could understand

- Were courteous and respectful
- Were knowledgeable about the services and information the client asked about
- Seemed to care about the client as a person
- Assisted the client in taking care of their needs (when applicable)
- Gave the client a support plan that was helpful to them (when applicable)
- Gave the client referrals or connections that were helpful to them

7) Possible Improvements to Measurable Outcomes

- We identified possible improvements to the measurable outcome submitted in our 2015 NWD proposal. For example, we feel it might be valuable to measure the extent and quality of person-centered counseling occurring and provide an opportunity to integrate both consumer and Door perspectives. For starters, we will work with each Door to understand what is currently being collected and in what forms may be available to the NWD project. Some questions we have include: what tools are being used; what data are being collected that capture client perspectives; what possible gaps exist; what ideas do Doors have regarding the gaps; what solutions may have already been tried in the past; and what common interests do Doors have regarding key client perspectives. Evaluation efforts that align with existing data collection efforts are an efficient use of time and resources, and can be sustained.
- We had discussions regarding Hawaiʻi participation in national surveys such as the NCI-AD and CAHPS HCBS. Both surveys piqued interest when they were presented at the September 2016 HCBS Conference. UH has experience implementing NCI-DD (for individuals with intellectual and developmental disabilities) and Med-QUEST has experience with a variety of CAHPS surveys, however, cost of using these tools are major barrier. Discussions are on-going including identifying ways the NWD project can support Hawaiʻi Doors in participating or at minimum preparing for sustainable and standardized data collection across multiple-Doors.

PRODUCTS

What was produced during the reporting period and how have these products been disseminated? Products may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audiovisuals, and other informational resources.

During the first year of the grant period, we developed the following products that have been reviewed by the NWD Advisory Committee and placed on the NWD website.

- Website: http://hinwd.blogspot.com This website provides information about our NWD initiative for public review and comment. The three-year plan, meeting minutes and other information presented at Advisory Committee meetings are available. The public is also able to post comments or questions on this website.

The following products are available on the NWD website:

- Handouts:
  - 1-page overview of the NWD project used to inform Legislators and other interested stakeholders
  - VF- PCC handout used to inform VHA and VAMC leadership
- NWD Advisory Committee working documents:
  - Communication plan
  - Crosswalk of all of the LTSS programs in Hawaii
  - Chart that demonstrates how the implementation of the person-centered standards will impact each of the Doors
  - Common consent form
  - Common referral form
  - ADRC Feedback survey
- Power point presentations:
  - HCBS 2016 Conference workshop presentation on FFP
  - Neighbor island site visit power point
- Reports
  - Results from Hawai'i's Time Study Pilot to Support Medicaid Administrative FFP Claiming, July 12, 2016