

**REPORT TO THE TWENTY-FIFTH LEGISLATURE
STATE OF HAWAII
2010**

**PURSUANT TO H.C.R. 13, SESSION LAWS OF HAWAII, 2009,
REQUESTING A STUDY OF VARIOUS UNRESOLVED ISSUES RELATING TO AGING**

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**STATE OF HAWAII
DEPARTMENT OF HEALTH
EXECUTIVE OFFICE ON AGING
AND
UNIVERSITY OF HAWAII
SCHOOL OF SOCIAL WORK
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SECTION 1 - INTRODUCTION

House Concurrent Resolution (HCR) No. 13, which was adopted during the 2009 Regular Session, requested the Executive Office on Aging (EOA) and the University of Hawaii (UH) Center on Aging to continue their research and analysis to do the following:

1. Develop a cash and counseling model and to apply for related grants;
2. Determine how best to compensate caregivers for respite services;
3. Determine best practices for state agencies to collaborate and coordinate with area agencies on aging and local community service providers (including those for the disabled community);
4. Enhance funding from all sources for Medicaid and Medicare services, including, but not limited to, removing or adjusting income limits and non-exempt asset limitations;
5. Determine how best to accommodate language barriers;
6. Determine how best to overcome access to long-term care services barriers; and
7. Identify more funding sources for long-term care services.

HCR No. 13 also requested EOA and the Center on Aging to report their findings and recommendations to the Legislature no later than twenty days prior to the convening of the regular session of 2010.

EOA wishes to note that the request to study various unresolved issues relating to aging should be appropriately handled between EOA and the UH School of Social Work (SSW), not the Center on Aging. There are several contracts that currently exist between EOA and SSW, including the Caregiver's Resource Initiative, Cash and Counseling, and the Aging and Disability Resource Center. The scopes of work for these projects, which are directly related to the requests made by HCR No. 13, fall within the jurisdiction of EOA's contracts with the SSW, and EOA does not currently have a contract with the Center on Aging. Therefore, EOA and the SSW have continued to work collaboratively to fulfill its responsibilities to meet the request of HCR No. 13.

This report is divided into nine sections as follows:

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| Section 2 | Develop a Cash and Counseling Model and to Apply for Related Grants |
| Section 3 | Determine How Best to Compensate Caregivers for Respite Services |

- Section 4 Determine Best Practices for State Agencies to Collaborate and Coordinate with Area Agencies on Aging and Local Community Service Providers (Including Those for the Disabled Community)
- Section 5 Enhance Funding from All Sources for Medicaid and Medicare Services, Including but Not Limited to, Removing or Adjusting Income Limits and Non-Exempt Asset Limitations
- Section 6 Determine How Best to Accommodate Language Barriers
- Section 7 Determine How Best to Overcome Access to Long-term Care Services Barriers
- Section 8 Identify More Funding Sources for Long-Term Care Services
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SECTION 2 - DEVELOP A CASH AND COUNSELING MODEL AND APPLY FOR RELATED GRANTS

Background of Cash and Counseling

Cash and Counseling (www.cashandcounseling.org) is a promising program that ensures consumer-directed home and community-based care for elders and persons with disabilities. There are essentially two basic components to this program. First, the “Cash” portion is the method through which recipients are able to pay for the services or products that they choose to receive using an individualized budget. “Counseling” refers to the services provided by an agency where a case manager collaborates with the recipient to construct a needs assessment and budget in order to make a determination about which services and/or products to purchase.

Cash and Counseling provides elders and persons with disabilities an opportunity to have a voice in their care through a highly-collaborative approach. Consumers participate in every stage of the process of obtaining and maintaining services and products that are necessary for an optimal quality of life. Initially a successful three-state Medicaid waiver demonstration program, Cash and Counseling has been replicated in 12 additional states. In addition, nearly half the states, 22, have or are actively planning programs for the frail elderly using the individual budget model. Twelve states have individual budget programs in various stages of development, 11 of which are recognized as having program designs consistent with Cash and Counseling. Fourteen states and the District of Columbia have or are planning programs with some degree of participant direction that include the elderly, although these programs are generally limited to personal assistance services and only in some cases include a budget for those services. For example, Delaware, Georgia, Ohio, Oklahoma, and Texas allow a beneficiary budget or allowance, but the budget authority applies only to personal care services. Maine, New Hampshire, New York, Nebraska, Kansas, and Virginia allow elderly participants to hire their workers and use a fiscal agent to handle payments, but there is no individual budget.¹

In order to explore the possibility of implementing such a program in Hawaii, the National Cash and Counseling Program Office Director, along with contact personnel from the various state Cash and Counseling programs, were contacted in an effort to explore

¹ Spillman, B.C., Black, K.J., and Ormond, B.A. (2006). “Beyond Cash and Counseling: An Inventory of Individual Budget-based Community Long Term Care Programs for the Elderly.” The Urban Institute, April, 2006.

their programs. Additionally, interviews with the Department of Human Services-Adult and Community Care Services and the Department of Health-Developmental Disabilities Division were conducted in order to ascertain the availability of services to elders and persons with disabilities in the state of Hawaii. Finally, evaluation research data from Mathematica Policy Inc. was collected from the Cash and Counseling web site.

The evaluation research data strongly indicate that Cash and Counseling is a consumer-directed approach that promises positive results for elders and persons with disabilities. Based on the evaluation data from the three-state demonstration project, both consumers and caregivers who participated in Cash and Counseling reported higher levels of satisfaction than consumers and caregivers who received traditional program services. Consumers used the counseling and fiscal services widely and were very satisfied with them.² In addition, program counselors reported very few cases of abuse and neglect of the consumers and little fraud, in terms of the use of allowance.³ Under the Cash and Counseling program, caregivers reported much lower rates of adverse effects on their social lives, work lives, and physical and emotional health than caregivers who did not fall under this model. Consequently, the Cash and Counseling caregivers reported much greater satisfaction with life. Increased costs for Cash and Counseling resulted primarily from consumers who were previously eligible for services but did not receive them under the Medicaid waiver, indicating more clients were getting more services under Cash and Counseling.

In considering the adoption of Cash and Counseling for the state of Hawaii one must consider recommendations that stem from the “lessons learned” from past implementations. As the number of those in need of assistance continues to grow in our state, attention to the availability of consumer-directed home- and community-based services must increase as well. Cash and Counseling is a viable option that has been successful in many states.

Developing a Cash and Counseling Model for Hawaii

In 2008, the Joint Legislative Committee on Family Caregiving requested EOA to undertake a study investigating the feasibility of implementing a Cash and Counseling

² Mathematica (2007). “Evaluating Cash and Counseling.” Downloaded at: <http://www.mathematica-mpr.com/enews/index22207.asp>.

³ Ibid.

model for non-Medicaid recipients. The SSW was contracted to conduct this study. This approach to providing care differs substantially from other programs currently underway in Hawaii in that it would provide a flexible monthly cash benefit to elders, those with a disability, and to their caregivers. Furthermore, this benefit would be available to all elders and those with disabilities who have an expressed level of unmet need. The final report, “Report on the Feasibility of Providing Consumer Directed Services for Non-Medicaid Eligible Older Adults and Persons with Disabilities in the State of Hawaii,” was submitted to the Legislature in January, 2009. A summary of the recommendations are as follows:

1. Based on the findings of the attached report and the ensuing community input, it is recommended that the state of Hawaii undertake a three year demonstration to test the effectiveness of this model of service delivery. Three possible sites for this program would be: (1) Kauai County with both developmental disability and elderly providers in coalition; (2) health plan providers for the Department of Human Services; and/or (3) Kupuna Care in Honolulu.
2. It is recommended that the demonstration enroll 200 consumers who will receive up to \$750/month to purchase needed care and services as defined by their care plan, including the ability to hire family members as caregivers if they wish. The amount of the monthly benefit should remain flexible, allowing the consumer the freedom to “save up” a portion of the benefit and make a one-time purchase of a needed item or have a costly consultation.
3. Eligibility for the program should be determined by four criteria: (1) requiring assistance with two or more activities of daily living (note: not instrumental activities of daily living); (2) having a cognitive impairment; (3) not being Medicaid eligible but being uninsured or underinsured; (4) not eligible for similar benefits under Medicare (including the disability benefit), the Veteran’s Administration, or other similar programs.
4. It is recommended that the Aging Disability Resource Centers (ADRC) sites serve as the enrollment sites for the project and assist with outreach and project enrollment. The purpose of ADRC is to ensure consumer access to services and streamline the process by which that occurs, so ADRC is a natural site to provide this service.
5. It is recommended that the program will have two components: (1) counselors

whose responsibility is to meet with potential consumers, determine eligibility, develop a flexible monthly budget, establish a service plan, and monitor service delivery on a quarterly basis and (2) a fiscal component which acts as a fiscal agent/employer proxy for the consumer to establish representative payees early in the program, develop forms for employers' reporting responsibilities, and report state and federal taxes.

6. It is recommended that a project director be hired to provide both contract and fiscal oversight and to assess after the demonstration, whether or not these functions should be separated later on in the program. This individual should also be responsible for overall quality assurance to determine that services are delivered as outlined in the service plan and that providers, especially personal care providers, are meeting client needs and that funds are only being spent on items specified in the care plan.
7. It is recommended that an evaluation of the demonstration be put into place at the beginning, with consumers assigned to treatment (consumer directed) and comparison groups (standard Kupuna Care or another program). Baseline and ending measures will assess whether or not reduction of unmet need, consumer satisfaction, health, and cost outcomes vary between treatment and comparison groups.

If these general program guidelines are adhered to, after the planning year, it is estimated that program implementation costs will be \$1,375,000 in the second year (from 2009 to 2010) and for the third year of the demonstration \$1,550,000 (from 2010 to 2011). However, during the planning year, aspects of this original outline may change as Hawaii gathers feedback from the other states that are beginning to provide consumer directed services to non-Medicaid populations, including the 28 states awarded federal grants for the Community Living Program.

On August 3, 2009, EOA applied for AoA's Community Living Program grant (CLP). CLP requires grantees to offer clients consumer-directed services (such as the Cash and Counseling model) as an option to traditional agency-directed services. EOA has been awarded this CLP grant and is committed to offer consumer-directed services to a subset of clients beginning in October 2010. EOA used the SSW January 2009 report on Cash &

Counseling to prepare the successful CLP grant proposal. Hawaii will be one of 28 states implementing CLP.

Specific points in these states' current plans for implementation that will be under discussion in the next year include:

- Whether or not to have limits on income and non-exempt assets (cars, homes, and certain other assets are excluded from this limitation), essentially targeting the Medicaid "spend down" population, addressing participation in the CLP.
- How to accommodate language barriers and cultural values (a significant point for Hawaii).
- The best way to work with the Area Agencies on Aging, the National Family Caregiver Support Program, and local community-service providers, including service providers for the disability community.
- Whether or not to consider a model in which caregivers are allotted a specified dollar amount annually for respite services (recently Hawaii has begun to compile a respite agency/care provider list that will be useful for this purpose).

Applying for Related Grants

EOA recently received funding through the Administration on Aging in collaboration with the U.S. Department of Veterans Affairs - Veterans Health Administration to develop and implement Hawaii's Community Living Program (CLP): Supporting Independence and Choice in the Community. The grant period is from September 30, 2009 through September 29, 2011, and includes Kauai, Maui, and Hawaii counties.

The overall goal of this project is to assist individuals who are not Medicaid eligible, but who are at imminent risk of nursing home placement, to remain in the community, and avoid institutionalization and spend-down to Medicaid. At-risk individuals will be identified through the Aging and Disability Resource Centers (ADRC), and they will be linked to home and community-based services in community living programs, offering options of consumer-directed services or traditional agency-directed services.

The project objectives are five-fold: (1) Coordinate ADRC's intake and assessment protocol with Medicaid level-of-care and eligibility tools; (2) Identify those at risk of nursing home placement, and who are not Medicaid eligible by adding CLP data elements to ADRC assessment protocols; (3) Use existing state and federal funds to help these individuals remain in the community; (4) Contract for financial management services to

activate the option for consumer direction; and (5) Provide at least 90 individuals at risk of nursing home placements and spend down to Medicaid with quality consumer-directed or traditional agency-directed HCBS. Through the CLP grant, consumer directed services will be used to assist individuals who are not Medicaid eligible, but who are at imminent risk of nursing home placement, including veterans.

SECTION 3 - DETERMINE HOW BEST TO COMPENSATE CAREGIVERS FOR RESPITE SERVICES

Background of Respite Services in Hawaii

Respite care can be defined as the temporary physical, emotional, or social care of a dependent person in order to provide relief from caregiving to the primary care provider.⁴ The major assumption underlying respite care is that the provision of temporary relief from caregiving responsibilities will reduce stress.⁵

In response to Senate Bill No. 2830, which was enacted as Act 220, SLH 2008, EOA contracted with the SSW to conduct an inventory of respite services in Hawaii for family caregivers of older adults. The final report, "Respite Care in the State of Hawaii," was submitted to the Legislature in January, 2009. A summary of the findings are found below.

A survey of respite services in Hawaii found that there are 31 respite programs available to elders on Oahu. Hawaii County had approximately 13 respite programs available, island wide, and Maui County had 9 respite agencies. Only 2 respite agencies on Kauai are available to provide coverage for the entire island.

Overall, out of home and in home respite services were roughly equal. A small percentage, roughly 15%, provided services for elders who required specialty care, i.e. Alzheimer's and mental health issues. Only 5% provided transportation. The majority of the out of home respite agencies provided meals. While most agencies were prepared to handle issues such as incontinence, only a few provided skilled services, such as nursing

⁴ Weber, N.D. and Schneider, P. (1993). "Respite Care for the Visually Impaired and Their Families." In Tepper, L.M. and Toner, J.A., eds (1993). Respite Care: Programs, Problems and Solutions. The Charles Press. Philadelphia, PA, pp. 62-77.

⁵ Toner, J.A. (1993). "Concepts of Respite Care: A Gerontologist's Perspective." In Tepper, L.M. and Toner, J.A., eds (1993). Respite Care: Programs, Problems and Solutions. The Charles Press. Philadelphia, PA, pp. 123-131.

or physician care. For additional services, including assistance with mobility or incontinence, agencies required an increase in fees. Service gaps included the following:

1. Virtually no transportation to or from sites.
2. Little, if any, care for moderate to severe Alzheimer's disease.
3. Almost no emergency, overnight, or weekend respite services.
4. Prohibitive costs associated with service delivery if private pay.

There are a wide range of statutes with respite care definitions. Two of the states with the most inclusive and exhaustive definition are Illinois and New Jersey, either of which might serve as a model for Hawaii. In general, the more workable definitions are probably those not linked to a specific disease or condition, and are population inclusive, based on combination of medical and financial need, rather than age, type of illness, or disability.

Most states do not have service caps; those that do often define them in terms of hours or days of service provision; a few have fiscal caps which vary by funding source ranging from as little as \$250/yr to as much as \$12,000/yr. There are few funding sources for respite care; most states utilize two sources to fund respite: (1) the Medicaid Home and Community Based Services Waiver Program and (2) the National Family Caregiver Support Program. In addition, about 60% of the states augmented these funds or implemented their programs with state general funds, tobacco, or lottery funds. The federal Lifespan Respite Act is another possible source of support as would be a statewide partnership for long-term care insurance.

There is very little information on program evaluation. The few evaluations that exist have focused on caregiver outcomes that measure service use and satisfaction. A few states have participated in evaluation efforts undertaken by the ARCH National Respite Network and Resource Center out of the University of North Carolina in Chapel Hill; however, these were quite dated and were generally not statewide; however Oklahoma is one of these states and does have validated outcomes that extend beyond caregiver stress relief.

As there were minimal evaluation findings, the peer reviewed literature was explored in order to ascertain what might be expected for positive outcomes from respite care programs, as well as current issues encountered in program implementation. The following issues were revealed:

1. The use of the term 'respite' service may not be desirable for consumer outreach and marketing. It is a professional term and is perhaps poorly understood by caregivers.
2. There are few measurable outcomes from respite care other than those related to quality of life for caregivers. However, few programs have measured the impact on such issues as delaying institutionalization or on employment interruption. Furthermore, few programs have investigated outcomes for care recipients.
3. Underutilization of services is a problem. Packaging respite care as part of a consumer directed 'bundle' of services for caregivers is the most desirable way to insure appropriate service utilization.
4. Appropriate respite care for caregivers of the cognitively impaired requires special features and should probably be differentiated from other general respite programs.
5. Both in-home and out-of-home respite services have advantages for caregivers; however neither is more cost effective.

Compensating Family Caregivers

Various methods of compensating family caregivers have been examined over the past two years, including Cash and Counseling, paid family leave, and a caregiver tax credit. Cash and Counseling, which was discussed in the preceding section, is a viable alternative to compensate family caregivers because under this model the individual's budget may be used to hire a family member to perform duties that would otherwise be done by an agency or be done without compensation by the family caregiver.

Another alternative is caregiver tax credit. A report completed in 2007 for EOA by the UH Public Policy Center, "Tax Incentives for Family Caregivers: A Cost-Benefit Analysis," draws from the Hawaii Caregiver Needs Assessment Survey and is a stratified random telephone survey of 600 family caregivers in Hawaii. The survey results are weighted to be representative of the Hawaii population, based on 2006 Census estimates. This analysis deals with the implications of providing a refundable tax credit of up to \$1,000 to Hawaii caregivers caring for a person aged 60 or older.

Some major findings include the following: (1) caregivers are likely to spend a potential tax credit in the following ways – 38% on personal & family consumption; 40% on

personal and retirement savings; and 22% on home and adult day care for the recipient; (2) Hawaii caregivers spend on average 22 hours per week caring for their elders; (3) self-reported costs of caregiving average \$11,565/year, though these costs vary widely; (4) the home care labor market may need to increase by as much as 12% to meet the increased demand induced by the tax credit; and (5) the estimated cost of this type of caregiver tax credit is \$37.4 million/year while the likely consumer benefit is \$38.2 million.

A third alternative that has been researched is paid family leave. Act 243, Session Laws of Hawaii 2008, required the Joint Legislative Committee on Aging in Place (JLCAIP) to explore the provision of wage replacement benefits to employees who need to take time off from work to care for a family member with a serious health condition. To that end, the Family Leave Working Group (Working Group) was established as part of, and reporting to, the Joint Legislative Committee on Aging in Place with the instruction to explore the provision of wage replacement benefits to employees who need time off from work to care for a family member with a serious health condition.

The Working Group found that in seeking to analyze and develop improvements to the family leave system, inadequate data existed about the use and need for paid family leave. Therefore, the Working Group endorsed a continuum of short-and long-term concepts that the JLCAIP or other individuals/organizations may adopt for introduction in the 2009 session. The continuum consisted of three parts: (1) the creation of a data collection system that is capable of analyzing and reporting family care data for both public and private employees, (2) the establishment of an eldercare tax credit for employees, similar to tax credits for childcare, and (3) the establishment of a state-sponsored long-term care insurance program through employee payroll deductions along with a tax credit for employers who purchase long-term care insurance for their employees.

H.B. No. 982, C.D. 1, enacted into law as Act 7, Special Session of 2009, was passed to establish a data collection system that was capable of analyzing and reporting family care data for both public and private employees. The Department of Labor and Industrial Relations (DLIR) was tasked to establish the web-based family leave data collection system and was authorized to spend \$10,000 out of the Disability Benefits Special Fund for this purpose. Per the DLIR, the data collection system has not yet been established.

Compensating Family Caregivers for Respite Services

Based on “Respite Care in the State of Hawaii,” the following policy recommendations were made for direct service provision:

1. Define respite using an inclusive lifespan approach. The definition of respite should carefully define all potential recipients and targeted populations, describe the services that fall under the definition, define any caps or limits (dollars, hours, etc.) to these services, especially reimbursement limits, and define the expected outcomes.
2. Address causes of potential underutilization at the outset. The provision of professional assessment and advice about how to access respite care will be needed. In addition, a range of flexible respite care services needs to be available. Appropriate respite care based on the needs of caregivers as defined by caregivers themselves is desirable to address underlying causes of underutilization.
3. Create a supply of trained workers. Trained center/facility staff and in home workers, especially to work with cognitively impaired clients, are needed for respite care to be a success.
4. Weigh costs and benefits. There are few sources of funding for respite care outside of state funds, and the state needs to be prepared to shoulder ongoing costs even though ‘hard’ benefits may be difficult to measure or even achieve.
5. Target employed caregivers. Of the possible groups to be targeted in terms of respite services, employed caregivers should certainly be considered. Older/retired spouses are less likely to use this service.
6. Create at least one special needs program for each county. Dementia care and respite for caregivers of cognitively impaired adults is a big gap in this program. More sites and more trained workers need to be available to meet this need, especially in the more rural areas.
7. Offer respite as part of a bundle of caregiver services. Appropriate service utilization is more likely if the respite services are offered as part of a “package” of available services to caregivers.
8. Additional services/issues. Services that support respite care are also helpful and should be considered as part of the “service bundle.” Accessible transportation in particular, or escort services, is greatly needed, both in urban and rural areas.

EOA and the SSW have researched the four main public policy approaches to support caregiving families -- direct services including additional funding for Kupuna Care, financial incentives and compensation including direct payments and tax incentives, Cash and Counseling, and employer-based mechanisms including paid family leave. However, EOA and the SSW have not yet determined if Hawaii's caregivers generally prefer services which provide relief from daily caregiving and increase coping skills rather than financial supports, and neither organizations have followed up on determining how to best compensate caregivers for respite services.

SECTION 4 - DETERMINE BEST PRACTICES FOR STATE AGENCIES TO COLLABORATE AND COORDINATE WITH AREA AGENCIES ON AGING AND LOCAL COMMUNITY SERVICE PROVIDERS (INCLUDING THOSE FOR THE DISABLED COMMUNITY)

Best Practice for Collaboration and Coordination: the ADRC

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). The solicitation contained very specific requirements based upon the federal vision for ADRCs. This vision is the creation of a single, coordinated system of information and access for all persons seeking long term support services.

The best practices for state agencies to collaborate and coordinate with area agencies on aging and local community service providers, including those for the disabled community, are articulated by federal ADRC guidelines, components of which are described below. As a result, joint projects are developed and managed effectively, partnership's goals and activities to professionals and the community are clearly communicated, resources across agencies are shared, consensus among constituencies are built, conflicts that impede improvements to services are resolved, and effective relationships across agencies are maintained.

Hawaii shares the same national vision, which is to have ADRC sites 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 vision also serves as Hawaii's philosophy.

In 2005, the State of Hawaii through the EOA received a grant for \$800,000 from the AoA and the CMS to develop ADRC sites in Hawaii over three years. Currently, the Hawaii ADRC network consists of ADRC sites at the Hawaii County Office of Aging (HCOA) in Hilo on the island of Hawaii and the Honolulu Elderly Affairs Division (EAD) on the island of Oahu.

The physical site in Hilo is in a newly renovated building that co-locates public and private agencies including: HCOA, the senior employment program, the local Medicaid service center, the Hawaii Center for Independent Living, several community providers of

home and community based services, the Alzheimer's Association, and the University of Hawaii's College of Pharmacy interns who provide medication management.

The Oahu site is under development and consists of a virtual website at www.hawaiiadrc.org, with planned web access, a call center, and face-to-face service at several planned Honolulu satellite locations. Ongoing information and assistance services at AAAs in Kauai and Maui counties will also be reorganized into the ADRC model.

In 2009, EOA was awarded three grants which impact the process of systems change and builds on the functions of the Hawaii ADRC by enhancing the design, accessibility and coordination of home and community long term support services in the state. The grants are the Aging and Disability Resource Center Expansion, Community Living Program, and CMS Person-Centered Hospital Discharge Planning Model.

Developing a Vision

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. A vision that is shared by critical partners and by staff must be articulated by all of these groups. Systems change is difficult and slow; the vision of how consumers will be better served sustains the commitment to make these difficult changes. The vision must always remain front and center, and it must drive policy and operational decisions. While this vision may seem self-evident, failure to articulate it and to keep it in focus can lead easily to designing policies and procedures that take the system in far different directions than intended.

To reflect this vision and philosophy, Hawaii's ADRC has adopted the following care 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 requires buy in from the leaders of government agencies, local health and human service agencies, the faith community, and private partners such as service provider organizations to develop partnerships and working agreements. The leaders of these entities will provide the leadership and embrace the vision of the ADRC. 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 do not agree with the vision. All ADRC sites will share the over-arching federal and state vision and model while adapting to fit unique needs and concerns of the local consumer population and service environment.

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 the buy-in from the heads of the organizations. 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 details 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:

- All Four Area Agencies on Aging
- AARP Hawaii
- Alzheimer's Association
- Alu Like, Inc.
- Core Group One
- Hawaii Center on Disability Rights
- Hawaii Centers for Independent Living

- Department of Human Services (Medicaid, Adult Protective and Community Care Services)
- University of Hawaii (School of Social Work, Center on the Family, School of Travel Industry Management, and Center on Aging)
- Developmental Disabilities Council
- Disability Communications Access Board
- Department of Health – Developmental Disabilities, Adult Mental Health
- Hawaii Long Term Care Association
- Healthcare Association of Hawaii
- Kapiolani Community College
- Kokua Kalihi Valley Health Center
- Project Dana

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 service agencies
- Faith-based organizations and community
- Human resource departments of local employers
- Hospitals
- Community health centers
- Media
- Transportation agencies
- Home health agencies
- Housing agencies
- Employment agencies
- Veteran’s Administration

Roles and Relationship Between the State EOA and County AAAs

As the Hawaii State Unit on Aging, EOA serves as the lead agency and provides the project oversight and leadership for the ADRC, developing statewide infrastructure and resources to articulate local community-based ADRC sites. EOA interfaces with the AoA and CMS and ensures fidelity to the defined criteria of a fully functioning ADRC, to other grant requirements, and submits progress reports and data to funders and others. EOA 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 operated by county Area Agencies on Aging with resources such as the state-level project management, coordination, evaluation, advocacy, and promotion of the ADRC at the legislature and with other key community partners, Governor's office, and media.

The county Area Agencies on Aging (AAAs) are responsible for planning, developing, and operating the ADRC in their respective areas. The staff performs the key functions of the ADRC, including intake/screening, assisting in eligibility determination, options counseling, providing information, referral, and linkages to other agencies and programs, and offering short term case management and follow up to ensure that the consumer obtains the needed services. They work closely with local agencies and community partners, especially within the aging and disability network, for client referrals, organizing staff cross training, and conducting community outreach and education. Businesses, educational institutions, labor unions, and civic groups are also important stakeholders and partners.

Memorandums of agreement define and strengthen the functions and roles between the ADRC and its community partners whenever applicable. A respectful and symbiotic relationship between the state and counties is essential to ensure successful replication statewide. Maintaining the integrity of the ADRC mission while adapting the ADRC functions/processes to meet the needs of consumers within the uniqueness of each site's environment and infrastructure is important. 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 to do it. The original two pilot sites developed and followed a work plan which served as their compass in project development and management. This plan should be continuously updated since it is often very difficult to accomplish tasks as scheduled because of unforeseen obstacles which may arise during the course of the project development. EOA has obtained a 3-year federal grant for ADRC Expansion. In the first

18 months of this grant period, partners will collaborate to design a 5-year operating plan and budget for Hawaii's statewide ADRC.

Staffing the ADRC

Staffing the ADRC will require that AAA's examine existing staffing patterns and staff skills to determine how best to organize the staff to perform new functions required when operations transition from the prior model to an ADRC. Changes 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. EOA has allocated some of its 2009 ADRC grant funds to Area Agencies on Aging to be used as they determine, for their staffing, training, travel, or other operational costs of the ADRC sites.

In most AAAs, 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 have 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. EOA, through its ADRC Expansion 2009 grant, will be hiring a Disabilities Program Specialist to provide technical assistance, training, and other resources to ADRC staff statewide.

Most AAAs will find it helpful to designate a person to serve as the manager or coordinator of the ADRC. As the ADRC site 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 repetitious interviewing 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 ADRC Advisory Board assists in the development and implementation of Hawaii's ADRC program. The Advisory Board advises the EOA, the lead state agency of the ADRC initiative, on (a) the design and operations of the ARDC, (b) the 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 ADRC.

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 ADRC including individuals who have a disability or a chronic condition requiring long term support, (b) representatives from organizations that provide services to the individuals served by the program, and (c) representatives of the government and non-government agencies that are impacted by the program.

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. National best practice examples of operational procedures are available at the funders' technical assistance website for grantee states. (www.adrc-tae.org). The experiences of Hawaii's pilot sites can help identify areas in which policies and procedures are most needed and provide examples that may be adopted or modified.

SECTION 5 - ENHANCE FUNDING FROM ALL SOURCES FOR MEDICAID AND MEDICARE SERVICES, INCLUDING BUT NOT LIMITED TO, REMOVING OR ADJUSTING INCOME LIMITS AND NON-EXEMPT ASSET LIMITATIONS

Medicare is the federal health insurance program for Americans age 65 and older and for certain disabled Americans. Medicare has two segments: hospital insurance, known as Part A, and supplementary medical insurance, known as Part B, which provides payments for doctors and related services and supplies ordered by the doctor.

Medicare will pay for many health care expenses, but not all of them. In particular, Medicare does not cover most nursing home care or long-term care services in the home, and some prescription drug benefits are covered under Medicare Part D. Medicare usually operates on a fee-for-service basis. Health maintenance organizations and similar forms of prepaid health care plans are now available to Medicare enrollees in some locations.

Medicaid provides health care coverage for some low-income people who cannot afford it, including people who are eligible because they are aged, blind, or disabled or certain people in families with dependent children. Medicaid is a federal program that is operated by the states, and each state decides who is eligible and the scope of health services offered.

In Hawaii, the Medical Assistance Program (Medicaid) has been in effect since January, 1966. In August, 1994, Hawaii's Medicaid program separated into two methods of providing services for the two major groups of recipients. Hawaii QUEST, commonly known as QUEST, is a managed care program that provides health coverage through health plans for eligible Hawaii residents and includes medical and mental health services. Dental services are provided under the Medicaid Fee-For-Service Program.

Generally, for individuals who are age 65 and over or certified blind or disabled, coverage is provided under QUEST Expanded Access (QExA), which is a managed care delivery system.

QUEST and QExA are administered by the Department of Human Services, Med-QUEST Division, and is financed through the state of Hawaii and the Federal Centers for Medicare and Medicaid Services.

Plans have been made to address enhanced funding from all sources for Medicaid and Medicare services, including but not limited to, removing or adjusting income limits

and non-exempt asset limitations. However, because of limited staff resources and other time-sensitive commitments, these issues will be dealt with in the near future.

SECTION 6 - DETERMINE HOW BEST TO ACCOMMODATE LANGUAGE BARRIERS

Almost 35%, or more than 45,000 people, of the limited English proficient (LEP) population in Hawaii are 60 years old and above, according to the U.S. Census Bureau's 2006 American Community Survey. The availability of language access through an interpreter or bilingual caregiver staff is a vital component for Hawaii's aging LEP population as they seek to understand and make decisions on their health and long-term care. EOA and the SSW support the goals of the state Language Access Law, which was enacted by the Legislature in 2006 and signed into law by Governor Lingle, to ensure meaningful access to state funded services, programs, and activities by persons with limited English proficiency.

The Community Living Program with its consumer-directed service option holds promise of providing supportive services to people with LEP. While traditional agencies often have difficulty obtaining sufficient staff members who are proficient in needed languages, clients who use consumer-directed services can hire as caregivers neighbors or relatives who speak their language and share their culture.

Plans have been made to address how to best accommodate language barriers. However, because of limited staff resources and other time-sensitive commitments, this issue will be dealt with in the near future.

SECTION 7 - DETERMINE HOW BEST TO OVERCOME ACCESS TO LONG-TERM CARE SERVICES BARRIERS

Functions and Requirements of an Aging and Disability Resource Center

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). The solicitation contained very specific requirements based upon the federal vision for ADRCs. 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 intent of the centers is to minimize confusion, reduce the number of hoops that must be jumped 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 as required by the AoA and CMS.

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, and also aware of the ADRC.

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.

Additionally, to accomplish the goals of the ADRC, states must also adhere to the following federal requirements:

- 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.

History of the ADRC in Hawaii

In 2005, the State of Hawaii received an \$800,000 federal grant from AoA and CMS to develop an ADRC within a three year funding period starting from October, 2005 - September, 2008. Hawaii became one of 43 states and territories receiving this federal grant to initiate the ADRC project.

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 ADRC on the islands of Hawaii and Oahu, with the goal of expanding statewide. Serving as the project manager and lead agency, EOA 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, and (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 three 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 ten years and co-locate the Hawaii County Office of Aging and other aging and disability agencies and programs in the facility. Between the lease rental 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 the basement, and the new second level additional space is 5,472 square feet. The total facility space is 22,616 sq. feet plus parking. This additional funding support from Hawaii County has made the renovation and construction of the ADRC physical site in Hilo a reality.

Meanwhile, the Honolulu's Elderly Affairs Division (EAD) launched a virtual ADRC site in October, 2009 and is available through the statewide ADRC portal at www.hawaiiadrc.org. 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. 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 initial federal funds allocation of \$131,779 through EOA's 2005 grant 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.

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. All counties now have websites that are accessible through the statewide ADRC portal at www.hawaiiadrc.org.

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 the same 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 because of 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, uniformity and standardization among the sites in key functions and processes with fully functioning criteria is important to create a seamless system statewide. Both AoA/CMS and EOA recognized and allowed for each ADRC site to have some flexibility for adaptation to the sites' respective circumstances (i.e. consumer population needs, service environment, staffing pattern, flow of operations) 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 ADRC statewide website, telephone system (which include a single statewide number), and a physical site in Hilo are the major access venues or tools presently available to the public. In working with other service providers and groups identified as 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 so that 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 four 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 satellite sites in Kahuku and Hauula, with two more sites under renovation in strategic locations on Oahu. ADRC pilot site staff have been oriented /trained in the ADRC model.

SECTION 8 - IDENTIFY MORE FUNDING SOURCES FOR LONG-TERM CARE SERVICES

In 2009, EOA identified several federal grant opportunities. EOA applied for and was awarded three federal grants as described below.

Hawaii's Community Living Program

EOA recently received funding through the Administration on Aging in collaboration with the U.S. Department of Veterans Affairs - Veterans Health Administration to develop and implement Hawaii's Community Living Program (CLP): Supporting Independence and Choice in the Community. The grant period is from September 30, 2009 through September 29, 2011, and includes Kauai, Maui, and Hawaii counties.

The overall goal of this project is to assist individuals who are not Medicaid eligible, but who are at imminent risk of nursing home placement, to remain in the community, and avoid institutionalization and spend-down to Medicaid. At-risk individuals will be identified through the ADRCs, and they will be linked to home and community-based services (HCBS) in community living programs, offering options of consumer-directed services or traditional agency-directed services.

The project objectives are five-fold: (1) Coordinate ADRC's intake and assessment protocol with Medicaid level-of-care and eligibility tools; (2) Identify those at risk of nursing home placement, and who are not Medicaid eligible by adding CLP data elements to ADRC assessment protocols; (3) Use existing state and federal funds to help these individuals remain in the community; (4) Contract for financial management services to activate the option for consumer direction; and (5) Provide at least 90 individuals at risk of nursing home placements and spend down to Medicaid with quality consumer-directed or traditional agency-directed HCBS.

Hawaii's Person-Centered Hospital Discharge Planning Model

EOA was recently awarded a grant from the Centers for Medicare and Medicaid Services to develop a Person-Centered Hospital Discharge Planning Model and expand/enhance the Aging and Disability Resource Center (ADRC) to include the islands of Kauai and Maui and a physical site within the City and County of Honolulu in Kahuku.

The federal grant award to the state was \$1,167,000 for a grant period of July 1, 2009 to September 29, 2012. The target population is Medicaid-eligible individuals

discharging from a hospital stay from Kauai Veterans Memorial Hospital, Kahuku Medical Center, Maui Memorial Medical Center, and North Hawaii Community Hospital.

The focus of the discharge planning model is to develop sustainable and collaborative partnerships between the state, hospitals, institutional, and community-based providers. The focus is to also provide meaningful involvement of the individual and his/her informal caregiver(s) in the discharge planning process. Additionally, the discharge planning model will create or enhance Hawaii's system of access to accurate, useful, and timely information on available home and community based long-term supports (through ADRC or other means) by community based providers, discharge planners, and individuals and their caregivers. For instance, development of a web-based tool that provides information on available resources, eligibility information, and contact information will assist hospital discharge planners in locating community based care options. Finally, the planning model will coordinate hospital discharge planning activities with existing Medicaid case management functions, if appropriate.

Aging and Disability Resource Centers: Empowering Individuals to Navigate their Health and Long Term Support Options

EOA has received funding through the Administration on Aging in collaboration with the Centers for Medicare and Medicaid Services to expand the current ADRC statewide. The purpose is to engage in a system transformation to achieve a fully functional ADRC.

The grant award period is from September 30, 2009 through September 29, 2012, and includes all counties. The goals of the ADRC are (1) to empower consumers to make informed decisions about their options, (2) to streamline access to the services and support they and their family caregivers need, and (3) serve as highly visible and trusted places where people with disabilities of all ages can find information on the full range of long-term support options and can access a single entry point to public long-term support programs and benefits.

The objectives of the ADRC grant are five-fold: (1) Develop a five -year operational plan and budget for achieving statewide coverage of ADRCs, (2) Expand and formalize linkages with key aging, disability, and health care providers, (3) Provide options counseling training to staff on specific aging and disability topics (e.g., private pay services, care home placement, disability services), (4) Make enhancements to the ADRC

website to improve access to information and services, and (5) Maintain a data collection and reporting system for quality assurance and evaluation.

SECTION 9 - RECOMMENDATIONS

Cash and Counseling

EOA has contracted with the SSW to research approaches to provide financial assistance to family caregivers. The current contract, UH-CC-07, Supplemental Contract No. 2, expires on June 30, 2010. It is recommended that EOA and the SSW use the existing balance of approximately \$50,000 of this contract by June 30, 2010 to execute one or more of the following:

- (1) Plan for a Cash and Counseling demonstration project for Hawaii as recommended in the EOA study, "Report on the Feasibility of Providing Consumer Directed Services for Non-Medicaid Eligible Older Adults and Persons with Disabilities in the State of Hawaii."
- (2) Design and refine the consumer-directed approach of Hawaii's Community Living Program: Supporting Independence and Choice in the Community.

Compensating Family Caregivers for Respite Services

It is crucial to advocate for policies that enable families to continue to provide care, particularly respite services. Public policies are needed to provide both direct services and financial support strategies. Moreover, policymakers need to recognize and address the real need of older adults and their families: to ensure access to quality, affordable long-term care, in the least restrictive setting for the person needing care, that best meets family needs. What public policy can and must do is guarantee a statewide program that protects families from the emotional and financial bankruptcy that are often the result of providing long-term care. It is recommended that EOA build the reach of the federally funded National Family Caregiver Support Program by using the capabilities of the Aging and Disability Resource Center.

Collaborating with Area Agencies on Aging and Local Community Service Providers

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 will 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.

Additionally, it is paramount that the ADRC program is comprehensive, standardized, and accessible while recognizing the uniqueness of each county's communities, finances, and resources. Standardization is being developed in the following areas through the creation of statewide infrastructure for:

- 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 sites.
- Website.
- Marketing.
- Staff training program.
- MIS system.

It is recommended that EOA: (1) establish written memorandums of agreement with all ADRC partners, and (2) continue to pursue fidelity to the nationally defined “Criteria for a Fully Functioning ADRC.”

Enhance Funding from Sources for Medicaid and Medicare Services

EOA and the aging network are recommended to work with the Department of Human Services, MedQUEST Division, to address enhanced funding from all sources for Medicaid and Medicare services, including but not limited to, removing or adjusting income limits and non-exempt asset limitations. Collaborative work to implement EOA's Hospital Discharge Planning grant which assists Medicaid patients using ADRC capabilities will be a venue for such work.

Determine How Best to Accommodate Language Barriers

This issue of availability of language access for Hawaii's older adults and their family caregivers is recommended to be addressed in the planning cycle for the upcoming 4-year State Plan on Aging to ensure that this issue is addressed by the aging network as a whole.

Overcoming Access to Long Term Care Service Barriers

The Hawaii ADRC marketing plan/strategies should be fully executed and recommended to address the general barriers to successful access and linkages, including:

- 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).

Identify More Funding Sources for Long-term Care Services

EOA should collaborate with other organizations and leverage their resources to apply for additional grants through multiple funding sources (i.e. federal, private foundation, state, etc.) to sustain and expand current projects and create new ones.