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Aging and Disability Resource Centers:

Empowering Individuals to Navigate Their Health

and Long Term Support Options

U.S. Administration on Aging
In Collaboration with
The Centers for Medicare and Medicaid Services
2009

Department of Health and Human Services (HHS)

Administration on Aging (AoA)

AoA Office for Planning and Policy Development

Funding Opportunity Title: Aging and Disability Resource Centers: Empowering Individuals to Navigate Their Health and Long Term Support Options

Announcement Type: Initial

Funding Opportunity Number: HHS-2009-AoA-DR***-0915***

Catalog of Federal Domestic Assistance (CFDA) Number: 93.048

Key Dates:

Open Information Teleconference:	July 8, 2009
Teleconference Number:	1-888-396-9185, pass code: 2043392.
Voluntary Notice of Intent to Apply:	July 15, 2009
Grant Application Due Date:	August 10, 2009
Issuance of Notice of Grant Awards:	Prior to September 30, 2009
Grant Period Start Date:	September 30, 2009

Funding Opportunity:	**Expansion and Enhancement of ADRCs**
Award Type:	**Cooperative Agreement**
Federal funds available:	**Up to $10,000,000 for year 1** (Funding for Years 2 & 3 contingent upon program performance and availability of Funds)
Est. Number of Awards:	**50**
Project Start Date:	**Sept 30, 2009**
Length of Project:	**36 Months**
Eligible Applicants:	**Any State Agency or instrumentality of the State (e.g. State Unit on Aging, State Medicaid Agency, State Disability Agencies)**
Est. Total Award:	**Award will range from $600,000 to $750,000 over the 3 year project period**
Est. Amount Each Year:	**Award will range from $200,000 to $250,000 for each respective year**

The average cooperative agreement amount is anticipated to be approximately $600,000 to $750,000 over the entire 3 year project period. These grants will be funded at the federal share of approximately $200,000 to $250,000 per year for a project period of three years, contingent on program performance and the availability of funds.

Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA reserves the right to offer a funding level that differs from the requested amount, including amount less than the amount the applicant has requested. Grantees will be required to contribute a match

– either cash or in-kind - equal to five percent of the total budget.

These grants will be issued as Cooperative Agreements because AoA anticipates having substantial involvement with the recipients during performance of funded activities. For additional information on the level of AoA's and grantee involvement as outlined in the Cooperative Agreement please see **Attachment H**. Grantees will be expected to maintain regular contact with their federal project officer and to cooperate with the AoA Technical Assistance Center. Grantees will also be expected to share all significant products and activities with AoA.

I. FUNDING OPPORTUNITY DESCRIPTION

1. Statutory Authority

The statutory authority for grants under this Program Announcement is contained in Titles II and IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects).

Title II Section 202b specifically authorizes the Assistant Secretary for Aging to work with the Administrator of the Centers for Medicare and Medicaid Services to: "implement in all states Aging and Disability Resource Centers –

> (A) to serve as visible and trusted sources of information on the full range of long-term care options that are available in the community, including both institutional and home and community-based care;
>
> (B) to provide personalized and consumer friendly assistance to empower people to make informed decisions about their care options;
>
> (C) to provide coordinated and streamlined access to all publicly supported long-term care options so that consumers can obtain the care they need through a single intake, assessment and eligibility determination process;
>
> (D) to help people to plan ahead for their future long-term care needs; and
>
> (E) to assist, in coordination with the State Health Insurance Assistance Program, Medicare beneficiaries in understanding and accessing the Prescription Drug Coverage and prevention health benefits available under the Medicare Modernization Act".

2. FY 2009 ADRC Funding Opportunity

Beginning in 2003, AoA and CMS offered grants to states to develop Aging and Disability Resource Center (ADRCs) Programs, consistent with the statutory functions describe above. With the current grant opportunity, the goal of ADRCs is to empower consumers to make informed decisions about their long-term service and support options and to streamline their access to existing services and supports. To-date, 45 states and territories have received ADRC grants and there are currently over 200 ADRC sites in operation across the nation.

In addition, 2 states have developed ADRCs as part of their Community Living Program grant.

ADRC grants have never been designed to pay for the on-going cost of operating ADRC services, but instead are to help states and communities to realign and make more optimal use of the existing financial and other resources that are already being deployed under federal and state long-term services and supports programs, including Medicaid, OAA and state revenue programs for the purpose of helping consumers learn about and access services and supports. ADRCs make it easy for consumers of all ages, incomes and disabilities, and their families, to learn about and access the full range of long-term services and supports available in their communities. Specifically, ADRC grant funds are being made available to help states and communities to integrate and/or better coordinate the following functions that cut across multiple federal and state programs: providing information to consumers on available options; one-on-one counseling to help people understand how the options relate to their particular needs and circumstances; working with consumers and their families to develop an assessment of their needs, a service plan to address those needs, and arranging the expeditious delivery of the services including a consumer directed option; conducting eligibility determination and enrollment in public programs as appropriate; and, arranging and ensuring that consumers receive the services and supports they need.

ADRCs are not necessarily located in a single physical place and the functions are not necessarily carried out by a single agency. ADRCs are information and access “programs” or “systems” that involve networks of state and community organizations that work together in a coordinated manner to provide consumers with a single point of entry to all long-term services and supports. In addition, ADRCs provide streamlined access to all publicly funded long-term services and supports, including both home and community based and institutional care. Even though multiple partner organizations will likely be involved in the operation of an ADRC – from the perspective of the consumer, their access to long-term service and support should be seamless, regardless of what program(s) they may use.

One model which AoA strongly endorses and supports is a “no wrong door” approach where aging and disability providers such as an Area Agency on Aging and a Center for Independent Living partner together to create an ADRC system. Due to service/geographic differences this may not always be possible but it is becoming a promising practice within the ADRC movement. For example, the **Massachusetts’s** Aging Services Access Points and Centers for Independent Living have partnered to create ADRC networks within Massachusetts. Each organization in the partnership continues to advertise their existing local telephone numbers but all partners use a common intake form and information and assistance procedures and can access the same resource and services database. One pilot site invested in a telephone system that allows partnering organizations to make “soft transfers” to other partners in the network. Several other states have used similar models for their ADRC networks, including Arizona, Georgia, Texas and California. In addition, one Massachusetts ADRC developed a special information technology interface so that the organizations using different information and assistance software systems can easily share resources and service data electronically without having to invest in new software.

The Administration on Aging - in collaboration with the Centers for Medicare and Medicaid Services which has awarded grants to additional ADRC programs under its FY 2009 Real

Systems Change Program - is making FY 2009 AoA Discretionary funds available to all states to achieve the joint AoA/CMS goal of taking the initiative to all states this year.

Under this Program Announcement, AoA is making funds available for states to:

1.) Establish new or significantly strengthen existing ADRC Programs consistent with the functions specific in OAA II Section 202(b)7 and the requirements in this Program Announcement, and,

2.) Develop a five year operational plan and budget – with input from all the key stakeholders - that are approved by the State Unit on Aging, State Medicaid Agency, and State Disability Agencies where applicable, for achieving statewide coverage of ADRCs that are fully capable of performing the functions specific in OAA II Section 202(b)7 and the requirements in this Program Announcement.

Applications submitted under this Program Announcement must – at a minimum - involve a full partnership of the State Unit on Aging, the State Medicaid Agency, and State Disability Agencies where applicable, and at the community level, a substantive role for any Area Agency on Aging, Local Medicaid Office, Center for Independent Living, State Health Insurance Counseling Program, and Benefits Outreach and Enrollment Center, located in the geographic areas covered by a state's ADRC Program. Applications must also include a substantive advisory role for consumers, their families and other key stakeholders affected by a state's ADRC to assist the state in the development and implementation of its ADRC program.

As part of this year's Program Announcement, states are encouraged to serve Medicare beneficiaries or individuals with chronic conditions at risk of unnecessary re-admission to hospitals by strengthening ADRC coordination with hospital discharge planning programs and physician practices. ADRC's help consumers and their families access and receive the long-term services and supports that enable them to live at home and engaged in community life. ADRCs are positioned to develop an on-going relationship with the consumer and their family to assure that the long-term services and supports they need are arranged and provided. This includes helping individuals with chronic conditions and/or disabilities who are being discharged to avoid unnecessary nursing home admissions as well as to avoid unnecessary readmission to the hospital. At the discretion of the applicant, funding under this announcement can be used to develop formal linkages with federally supported Care Transition Programs, such as the subnational care transitions program operated by CMS through the Quality Improvement Organizations in the 9th scope of work and other evidence based care transitions interventions designed to increase linkages with physicians.

In 2007, researchers suggested that the rate of rehospitalization could serve as a useful indicator of the performance of our health care system[1]. In 2009, a new study described rehospitalization as a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care. The same article reported that almost 1 out of every 5 Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days, and 1 out of every 3 were rehospitalized within 90 days. It is estimated that

[1] Adeyemo D, Radley S. Unplanned general surgical re-admissions - how many, which patients and why? Ann R Coll Surg Engl 2008;89:363-7.

the national fiscal impact to Medicare as a result of unplanned rehospitalization in 2004 was $17.4 billion[2].

One promising example of a care transitional model is Dr. Coleman's Care Transition Intervention. This intervention consists of four key pillars which include: medication self-management, a patient-centered record, primary care and specialist follow-up and knowledge of "red flags," a warning symptom or sign indicative of a worsening condition. To help manage these four processes a "transition coach" is trained and identified. One example of how states can enhance their ADRC is to explore how existing Options Counselors could support a transition coach in such a model.

Another promising model is Dr. Chad Boult's *Guided Care* Model. Surveys of the patients who received *Guided Care* and similar patients who received "usual care" in the practice showed that *Guided Care* recipients experienced more improvement in the quality of their care than did the usual care group. Insurance claims revealed that the costs of health care were lower for the *Guided Care* patients than for the usual care patients.

Guided Care is driven by a highly skilled registered nurse in a primary care office typically assisting three to four physicians in providing high-quality chronic care for their patients in need of good chronic care. The eight key components which define *Guided Care* include:

1. Assessing
2. Planning Care
3. Monitoring
4. Coaching
5. Chronic Disease Self-Management
6. Educating and Supporting Caregivers
7. Coordinating Transitions Between Providers and Sites of Care
8. Access to Community Services

Please see Appendix F for additional examples and further description of person centered care coordination models.

Applicants will be expected to meet the following key deadlines:

- For states receiving ADRC funding for the first time, have at least one ADRC Program operational in one community **within 12 months** of receipt of grant funds that at a minimum is providing information and one-on-one counseling on long-term support options for the elderly and younger adults with physical disabilities, and **within 18 months**, is beginning to provide streamlined access to all publicly funded long-term services and supports, including those supported by Medicaid, OAA and state revenue. These states include: Delaware, Oklahoma, Nebraska, North Dakota, South Dakota and Utah.

[2] Jencks S, Williams M, Coleman E. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360:1418-28.

- For states receiving an award that have previously received funding from either AoA or CMS for ADRCs, **within 18 months** of receipt of grant funds, have made significant progress in strengthening the streamlined access and/or person-centered hospital discharge planning components of its ADRC programs.

- For all states receiving AoA FY 2009 ADRC funding, **within 18 months** of receipt of grant funds, have submitted a detailed 5 year plan to AoA and CMS that has been developed with input from the key stakeholders in the state and approved by the directors of the State Unit on Aging, State Medicaid Agency, and State Disability Agencies where applicable that describes how the state is going to realign and more optimally coordinate the existing information and access functions of the state and federal programs it administers in order to operationalize ADRCs statewide that are capable of performing the functions specified in Title II Section 202(b)7 and the requirements in this Program Announcement. This plan should identify existing funds/programs that will be used and include a budget that identifies the added costs to the state, above and beyond funding that is already being expended on ADRC-type functions under existing programs, to implement the plan. The plan should also include projected cost savings that the state will achieve as a result of statewide implementation. The AoA Technical Assistance Center will work with states in developing these plans as well as cost savings projections.

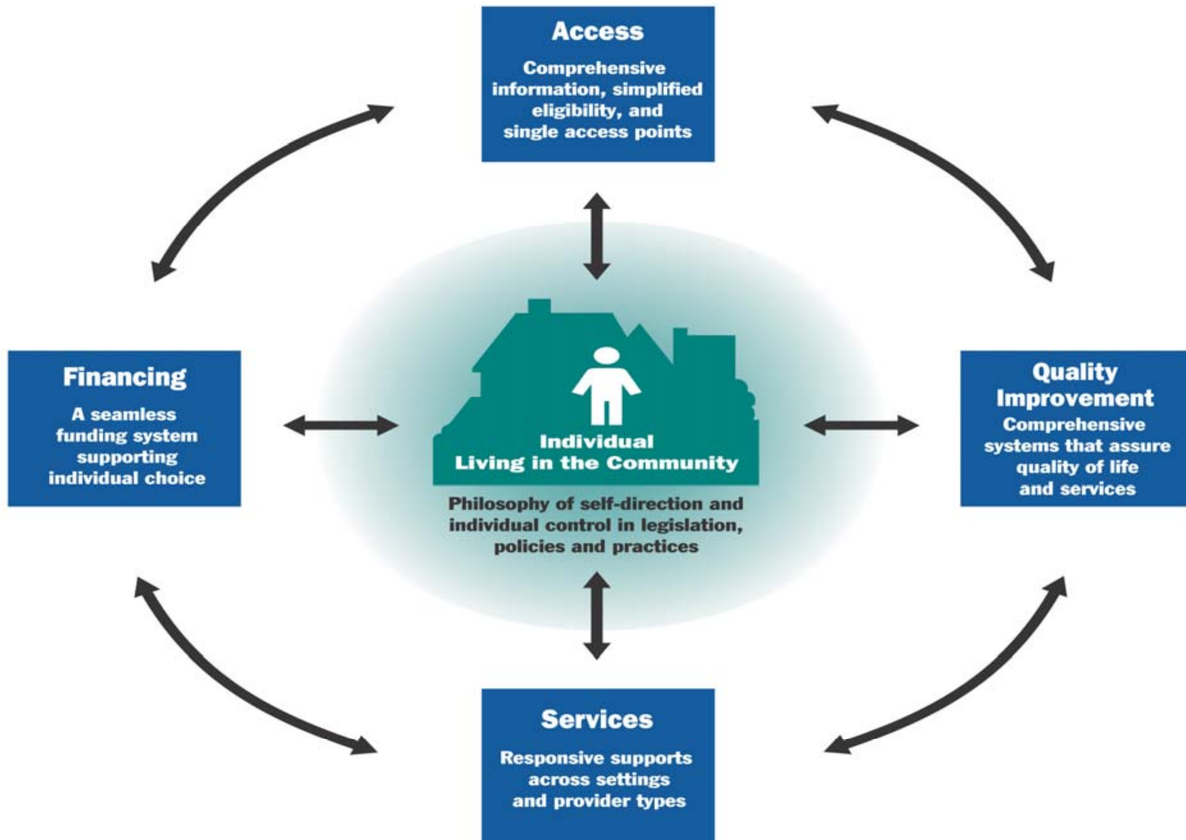
The third year of continuation funding for all grants awarded under this Program Announcement will be contingent on a state's performance in meeting the above requirements and deadlines.

3. **The Policy Context: The Role of ADRCs in Health and Long-Term Care Reform**

AoA and CMS share a vision of ADRCs being an integral component of health and long-term care reform and existing state efforts to develop effectively managed person-centered systems. A person-centered system will be comprehensive, coherent, sustainable for the coming decades, and organized around the needs of the individual, rather than around the settings where care is delivered. The system will:

- optimize choice and independence;
- be served by an adequate workforce;
- be transparent, encouraging personal responsibility;
- provide coordinated, high quality care;
- be financially sustainable; and,
- utilize health information technology.

Optimizing choice and independence will enable individuals to have greater flexibility to choose from a broad spectrum of long-term services and supports, including greater access to home and community-based services as well as institutional services. Studies have documented that giving consumers more choices and options, including less expensive alternatives, can over time reduce the rate of growth in state long-term service and support expenditures. A visual representation of the key components of a coherently managed person-centered system is provided below.



Centers for Medicare and Medicaid
Visual Depiction of Coherent System Management

AoA and CMS view ADRCs playing a critical role in the *Access* component of a person-centered system. In many states and communities, long-term support services are supported by numerous funding streams, administered by multiple agencies and have complex, fragmented, and often duplicative intake, assessment and eligibility functions. Figuring out how to obtain services can be difficult, confusing and frustrating for persons who qualify for publicly-funded supports as well as for those who can pay privately. These difficulties can lead to institutional long-term support as a default outcome.

The overarching goal of ADRCs is to empower consumers to make informed decisions about their options, and to streamline access to the services and support they or their family caregivers need. AoA and CMS's vision is to have ADRCs in every community across the country serving 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 point of entry to public long-term support programs and benefits. A single, coordinated system of *Access* that provides all persons seeking long-term service and support with information and assistance in accessing the full range of options will minimize confusion and enhance individual choice. ADRCs will be a resource for elderly people, younger people with disabilities, family caregivers, as well as for people who want to plan ahead for long-term services and supports. ADRCs will also be a resource for professionals and others who provide services to the elderly and people with disabilities. Finally, ADRC will improve the ability of state and local governments to effectively manage public long-term service and support resources, monitor program quality, and measure the responsiveness of

state and local systems of care to the needs and preferences of its citizens.

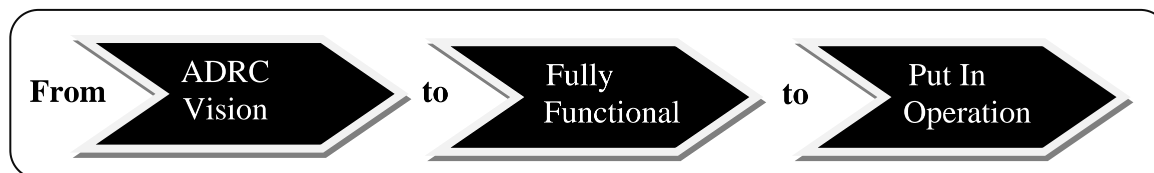
Making ADRCs, especially the information and awareness and options counseling components, available to all private-pay individuals is a central element of the AoA/CMS vision. Over half of the elderly individuals who are in nursing homes for a long stay and are on Medicaid entered as private paying individuals. Reaching people before they become Medicaid-eligible, and helping them to learn and access lower cost options, can help people realize their desire to remain at home and in the community, and also allow them to make better use of their own resources and thereby prevent or delay their spend-down to Medicaid.

4. Key Operational Components of an ADRC Program.

The key operational components of an ADRC Program include:

- Information and Awareness;
- Options Counseling;
- Streamlined Access;
- Person-Centered Hospital Discharge Planning; and
- Quality Assurance and Evaluation.

ADRCs are now six years removed from the original inception of the AoA/CMS grant program and we have reached a point where proven models have emerged that AoA and CMS encourage states to move towards. In an effort to assist states in developing their grant applications, state profiles of successful models are highlighted below for each of the ADRC core functions.



a. Information and Awareness

The ***Information and Awareness*** component of an ADRC is defined by the ADRCs ability to serve as a highly visible and trusted place where people can receive objective information on the full range of long-term support options. It is also defined by its ability to promote these options, especially among underserved, hard-to-reach and private paying populations. This includes the ADRC capacity to help people understand their health and prevention benefits and programs and other federal and state programs by partnering with State Health Insurance Counseling and Benefit Outreach and Enrollment Centers where they exist; and, the capacity to link consumers with needed support through appropriate referrals to other programs.

A number of states have been able to operationalize the ***Information and Awareness*** component so that it is fully integrated with other ADRC functions as well as with their

overall statewide systems of care. Some leading examples include:

> ***South Carolina*** *developed and centrally maintains (at the state level) a universally accessible, web-based, searchable database for seniors, consumers with all types of disabilities, family caregivers, and professionals to use to find information, resources and services that match consumers' needs and preferences. ADRC staff and their partners at Medicaid and other community organizations have secure access to a web-based client tracking system connected through the same website. Over 90 percent of ADRCs operating across the country now use specialized I&R/A software that allows them to maintain comprehensive electronic resource databases and client tracking systems that can be shared with their community partners either through public websites or secured networking systems.*
>
> ***Arkansas*** *has one statewide toll-free number with a call center that is operated by state employees. The call center can provide I&R/A, some preliminary options counseling, and can assist callers with beginning the application process for Medicaid and other long term care programs. If callers need a comprehensive assessment, more in-depth options counseling or other in-person assistance, call center staff connects them to local ADRC partners including AAAs, CILs or regional Medicaid offices. Several other states use similar statewide call center models including Minnesota, West Virginia, New Mexico and Rhode Island.*
>
> ***Minnesota*** *has developed a model that shows how Information and Awareness, SHIP and Options Counseling work best when they are coordinated. Minnesota has created the MinnesotaHelp Information Network. The ADRCs are part of this Network, which includes the Senior LinkAge Line™, Disability Linkage and Veteran Linkage. The Senior LinkAge Line™ is a free telephone information and assistance service that helps seniors and their families find community services anywhere in Minnesota. Each year, Senior LinkAge Line™ provides service to almost 100,000 unduplicated contacts. The Senior LinkAge Line also serves as the Minnesota SHIP (the State Health Insurance Assistance Program). As a result of the integration of SHIP, certified health insurance counselors provide callers comprehensive information on community programs and services for seniors and caregivers for Medicare, Medical Assistance (Medicaid), Medicare Supplemental insurance, long-term care insurance policies, Long-term Care Partnership, Reverse Mortgages, Medicare Advantage, Medicare Savings Programs, other many health insurance options.*
>
> *Another feature of Minnesota's Network is the Long-term Care Choices Navigator which helps individuals develop a customized plan just for them. This resource is a step-by-step tool that helps individuals determine what they need to live well and age well. Access to this Network is available on-line, on the phone and in places where people currently seek and receive information such as health clinics, community agencies, hospitals, libraries, senior centers, faith communities and places where they work. Community providers, such as in Hennepin County, serve as Network Portals which provide a vital link to Long Term Care Consultation and Assessment process. In Minnesota, any citizen is eligible for an in person Long Term Care Consultation by a local county social worker and/or public health nurse. The Long Term Care Consultation provides an assessment of needs and current*

supports, information on resources and options and helps people access benefits and services.

b. Options Counseling

The ***Options Counseling*** component of an ADRC is defined as an interactive decision-support process whereby consumers, and their family members and/or caregivers, receive "one-on-one" counseling on an as needed basis. The main purpose of *Options Counseling* is to help consumers identify and understand their needs and to assist them in making informed decisions about appropriate long-term service and support choices in the context of their personal needs, preferences, values and individual circumstances. *Options Counseling* also involves assisting people in understanding their health care and other benefits through SHIPs and Benefit Outreach and Enrollment Centers, as well as helping middle aged individuals to plan ahead for their long-term care through the use of private insurance, home equity mortgage and alternative living arrangements. Finally, through *Options Counseling*, ADRCs provide a vehicle for helping individuals understand – and in some cases even manage – the available range of consumer directed models of care, including Cash and Counseling.

Examples of how states have operationalized the Options Counseling function include:

> ***Wisconsin*** *has developed a Wisconsin Options Counseling Toolkit as well as a Web Based Training Curriculum, as part of their ADRC Program. The toolkit is designed to educate new and current ADRC pilots about the details of providing options counseling. The toolkit contains introductory material, a DVD, a series of recorded web casts, and discussion questions to support training new ADRC staff and provide opportunities to re-visit key aspects of the provision of this service. A state-wide information and assistance workgroup developed, filmed, and produced a 37 minute DVD featuring an overview of the options counseling process. Detailed discussions of why Options Counseling is a central function of the ADRC and of how the process works are demonstrated through scenarios featuring county representatives and clients. Currently available web casts cover legal decision making tools, residential/housing options, benefits for people with disabilities, etc. The web casts pair presentations by experts in subjects important to long-term care options counseling with materials to retain for ongoing reference. The toolkit is part of their next phase of statewide expansion, which is currently in progress. In addition, Wisconsin ADRC I&A specialists may provide short-term service coordination to help consumers connect to needed services during crisis situations when the individual or family can not take on that role. This assistance enables individuals to continue to live in the community through and after the crisis if they so desire.*

> ***New Hampshire*** *is another example of a state that has operationalized Options Counseling. New Hampshire's ADRCs across the state employ Long Term Support (LTS) Counselors that provide options counseling to consumers as needed. I&R/A specialists determine which callers might benefit from options counseling and refer them to the LTS Counselor on staff. The state has established minimum education and training standards for these positions including a Master's Degree in Social Work or equivalent work experience and AIRS certification. New Hampshire*

created the position of LTS Counselors at the ADRC to provide pre-screening for eligibility as well as provide comprehensive options counseling to individuals that are looking for long-term supports regardless of funding source or an individual's financial situation.

*In **Indiana**, the State Department of Insurance has responsibility for the State Health Insurance Counseling Program (SHIP). However, SHIP counselors are co-located with the ADRC in seven of the sixteen ADRCs across the State. In addition, some of the SHIP counselors in the ADRCs are OPTIONS counselors. When consumers contact the ADRCs which are co-located with SHIP counselors and have questions about health insurance, the ADRC can schedule appointments with these counselors eliminating the need for the consumer to make a second call. What makes Indiana a promising practice is the immediate scheduling by the ADRC worker and the fact that Indiana has managed this co-location even though SHIP is located within the state-level insurance department instead of the aging department. The recent funding opportunity provided by the US Administration on Aging and the Centers for Medicare and Medicaid Services, Medicare Improvements for Patients and Providers Act for Beneficiary Outreach and Assistance, will allow SHIP counselors to be co-located in additional ADRCs throughout the State since the co-location of the seven ADRCs has been a successful partnership.*

*In **Washington**, the ADRC has partnered with the National Council on Aging's BenefitsCheckUp, a web-based service that can be used to screen for benefit programs for people age 55 and over and some younger people with Medicare. The partnership has included training of ADRC pilot site staff in BenefitsCheckUp to ensure that personnel are fully aware and capable of using the resource on behalf of ADRC clients. There have also been several educational presentations during community forums. As a result of the partnership, Benefits CheckUp in Washington State has been expanded to serve the full spectrum of people, regardless of age or particular disability.*

c. Streamlined Access to Public Programs

The ***Access*** component of an ADRC is defined by its ability to serve as a single point of entry to publicly funded long-term supports, including those funded by Medicaid, the OAA and state revenue. This requires ADRC Programs to have the necessary protocols and procedures in place to facilitate integrated and/or fully coordinated access (i.e., client intake, needs assessment, care planning, eligibility determination, and ensuring that people get the services they need) to all publicly supported long-term services and supports – both community-based and institutional. The goal is to create a process that is seamless for consumers regardless of which service they choose.

Some states that have made significant progress in establishing operational models for the Access component include:

*In **New Hampshire**, the Department of Health and Human Services established ADRCs as the single entity responsible for conducting intake, assessment, and eligibility determination for all long-term care programs across institutional and community-based settings. ADRCs have also been established as the single entity*

for programs such as Caregiver Support, SHIP and SMP. To carry this out when accessing public programs, New Hampshire's regional Medicaid financial eligibility workers and state-employed nurses who conduct comprehensive assessments and determine Medicaid functional/clinical eligibility are co-located with the ADRCs. A benefit of having co-located staff is that they have access to Medicaid information technology systems on-site at the ADRC. From the consumer perspective, it appears that the ADRC is the only organization involved in eligibility determination, even though the staff they encounter at the ADRC are employed by multiple organizations.

*In **Florida**, staff who conduct functional/clinical eligibility determination for Medicaid long term care are co-located with the ADRCs. Florida ADRCs have electronic access to the Medicaid financial eligibility system so that they can submit applications and track eligibility status directly. ADRC staff assists consumers in completing the applications and submitting all the required documentation so that applications are complete upon arrival. This arrangement has reduced the average time from submission to determination significantly. ADRCs also serve as a streamline access point for individuals not seeking public benefits or who are waiting to access public benefits. ADRCs, have reported effective efforts in providing persons alternative private options to help expedite services and keep individuals in the community.*

***Wisconsin** has a single, standardized process for accessing all adult long-term care programs through the ADRC. ADRC staff perform the functional eligibility determination and assist individuals through the financial eligibility process in an efficient and customer friendly manner. In addition, staff conduct level of care assessments and make the functional eligibility determination for Medicaid HCBS waiver programs, including their managed long term care programs. While a separate county Economic Support Unit determines financial eligibility, most ADRCs have financial eligibility workers co-located at least part-time, and even in those that do not have co-location, the county often has financial eligibility workers that specialize in LTC applications. ADRCs use a tickler file system to follow up with the Economic Support Unit when they have not heard back regarding a particular eligibility determination within specified time frames. If someone is found ineligible, there are protocols in place for the ADRC to follow up with that individual and provide additional options counseling about private pay options. Local ADRCs are required to have an enrollment plan which outlines how the ADRC and Economic Support Unit work together to help a consumer access public benefits.*

d.) Person-Centered Hospital Discharge Planning

As noted in the original 2003 ADRC grant announcement: *"ADRCs will create formal linkages between and among the major pathways to long term support, including preadmission screening programs for nursing home services, hospital discharge planning, physician services, and the various community agencies and organizations that serve the Resource Center's target populations. These linkages will ensure people have the information they need to make informed decisions about their support options as they pass*

through critical transition points in the health and long term support system."

State examples of ADRC's achieving successful outreach with hospital discharge planning programs:

> *In* ***Texas,*** *the Central Texas ADRC partnered with Scott & White HealthCare's Department on Aging and Care to implement the Colorado Care Transitions Intervention (www.caretransitions.org). The ADRC and hospital discharge planners work together to identify consumers and their caregivers who are at risk of institutionalization. ADRC Care Transition Specialists are embedded with the Scott & White HealthCare's Department of Continuum of Care (i.e., discharge planning and rehabilitation services) on the main campus of Scott & White HealthCare to coach consumers and their caregivers to ensure that their needs are met in the transition from acute care to a community setting. Central Texas ADRC also provides training to staff and other health professionals about the ADRC.*
>
> ***New York*** *has established a statewide, locally based program to provide Information and Assistance on Long Term Care through its* ***NY Connects****: Choices for Long Term Care program. Many counties have established effective relationships with the local hospitals, rehabilitation programs, and nursing homes to collaborate on care transitions, and develop protocols for accessing and maximizing partner resources. Health outcomes can be positively or negatively impacted by the quality of communication and collaboration among professionals with regard to implementing a valuable care transition plan.* ***NY Connects*** *staff participate in a statewide Discharge Planning Workgroup, whose mission is to work toward better communication and collaboration between systems to reduce barriers and improve transitions between levels of care.*
>
> ***NY Connects*** *staff participate in care transition planning rounds to help brainstorm around difficult discharges, provide information on options and assist with coordination of services to facilitate a smooth transition between levels and locations of care. They meet with the social workers and families in nursing homes to provide information on community based alternatives and even schedule trial visits home for the Medicaid population. Three counties in New York are participants in an AoA Community Living Program grant.* ***NY Connects*** *is the conduit for screening and assessment for that program, in addition to developing collaborations with the Veterans' Administration.*
>
> *Other efforts to improve care transitions include the development of a service ID card system for consumers of multiple long-term care services. This innovative initiative alerts discharge planners and service coordinators that an individual is already receiving community services. This reduces unnecessary duplication and streamlines access to additional services that may be needed. Several counties are also looking at providing coaching and education to support families as their loved one moves from one transition point to another, be it from, one service to another service, home to health care agency or other transitional phases of care.*
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> ***Georgia's*** *ADRC collaborates with the Georgia Hospital Association to facilitate education and dialogue with hospital discharge planners around the state. ADRC*

staff have conducted statewide educational training sessions for discharge planners and social workers about the ADRC. These sessions have included discussions about the role and responsibilities of discharge planners and how community agencies can work together to transition target populations into community settings. Georgia's ADRC also uses Money Follows the Person grant funds for transitioning individuals from nursing facilities to the community. Transition coordinators who work with nursing facilities are co-located at ADRC's.

AoA and CMS are encouraging states to strengthen the coordination of ADRC and Hospital Discharge Planning operations with FY 2009 funding to ensure that people with chronic impairments and disabilities who are coming out of hospitals are able to return to their homes and communities and remain there for as long as possible. Interventions that help people coming out of hospitals also play an important role in the broader health care system. Several federally supported efforts are already underway to bridge this gap including CMS' most recent discharge planning-related projects including:

- Development of a Consumer Discharge Planning checklist (for use by consumers and their caregivers) and outreach campaign in spring 2008, followed by development of a best practice discharge planning model.
- Quality Improvement Organizations (QIO) Program 9th Statement of Work: QIOs work with providers in geographically defined areas to improve after hospital care by improving the reliability of high quality care, improve efficiency and value of care, and develop insights and infrastructure.
- Development and testing of a consumer assessment instrument; "Internet-based CARE (Continuity Assessment Record & Evaluation) Patient Assessment Instrument" being tested for use by multiple providers including hospitals.

Any effort and or activity described in your proposal must demonstrate that it is supporting and not duplicating any existing CMS efforts.

e. Quality Assurance and Evaluation

Every ADRC Program should have an on-going system for assuring the quality of the ADRC and evaluating its impact on consumers, system efficiencies and public costs. Grantees must establish measurable performance goals for their programs, along with measurable indicators that can be used to track progress on the performance goals. The measurable performance goals and indicators should be incorporated into the design of the program's evaluation, and be used to measure the success of the ADRC system over the long run. The goals and indicators must be developed with input from the stakeholders and the advisory board specified for these grants.

At a minimum, grantees must establish and track performance goals and indicators related to their ADRC system: (a) **Visibility** - extent to which the public is aware of the existence and functions of the ADRC, (b) **Trust** on the part of the public in the objectivity, reliability, and comprehensiveness of the information and assistance available at the ADRC, (c) **Ease of Access** (e.g., reduction in the amount of time and level of frustration and confusion individuals and their families experience in trying to access long-term support), and (d) **Responsiveness** to the needs, preferences, unique circumstances, and feedback of individuals as it relates to the functions performed by the ADRC. Grantees must also

establish performance goals and indicators related to the program's **Efficiency** and **Effectiveness** (e.g., reduction in the number of intake, screening, and eligibility determination processes for consumers, diversion of people to more appropriate, less costly forms of support, improved ability to match each person's preferences with appropriate services and settings, ability to rebalance the state's long-term support system, ability to implement methods that enable money to follow the person. etc.)

Some examples of ADRC Programs that have successfully operationalized the Quality Assurance and Evaluation function include:

> *The **Wisconsin** ADRC conducted an extensive evaluation of consumer satisfaction with the information and assistance and options counseling provided by the ADRCs through a statewide telephone survey of 1,673 individuals, as well as focus groups and interviews with staff and program managers at 18 local sites. The evaluation assessed several domains of consumer satisfaction from staff and consumer perspectives and identified program strengths as well as areas for improvement. The state uses the findings to assist its ADRCs to achieve and maintain high quality services for the state's aging and disability populations by providing ADRCs with constructive feedback.*
>
> ***Idaho's** ADRC, Aging Connections, routinely called a random sample of individuals who had contacted the ADRC to obtain long-term care assistance. The "check back" calls were made to determine consumers' satisfaction with staff interactions as well as with the quality of the assistance and supports they received. These "check back" calls were made within 10 days of the consumers' original contact with the ADRC and were not done by staff who had previously interacted with the consumers. Overall, most consumers rated their experiences with Aging Connections staff, staff knowledge, listening skills and responsiveness to the consumers' needs as "satisfied" or "very satisfied." The "check back" call process also enabled program managers to quickly identify and resolve any reports of dissatisfaction with services.*
>
> *Evaluators for **New Hampshire**'s ServiceLink Resource Center (SLRC) established performance goals and indicators to measure ease of access, responsiveness, efficiency, effectiveness, staff knowledge, agency interactions, visibility and trust, and other dimensions of service delivery. Surveys revealed high levels of consumer satisfaction across all performance measures. Evaluators and SLRC staff consistently assessed these service dimensions, reported findings on a semi-annual basis, and used the results for program planning and quality improvement. Evaluators also compared survey data at different times during program implementation to document trends in service delivery over time. In addition to evaluating consumer satisfaction, the SLRC measured perceptions and level of awareness of service providers and agency staff across the state to assess the effectiveness of their outreach and marketing activities.*

f. Use of grant funds.

As noted above, historically ADRC grant funds have not been designed to pay for the on-going cost of operating ADRC services, but instead are to help states and communities

to realign and make more optimal use of the existing financial and other resources that are already being deployed under federal and state programs, including Medicaid, OAA and state revenue programs, for the purpose of helping consumers learn about and access long-term services and supports. ADRCs should make it easy for consumers of all ages, incomes and disabilities, and their families, to learn about and access the full range of services and supports that are available in their communities. Specifically, ADRC grant funds are being made available to help states and communities to integrate and/or better coordinate the following functions that cut across multiple federal and state programs: providing information to consumers on available options; one-on-one counseling to help people understand how the options relate to their particular needs and circumstances; intake; needs assessment; care planning; eligibility determination; and, ensuring that consumers receive the supports they need.

In addition to the activities described above, applicants may use funding for the following activities:

- Project activities designed to foster coordination between ADRCs and hospitals around diverting individuals from institutional care may be proposed.
- Enhance the ability of management information systems to be used across agencies to avoid duplication of information and permit ADRCs to gather information and pass it onto other entities involved in approving applications for publicly funded programs. Such systems may also be used to allow other entities to gather information and share it electronically with the ADRC.
- Activities designed to enhance the effectiveness of the ADRC through information technology. Fundable activities include activities to enhance or integrate management information systems, the development/expansion of ADRC websites including web-based resource databases (applicable only to new ADRC states), applications, assessment tools and client tracking capabilities.
- Applicants may propose to use grant funding to expand the target populations of people with disabilities served by the ADRC, working towards the goal of one day serving people with disabilities of all types and ages.
- Supplement evaluation activities to document the specific benefits of using the ADRC as the single point of entry for diversion programs such as the Person-centered Hospital Discharge Planning Model. Documented savings to Medicaid or other public funding may serve to encourage additional support from State, Federal, and other resources.
- In partnership with the Single State Medicaid Agency, fund activities that explore the feasibility of, or prepare for the implementation of the ADRC as the only point of entry to publicly funded long-term services and supports.
- Assist private-pay individuals to identify their needs, understand their long-term service and support options and how to get connected to services.

II. AWARD INFORMATION

Award Type:	**Cooperative Agreement**
Federal funds available:	**Up to $10,000,000 for year 1** (Funding for Years 2 & 3 contingent upon program performance and availability of Funds)

Est. Number of Awards:	**50**
Project Start Date:	**Sept 30, 2009**
Length of Project:	**36 Months**
Eligible Applicants:	**Any State Agency or instrumentality of the State (e.g., State Unit on Aging, State Medicaid Agency, State Disability Agencies)**
Est. Total Award:	**Award will range from $600,000 to $750,000 over the 3 year project period**
Est. Amount Each Year:	**Award will range from $200,000 to $250,000 for each respective year**

The average cooperative agreement amount is anticipated to be approximately $600,000 to $750,000 over the entire 3 year project period. These grants will be funded at the federal share of approximately $200,000 to $250,000 per year for a project period of three years, contingent on program performance and the availability of funds.

Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA reserves the right to offer a funding level that differs from the requested amount, including amount less than the amount the applicant has requested Grantees will be required to contribute a match – either cash or in-kind - equal to five percent of the total budget.

These grants will be issued as Cooperative Agreements because AoA anticipates having substantial involvement with the recipients during performance of funded activities. For additional information on the level of AoA's and grantee involvement as outlined in the Cooperative Agreement please see **Attachment H**. Grantees will be expected to maintain regular contact with their federal project officer and to cooperate with the AoA Technical Assistance Center. Grantees will also be expected to share all significant products and activities with AoA.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Only a state agency or instrument of a state may apply for this funding opportunity. Only one application per state will be funded. The applicant agency must have the support and active participation of the State Unit on Aging, the Single State Medicaid Agency, and State Disability Agencies where applicable. "State" refers to the definition provided under 45 CFR 74.2.

Executive Order 12372 is not applicable to these grant applications.

2. Cost Sharing or Matching

States will be required to contribute an amount equal to five percent of the total budget. This match can be a cash and/or in-kind contribution.

Please note, applications with a match greater than the minimum required will **not** receive additional consideration under the review. Match is not one of the responsiveness criteria as

noted in Section III, 3 Application Screening Criteria.

3. Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the screening criteria described below will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

1. Applications must be submitted electronically via www.grants.gov by 11:59 pm on **August 10, 2009**.

2. The Project Narrative section of the Application must be double-spaced, on "8 ½ x 11" plain white paper, with 1" margins on both sides, and a font size of not less than 11.

3. The Project Narrative must **not** exceed 10 pages per each respective application. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel **are not counted** as part of the Project Narrative for purposes of the 10-page limit.

4. Application Responsiveness Criteria

Again, to assure a level playing field for all applicants, applications that fail to meet the following responsiveness criteria will **not** be reviewed and will receive **no** further consideration:

1. Applicant is a State Agency or instrumentality of the State (e.g., State Unit on Aging, State Medicaid Agency, State Disability Agencies).

2. The application must include letters of commitment from the directors of relevant partner agencies at the state level related to their defined roles in the project, including at a minimum, letters from the directors of the State Unit on Aging, the State Medicaid Agency, and, where applicable, the State Disability Agencies.

3. The application must include evidence – either in the project narrative and/or in the letters of support – that the project includes a substantive role for any Area Agency on Aging, Center for Independent Living, State Health Insurance Counseling Program, and Benefits Outreach and Enrollment Center that operates in the geographic areas covered by the project.

5. Letter of Intent

To apply for this funding opportunity, AoA strongly recommends that applicants submit a "letter of intent" by email or voice message to assist AoA in planning for the application independent review process. The deadline for submission of the "letter" is July 15, 2009.

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development
Washington, D.C. 20201
Or by calling: 202-357-3417
Or e-mailing: joseph.lugo@aoa.hhs.gov

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.aoa.gov/AOAROOT/Grants/funding/index.aspx.

Application materials are also available by writing to:

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development
Washington, D.C. 20201

Or by calling: 202-357-3417
Or e-mailing: joseph.lugo@aoa.hhs.gov

Please note, AoA is requiring applications for all announcements to be submitted electronically through www.grants.gov. The Grants.gov registration process can take several days. If your organization is not currently registered with www.grants.gov, please begin this process immediately. **For assistance with www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the grants.gov website.

Applications submitted via www.grants.gov :

- You may access the electronic application for this program on www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (HHS-2009-AoA-DR-0915) or CFDA number (93.048).
- At the grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through grants.gov because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the

CCR registration.

- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- Your application must comply with any page limitation requirements described in this Program Announcement.
- After you electronically submit your application, you will receive an automatic acknowledgement from grants.gov that contains a grants.gov tracking number. The Administration on Aging will retrieve your application form from grants.gov.
- After the Administration on Aging retrieves your application form from grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov
- Each year organizations that registered to apply for Federal grants through www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online. The registration process will take about 30 minutes (http://www.ccr.gov).

2. Content and Form of Application Submission

A. Letter of Intent

To apply for this funding opportunity, AoA strongly recommends that applicants submit a "letter of intent" via email or voice mail to assist AoA in planning for the application independent review process. The deadline for submission of the "letter" is July 15, 2009.

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development
Washington, D.C. 20201
Or by calling: 202-357-3417
Or e-mailing: joseph.lugo@aoa.hhs.gov

B. DUNS Number

The Office of Management and Budget requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, **nine-digit identification number** that provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-

free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf .

C. Project Narrative

The Project Narrative must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. **AoA will not accept applications with a Project Narrative that exceeds 10 pages**. The Project Work Plan, Letters of Commitment, and Vitae of Key Personnel are not counted as part of the Project Narrative for purposes of the 10-page limit, but all of the other sections noted below are included in the limit.

The components counted as part of the 10 page limit include:

- Summary/Abstract
- Current Status of State's ADRC or ADRC-Type Programs
- Goal(s) and Objective(s)
- Proposed Project
- Involvement of Key Stakeholders
- Project Outcomes
- Quality Assurance, Evaluation and Reporting
- Project Management
- Organizational Capability Statement

The Project Narrative is the most important part of the application because it will be used as the primary basis to determine whether or not your project meets the minimum requirements for grants under Title IV of the Older Americans Act. The Project Narrative should provide a **clear and concise** description of your project. AoA recommends that your project narrative include the following components:

Summary/Abstract. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: the goal(s) and objectives, description of type of expansion and enhancement state is pursuing and specific types of changes that will be made to existing federal and state programs that are administered by the state as a result of the proposed project.

Current Status of State's ADRC or ADRC-Type Program (Past Accomplishments and Remaining Barriers): This section should describe the accomplishments to date of your existing ADRC or ADRC-type programs to fully operationalize the functions described in OAA II Section 202(b) and the requirements in this Program Announcement. Applicants must describe how the current system limits or facilitates individual choice and access for both public- and private-pay individuals, and the specific barriers that need to be overcome to achieve successful implementation of a fully functional ADRC Program within the state; in the case of ADRC Programs that are already considered fully operational, describe the barriers that need to be overcome to further strengthen the program. Be sure to describe your existing efforts to address *Information and Awareness*, *Options Counseling*, *Streamlined Access, Person-Centered Hospital Discharge Planning,*

and Quality Assurance and Evaluation.

Goals and Objectives: Applicants should describe the proposed project's goals and objectives.

Proposed Project: This section should provide a clear and concise description of the specific changes you are proposing to make in your existing state and federal programs, including at a minimum, Medicaid, OAA and state general revenue programs, in order to fully operationalize one or more fully functional ADRC Programs within your state within the three year grant period, or to strengthen existing ADRC Programs that are already fully operational. You should note any major barriers you anticipate encountering and how your project will be able to overcome those barriers. Be sure to describe the changes you plan to make in the functional areas of *Information and Awareness*, *Options Counseling*, *Streamlined Access, Person-Centered Discharge Planning, and Quality Assurance and Evaluation.*

Involvement of Key Stakeholders. Describe how the state will substantively involve key stakeholders, including consumers and others affected by the proposed ADRC project, in the design and implementation of its ADRC Program.

Project Outcomes. This section of the project narrative must clearly identify the project outcomes to be accomplished by the end of the 36-month project period.

Quality Assurance, Evaluation and Reporting This section should describe the method(s), techniques, systems and tools that you will use to determine whether or not the proposed project is achieving its anticipated goals, objectives and outcomes. Include a description of the specific measurable performance goals and indicators you plan to use to measure the success of your proposed project related to your ADRC Program's visibility, trust, ease of access, responsiveness, efficiency, and cost effectiveness. Also describe how you plan to document the "lessons learned" - both positive and negative - from your project that will be useful to other states and communities interested in replicating your ADRC model. AoA will be seeking OMB approval this year of a minimum data set all ADRC grantees will be required to report on starting next year. In the meantime, AoA is encouraging state grantees to voluntarily use the reporting tool and the reporting instructions that are described in **Attachment I** in order to provide AoA with reports on the progress you are making with these grant funds.

Project Management. Applicants should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes, including the changes you plan to make to the operations of existing federal and state programs. It should specify who will have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports; communications with partner agencies and key stakeholders, and AoA.

Organizational Capability Statement. Applicants should include an organizational capability statement, organizational charts, and vitae for key project

personnel. The organizational capability statement should describe the organization and capacity of the key state and local organizations that will have an operational role in performing the functions of your ADRC Program which should include all of the ADRC functions outlined in Section 202 of the OAA and this Program Announcement. Neither vitas nor an organizational chart will count towards the narrative page limit.

D. Work Plan: Applicants should provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity within the 36 month project period as well as a description of how each activity will contribute to the overall goals and objectives of the program and to the system changes described in the Announcement.

The Project Work Plan should reflect and be consistent with the Project Narrative and Budget and should cover all 3 years of the project period. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify the timeframes involved (including start- and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in the Attachments.

E. Letters of Commitment from Key Participating Organizations and Agencies:
Applicants should include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies. This should include at a minimum letters of commitment from the directors of: 1) the State Unit on Aging, the State Medicaid Agency, and State Disabilities Agencies where applicable, as well as letters from collaborating AAA(s), CIL(s); local Medicaid offices, SHIP programs, and Benefit Outreach and Enrollment Centers. For applications submitted electronically via www.grants.gov, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3466 no later than the application submission deadline.

F. Budget Narrative/Justification

The Budget Narrative/Justification should be provided using the format included as an attachment of this Program Announcement. **Applicants are encouraged to pay particular attention to Attachment B, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required. PLEASE NOTE THAT WHEN MORE THAN 33% OF A PROJECT'S TOTAL BUDGET IS LISTED IN THE CONTRACTUAL LINE ITEM, DETAILED BUDGET NARRATIVES/JUSTIFICATIONS MUST BE PROVIDED FOR EACH SUB-CONTRACTOR OR SUB-GRANT FOR EACH YEAR OF POTENTIAL GRANT FUNDING.** Applicants should also ensure that funds are delineated for two representatives to attend two ADRC meetings/events during each of the three years of the overall project period.

3. Submission Dates and Times

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity. The letter of intent assists AoA in planning for the independent review process of the applications. The deadline for submission of letters of intent is July 15, 2009.

The deadline for the submission of completed applications under this program announcement is August 10, 2009. Applications must be submitted electronically at www.grants.gov by 11:59 p.m. Eastern Time, August 10, 2009. Applications that fail to meet the application due date will **not** be reviewed and will receive **no** further consideration.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in Grants.gov. After the Administration on Aging retrieves your application form from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov

An open information teleconference for applicants of this solicitation will be held July 8, 2009 at 2:00 p.m., EST. The toll-free teleconference phone number will be 888-396-9185, pass code: 2043392.

4. Intergovernmental Review

This funding opportunity announcement is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

5. Funding Restrictions

The following activities are not fundable:
- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.

6. Other Submission Requirements

Electronic submissions must be sent to: http://www.grants.gov.

Applicants submitting their application through www.grants.gov must register in the Central Contractor Registry (CCR) database in order to be able to submit the application. One element of the CCR is the DUNS number (see section IV.2), which must be obtained separately from CCR registration. Information about CCR is available at http://www.grants.gov/CCRRegister. You must also register with a Credential Provider to receive a username and password to securely submit your grant application. Information is available at http://apply07.grants.gov/apply/OrcRegister.

V. APPLICATION REVIEW INFORMATION

The Review Criteria listed below will be used by an Independent Review Panel to score applications. In applying for this opportunity, applicants should therefore be sure to adequately address all of the elements noted below. Applications are scored by assigning a maximum of 100 points across the following criteria:

1. Application Review Criteria

1. Current Status of ADRC / ADRC-Type Programs (Weight – 10 Points)

   - Does the applicant describe and demonstrate an understanding of: (i) how the system currently limits or facilitates individual choice and access for both public- and private-pay individuals in the applicant's target population? Does the applicant adequately: (i) analyze the strengths and challenges of its current system as it related to information and awareness, options counseling, streamlined access, person-centered hospital discharge planning and quality assurance and evaluation? (ii) highlight current strengths that the ADRC will be building on and what challenges must be overcome for it to succeed; (10 Points)

2. Goals and Objectives, Proposed Approach, Project Outcomes (Weight – 60 Points)

   - Target Population/Goals/Objectives: Has the applicant evidenced clear goals and objectives that are related in a meaningful way to the problems of citizen access and choice of long-term services and supports? Are the goals and objectives reasonable and likely to be effective in accomplishing the purpose of the grant? Has the applicant identified the geographic reach and scope of partnering with a care coordination model? (20 Points)

   - Proposed Project: Has the applicant clearly described a coherent approach that would successfully address the existing systemic problems in the areas of *Information and Awareness, Options Counseling, Streamlined Access Quality Assurance and Evaluation*, and *Person-Centered Hospital Discharge Planning*? Did the applicant describe how they will make more optimal use of existing financial and other resources that are already being deployed under federal and state long-term services and supports programs, including Medicaid, OAA and state revenue programs for the purpose of helping consumers learn about and access services and supports? (20 Points)

   - Are the proposed changes that state plans to make to the operations of its existing federal and state programs sufficient to fully operationalize a fully functional ADRC Program consistent with the functional requirements described in Section 202b of the OAA and this Program Announcement? Did the applicant describe its ability to form and sustain the collaborative partnerships that will be needed to coordinate and support a fully functioning ADRC Program? (20 Points)

3. Organizational Capability Statement (Weight – 5 Points)

- Organization, Management, and Qualifications: Has the applicant: (i) indicated that a project lead will be designated within six months of receipt of funds (ii) provided evidence that key project staff, stakeholders and partners are qualified and possess the experience and skills to design, implement, and evaluate the program within the available time frames; (iii) provided information to show that key project staff who will be working at the community level have direct professional experiences serving populations targeted by the program; (iv) addressed any significant circumstances that would affect the ability of the applicant to recruit and hire staff for the project (e.g., identified whether there are any current hiring freezes or other obstacles that would affect staffing) and, if so, identified methods by which such obstacles will be overcome? (5 Points)

4. Project Management, Work Plan and Budget (Weight – 15 Points)

- Work Plan and Timeline: Has the applicant included a work plan that documents reasonable benchmarks, measurable outcomes, milestones, timeframes, and identifies the responsible parties to accomplish the goals of the project? Are there specific milestones developed for each year of the grant project? (5 Points)

- Has the applicant proposed: (i) a reasonable and detailed budget; (ii) budgeted costs that are reasonable in relation to the project's objectives, design and significance; and (iii) a budget that follows the requirements stated in the program announcement and specifically does not use grant funds to supplant existing funds. Does the applicant delineate funds for two representatives to attend two ADRC meetings/events during each year? (5 Points)

- Has the applicant outlined proposed data collection and management strategies, consistent with the ADRC vision and voluntary reporting tool outlined in **Attachment H**. Does the response demonstrate that the applicant accessed the ADRC web site and is using lessons learned from existing ADRC grantees in developing the evaluation criteria and the management information system and other information technology tools? (5 Points)

5. Significance and Sustainability (Weight – 10 Points)

- Has the applicant demonstrated that the state seeks to implement enduring and effective systems changes and develop relationships among stakeholders that will advance the goal and vision of the AoA/CMS ADRC Program? (5 Points)

- Has the state taken steps to ensure that the ADRC endures after the grant period? Is senior leadership engaged in specific activities targeted at embedding the ADRC program in the state's long-term services and supports system? (5 Points)

2. Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening. These reviewers are experts in their field, and are drawn

from academic institutions, non-profit organizations, State and local government, and federal government agencies. Based on the specific programmatic considerations as outlined under the 'Funding Opportunity Description', the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the criteria identified above.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; geographic distribution; program diversity; whether the state is receiving funding under the CMS Real Choice Systems Change grant program, and the likelihood that the proposed project will result in the benefits expected.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration on Aging authorizing official, Officer of Grants Management, and the AoA Office of Budget and Finance. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement, located at: http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

3. Reporting

The SF-269 (Financial Status Report) is due annually and the AoA program progress report is due semi-annually. Final performance and SF-269 reports are due 90 days after the end of the project period. For more information on this process, please see **Attachment I** of this solicitation on Measurable Performance Goals.

VII. AGENCY CONTACTS

Project Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Joseph Lugo
Telephone: (202) 357-3417, e-mail: joseph.lugo@aoa.hhs.gov

Grants Management Officer:

U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Margaret Tolson
E-mail: margaret.tolson@aoa.hhs.gov

VIII. OTHER INFORMATION

1. Application Elements

A. SF 424 – Application for Federal Assistance.

B. SF 424A – Budget Information.

C. Separate Budget Narrative/Justification (See Attachments for Sample Format).

NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. Also, when more than 33% of a project's total budget is listed in the contractual line item, detailed Budget Narratives/Justifications are REQUIRED for each sub-contractor or sub-grant for each year of potential grant funding.

D. SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

E. Lobbying Certification

F. Proof of non-profit status, if applicable

G. Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

H. Project Narrative with Work Plan (See Attachment D for Sample Work Plan Format).

I. Organizational Capability Statement and Vitae for Key Project Personnel.

J. Letters of Commitment from Key Partners.

K. "Survey on Ensuring Equal Opportunity for Applicants" (Optional non-profit applicants)

2. The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

The project description and budget justification is approved under OMB control number 0985-0018 which expires on 05/31/2010.

Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

ATTACHMENTS

Attachment A:
Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative and Other Required Forms

Attachment B:
Budget Justification Format – Sample Format with Examples

Attachment C:
Budget Justification – Sample Format

Attachment D:
Project Work Plan - Sample Format

Attachment E:
Instructions for Completing the Summary/Abstract

Attachment F:
Care Coordination

Attachment G:
Fully Functional Criteria for Aging and Disability Resource Centers

Attachment H:
Grant Program Cooperative Agreements

Attachment I:
Proposed Minimum Data Elements

Attachment J:
Definitions

Attachment A: Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative/Justification, and Other Required Forms

This section provides step-by-step instructions for completing the four (4) standard Federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of Federal grant programs, and Federal agencies have the discretion to require some or all of the information on these forms. AoA does not require all the information on these Standard Forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms.

a. Standard Form 424

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.
• Pre-application • Application • Changed/Corrected Application – If AoA requests, check if this submission is to change or correct a previously submitted application.

2. **Type of Application**: (Required) Select one type of application in accordance with agency instructions.
• New • Continuation • Revision

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5a **Federal Entity Identifier**: Leave this field blank

5b. **Federal Award Identifier**: For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award (grant) number.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

a. Legal Name: (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website.

b. Employer/Taxpayer Number (EIN/TIN): (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

c. Organizational DUNS: (Required) Enter the organization's DUNS or DUNS+4 number

received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website.

d. Address: (Required) Enter the complete address including the county.

e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable) that will undertake the project.

f. Name and contact information of person to be contacted on matters involving this application: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

9. **Type of Applicant:** (Required) Select the applicant organization "type" from the following drop down list.
A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

10. **Name Of Federal Agency**: (Required) Enter U.S. Administration on Aging

11. **Catalog Of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the Program Announcement.

12. **Funding Opportunity Number/Title:** (Required) The Funding Opportunity Number and title of the opportunity can be found on page one of the Program Announcement.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state etc).

15. **Descriptive Title of Applicant's Project:** (Required) Enter a brief descriptive title of the project.

16. **Congressional Districts Of**: (Required) 16a. Enter the applicant's Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina's 103rd district.

• If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. • If nationwide, i.e. all districts within all states are affected, enter US-all.

17. **Proposed Project Start and End Dates**: (Required) Enter the proposed start date and final end date of the project. Therefore, if you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date.

18. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372

19. **Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

20. **Authorized Representative**: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

b. Standard Form 424A

> NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this AoA program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a one year budget.

Section A - Budget Summary

Line 5: Leave columns (c) and (d) blank. Enter TOTAL Federal costs in column (e) and total non-Federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories

Column 3: Enter the breakdown of how you plan to use the Federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-Federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

Separate Budget Narrative/Justification Requirement

You must submit a separate Budget Narrative/Justification as part of your application. When more than 33% of a project's total budget falls under contractual, detailed Budget Narratives/Justifications must be provided for each sub-contractor or sub-grantee. **Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.**

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: Federal; non-Federal cash; and non-Federal in-kind. Cost breakdowns, or justifications, are required for any cost of $1,000 or more. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-Federal cash as well as, sub-contractor or sub-grantee (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a: Personnel: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants; consultant costs should be included under 6h - Other. **In the Budget Narrative/Justification**: Identify the project director, if known. Specify the key staff, their titles, brief summary of project related duties, and the percent of their time commitments to the project in the Budget Narrative/Justification.

Line 6b: Fringe Benefits: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate. **In the Justification**: Provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement insurance, etc.

Line 6c: Travel: Enter total costs of **out-of-town travel** (travel requiring per diem) for staff of the project. Do not enter costs for consultant's travel - this should be included in line 6h. **In the Justification**: Include the total number of trips, destinations, purpose, length of stay, subsistence allowances and transportation costs (including mileage rates).

Line 6d: Equipment: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e. **In the Justification**: Equipment to be purchased with

Federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions; the equipment, or a reasonable facsimile, must not be otherwise available to the applicant or its sub-grantees. The justification also must contain plans for the use or disposal of the equipment after the project ends.

Line 6e: Supplies: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d. **In the Justification:** Provide general description of types of items included.

Line 6f: Contractual: Enter the total costs of all contracts, including (1) procurement contracts (except those, which belong on other lines such as equipment, supplies, etc.). Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals or consultants on this line. **In the Budget Narrative/Justification**: Attach a list of contractors indicating the name of the organization, the purpose of the contract, and the estimated dollar amount. If the name of the contractor, scope of work, and estimated costs are not available or have not been negotiated, indicate when this information will be available. **Whenever the applicant/grantee intends to delegate more than 33% of a project's total budget to the contractual line item, the applicant/grantee must provide a completed copy of Section B of the SF 424A Budget Categories for each sub-contractor or sub-grantee, and separate Budget Narrative/Justification for each sub-contractor or sub-grantee for each year of potential grant funding.**

Line 6g: Construction: Leave blank since construction is not an allowable cost under this AoA program.

Line 6h: Other: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits); non-contractual fees and travel paid directly to *individual* consultants; **local** transportation (all travel which does not require per diem is considered local travel); postage; space and equipment rentals/lease; printing and publication; computer use; training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs. **In the Justification:** Provide a reasonable explanation for items in this category. For individual consultants, explain the nature of services provided and the relation to activities in the work plan. Describe the types of activities for staff development costs.

Line 6i: Total Direct Charges: Show the totals of Lines 6a through 6h.

Line 6j: Indirect Charges: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency; or (2) the applicant is a state or local government agency.

Budget Narrative/Justification: **State governments should enter the amount of indirect costs determined in accordance with DHHS requirements**. An applicant

that will charge indirect costs to the grant **must enclose a copy of the current indirect cost rate agreement**. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.
If the applicant organization is in the process of initially developing or renegotiating a rate, it should immediately upon notification that an award will be made, develop a tentative indirect cost rate proposal based on its most recently completed fiscal year in accordance with the principles set forth in the cognizant agency's guidelines for establishing indirect cost rates, and submit it to the cognizant agency. Applicants awaiting approval of their indirect cost proposals may also request indirect costs. It should be noted that when an indirect cost rate is requested, those costs included in the indirect cost pool should not also be charged as direct costs to the grant. Also, if the applicant is requesting a rate which is less than what is allowed under the program, the authorized representative of the applicant organization must submit a signed acknowledgement that the applicant is accepting a lower rate than allowed.

Line 6k: Total: Enter the total amounts of Lines 6i and 6j.

Line 7: Program Income: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project. Program Income must be used as additional program costs and can not be used as match (non-Federal resource).

Section C - Non-Federal Resources

Line 12: Enter the amounts of non-Federal resources that will be used in carrying out the proposed project, by source (Applicant; State; Other) and enter the total amount in Column (e). Keep in mind that if the match requirement is not met, Federal dollars may be reduced.

Section D - Forecasted Cash Needs - Not applicable.

Section E - Budget Estimate of Federal Funds Needed for Balance of the Project

Line 20: Section E is relevant for multi-year grant applications, where the project period is 24 months or longer. This section does not apply to grant awards where the project period is less than 17 months.

Section F - Other Budget Information

Line 22: Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23: Remarks: Provide any other comments deemed necessary.

c. Standard Form 424B - Assurances

This form contains assurances required of applicants under the discretionary funds programs administered by the Administration on Aging. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

e. Other Application Components

Proof of Non-Profit Status
Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a State taxing body, State attorney general, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

Indirect Cost Agreement
Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

Attachment B: Budget Narrative/Justification, Page 1 – Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$40,000	$5,000		$45,000	Project Supervisor (name) = .3FTE @ $50,000/yr = $15,000 ($10,000 = Federal; $5,000 = Non-Federal cash) Project Director (name) = 1FTE @ $30,000 = $30,000 (Federal) TOTAL: = $45,000
Fringe Benefits	$12,600	0	0	$12,600	Fringes on Supervisor and Director @ 28% of salary. (Federal) FICA (7.65%) = $ 3,442 Health (12%) = $ 5,400 Dental (5%) = $ 2,250 Life (2%) = $ 900 Workers Comp Insurance (.75% = $ 338 Unemployment Insurance (.6%) = $ 270 TOTAL: = $12,600
Travel	$2,450	$1,547		$3,997	Travel to Annual Grantee Meeting: (Federal) Airfare: 1 RT x 2 people x $750/RT = $1,500 Lodging: 3 nights x 2 people x $100/night = $ 600 Per Diem: 4 days x 2 people x $40/day = $ 320 TOTAL: = $2,420 Out-of-Town Project Site Visits (Non-Federal cash) Car mileage: 3 trips x 2 people x 350 miles/trip x $ .365/mile = $ 767 Lodging: 3 trips x 2 people x 1 night/ trip x $50/night = $ 300 Per Diem: 3 trips x 2 people x 2days/trip x $40/day = $ 480 TOTAL: = $1,547

NOTE: Applicants requesting funding for multi-year grant programs MUST provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required.

Attachment B: Budget Narrative/Justification, Page 2 - Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Equipment Equipment is non-expendable, tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the individual item does not cost more than $5,000, include it in your budget under Supplies	0	0	0	0	No equipment requested
Supplies	$1,340	$2,160		$3,500	Laptop computer for use in client intakes = $1,340 (Federal) Consumable supplies (paper, pens, etc.) $100/mo x 12 months = $1,200 (Non-Federal cash) Copying $80/mo x 12 months = $ 960 (Non-Federal cash) TOTAL: = $3,500

Attachment B: Budget Narrative/Justification, Page 3 – Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Other Note: Items such as Video Production shown in this example, which are priced at a set fee, still require a cost breakdown.	$10,000	$8,000	$19,800	$37,800	Local conf registration fee (provide conference name) =$ 200 (Non-Fed cash) Printing brochures (50,000 @ $0.05 ea) = $ 2,500 (Non-Fed cash) Video production (set fee) = $19,800 (Non-Fed in-kind) Video Reproduction = $ 3,500 (Non-Fed cash) NF Respite Training Manual reproduction $3/manual x $2000 manuals = $ 6,000 (Federal) Postage: $150/mo x 12 months = $ 1,800 (Non-Fed cash) Caregiver Forum meeting room rentals $200/day x 12 forums = $ 2,400 (Federal) Respite Training Scholarships = $ 1,600 (Federal) - (16 scholarships @ $100 each) TOTAL $37,800
TOTAL	$266,390 75% or less of Total Cost **(Federal $)**	$16,707* **(Non-Federal Cash Match)**	$72,300* **(Non-Federal In-Kind Match)**	$355,397	

***Be sure Non-Federal Cash and Non-Federal In-Kind match equals the total program specific match requirements; 25% required match used for example purposes only**

Attachment C: Budget Narrative/Justification — Sample Template

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual					
Other					
Indirect Charges					
TOTAL					

Attachment D: Project Work Plan, Page 1 – Sample Template

Goal:
Measureable Outcome(s):

Major Objectives	Key Tasks	Lead Person	TimeFrame (Start/End Dates by Month in Project Cycle)											
			1	2	3	4	5	6	7	8	9	10	11	12
1.														
2.														

Attachment D: Project Work Plan, Page 2 – Sample Template

Goal:
Measureable Outcome(s):

Major Objectives	**Key Tasks**	**Lead Person**	**TimeFrame (Start/End Dates by Month in Project Cycle)**											
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
3.														
4.														

Attachment D: Project Work Plan, Page 3 – Sample Template

Goal:
Measureable Outcome(s):

Major Objectives	Key Tasks	Lead Person	TimeFrame (Start/End Dates by Month in Project Cycle)											
			1	2	3	4	5	6	7	8	9	10	11	12
5.														
6.														

NOTE: Please do not infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.

Attachment E: Instructions for Completing the Project Summary/Abstract

- All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.
- To ensure uniformity, please limit the length to no more than 265 words on a single page with a font size of not less than 11, doubled-spaced.
- The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

Goal(s) – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be

Objective(s) – narrow, more specific, identifiable or measurable steps toward a goal. Part of the planning process or sequence (the "how"). Specific performances which will result in the attainment of a goal.

Outcomes - measurable results of a project. Positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities. (outcomes are the end-point)

Products – materials, deliverables.

- A model abstract/summary is provided below:

The grantee, Okoboji University, supports this three year Dementia Disease demonstration (DD) project in collaboration with the local Alzheimer's Association and related Dementias groups. The **goal** of the project is to provide comprehensive, coordinated care to individuals with memory concerns and to their caregivers. The approach is to expand the services and to integrate the bio-psycho-social aspects of care. The **objectives** are: 1) to provide dementia specific care, i.e., care management fully integrated into the services provided; 2) to train staff, students and volunteers; 3) to establish a system infrastructure to support services to individuals with early stage dementia and to their caregivers; 4) to develop linkages with community agencies; 5) to expand the assessment and intervention services; 6) to evaluate the impact of the added services; 7) to disseminate project information. The expected **outcomes** of this DD project are: patients will maintain as high a level of mental function and physical functions (thru Yoga) as possible; caregivers will increase ability to cope with changes; and pre and post – project patient evaluation will reflect positive results from expanded and integrated services. The **products** from this project are: a final report, including evaluation results; a website; articles for publication; data on driver assessment and in-home cognitive retraining; abstracts for national conferences.

Attachment F: Person-Centered Care Coordination

As part of this announcement, states will have the opportunity to coordinate with and support person-centered care coordination models (e.g. *Person-Centered Hospital Discharge Planning)* in their community that systematically solicit input regarding the needs, preferences, strengths, capacities and desired health outcomes of the individual. In the process, the patient should be given the tools they need to make informed decisions about where and how they will receive services and supports. This announcement will provide an opportunity to position ADRCs as key facilitator in care coordination in an effort to maximize opportunities for people to live in the community post hospitalization and institutional care.

What do we mean by Care Coordination?

To date there is not an official definition of care coordination which is consistently used across organizations or industries. However, the National Coalition on Care Coordination (N3C) has defined this term in the following manner:

"Care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care."

A unique aspect of care coordination when it is defined in these terms is that it includes both health care and social support interventions. Care coordination is not a single approach but encompasses a number of different interventions that ADRCs would be able to coordinate and support depending on the unique characteristics within a state. One intervention which is demonstrating to be effective in reducing hospitalization for Medicare beneficiaries with multiple chronic conditions is transitional care interventions.

In terms of locations where care transition can occur, some examples include hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners that are well-trained in chronic care and have current information about the patient's goals, preferences and clinical status. It includes logistical arrangements, education of the patient and family and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and receiving aspects of the transfer, is essential for persons with complex care needs[3].

Role of care coordination in an integrated service delivery system

[3] Coleman E, Boult C. Improving the quality of transitional care for persons with complex care needs. J Am Ger Soc. 2003;51(4):556-557.

In 2007, researchers suggested that the rate of rehospitalization could serve as a useful indicator of the performance of our health care system[4]. In 2009, a new study described rehospitalization as a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care. The same article reported that almost 1 out of every 5 Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days, and 1 out of every 3 were rehospitalized within 90 days. It is estimated that the national fiscal impact to Medicare as a result of unplanned rehospitalization in 2004 was $17.4 billion[5].

Some issues affecting discharge decisions and planning include:
• Institutional providers do not have strong relationships with the community-based resources such as the ADRCs, Area Agencies on Aging (AAAs), Centers for Independent living (CILs), and Home and Community Based Service (HCBS) providers;
• It is easier and may require less time to refer to familiar nursing home providers instead of providing caregivers the needed supports to provide care in the home with appropriate healthcare supports;
• Often discharge planning does not take place until the day of discharge which may be too late to effectively involve the caregiver and arrange for HCBS services; and
• Discharge planners are currently relying on whatever information is readily accessible and available and are often not afforded the opportunity to research and access community information that would benefit beneficiaries on a case-by-case basis.

Optimally, effective discharge planning is further compromised by a lack of understanding of the presence and role of informal caregivers. Although caregivers offer invaluable, uncompensated support, many times they are not recognized as individuals with needs separate from those of the patient. Many argue for a routine assessment of the caregiver's needs for support, including training. Informal caregivers are often not seen as integral members of the health care team and are not incorporated into the hospital discharge planning process. Also, informal caregivers are often not given training essential to ensuring patient safety and preventing unnecessary emergency room visits and re-hospitalization. In addition, in recent years the tasks caregivers are asked to do have become increasingly complex as a result of shortened hospital lengths of stay and increased reliance on complex treatments.

In 2006, Dr. Eric Coleman concluded that enabling patients and caregivers to take a more active role in care transitions appears to reduce the rate of hospitalization[6]. One promising example of a care transitional model is Dr. Coleman's Care Transition Intervention. This intervention consists of four key pillars which include: medication self-management, a patient-centered record, primary care and specialist follow-up and knowledge of "red flags," a warning symptom or sign indicative of a worsening condition. To help manage these four processes a "transition coach" is trained and identified. One example of how

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[4] Adeyemo D, Radley S. Unplanned general surgical re-admissions - how many, which patients and why? Ann R Coll Surg Engl 2008;89:363-7.

[5] Jencks S, Williams M, Coleman E. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360:1418-28.

[6] Coleman EA, Parry C, Chalmers S, Min SJ. "The Care Transitions Intervention: Results of a Randomized Controlled Trial" Archives of Internal Medicine 2006;166:1822-8

states can enhance their ADRC is to explore how existing Options Counselors could support a transition coach in such a model.

Another promising model is Dr. Chad Boult's *Guided Care* Model. Surveys of the patients who received *Guided Care* and similar patients who received "usual care" in the practice showed that *Guided Care* recipients experienced more improvement in the quality of their care than did the usual care group. Insurance claims revealed that the costs of health care were lower for the *Guided Care* patients than for the usual care patients.

Guided Care is driven by a highly skilled registered nurse in a primary care office typically assisting three to four physicians in providing high-quality chronic care for their patients in need of good chronic care. The eight key components which define Guided Care include:

1. Assessing

The nurse begins by performing a two-hour comprehensive assessment at the patient's home. This assessment covers medical conditions, medications, functional ability, mental status, exercise, nutrition, home safety, caregivers, other providers, and insurance. The nurse then reviews the patient's medical record and enters all the assessment data into the *Guided Care* EHR, which is separate from KP's "HealthConnect" electronic medical record.

2. Planning Care

On the basis of this assessment data and recent evidence-based guidelines, which are programmed into the EHR, the EHR generates the patient's individualized Care Guide. This Care Guide is an integrated compilation of all the recommendations for managing the patient's chronic conditions. The nurse and the primary care physician discuss and modify the Care Guide to meet the patient's unique circumstances. The nurse then discusses it with the patient and family, modifying it further to conform to their preferences and to obtain their "buy-in." The final result is an evidence-based, realistic plan that addresses medications, diet, physical activity, self-monitoring, targets, and follow-up. The Care Guide is placed in the medical record and shared with other clinicians, as needed. On the basis of the Care Guide, the nurse then drafts a patient-friendly *My Action Plan,* which is owned by the patient and displayed in a plastic jacket on the refrigerator or other obvious visible place in the home. This two-page summary reminds the patient when to take medicines, what diet to follow, what exercise to do, when to monitor weight and blood pressure, what to watch out for, and when to see the doctor.

3. Monitoring

The nurse then begins the proactive monitoring phase of *Guided Care.* Rather than waiting for a problem to prompt the patient to access the health care system, the nurse reviews the *Action Plan* at least monthly with the patient. Most of these contacts are by telephone, but some are in person in the office, at the hospital, or in the home. If the patient doesn't call, the EHR reminds the nurse to call the patient or caregiver. The frequency of nurse's contacts with each patient fluctuates according to need.

4. Coaching

During the monitoring contacts, the nurse reviews the patient's self-management, point by

point, making certain that all components of the plan are being followed. The nurse uses motivational interviewing techniques to help the patient overcome obstacles. The nurse confers with physicians as needed, making adjustments to the *Action Plan* and Care Guide.

5. Chronic Disease Self-Management

The *Guided Care* nurse refers most patients to a local "chronic disease self-management" (CDSM) course. The course consists of one two- to two-and-a-half-hour session per week for six weeks. At each session, a group of 10-15 patients meets with two trained, certified lay leaders, who lead a structured course that Stanford University has developed. The course aims to move people from passivity about their health care to a position of "mastery," in which each person adopts an attitude of "I'm the master of my health; I'm primarily responsible." Patients learn to set and attain health-related goals, interpret their own symptoms, and use the health care system appropriately.

6. Educating and Supporting Caregivers

Each *Guided Care* nurse leads a sequence of classes and support group sessions for 5-10 caregivers. The caregiver classes, which meet weekly for six weeks, provide general information on how to be a caregiver. Following this course, the nurse leads an ongoing monthly support group for caregivers and monitors their status quarterly by telephone.

7. Coordinating Transitions Between Providers and Sites of Care

To help coordinate complex care, the *Guided Care* nurse provides a brief but complete summary of the patient's health and health care (the Care Guide) to the patient's other providers, e.g., hospitals, specialists, rehabilitation therapists, and home care nurses. One of the nurse's highest priorities is to smooth transitions between sites of care, especially into and out of hospitals. The nurse monitors the patient and family through the hospital stay and prepares them for discharge before they go home. When they do go home, the nurse visits them on the first day, making sure they have what they need and that they understand how to care for themselves, how to take medications, what to watch for, and that they have necessary contact information—emergency phone numbers and e-mail addresses—should problems or questions arise.

8. Access to Community Services

The *Guided Care* nurse also facilitates patients' access to many services provided by community agencies, such as Meals-on-Wheels, transportation services, senior centers, adult day health centers, and the Alzheimer Association.

Some might argue, "is there even a need to have care coordination that encompasses both health care and social supports when a plethora of community based care coordination models already exist?" A new study in the Journal American Medical Association (April 2009) reviewed fifteen randomized trials and concluded that "viable care coordination programs without a strong transitional care component are unlikely to yield net Medicare savings." As a result, care coordination that is based solely in a community setting, with no connection to the acute care domain, will most likely not yield the same results as a community-based care coordination that incorporates acute care as part of its everyday

process[7]. The implications of all these suggest that care coordination can and will continue to serve as a vital part of an integrated service delivery system.

Due to the potential impact care coordination and care transitions could have on hospital readmissions, CMS incorporated care transitions as part of the 9th Scope of Work for Quality Improvement Organizations. Communities in the following regions have been selected to participate in these projects include: Providence, R.I.; Upper Capitol Region, N.Y.; Western Pennsylvania; Southwestern New Jersey; Metro Atlanta East, Ga.; Miami, FL.; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing Area, Mich.; Omaha, Neb.; Baton Rouge, La.; Northwest Denver, Colo.; Harlingen, Texas; and Whatcom County, Wash. The work of the Care Transitions Project will respond to the unique needs of each of the 14 communities. Each of the Care Transitions communities is led by a state Quality Improvement Organization (QIO). QIOs work throughout the country as part of CMS's quality program to help health care providers, consumers and stakeholder groups refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high-value healthcare that they deserve. Each QIO in the project is required to work with partners to implement the following:

1. hospital and community system-wide interventions;
2. interventions that target specific diseases or conditions; and
3. interventions that target specific reasons for admission.

A listing of the 14 QIOs including the Care Transitions National Lead as well as Community Project Contacts can be found at:
http://www.cfmc.org/caretransitions/contact.htm

[7]Piekes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. JAMA 2009; 301:603-18

Attachment G: Fully Functional ADRC

These criteria were developed to assist states measure and assess their progress toward developing fully functional ADRCs. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. Depending on the model of ADRC a state is implementing, the term may be interpreted to represent one operating organization in each community at the local level, a network of organizations serving as operating partners in each community at the local level, or a combination of state level and local level organizations operating in partnership. Metrics that should be interpreted or applied differently to systems with a "single entry point" than to systems where there are "multiple entry points" are noted.

Program Component	Criteria/ Description	Recommended Metrics
Information and Awareness	*Public education; information on long-term support options.* • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options. • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.	• The ADRC has a proven **outreach and marketing plan** in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The ADRC has a **comprehensive resource database** which includes information about the range of long term support options in the ADRC service area. Information regarding providers, programs, and services available in the ADRC service area (including for private-payment) is collected into a central database. - Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide **consistent and uniform information.** • The ADRC actively markets to and serves **private pay** consumers in addition to those that require public assistance.

Program Component	Criteria/ Description	Recommended Metrics
Options Counseling	*Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.* • The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts follow-up when needed to determine outcome of options counseling. • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs.	<u>Options Counseling</u> • ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. • All ADRC entry point agencies use standard intake and screening instruments. • Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumers who have gone through a comprehensive assessment process. • Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. • ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. <u>Information and Referral</u> • ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living <u>Referrals and Follow Up</u> • ADRC has the ability to track referrals made. • ADRC consistently conducts follow-up to determine outcome of options counseling. <u>Crisis Intervention</u> • ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. • Short-term case management is available as needed for all target populations and provided directly by ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. <u>Future Long Term Support Needs Planning</u> • Evidence of one of the following: (1) ADRC is involved with Own Your Future Campaign; (2) ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.

Program Component	Criteria/ Description	Recommended Metrics
Access	*Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.* • ADRC serves as the entry point to publicly funded long term care. • The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services.	• ADRC has a single, standardized entry process for accessing public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. • For ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • Financial and functional eligibility determination processes are highly coordinated. • ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. • ADRC staff conducts level of care assessments that are used for determining functional eligibility, or ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. • ADRC staff assists consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). • Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. • ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and re-determination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the ADRC is informed of consumers who are on the waiting list and the ADRC conducts follow-up with those individuals. • There is a process by which the ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals. • ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. • There is a reduction in the rate of institutional placement in the ADRC service area. • ADRC tracks diversions and transitions (i.e., # Community Living Programs attempted and # of successful diversions; # nursing home relocations to community completed). • ADRC can report the proportion of consumers requesting services that actually receive them. • ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).

Program Component	Criteria/ Description	Recommended Metrics
Target Populations	*ADRCs must serve the elderly and at least one* ***target population*** *of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.*	• The ADRC tracks the number of actual individuals served against the resident population estimate, by target population. • ADRC demonstrates competencies relating to serving all of its target populations. • ADRC is accessible to all of the populations it serves. • There is evidence that the ADRC is moving towards the goal of serving all persons with disabilities, either through a single operating organization or through close coordination among operating partners.
Critical Pathways to Long Term Support	*ADRCs will create formal linkages between and among the* ***critical pathways to long-term support.***	• ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: (1) providing training and education about the ADRC to critical pathway providers (CPPs); (2) involving CPPs in advisory board representation; and (3) establishing protocols for referrals, particularly with hospitals and LTC facilities.
Partnerships & Stakeholder Involvement	*ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.* *ADRCs must establish strong partnerships with the* ***State Health Insurance Assistance Program (SHIP)*** *and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.* *ADRCs must* ***meaningfully involve stakeholders, including consumers****, in planning, implementation and evaluation activities.*	<u>Medicaid</u> • ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. <u>Aging and Disability Partners</u> • There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners. • ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. <u>Stakeholders</u> • If the ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. • There is evidence of strong collaboration with programs and services instrumental to ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. <u>Consumers</u> • Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.

Program Component	Criteria/ Description	Recommended Metrics
IT/MIS	*The ADRC program must have a* ***management information system*** *that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.*	• ADRC uses a management information system that can support the program functions. • ADRC can submit evidence of reports on the following: - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. o Types of assistance provided o Timing of eligibility determinations o Information regarding level of impairment and preferred support need o Disposition/placements (ex. waiver, institution) • ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.
Evaluation Activities	*At a minimum, ADRCs must have* ***performance goals and indicators*** *related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.*	• ADRC is measuring performance related to the established indicators. • ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. • ADRC has used information obtained from consumer satisfaction evaluations to improve performance. • ADRC can demonstrate ability to document the impact on nursing home use • ADRC can demonstrate the ability to document the impact on the use of home and community based services. • ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.
Staffing and Resources	• Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs	• ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • ADRC has an individual assigned to be the overall director/manager/coordinator of all ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when ADRC functions occur in more than one location or agency. • ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.

Attachment H: Aging and Disability Resource Centers

GRANT PROGRAM

(HHS-2009-AoA-DR-0915)

COOPERATIVE AGREEMENT

Consistent with the Federal Grant and Cooperative Agreement Act of 1977 (P.L. 95-224), the **(Grantee name)**, also herein referred to as the **grantee**, has received a Notice of Award to establish a Cooperative Agreement between the Administration on Aging (AoA) and the **grantee**. This Cooperative Agreement, whose terms are described below, provides for the substantial involvement and collaboration of AoA in activities the recipient organization will complete in accordance with the provisions of the approved grant award.

Grantee Responsibilities
As proposed in its approved application, the **grantee** agrees to carry out the objectives and activities of the project announced as the Aging and Disability Resource Grants (ADRC) Program. The **grantee** will design and implement an ADRC in accordance with the following conditions described in the ADRC Program Announcement:

> The grantee must – at a minimum - involve a full partnership of the State Unit on Aging, the State Medicaid Agency, and State Disability Agencies where applicable, and at the community level, a substantive role for any Area Agency on Aging, Local Medicaid Office, Center for Independent Living, State Health Insurance Counseling Program, and Benefits Outreach and Enrollment Center, located in the geographic areas covered by a state's ADRC Program. Applications must also include a substantive advisory role for consumers, their families and other key stakeholders affected by a state's ADRC to assist the state in the development and implementation of its ADRC program.

Projects to be funded under this Announcement must:

1. For states receiving ADRC funding for the first time, have at least one ADRC Program operational in one community **within 12 months** of receipt of grant funds that at a minimum is providing information and one-on-one counseling on long-term support options for the elderly and younger adults with physical disabilities, and **within 18 months**, is beginning to provide streamlined access to all publicly funded long-term services and supports, including those supported by Medicaid, OAA and state revenue. These states include: Delaware, Oklahoma, Nebraska, North Dakota, South Dakota and Utah.

2. For states receiving an award that have previously received funding from either AoA or CMS for ADRCs, **within 18 months** of receipt of grant funds, have made significant

progress in strengthening the streamlined access and/or person-centered discharge planning components of its ADRC programs.

3. For all states receiving AoA FY 2009 ADRC funding, **within 18 months** of receipt of grant funds, have submitted a detailed 5 year plan to AoA and CMS that has been developed with input from the key stakeholders in the state and approved by the directors of the State Unit on Aging, State Medicaid Agency, and State Disability Agencies where applicable that describes how the state is going to realign and more optimally coordinate the existing information and access functions of the state and federal programs it administers in order to operationalize ADRCs statewide that are capable of performing the functions specified in Title II Section 202(b)7 and the requirements in this Program Announcement. This plan should identify existing funds/programs that will be used and include a budget that identifies the added costs to the state, above and beyond funding that is already being expended on ADRC-type functions under existing programs, to implement the plan. The plan should also include projected cost savings that the state will achieve as a result of statewide implementation. The AoA Technical Assistance Center will work with states to develop these cost savings projections.

The third year of continuation funding for all grants awarded under this Program Announcement will be contingent on a state's performance in meeting the above requirements and deadlines.

4. Applicant should be able to ensure that the appropriate level of focus is directed towards ADRC design and implementation and an ADRC project lead will be designated/hired within 6 months of receipt of an ADRC award.

5. Applicant should also be able to ensure that the state will establish or designate an Advisory Board to assist in the development and implementation of their ADRC program.

6. Applicants seeking funding under this option must be expanding and enhancing their ADRC projects within the framework established under the AoA and CMS ADRC Program Announcements published in 2003, 2005 and 2009 within the operational examples provided.

7. Applicants should include a description of the commitment from partners and include any letters of support in an appendix to your application.

8. Agree to work with AoA, the Technical Assistance Center, and the other ADRC grantees to identify and collect common measures.

9. Fully coordinate the project(s) with other state-administered long-term service and supports and rebalancing efforts.

The **grantee** agrees that activities under this initiative will not duplicate activities funded under other resources.

AoA Responsibilities

The Administration on Aging agrees to work cooperatively in the development and execution of the activities of the project as follows:

a. AoA Project Officer will perform the day-to-day Federal responsibilities of managing the Aging and Disability Resource Grants Program.

b. AoA and the **grantee** will work cooperatively to clarify the programmatic and budgetary issues to be addressed by the project. Based on these negotiations, the **grantee** will revise the project work plan detailing expectations for major activities and products during the 36 month grant. The work plan will include key tasks, timelines, and staff assignments. AoA or the **grantee** can propose a revision in the final work plan at any time. Any changes in the final work plan will require agreement of both parties.

c. AoA will assist the **grantee** project leadership in understanding the policy concerns and/or priorities of AoA by conducting periodic briefings and by carrying out ongoing consultations.

d. AoA will work with the **grantee** to ensure that the minimum requirements of the grant are met. Particular attention will be paid to the grantees ability to develop an ADRC which is carrying out key operational components of an ADRC program including 1) Information and Awareness, 2) Options Counseling, 3) Streamline Access and 4) Person-Centered Hospital Discharge Planning, 5) Quality Assurance and Evaluation.

e. AoA will work with the **grantee** on the development and implementation of evaluation and quality assurance systems in an effort to ensure consistency with program goals and the activities of other ADRC grantees.

f. AoA will designate technical assistance providers to design and implement, in cooperation with AoA**,** technical assistance to support grantee activities.

The grant period for this project is up to 36 months beginning no later than **September 30, 2009**.

Requests to modify or amend this Cooperative Agreement may be made at any time by AoA or the grantee. Any modifications and/or amendments shall be effective upon the mutual agreement of both parties.

Draw down of funding for this grant through the Federal Payment Management System serves as official acceptance of this Cooperative Agreement. If you do not plan to accept the grant award, please send a letter of declination to the AoA Grants Management Officer with a copy to the AoA Project Officer within 30 days of receipt of the Notice of Award.

Attachment I: Voluntary Semi-Annual Reporting Process for ADRC

AoA and CMS, together with our technical assistance providers, have developed a data set and processes for data collection for Aging and Disability Resource Center grantees. Evaluation and analysis of these data will result in increased understanding of outcomes and strategies that are effective in serving people with a disability. Evaluation also serves a valuable purpose as a decision making and reporting tool for state leadership. Sustainability is often linked to sound performance metrics and continuous improvement, concepts enabled by effective evaluation processes.

ADRC grantees will be asked to use a web-based system to report a narrative summary of their activities every six months. In addition, grantees will use a simple Microsoft Excel data entry tool to report quantitative outcomes data from the local level. This tool has a simple user interface and is supported by considerable functionality such as data validation, automatic calculations, and Visual Basic programming that allows pre-population of information and previously reported data elements for each grantee. Prior ADRC grantees have reported that they prefer this format for inputting quantitative data because they can use its basic spreadsheet features to make calculations, double check answers, edit, and share with partners across the state for review before submitting. Grantees will be provided with a guide that provides step-by-step directions to the reporting and data entry process as well as teleconference/webinar training opportunities.

Exhibit 1.a Basic ADRC Data Elements

	Program Site Opening, Service Area, and Population
1	Expected "Opening" or "Kick-off" date of this program site, if not open yet
2	Actual "Opening" or "Kick-off" date of this program site
3	Service area of program site (names of counties served, region or MSA)
4	Total resident population in the service area of this program site
	Model and Operating Organizations
5	How many operating organizations are involved in the day-to-day operations of this Program Site, performing some or all ADRC functions?
6	Do you consider this ADRC program site to be a "single point of entry" or "one-stop shop"?
7	Do you consider this ADRC program site to be a "decentralized" or "no wrong door" model?

	Model and Operating Organizations
8	If you have one operating organization, does it operate in more than one place in the service area?
9	If you listed more than one operating organization above, please describe where these organizations are physically located in relation to one another.
10	Operating Organization Name (space for up to 8)
11	Operating Organization Type (space for up to 8)
12	Services and Functions offered as part of the ADRC (space for up to 8) a) Outreach and Marketing b) Information and Referral/ Assistance c) Short Term Case Management d) Benefits Counseling e) Options Counseling f) Planning for Future LTC Needs g) SHIP Counseling h) Peer Counseling i) Adult Protective Services j) Skills Training k) Advocacy l) Screening/Intake for Medicaid or Other Public LTC Programs m) Pre-screening for Nursing Home Admission n) Conducting Level of Care Assessments o) Assisting to Complete and/or Submit Financial Eligibility Applications p) Making Financial Eligibility Determinations q) Case Management for Medicaid HCBS Waiver r) Case Management for State-funded LTC Programs s) Assisting with Medical or Pharmaceutical Assistance Programs t) Caregiver Support Services u) Prevention, Health Promotion, or Risk Reduction Programs v) Employment Services or Service Coordination w) Housing Services or Service Coordination x) Assistive Technology or Home Modification Services y) Transportation Services or Service Coordination Older Americans Act Services not otherwise listed above z) Other Services

	Operating Budget and Staffing
13	Total annual ADRC program site operating budget
14	How many organizations are included in this budget figure?
15	Total dollar amount received and included in Total Annual Operating Budget from these sources: a) ADRC grant (money allocated to program site by state) b) Medicaid for direct services c) Medicaid Administrative Match (Federal Financial Participation) d) Older Americans Act (other than NFCSP) e) National Family Caregiver Support Program (NFCSP) f) Other federal funding g) State general revenue funding h) County or local government funding i) Private (non-governmental) grants j) Consumer fees and cost-sharing k) Charitable donations l) Other
16	Total No. of FTE
	IT/MIS Software Information
17	IT/MIS Software used for a) Information and Referral b) Client Tracking c) Public Website
	Total Contacts to the ADRC
18	Dates between which these data were collected a) Start Date b) End Date
19	Total Contacts made to ADRC during this period (calls or walk-ins)
20	Contacts by Age a) Contacts made by or on behalf of a Consumer Aged 60 and Over b) Contacts made by or on behalf of a Consumer Under Age 60 c) Unknown Contacts by Age
21	Contacts by Type a) Contacts by Consumers b) Contacts by Caregivers c) Contacts by Professionals d) Contacts by Others (not consumers, caregivers, or professionals) e) Unknown Contacts by Type

	Total Clients (Unduplicated)
22	Total ADRC Clients
23	Clients by Disability Type (Unduplicated, all ages) a) No. ADRC Clients with Multiple Disabilities b) No. ADRC Clients with a Physical Disability c) No. ADRC Clients with MR/DD/ID d) No. ADRC Clients with Mental Illness e) No. ADRC Clients with Traumatic Brain Injury f) No. ADRC Clients with Unspecified Disability g) No. ADRC Clients with No Disability h) No. Unknown ADRC Clients (no information about disability)
24	Clients by Income Level (Unduplicated) a) No. ADRC Clients - Low Income b) No. ADRC Clients - Not Low Income c) No. ADRC Clients - Income Level Unknown
	Type of ADRC Assistance or Service
25	Type of ADRC Assistance a) No. Contacts provided Information and Referral b) No. Contacts noted for Follow Up after Information and Referral c) No. Contacts provided ADRC Short-Term Case Management (beyond a one-time follow-up) d) No. Contacts provided ADRC Options Counseling e) No. Contacts provided ADRC Benefits Counseling f) No. Contacts provided Assistance with LTC Futures Planning g) No. Contacts provided some other type of ADRC assistance or service h) No. Contacts provided no assistance or unknown type of assistance
	Average Monthly Public LTC Program Enrollment
26	Average Monthly Public LTC Program Enrollment in WHOLE ADRC SERVICE AREA (should include ADRC Clients and might include Non-ADRC Clients) a) Average number of Individuals enrolled in Medicaid HCBS Waivers in ADRC Service Area each month b) Average number of Individuals enrolled in Medicaid residing in institutions in ADRC Service Area each month c) Average number of individuals enrolled in other public LTC programs in ADRC Service Area each month d) What HCBS Waivers are included above (e.g. aged and disabled, MR/DD)? e) What other public LTC programs are included above?

	Average Monthly Public LTC Program Enrollment
27	Total New Enrollment in WHOLE SERVICE AREA in Public LTC Programs (ADRC Clients and Non-ADRC Clients) a) No. of individuals newly enrolled into a Medicaid HCBS Waiver this reporting period in ADRC Service Area b) No. of individuals newly enrolled into Medicaid institutional services in ADRC Service Area this reporting period c) No. of individuals newly enrolled into other public LTC programs in ADRC Service Area this reporting period d) What HCBS Waivers are included above (e.g. aged and disabled, MR/DD)? e) What other public LTC programs are included above?
28	Total New Enrollment among ADRC CLIENTS ONLY in Public LTC Programs (including individuals enrolled by ADRC staff and individuals referred for assessment/application by ADRC staff) a) No. of ADRC Clients newly enrolled into a Medicaid HCBS Waiver this reporting period b) No. of ADRC Clients newly enrolled into Medicaid institutional services this reporting period c) No. of ADRC Clients newly enrolled into other public LTC programs this reporting period d) What HCBS Waivers are included above (e.g. aged and disabled, MR/DD)? e) What other public LTC programs are included above?

Attachment J: Definitions

Definitions for this solicitation:

For purposes of this Announcement, an “aging services provider organization” is an organization that is currently operating a program that serves older adults and is funded (at least in part) through the Older Americans Act. A Native American Tribal Organization funded under Title VI of the Older Americans Act may be included as an aging services provider under this grant announcement.

Aged (or Older adult Person): As defined in the Older Americans Act, “an individual who is 60 years of age or older.”

State: Refers to the definition provided under 45 CFR 74.2 any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments.

Broad definition of **Options Counseling** is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer’s needs, preferences, values, and individual circumstances.

Benefits Counseling: The provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medigap policies), Supplemental Security Income (SSI), Food Stamps, Medicare, Medicaid and private pension benefits. For purposes of this program, Benefits Counseling funded under the Older Americans Act that is provided to individuals who need help in order to remain in the community, is included in this definition.

Centers for Independent Living (CIL):
(1) Center for independent living. The term "center for independent living" means a consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that--
(A) is designed and operated within a local community by individuals with disabilities; and
(B) provides an array of independent living services.
(2) Consumer control. The term "consumer control" means, with respect to a center for independent living, that the center vests power and authority in individuals with disabilities.

Coordination With Medicaid Financial Eligibility Determination: The determination of financial eligibility for Medicaid may take place either at the ADRC or off-site. Regardless of where it takes place, the ADRC must assure that the process is coordinated

or integrated with the functions of the ADRC so that it takes place in an expeditious manner that avoids duplication of effort for individuals, their families and agency workers. The result of this coordination should be a seamless system of long-term support as experienced by the individual.

Counseling and Referral to Help People Remain in the Community: The provision of comprehensive and accurate information on services and programs that can help people to remain at home and in the community. These include (a) direct services (such as home and community-based waiver programs, home health, personal care, case management), (b) generic community sources of help (such as nutrition programs, prescription drug programs, health promotion and disease prevention programs, transportation services, home repair programs, real property tax relief), and public or private insurance (such as long-term care insurance, Medicare, Social Security Disability Insurance (SSDI), and SSI). For purposes of this program, counseling and referral activities designed to help individuals to remain in the community that are funded under the Older Americans Act are included in this definition.

Eligibility Screening: Is a non-binding inquiry into an individual's income and assets, as necessary, and other circumstances in order to determine probable eligibility for programs, services, and benefits, including Medicaid. This screening should be provided to all individuals who may be eligible for publicly funded programs.

Crisis Intervention: ADRC programs must be able to respond to situations where short-term assistance is needed to support an individual until a plan for long-term support services can be put in place. For example, an individual whose existing support system has fallen apart may need immediate support to assist them while a more comprehensive plan is developed and implemented. If an individual is in danger to self or others, ADRC will refer to, and coordinate with, existing supports such as Adult Protective Services, in accordance with state laws and agency procedures.

Information on Long-term Support Options: The information available must be comprehensive, objective, up-to-date, citizen-friendly, and cover the full range of available options, including in-home, community-based, and institutional services (including nursing home services). The information must cover options that people will use immediately (such as Medicaid services) to long-range options (such as private long-term care insurance). The information must also cover programs and services that support family caregivers, as well as any special options in the state to maintain independence or direct one's own long-term support services.

Long-term Support Services: Long-term support refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help individuals with disabilities or chronic conditions with activities of daily living or instrumental activities of daily living. Public long-term support services are those administered by a governmental entity. For purposes of this program, long-term support services under Medicaid include home health, personal care, targeted case management, home and community-based waivers under section 1915(c) of the Social Security Act,

nursing facility services, and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). Long-term support services under the Older Americans Act include personal care and other in-home services similar to those provided under section 1915(c) of the Social Security Act. Long-term support services under state-only programs include home health and personal care. Finally, for purposes of this program, the state may include in the definition of long-term support services any other publicly-funded service which the state determines should be accessed through the assessment process of the ADRC.

Long-term Support Options Counseling : ADRCs will help people make informed decisions by assisting individuals and their families in understanding how their strengths, needs, preferences, and unique situations translate into possible support strategies, plans, and tactics, based on the options available in the community. The counseling includes helping individuals assess their needs and resources, the assessment of the needs of family caregivers, developing a plan, and assisting the individual/family in implementing their long-term support choices. Counseling links individuals to other counseling programs and services, including Web-based information and counseling programs. For purposes of this program, Long-term Support Options Counseling activities funded under the Older Americans Act are included in this definition.

One-Stop Access to Public Programs: The organizational ability and authority to provide intake, full access, and comprehensive point of entry to publicly supported long-term support services for individuals who are eligible for, or appear to be eligible for, publicly supported long-term support services, as those services are defined under Section II. A single program performs these functions, along with information and assistance, through a simple, convenient, single contact point. The program may involve more than one entry point (or "site) at the community level (e.g., different access points for different populations) so long as (a) each access point is authorized and performs all functions of a single point of entry, (b) the process of access experienced by individuals is uniform across all entry points, and (c) individuals do not access long-term support services through admission points that do not perform all functions of a single point of entry. One-stop access to public programs also ensures that individuals have the information they need to make informed decisions and that individuals reliant on public support are not admitted to service by alternate means or by direct admission through an individual provider of services.

Programmatic Eligibility Determination: A determination of the publicly supported benefits or services to which a person is eligible, based on non-financial criteria. This may require a formal assessment to determine the full scope of the individual's needs. It may include a functional assessment of the individual's current health conditions and provide a situational assessment of the client's environment, available resources, and current support. For Medicaid services, this function includes the "Level of Care" determination process.

Public Education and Outreach: Activities related to ensuring that all potential users of long-term support (and their families) are aware of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.

A **consumer** is defined as a person of any age or disability who seeks to reside in the community with the support of public funding. Persons included are patients being discharged from hospitals to rehabilitation facilities, nursing homes ICF-MR and other types of institutional settings.

Informal Supports are defined as family members, neighbors or friends whose regular assistance helps the consumer reside in the community. The consumer chooses support from the family caregiver(s) as part of the PCP process for community living.

Person-centered Planning is defined as a plan that empowers people with disabilities by focusing on the desires and abilities of the individual. Person-centered Planning involves a team of family members, friends, professionals and most importantly, the individual. The individual chooses their team members. This team then identifies the skills and abilities of the individual that can help them achieve their goals of competitive employment, independent living, continuing education, and full inclusion in the community. They also identify areas in which the individual may need assistance and support and decide how the team can meet those needs. While it is recognized that not all of the elements of a complete person-centered plan can be achieved prior to discharge from the hospital, many elements can be addressed. Elements, such as working with the patient to develop the most independent living arrangement and providing assistance and supports that are desired by the patient are included. The patient with involvement of family members, professionals and others work toward the ultimate discharge plan goal of living as independently as possible with home and community-based services.

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Informal Community Network is defined as the consumer's current and potential friends and other social connections that do not provide continual care to the person but provide social support and may help intermittently with tasks and chores.
Helpful information may be accessed at the following websites:

- *Caregiver Assessment: Principles, Guidelines & Strategies for Change. Vol. 1.* April 2006. http://www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf
- *Caregiver Assessment: Voices and Views from the Field. Vol. II. April 2006.* http://www.caregiver.org/caregiver/jsp/content/pdfs/v2_consensus.pdf
- *Caregivers Count Too. An Online Toolkit to Help Practitioners Assess the Needs of Family Caregivers.* June 2006. http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1695
- Feinberg, Lynn Friss. *The State of the Art: Caregiver Assessment in Practice Settings.* 11/02. http://www.caregiver.org/caregiver/jsp/content/pdfs/op_2002_state_of_the_art.pdf