No Wrong Door System

An Assessment of Long-Term Supports and Services in Idaho

Prepared for the Idaho Commission on Aging

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EXECUTIVE SUMMARY

"Under Medicare, we are only allowed a short time in a nursing home after a hospital stay. In 2013, my husband fell and sustained a broken neck. He was also a cancer patient. He was discharged to home at 100 days after spine surgery. The cancer doctor said go home with "hospice". However there are NO hospice services on top of the Greer grade, our area. We had to contend with someone who should have still been in the hospital by ourselves. Total care is hard on backs. In the drug store one day a clerk told me to call Area Agency on Aging. Our first and only real help. This was after 3 months without help, another hospital stay for my husband, and another nursing home stay. I am trying to stay alive as the only help for my husband and our son, a diabetic since age 2 on insulin for 59 years. I really appreciate the help from the Agency on Aging and wish I had known of it sooner. Thank you".

The voice of an Idaho Senior

This document presents the findings from a two-part needs assessment of Idaho's system of long-term services and supports. The first part of the needs assessment focuses on feedback from the stakeholders currently engaged in the Aging and Disability Resource Center (ADRC) project. The survey focused on the ADRCs and their partner organizations across the state to examine the current environment to implement a No Wrong Door (NWD) System in Idaho. Twenty-six agency directors and managers from across the long-term care spectrum were interviewed. They provided their own organization's information sharing methods and the array of services and supports they provide. The interviews also gathered input on the components of a NWD System and identified the perspective of each stakeholder for such a system.

The second part of the assessment involved gathering information from 2,605 individual Idahoans over the age of 60 or between the age of 18 and 60 with disabilities. These were respondents to a survey conducted via 12,963 paper surveys distributed through the Senior Center Meal sites and the Centers for Independent Living (CILs) and an online version with a link posted on the ICOA website and sent out to long-term services and supports (LTSS) networks and providers.

These two methodologies allowed the examination of Idaho's LTSS system from both a macro and micro level and permitted comparisons of the two. The interviews and survey results revealed a wealth of information that will be valuable in developing ADRC strategies moving forward with system improvements. The data identified both opportunities and strengths in this process and also show where the challenges and obstacles lie in guiding the development of a plan.

The following are the key findings of this assessment:

1. **There is no shortage of LTSS information.** The issue is getting it out and to the right people at the right time in the right format. Most survey respondents indicate they rely on newspapers (58.1%) and friends and family members (57.6%) for information about LTSS. Agencies and organizations tend to share information by websites, email, social media, and printed materials. Several agencies and organizations pointed to 211 Careline as an information source but the survey found that it is used by only 2% of seniors and people with disabilities respondents. The challenge will be to find the intersection between providers and users that will maximize the sharing of information.

2. **Senior Centers are important to many elder Idahoans**, mainly for meals and socialization. Although 60.7% of the survey respondents indicated that they get information on LTSS from Senior Centers, many of them recognize that the centers could be even more valuable by using them as information hubs, providing classes, having presentations, and other ways of providing information about LTSS, eligibility, costs, and different options.

3. **Organizations operate in silos**, sometimes even within the same agency. Formal and informal barriers impede expanded working relationships among agencies, many with the same constituencies. Some of these are easier to overcome than others but most people interviewed recognized the merit of trying to do so. Working collaboratively to serve Idaho's senior and disability community may be cumbersome initially but, in the long run, will improve ease of access and quality of service.

4. **ADRC is an unfinished product**. This model makes sense philosophically but for many it runs into difficulties operationally. The Area Agencies on Aging (AAAs) have been designated as the ADRCs for Idaho but there is confusion about what this means, for them and for the CILs with whom they are to work to embrace the D in ADRC. Turf and other issues that emerged in the early discussion and implementation of this effort have been somewhat mitigated but continue to hamper a truly collaborative approach to serving seniors and people with disabilities. Improving this environment requires strong collaborative leadership at the state level, in combination with an understanding at the local level about how this model can work and the benefits it can provide. This will take time, commitment, and a clear, uniform understanding of terminology, requirements, possibilities, constraints, and reciprocal responsibilities. Sharing that information and developing relationships among partners is key.

5. **The pressure on the long-term care system will continue to grow**. Aging baby boomers will create ever increasing demand for a wider range of options and services for a longer period of time. Senior Centers are not the choice for younger seniors who often look to other programs in the community for recreation, socialization and information. This will mean a transformation for the Senior Center concept, perhaps partnering with others like community colleges to expand their reach and appeal. It will mean more long-term services in the community that support people living at home and postponing or avoiding out-of-home care. And it will mean a greater emphasis on health and disease management to keep that growing population of seniors in better health and avoiding more expensive procedures.

6. **Change is happening that presents opportunities** for implementing system structure consistent with the NWD philosophy. The transformation of practice within the primary care system includes the prospect of enhancing the health care community's awareness and understanding of person-centered counseling practice. It also provides the possibility of creating linkages at the regional and local level among public health districts, behavioral health boards, long-term service providers, AAAs, CILs, and others. These local/regional partnerships will hopefully build relationships and improve knowledge of one another's programs to move toward a continuum that links primary care, behavioral health and long term services.

7. **Streamlining access to care requires collaboration and innovation**. In the long-term care system and beyond, each agency or program has its own eligibility criteria, intake process, database format and content, service delivery model(s), and monitoring standards. Recognizing that many people served by one agency are served by others, some efforts have been made toward streamlining. The Self Reliance application in Department of Health and

Welfare (DHW) is the gateway for multiple services. The health care portion of that application is linked with Medicaid and Your Health Idaho and can now be submitted online. This approach could serve as a model for other programs or perhaps as a partner with them.

8. **Technology is an important resource in the LTSS arena**. Public outreach, coordinated applications for service, staff training, service plan management (including quality assurance) are just a few of the ways that emerging technology developments can benefit providers and consumers of long term services and supports in Idaho. Colleges and universities provide a ready source of expertise, innovation, and research that this effort can draw upon. A majority of seniors and adults with disabilities have internet access at home (55.5%) and 19.2% state they get LTSS information from websites. These numbers can be expected to grow.

9. **Family caregivers must be included**. Families provide a large percentage of the long-term caregiving in Idaho. In doing so they are saving the state dollars and providing a richer life experience for their family member. But as was seen in survey responses and in information shared by the Alzheimer's Planning Group and the Family Caregiver Alliance, that savings to the state often comes at a cost to those providing care. Exhaustion, burnout, and worse are the result of caregivers who do not or cannot care for themselves. Programs like *Powerful Tools for Caregivers* provide valuable information and strategies for family caregivers but if people cannot get away to attend these classes or to just get a break, it can end up costing the system more. Caregivers need to know some of the emerging practices in long-term care so that they are better able to support the person to stay as independent as possible for the longest period of time.

10. **Public outreach is important to agencies and organizations.** providing health and social services to seniors and adults with disabilities in Idaho. People need to know what services are available, when, where and at what cost. But when budgets and services are cut, agencies are reluctant to reach out knowing that they may be creating demand they cannot meet. At the same time, however, they realize that it is important for policy makers and others to see that demand in order to adequately fund services.

11. **People are open and interested**. All of the stakeholders interviewed have been involved in some system change efforts. They understand the costs, benefits and challenges of change. Most are willing to commit time and effort toward improving long-term care information and services in Idaho as long they perceive it to be realistic, organized, focused, and dynamic. They do not want to attend meetings where nothing is done or to engage in a process that keeps getting side-tracked by other agendas. They appreciate that most of the key stakeholders are at the table and are talking together about system improvement. They are willing to share resources if it is doable and if the process is a true partnership.

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BACKGROUND

The Administration for Community Living (ACL) and the Centers for Medicare and Medicaid Services (CMS) have provided grants to states since 2003 to develop person-centered systems of access, known as "Aging and Disability Resource Centers" (ADRC), "No Wrong Door (NWD)" system, to make it easier for individuals to access Long-Term Services and Support (LTSS) options. These programs are designed to serve as visible and trusted sources where people access objective information on their LTSS options including Medicare benefits, as well as one-on-one counseling to ensure that consumers, including private pay individuals, fully understand available options to meet their needs and preferences.

Idaho Commission on Aging (ICOA's) outcome of this process is to complete a NWD assessment to identify the strengths, weaknesses and barriers in the aging and disability network in Idaho. Through collaboration with state and local agencies, the NWD Assessment will identify potential solutions needed to integrate agencies' policies and procedures to implement a NWD long-term-care information and resource system. The NWD Assessment will also be used as the foundation to develop a three-year strategic plan that will continue to keep stakeholders engaged in the NWD system

The NWD Assessment is intended to:

- Identify what needs to be in place to set a foundation that is both fundable and measurable
- Identify long-term-care resources
- Coordinate existing efforts
- Provide a fresh look at the NWD system

Establish a positive and meaningful stakeholder engagement process that builds on continuous stakeholder feedback and follow through.

INTRODUCTION

In October of 2014, the Idaho Commission on Aging (ICOA) received funding specifically designed to help support states in developing a comprehensive strategic plan for the No Wrong Door (NWD) long-term-care supports and services (LTSS).

The NWD System is a collaboration of organizations working to improve access to LTSS by coordinating referrals and providing individuals with guidance in long-term care planning. Project partners include the Idaho Division of Medicaid, the State Independent Living Council (SILC), and the Idaho Council on Developmental Disabilities (ICDD).

The next step in this process was for the ICOA to engage in a NWD Assessment to identify the strengths, weaknesses and barriers in the aging and disability network in Idaho. Through collaboration with state and local agencies, the NWD Assessment will identify potential solutions for the integration of policies and procedures needed to implement a NWD long-term-care information and resource system. The NWD Assessment will be used as the foundation to develop a three-year strategic plan that will continue to keep stakeholders engaged in the NWD system.

The NWD has four major components:

- Public Outreach and Links to Long Term Care and Resources
- Access to and/or Training on Person-Centered Counseling
- Streamlined Access to Public Programs
- Shared Governance and Oversight of the NWD System

ASSESSMENT METHODOLOGIES

From February 2, 2015 through April 3, 2015, the ICOA through its contractor, the Frontier Group, LLC, conducted an Idaho NWD Needs Assessment. The data gathering involved two components:

- **In-person Stakeholder Interviews**
- **Online and Paper Participant/Caregiver Surveys** of seniors over 60 and adults with disabilities, age 18 and older and, where applicable, their caregivers.

Stakeholder Interviews

ICOA staff began the Idaho NWD Stakeholder engagement process in December, 2014. A group of stakeholders was identified and met to develop a mission and vision, discuss Person-Centered Counseling and begin early planning for stakeholder engagement. The deliverables from this work were reported to ACL on 1/31/2015.

ICOA staff and contractor formulated stakeholder interview questions to ensure, to the extent possible, a consistent gathering of information. (**Appendix A)**

The original stakeholder list was expanded to enrich the content and depth of the interviews **(Appendix B**). Each stakeholder was sent a letter from the ICOA Administrator, informing them of the project and requesting their participation in an interview. This was followed up by a phone and email confirmation by the contractor to schedule the interview.

Each of the stakeholders was given the interview questions in advance, and had a different perspective and level of involvement with the long-term care system and the work of ICOA. Some stakeholders had minimal knowledge of the LTSS system which limited their response to some of the questions. But it did provide the opportunity for sharing information and increasing awareness about the LTSS system.

Each interview lasted between 1-3 hours and all participants were helpful, candid, and informative. The results from the interviews were transcribed and summarized; that information is included in the Stakeholder Resource section and their comments on the ADRC/NWD system are incorporated in the Stakeholder Response to the NWD System section.

Participant/Caregiver Survey

The survey instrument that was developed used basic questions for gathering demographic information (zip code, date of birth, health status, living situation, transportation, and access to information) and then provided a list of long-term supports. Each person identified the supports and services they currently receive, those that they need but do not receive, and barriers they have. This was followed by a question about where they go for services and what recommendations or suggestions they have for improvements.

Input was sought on the content and format of the survey. Suggestions were incorporated to every extent possible. Of particular importance was that the survey was easy to read and understand and short enough to not discourage response (no more than 3 pages.) See **Appendices C** and **D** for the survey in English and Spanish.

The survey was distributed in two formats – on line via Survey Monkey and on paper. The paper copies were distributed to every senior meal site in Idaho with introduction and notification provided by the AAA Director in each area. Paper copies were also provided to the three CILs. The surveys were sent out with an instruction sheet to each site and a return envelope with a designated due date. See **Appendix E** for a copy of the instructions.

A total of 12,963 surveys were distributed, based primarily on meal counts for senior centers and home delivered meals which were the distribution points for the surveys. In Area V, at the request of the AAA Director the surveys were sent to her office and she distributed them to the 13 sites in that area. In Area II, an additional 100 surveys were sent to the AAA Director to distribute to providers of in-home services who in turn distributed the survey to the consumers. The Area II Director provided the envelopes and the postage for those individual surveys to be returned. The CILs were sent a total of 450 paper surveys but were also encouraged to have their constituents use the online version if it were convenient or easier for them. All other paper surveys were sent to 86 different local senior meal sites.

The survey was open for response from March 9, 2015 -April 1, 2015. A total of 2,605 responses were received, 2,476 paper surveys and 129 online. This constituted a response rate for the paper surveys of 20%. All paper surveys were manually entered into Survey Monkey to allow data management. Further detail and analysis of the survey is in the section dealing specifically with the survey process and data.

IDAHO'S LONG TERM SERVICES AND SUPPORTS ENVIRONMENT

During February and March, 2015, in-person interviews were conducted with 26 individuals representing organizations or programs with an interest in LTSS in Idaho. Each interview attempted to follow a set format (**See Appendix A**) but often included a much wider discussion of information, perspectives, opinion and ideas. Conducting the interviews in each stakeholder's location, allowed the interviewer to gain greater insight into the programs and services they provide but also the culture of the organization. It also provided the opportunity to witness the settings in which the target population might seek and receive information and services.

RESOURCES AVAILABLE THROUGH STAKEHOLDER ORGANIZATIONS

The initial information gained through the interviews involved basic data about the organization, its information sharing strategies and capacity, what services or supports they provided, and what resources could be shared with others. That information is shared here. The following section will outline the interviewee's response to the proposed elements of a NWD System. The information is presented in the order in which the interviews were conducted.

Idaho Health Care Association (IHCA)

IHCA-ICAL is a trade association made up of nursing home, assisted living and intermediate care facility (ICF-ID) providers. The primary role of the association is providing information to its members, including information on rules and regulations, policies, reimbursement, legislation, wage and hour laws, employment practices and laws, and best practice in the long-term care field. They provide this information via a newsletter, website, winter workshop and summer conference. All of these are directed to their members which include most of these facilities in Idaho.

IHCA-ICAL provides education, training, and networking opportunities for its 225 members on topics such as those listed above. They will provide referrals to legal and architectural services for those members seeking that assistance but do not provide those services directly.

Their organizational website and newsletter are for members (facility providers) but they do have the capacity to reach direct consumers. They could provide information for consumers on such topics as the difference between Medicaid and Medicare or how to choose a facility but that is really not the mission of their association. Most consumers are not aware of the association since consumers deal directly with the facilities, most of which have their own websites. Some facilities also have newsletters. IHCA's experience is that consumers do not seek information until they are in a crisis and their choices then become more restricted by their individual situations.

IHCA's semi-annual meetings provide opportunities for sharing information and, in the past, they have had workshop presentations or vendor booths from the ADRC and the Idaho Home Choice/Money Follows the Person (IHC/MFP) grant. Their criteria for presentations at these meetings is the usefulness of the topic in terms of day-to-day operations information for their members.

211 CareLine

211Careline is Idaho's health and human services Information and Referral program. It has been operated by the Idaho DHW for 12 years and prior to that was offered through a partnership

between DHW and United Way. It serves all of Idaho from one location in Boise. There are four numbers an individual can call: 211, 1-800-926-2588, locally 334-5647, and the TTY line, 335-7205. They operate Monday-Friday from 8 am – 6 pm. Staff include a supervisor and 9 agents who handle about 145,000 calls/year. They offer information in both English and Spanish and, using a language line and three-way calling, they have access to other language translations as well. They are currently implementing text messaging (texting 899211) with responses occurring during business hours only. As part of an upcoming system upgrade they will be rolling out a mobile application. 211 is available 24/7 via their website, (www.211.idaho.gov) where people can search all resources by city or county. Their website has about 17,000 hits/month.

There are approximately 4,500 resources in their database, all in the health and human resource field; all of these must offer free, low-cost or sliding-fee-scale services. The resource information they provide is statewide and includes access to such information as dental services, counseling, Head Start programs, etc. They are the main point of contact for reporting welfare fraud, receiving child care complaints, and for the Idaho Child Care Program and the Idaho STARS program.

211 Careline has had a contract with the ADRC to coordinate resources across databases. They have provided training to ADRC staff who in turn trained others in the ADRC network. This will need to be done again with their partners when the system is updated with a new vendor later this year.

211 Careline is engaged in public health awareness on a variety of health issues (colon cancer awareness, summer school lunch programs, Earned Income Tax Credit information, etc.) by serving as the referral number for public service announcements in partnership with entities such as Community Action Agencies or school districts.

Friends in Action (FIA)

Friends in Action, a multi-faceted program of Jannus (formerly Mountain States Group) provides information and support for family caregivers. Caregiver means any adult providing support and assistance to someone who cannot meet their own needs because of chronic illness or disability. Most are families caring for older adults.

The information FIA provides includes referral to services or supports. They are piloting a coaching program funded by United Way helping people find where to go for more information about a specific program or service. They use their information database, their self rescue manual, and community resources such as the Senior Blue Book.

FIA provides an array of services, many delivered by a cadre of trained volunteers. Some are fee-based. Their Education Programs are:

- *Powerful Tools for Caregivers* – teaches family caregivers tools to help manage stress, problem solve, improve communication, connect with resources, and take care of themselves
- *Living Well in Idaho* (Chronic Disease Self Management Program) – teaches caregivers and care receivers ways to manage their chronic illness and increase healthy behavior
- *Annual Family Caregiver Conference* provides information, workshops, presentations, and mutual support and networking for caregivers.

Their Workplace Caregiving Assessment provides businesses with data on the personal and performance challenges of their employees who are caregivers and helps them craft strategies to maintain productivity and employee health.

They offer Supportive Services which include in-home caregiver respite (3-4 hours), Legacy Corps Caregiver Support for respite for military caregiver families, and an array of volunteer supports such as transportation, companionship and minor home safety upgrades.

They are a recognized entity for information for caregivers and their Center for Excellence in Family Caregiving is working to build ties between non-profits, for-profits and public organizations to provide more coordinated supports for family caregivers across the Treasure Valley and the state.

In terms of information and referral, FIA has found that the 211 Careline does not necessarily meet their needs. They have found that the information provided is not always current, accurate, or timely and because it focuses on free or sliding-fee services for low-income individuals, it does not necessarily provide information for those who are seeking help and can pay for services.

Idaho State University Institute of Rural Health (ISU/IRH)

Idaho State University Institute of Rural Health is the lead state agency for the Traumatic Brain Injury Program (TBI) in Idaho. ISU/IRH has received over $2.3 million in Federal TBI Planning, Implementation and Implementation/Partnership Grants. The state has provided nearly $1.2 million in match. The objectives of the grants include the development of a screen for TBI to be used in Community Health Screening, educating parents of children with TBI, dissemination of educational materials about TBI related concussions, and the establishment of relationships with the Tribes in Idaho to overcome barriers to services for TBI.

ISU/IRH shares information through a website, a toll-free phone number, a lending library, and a volunteer ombudsman (Virginia Galizia, a retired ISU dean and TBI survivor). There is no long term care information that is specific to TBI, so they refer to the same programs as any disability. The Brain Injury Association is available for information and support to consumers and families. They advertise the screening clinics through flyers and door hangers in both English and Spanish.

In addition to information and referral, the grant provides:

- *Case management of resources* through community health screens
- *Professional development* by training graduate students to do assessments in their discipline and cross disciplines; graduate students are from Boise and Pocatello programs in PT/OT, Counseling, Speech/Audiology, Dentistry and Psychology.
- *Screening for TBI* through monthly community health screens in Ada and Canyon counties and on the Duck Valley reservation. These clinics are held at a variety of locations (churches, ISU Meridian campus, Boys and Girls Club) and offer screens for HIV, depression, substance abuse, hearing and vision, TBI, general health issues like cholesterol, blood pressure and diabetes; they also offer flu shots and smoking cessation information.

ISU also has the contract with the DHW for the Idaho Center on Disability Evaluation (ICDE) which administers the Scales of Independent Behavior – Revised (SIB-R), the assessment for individuals with developmental disabilities applying for developmental disabilities (DD) waiver services.

Idaho State Independent Living Council (SILC)

The Idaho State Independent Living Council is a group of 22 volunteers, appointed by the Governor for 3-year terms to develop and oversee the implementation of the State Plan for Independent Living (SPIL). The SILC is funded by a combination of state and federal funds. The SILC provides information and referral and is often the point of contact for people with disabilities looking for services. Referrals are made to Disability Rights Idaho, Legal Aid, the CILs,

and others. Because they have not been involved in public policy issues in the last few years, the number of calls in that area have dropped off.

The SILC has worked in conjunction with the Coalition Against Domestic Violence for a number of years. The grant that they had to do this work has ended but they have submitted a continuation grant that also includes partnership with the ICDD) and the Council for the Deaf and Hard of Hearing (CDHH). With a grant from Medicaid, the SILC has been a partner in the Idaho Home Choice/Money Follows the Person (IHC/MFP) Program. Currently they conduct the Quality of Life follow up surveys for participants in that program through a contract with the Northwest ADA Center.

The SILC is currently undergoing some transition with a change of staffing and direction. They do maintain a website and participate in the Able to Work website. They can present at meetings and welcome presentations at their quarterly Council meetings. They have had contracts with the Coalition on Domestic Violence and interface with the ADRCs. Their outreach network is through the CILs.

Area V Agency on Aging (AAAV)

The Area V Agency on Aging in Pocatello is the ADRC for the counties in Southeastern Idaho. As the ADRC, they provide families and caregivers with options for long term care; provide them with help to make their own long term care decisions; help streamline people's access to information, assessment and services; assist Medicare recipients to understand their prescription drug coverage and provide information and assistance about health benefits. Information and Assistance (I & A) is one of the primary services provided by the AAA.

The program provides the following services:

- *Long Term Care Ombudsman* helps problem solve complaints by residents of long term care facilities
- *Medicare/Medicaid* – provides assistance with questions related to Medicare Savings Progam, and the Low Income Subsidy and Fraud Prevention
- *Adult Protection* investigates and works to resolve reports of abuse, exploitation, neglect and self neglect of vulnerable adults ages 18 and older
- *Caregiver Support Program* provides caregivers with information and support through help in accessing services, support groups and training.
- *Respite Care* via contracts with 8 homecare agencies
- *Homemaker Services*
- *Ethnic Outreach* to minority organizations to identify and help them access needed services and education
- *Reutilization Equipment* provides a place to donate and contribute equipment and supplies
- *Legal Assistance* with Medicare appeals, Social Security issues, consumer fraud, probate, spousal impoverishment, landlord/tenant disputes and caregiver issues.
- *Transportation* through vans and public buses for non medical activities.
- *Meals* – both home delivered (for homebound/frail individuals) and congregate in 14 different senior centers in the area.

Due to funding constraints, they are shifting funds to help meet the high demand for respite care and homemaker services and are instituting a GoFundMe campaign on social media to raise funds to meet current needs. They have also received a donation from Valley Wide Cooperative to help pay for home-delivered meals, a grant of $10,000 from the Hospital Foundation, and a grant from the VA to help with HCBS services for veterans.

The AAAV is very collaborative, networking with at least 25 programs and services in their area, including LIFE, the local CIL. They are active in the Community Services Council composed of over 50 agencies that participate, network and share information. They also have a close working relationship with the local hospital. Their *Spidergram* in **Appendix F** illustrates their web of partnerships.

Living Independently for Everyone (LIFE)

Living Independently for Everyone or LIFE is the independent living center for 17 counties in southeastern Idaho with offices in Pocatello, Idaho Falls, Blackfoot, and Burley. CILs are required by their funding authority to provide five core services, including Information and Referral. LIFE provides information about housing, facilities, services, etc., using their own database, although each area office also has local information that they are knowledgeable about and refer people to. Cuts in funding have meant it is more difficult to keep information updated.

The other four core services provided by LIFE are:

- *Independent living skills training*, including parenting skills, budgeting, supervising staff under self direction and managing the Medicaid Fiscal Intermediary (FI) program for people on the A&D waiver; five staff members work on this service. 220 people are served through the independent living (IL) program and 120 people use their FI services
- *Peer counseling* which provides informal companionship and peer support
- *Personal advocacy* which assists people with applications for housing, resolves issues about support animals, works with city programs on the ADA, and manages a SSA payee program for about 200 people including seniors.
- *Transition services* designed to keep people from returning to a nursing home after discharge. This has been done in conjunction with the IHC/MFP program but there have been challenges in arranging adequate follow up services particularly for individuals with behavior issues.

There is strong collaboration among agencies in this area. The Idaho Falls AAA database information is accessible on the LIFE website. LIFE collaborates with the Area V AAA on the Durable Medical Equipment (DME) collection and distribution program and with Medicaid on the Fiscal Intermediary program. They have many joint meetings and the LIFE facility in Pocatello is used by many community and non-profit groups.

Area VI Agency on Aging (AAAVI)

The Area VI AAA is under the administration of the Eastern Idaho Community Action Partnership in Idaho Falls. Information and services provided are pretty consistent with other AAAs around the state. Information and Assistance {referral) is provided but it is not as in depth as it formerly was. Instead of providing a comprehensive benefits counseling program, they now refer callers to Social Security, Senior Health Insurance Benefit Advisors (SHIBA), and Medicaid, which means that there is not a person to help with making that connection. They assess for meals, respite, homemaker and referral.

AAAVI provides congregate and home-delivered meals, homemaker services for frail adults in their homes, respite for 24-hour caregivers, chore services to help ensure people are safe at home, support groups for grandparents raising their grandchildren, non-Medicaid transportation through contract providers, support groups for caregivers, long-term care ombudsman (trained advocate for individuals living in nursing homes). They do not provide AAA services for people eligible for Medicaid since they can get services via Medicaid. They do not have an ADRC funding source and do not provide Options Counseling.

Four of their staff along with three Twin Falls AAA staff will be trained this spring by DHW in the transition training for the Medicaid IHC/MFP program. This will permit them to provide transition services to people leaving hospitals or nursing homes to return home.

They are also working with the AAAV on Veterans Directed HCBS. They have established a memorandum of understanding with AAAV and, after the AAAV staff receive training from the VA, they will train the AAAVI staff. Eastern Idaho is unique since it is split in terms of which regional VA program it works with – about half from the Boise VA and half from the VA office in Salt Lake.

AAA VI collaborates with other community groups e.g, Community Partners (meets monthly and linked to 211 Careline and navigators through Family and Community Services or FACS) and the Bonneville Interagency Council, a organization of 10 agencies that share information and host an annual conference in conjunction with the Idaho Falls Health District. They collaborate with LIFE and the Idaho Falls Hospice program on a program to provide DME.

North Central Idaho Area Agency on Aging/ADRC (AAAII)

The North Central Idaho AAAII/ADRC is housed in the Community Action Partnership in Lewiston and provides information to seniors and others throughout a 10-county region. Being housed in the CAP helps reach them out into the community, be very creative with limited resources, and embrace collaboration. It also reflects their philosophy of abundance and appreciation.

AAAII provides resource and referral information to consumers and caregivers in person and by phone, support to caregivers and consumers by linking with Senior Medicare Patrol volunteer coordinator to assist with questions relating to Medicare, Medicaid, long-term care options and information about the Aged and Disabled (A&D) Waiver. They provide information about long-term care facilities in their region, including types of payment facilities accept. The information is provided through the local Long Term Care Ombudsman who provides advocacy for patient rights in facilities.

The array of services that they provide or partner with others to provide includes:

- *Adult Protection Services*
- *AAA In-home Services* – homemaker, respite, home delivered meals, case management, adult day care
- *AAA Contracted Services* – transportation, legal services, congregate nutrition
- *HOME MEDs* – in home medication reconciliation
- *Ombudsman Program/Volunteer Ombudsman Program* – 30 volunteers in 5 counties
- *Friendship Corps Homebound Outreach* – information and assistance in combination with friendly visiting
- *Loan Closet*

AAA II partners with the Community Health Clinic of Spokane to provide classes on chronic disease self management. They also partner with Aging and Long Term Care of Washington in providing *Powerful Tools for Caregivers* classes. They participate in hospital to home transition through *Project GRACE* (with Americorps VISTA) and *IHC/MFP* with Idaho Medicaid. They assist with outreach for the Blue Cross Medicare Medicaid Care Plan (MMCP) plan for dual eligible individuals in Nez Perce and Idaho counties, hold monthly webinars for training and info sharing, and collaborate with Disability Action Center (DAC).

Disability Action Center, Northwest (DAC/NW)

Disability Action Center (DAC/NW) is the independent living center for 13 counties in northern Idaho with offices in Lewiston, Moscow and Coeur d'Alene. They also serve three counties in

Eastern Washington. In addition, DAC/NW provides outreach and assistance on Thursdays at the Senior Center in Bonners Ferry.

Information and referral is one of their core services. People with disabilities, their family members and caregivers can get information on a variety of disability topics and obtain referrals to help people with disabilities live independently. DAC/NW also provides information and outreach through their website, social media, and advertising for CILs statewide, as well as printed information and one-to-one consultation in their offices.

The other core services that they provide are Personal and Community Advocacy, Peer Counseling and Support, and Independent Living Skills Training. They also offer a DME Exchange, transportation in rural areas (with ITD 5310 grant funds), and information about the ADA and accessibility. They operate the Fiscal Intermediary Service for people on the A&D waiver using Personal Assistance Services and, through a contract, conduct the Quality of Life surveys for the IHC/MFP program.

They have a strong and visible presence in the communities where their offices are located and hold joint staff meetings with the AAAII. They are beginning discussions to do the same with the AAA I.

Area Agency on Aging of North Idaho (AAAI)

The Area Agency on Aging serves the five northern Idaho counties and five counties in Washington State. They are under the administration of North Idaho College (NIC) in Coeur d'Alene. Through their Information and Assistance program, consumers or caregivers can learn about volunteer opportunities, get information about assistance at home for people with chronic health conditions, and report allegations of abuse, neglect or exploitation. They also maintain a website, a FaceBook page, and provide The Caregiver Assistance News.

The AAAI operates an array of programs in partnership with others. Among these are:

- *Community-Based Care Transition Program,* a free voluntary program for Medicare patients that helps with their transition from hospital to community and works to prevent re-hospitalization. This program is in partnership with Kootenai Health and Aging and Long Term Care of Eastern Washington, the ADRC in Spokane
- *Adult Protection* services using a multi-disciplinary team approach in conjunction with DHW, law enforcement and attorneys.
- Participates in the *RSVP Program* (part of AmeriCorps), providing trained volunteers for a variety of community programs
- *Training for Friendship Corps* which provides companion services to isolated seniors
- *Ombudsman Program* providing advocacy services for residents 60 and older who reside in institutional care settings.

Their affiliation with NIC provides them with increased visibility and networking in the community, although they hope to do more outreach. Since 2011, they have had an endowment with the Inland Northwest Community Foundation which provides unrestricted funds for their program. The endowment is current funded at $33,000 with a goal of $100,000.

Boise State University Center for the Study of Aging

The primary role of the Center for the Study of Aging (CSA) at BSU is to work with organizations to conduct needs assessments to help them implement programs for Idaho-based populations. The Lifespan Respite Assessment is on the Center's website. They have also worked with Living Well in Idaho and the Fit and Fall program. They are currently conducting the assessment for the City of Boise on the "age-friendliness" of Boise for seniors aging in place.

The Center is an external resource to individual support organizations that provide services. Some examples are:

- An *annual conference* for caregivers
- *Justice Alliance for Vulnerable Adults (JAVA),* a coalition that meets monthly and holds an annual conference on abuse and neglect
- *Legislative issues* – eg Family Caregiver Alliance and the resolution being presented in the 2015 session
- Participation with and support for the *Alzheimers Planning Group*
- *Interdisciplinary work* within BSU and engaging families in a broader network

Resources available through the CSA are grant writing, policy analysis, technical support, research capacity and providing students as a resource. The Center is self-supporting and does not have an ongoing funding stream (outside of grants which are typically time-limited); Sustainability is always a concern.

AARP

AARP is a national organization with three distinct elements: 1) the non-profit that provides information and outreach (this is the element that the public is most are familiar with); 2) a for-profit that sells insurance plans, primarily Medigap and Part D plans; and 3) a foundation that provides grants to fight hunger, provide tax aid, etc. There is an AARP in every state and the District of Columbia. Their current top priority has been long term care but that is shifting to caregiver support, mostly focusing on non-paid family members. Other priorities include community activities and presence, fraud prevention, Social Security and Medicare, and driver safety ("we need to talk" about taking away car keys).

Over the last few years, AARP Idaho has provided a guide about long term care services and payments that was put together in conjunction with SHIBA. It is uncertain if this will continue due to its high cost and the challenge of keeping the information updated. Instead they may move to providing a caregiver resource book (eg Senior Blue Book). In addition to information and outreach, AARP in Idaho maintains a presence in the legislative arena, educating policy makers at both the federal and state level.

AARP has an abundance of resources available to share, ranging from funding to research to facility space (their offices can accommodate meetings; also help organize conferences).

Division of Vocational Rehabilitation (VR)

The Idaho Division of Vocational Rehabilitation is an agency under the State Board of Education. They have eight offices across Idaho. VR contains three separate programs:

- *Vocational Rehabilitation* which is an individually-based program designed to assist eligible individuals in getting back to work, but it deals with the whole person and not just the ability to find work.
- *Extended Employment Services* provide Community Supported Employment (CSE), long-term on the job supports in integrated settings for people who have developmental disabilities, mental illness, serious emotional disturbance and traumatic brain injury. EES also provides Work Services composed of non-work and training towards employment in segregated settings.
- *Council for the Deaf and Hard of Hearing (CDHH)* is a state council of volunteers appointed by the Governor who advocate on behalf of individuals who are deaf or hard of hearing. This advocacy can be at the individual, community or systems level.

Eligibility for VR services is highly individualized and based on an assessment conducted by a Vocational Rehabilitation Counselor. Examples of VR services are career counseling, job

placement and supports, employee accommodations, on-the-job training, and training programs for students transitioning out of high school into adult life

In partnership with Medicaid, eligible Idahoans have been able to access employment supports through Medicaid waivers. These had been cut in 2010 which drove up the wait lists. After reinstating employment supports, the CSE wait list has dropped from 700 to 200. Medicaid waiver employment supports cannot be used for services in segregated settings.

VR has a number of partners in its work. They cross share program information with DHW, Medicaid, Behavioral Health, and Developmental Disabilities. They provide local information and referral service and funding for individual employment services/supports via Medicaid. They also have contracts with the schools for transition age programs. With the Department of Labor, they share resources and information at the regional level. Through their new enabling legislation, they are required to have common performance measures with specific partners.

State Health Insurance Benefit Advisors (SHIBA)

The State Health Insurance Assistance Program (SHIP) started in Idaho in 1986. It is a federally funded national network and there is an office in every state and territory. In Idaho, it is called the Senior Health Insurance Benefit Advisors or SHIBA. It operates within the Dept. of Insurance and is funded with both state and federal funds. SHIBA provides unbiased Medicare information and counseling to Idaho citizens; they do not sell or promote insurance plans. Additionally, the federal SHIP grant requires programs to provide information and counseling on long-term care insurance. In collaboration with AARP they publish a long term care guide.

SHIBA helps people apply for Medicare and, if needed and appropriate, perhaps Medicaid, and other federal programs like Social Security. They also provide information about and assist people to access the following programs:

- *Social Security Extra Help Program* that helps people with their Part D co-pays and deductibles.
- *Medicare Savings Program*, a group of federal program administered by DHW for people with limited incomes on Medicare. The four programs are Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled Working Individual (QDWI). These programs pay Medicare premiums and possibly copays and deductibles.

SHIBA operates on an extensive volunteer program (neighbors helping neighbors). They provide regular training (30 hours initially with quarterly trainings and monthly webinars). They have 150 volunteers statewide and 130 of those are trained counselors, many in Idaho's small communities.

SHIBA has three offices (Boise, Coeur d'Alene, and Pocatello); they have closed their Twin Falls office and serve that area with staff in Boise and Pocatello and trained volunteers in the Magic Valley. They have a toll free number and people can access information face to face by making an appointment with a SHIBA counselor. Staff consists of 8 coordinators, 2 administrative support staff, and a supervisor. There are 2 staff in each regional office and the remainder in Boise.

Idaho Legal Aid Services (ILAS)

Idaho Legal Aid Services is a nonprofit statewide law firm dedicated to providing equal access to justice for low income people through quality advocacy and education. They operate on grants from Legal Services Corporation (LSC) which, in combination with local partners, determines the priorities that are worked on in each funding cycle. LSC is a private, non-profit corporation established by Congress in 1974 to provide funds to entities in the states to provide civil legal services to low-income people. Community partners and judges provide input into their

priorities. 90% of those served through Legal Aid are low income but there is a broader mandate for seniors that permits them to serve seniors who are not low income.
Information is available at their seven offices across Idaho (printed materials, person-to-person consultation), and their website: http://www.idaholegalaid.org/. They are prohibited from taking certain types of cases and cannot charge a fee.

Idaho Legal Aid provides information and outreach in their priority areas. The following are examples of services that they can provide:

- *Housing* – evictions, public housing, Fair Housing Act complaints (seniors, people with disabilities), manufactured housing issues, foreclosures
- *Family law* – Food stamps, county services, some Medicare issues, domestic violence, stalking, protection orders
- *Public entitlements* – Medicaid (LTSS and long-term care), Social Security (in some offices), SSDI
- *Guardianship* – protection orders, custody, disability, seniors/Kin Care (grandparents caring for grandchildren), abuse, exploitation of vulnerable adults (also in "Family Law")

ILAS also has some regional, time-limited grants to work on specific issues and they have two grants to work with minority populations. They are also working with the United Way in the 6th judicial district on consumer protection issues like predatory pay-day loans and preventing scams.

Legal Aid currently contracts with ICOA to provide the Senior Legal Aid Hotline which is staffed with two Legal Aid attorneys and they collaborate with ICOA on Scam Jams to prevent abuse and exploitation.

Office on Aging at College of Southern Idaho (AAAIV)

The Office on Aging at the College of Southern Idaho in Twin Falls is the Area 4 Agency on Aging (AAAIV)and provides services through 14 staff members and cover eight south central Idaho counties. The aim of the agency is to provide services for individuals ages 60 and older to help them live a high quality of life at home with the supports they need. They provide information and assistance through email, phone, fax, mail and in person regarding a range of services and topics. As their resource list, they use the SAMS database, Excel, 211 Careline, the Hospital resource database, the ICOA website, and internet resources. They do not print a resource book due to expense and that it quickly becomes outdated. They do, however, print out resources from their databases upon individual request.

The AAAIV provides access to a range of services and supports including:

- *Home delivered meals and congregate meals* in 17 different sites in 15 Senior Centers
- *Homemaker services*
- *Respite care*
- *Adult Protection*
- *Ombudsman*
- *Support groups* (widowed wellness, grandparents as parents, caregiver, etc.)
- *Home modification* (in partnership with Interfaith group); don't use assistive technology project resources although LINC has loaner assistive technology program
- *Senior Corps* which includes
    - Senior Companion program (provides visiting and occasionally limited transportation)
    - Foster grandparents
    - Seniors Assisting Seniors, a 30-year program that provides transportation and assistance to help the person access the community

    - RSVP volunteers
- The local 5310 public transportation funds go to LINC for their voucher program; 5311 transportation funds go to TransFour, the local public transportation provider operated by CSI for non-fixed route buses in Twin Falls and Jerome counties and occasionally Burley

Informal supports must be used first before they use AAAIV funds for services. They are able to meet the needs of the AAAIV services but it's the gaps that they can't cover. They have no waiting list for Respite Care and Homemaker services and are starting to do more outreach.

The ADRC has been a very confusing concept; they regard it as an "unfunded mandate" since they cannot use Older Americans Act funds for those services. Options Counseling is now referred to as Person Centered Counseling, but implementation is confusing. Clarification and direction is needed.

Living Independence Network, Inc. (LINC)

LINC is a cross-disability, non-residential, consumer-controlled and community-based organization. It operates three offices in Boise, Caldwell, and Twin Falls. A majority of the staff and board of directors are people with disabilities. LINC is part of a national network of independent living centers across the U.S. and one of three in Idaho. With the reauthorization of their funding and reorganization at the federal level, they are now are included under the Administration for Community Living (ACL), the same agency that has authority over Older American Act funds and Commissions on Aging.

LINC is required to provide five core services, including Information and Referral. They use an area-wide comprehensive resource database that is maintained by staff who receive training on its use. It includes information on crisis, housing, food, shelter, transportation, health care, and assistive technology. A person may call in for information or receive help in person at their office. Staff always assumes competence, exploring and discussing the person's needs to help determine the real issue(s) and may offer alternatives to institutional programs. They will sometimes refer to 211 but if the issue is disability-related, 211 often refers back to LINC.

The four other core services that LINC provides are:

- *Peer support*, a "buddy system" approach to helping people navigate systems
- *Independent living skills training*
- *Individual and systems advocacy*, including advocating at the state and national policy level
- *Transition/diversion* (new effective 7/1/2014) has three components:
    - Transition out of facilities
    - Preventing institutionalization
    - Youth transition from school to adult life

The peer support program and independent living skills training offer classes in topics such as budgeting, health precautions/food handling, etc. They use a curriculum from the University of Montana called Living Well with a Disability/Working Well with a Disability. They also use guidance from the Independent Living Research Utilization (ILRU) program to help people become more independent such as teaching them how to use the bus system. In the Magic Valley, LINC operates a transportation voucher system with 10 vendors who provide rides to people with disabilities at a discounted rate. LINC also operates a Fiscal Intermediary/Personal Assistance Program for people on the Aged and Disabled Waiver. Through this they provide access to state plan Personal Care Services (PCS), attendant care, companion services, chore and homemaker services, and others. These may be paid by Medicaid (if the person is eligible) or private pay.

LINC was an early participant in the ADRC efforts which did not include independent living. This created some difficulties that, although somewhat mitigated, remain a barrier to full trust and cooperation.

Division of Behavioral Health (DHW)

The Division of Behavioral Health within the Department of Health and Welfare provides direct services in seven regional Behavioral Health Centers with satellite centers and two state hospitals. They also operate a nursing home unit (Syringa House) at State Hospital South. The calls they receive are situational and are generally referrals from 211, friends of people with mental health or behavioral health problems, hospitals, police, etc. They rely on various resource manuals including the self-rescue manual, VA resources and others.

Behavioral Health provides services to any adult (18+) in crisis and any individual with a severe and persistent mental illness (SPMI) who is not insured. The person could receive medications, crisis counseling, and case management. Very few adults age 60 and older are served because they are on Medicare; their issues are frequently dementia and other related health issues. When individuals are found to be a danger to self or others, they may be put on a mental health hold for evaluation by a Designated Examiner who assesses the person and the situation and figures out what to do. Following the evaluation, there is very little in terms of a support system in the community to help this population. People should not have to be committed to the state to get services but there is often no one to take responsibility. They do try to work with the family and others to provide that support for the person but Idaho has no protective custody law/capacity and Adult Protection is not much help.

The regional clinics are used to deflect crisis through emergency case management They may have a relationship with local resources (like Allumbaugh House) who agree to work with people for a specific length of time while they are waiting to get insurance or get into a clinic; some are recently discharged from inpatient services.

Behavioral Health is looking to establish a partnership with public health in the SHIP collaborative model. Regional Behavioral Health Boards could have representation on the Regional SHIP Collaboratives and provide a place for behavioral health in the Medical Neighborhoods that are being developed around Primary Care Medical Homes (PCMHs).

Veterans Health Administration, Boise VAMC, Behavioral Health Section

The Veterans Health Administration (VHA) provides callers (the veteran, spouse, caregivers, agency personnel, facility personnel) general to specific information about long term care and benefits available to veterans. The level of detail of information depends on the caller, HIPPA, level of confidentiality, and the presence or absence of a release of information. The VHA educates on long term care options at VHA Community Living Centers, State Veterans Homes, Skilled Nursing Facilities, Assisted Living Facilities, Medical Foster Homes, and Certified Family Homes. They provide education on pay source, and this is situation dependent. They facilitate discharge from the VHA hospital, admission to any/all above mentioned facilities, and liaise with the veteran/family, and provider.

They provide information on long term care supports and services to remain in the home, including VHA or State, or community supports for homemakers, home health aide, in-home or institutional respite and Adult Day Health Care.

When Veterans enroll they are assigned to a priority group which the VA uses to balance demand for services with resources. Depending upon veteran enrollment eligibility, the VA provides a range of services including clinical primary care, specialty medical care, mental health care,

inpatient medical or psychiatric hospitalization and inpatient or outpatient rehabilitation for substance abuse disorder. Depending on circumstance, VHA Boise can provide short term medical rehabilitation, skilled care, palliative care or hospice care. As needed, if the criteria is met, VHA can initiate all of the non-institutional, non-skilled care mentioned above as well as in-home skilled care or hospice care. In special situations, based on high service connection, VHA can also provide long term care in contract nursing home care facilities. VHA works with local organizations to deliver non-institutional care. Factors such as income, level of service-connected disability, service in combat theatres, are all considerations in determining what types and levels of services a Veteran may receive.

Institutional hospice is provided at the VA to enrollees in the Community Living Center (CLC) program or in a contract nursing home. For long-term care in the home, Medicare or the person's individual insurance is billed first and VA second. (VHA encourages veterans and their families to use their individual insurance first. VA is not an insurance policy, but specific funding resources can be used if insurance is exhausted or absent). Contrary to popular myth, the VA does not provide care from discharge to death. This can be a problem because Veterans may assume that coverage. In fact, 65% of them do not purchase Medicare Part B, leaving them vulnerable if they are not eligible for VA services.

The service area for the Boise VHA is across southern Idaho, eastern Oregon and north through Idaho County. Southeastern Idaho is served by the Salt Lake City VAMC and northern Idaho by Spokane and Walla Walla. The Boise VAMC has fiveout patient clinics in its service area in addition to the main campus in Boise.

Two services locally that may interface with the NWD initiative are:

- *Home-Based Primary Care (MBPC)* – clinic for Veterans who chronic conditions that make a campus visit difficult; these home-based clinic services are for individuals whose conditions do not qualify for skilled home health care; there are currently 130 individuals receiving this service provided by VA staff, not contract personnel
- *Medical Foster Homes* – Certified Family Homes for Veterans but limited to 2 residents and privately paid; providers must currently adhere to both DHW and VA requirements.

Idaho Council on Developmental Disabilities (ICDD)

The Idaho Council on Developmental Disabilities (ICDD) is a planning and advocacy agency governed by a 23-member group of volunteers appointed by the Governor. Council members are parents, self-advocates, agency representatives and others who work to improve the quality of life and access to needed services of Idahoans with developmental disabilities and their families. They encourage citizen involvement in policy making and promote innovation in service delivery, driven by the values of integration/inclusion, equality, independence and respect.

The ICDD provides information to a wide range of constituencies from people with disabilities and their families and service providers to policy makers and researchers. They maintain a website and Facebook page, provide publications on several disability and non-disability related topics, publish newsletters and an Annual Report, and, in partnership with others, host Disability Advocacy Day workshops each fall and Disability Advocacy Day at the Legislature each session. They field a number of phone calls and email inquiries about disability issues and use their own resources, the knowledge of staff, and the relationships with others to answer questions and keep people informed.

The ICDD does not provide direct services but does provide trainings and workshops, provides funding for conferences, convenes groups and coalitions to study disability issues or advance policies, and collaborates with partners on system changes. The Collaborative Work Group on

Services for Adults with Developmental Disabilities and the Employment First Initiative are two collaborative systems-change efforts that provide models of operation for a NWD effort.

In 2007, the ICDD also received a CMS Person-Centered Planning (PCP) Implementation grant that was used to develop and deliver a comprehensive training curriculum on the PCP through the Center on Disabilities and Human Development (CDHD) at the University of Idaho. The grant also was used to develop a web-based resource directory which has been maintained by the CDHD.

Idaho Division of Medicaid, Bureau of Long-Term Care and Idaho Home Choice Program (DHW)

The Division of Medicaid is the primary payer for services for people with disabilities or low-income in Idaho. For individuals who meet long-term care eligibility criteria, these services cover a wide range and include nursing home care and A&D HCBS as an alternative to nursing home services. They provide information about the services they cover via phone, printed materials and their website. The 2-1-1 Careline also provides a vast amount of information regarding all of the programs managed by the Bureau of Long Term Care.

The Bureau of Long Term Care, under the Division of Medicaid, administers the Aged and Disabled and State Plan Waivers, Private Duty Nursing, Katie Beckett and nursing home programs for participants residing in the community, nursing homes, or assisted living facilities. The Bureau monitors quality assurance and coordinates with the Medicaid staff responsible for operations and policy implementation. The IHC/MFP is under the Bureau of Long Term Care and provides additional services and benefits at the time that an individual transitions from institutionalized care to Home and Community Based Services. The IHC/MFP is grant funded and time-limited with an expected end date in 2020.

In terms of sharing database resources, this would involve a comprehensive discussion and understanding of who needs access to what and when and for what purpose? Medicaid does collaborate with Dept. of Labor and Social Security Administration in terms of sharing information about eligibility, etc. Medicaid provided $325,000 for IHC/MFP to work with the SILC and ICOA to develop standards for Options Counseling. Being able to submit an application online for Medicaid eligibility for health services is now in place.

Other Bureaus within Medicaid and Divisions within the DHW also provide some information, resources, and services to Idaho adults and children. The Medicaid Division also has two stakeholder groups that provide public and provider input into their programs. The two groups are the Medical Care Advisory Committee or MCAC and the Personal Assistance Oversight Committee or PAOC.

The Division of Licensure and Certification, formerly part of the Division of Medicaid, oversees assisted living facilities and certified family homes; a Community Care Advisory Council, composed of representatives of the Certified Family Home (CFH) and Residential Assisted Living Facility (RALF) provider community together with advocates and consumers of services provides input into the administration of that program.

St. Alphonsus Primary Care Medical Homes (PCMH)

St. Alphonsus Regional Medical Center operates fifty-five primary care clinics in southwestern Idaho and eastern Oregon. They are participating in the SHIP effort and have converted three of their clinics into PCMHs and plan more transformations in the coming year. The model uses provider-led Care Teams where the provider, a Medical Assistant and a Patient Service Representative provide care for a panel of patients. The focus is on wellness and prevention and

patient responsibility. They have RN wellness coaches and are looking to bring on social workers as part of their "whole person" model. There is potential for linkage with long-term care as they work toward to a "medical neighborhood" for all patients. They expect challenges to this conversion with medical professionals who adhere to the traditional doctor/patient approach but with the volume of patients expected to grow exponentially with aging baby-boomers, the medical home is anticipated to be the model of the future. It also lends itself to a managed care approach vs. fee-for-service which is being embraced nationally and in Idaho.

In addition, they are participating in the Idaho Health Data Exchange (IHDE) which permits sharing of patient data among members. Not all hospitals (or clinics) participate in the IHDE but the goal is a web-based database that can make information sharing easier while protecting patient privacy. This member-accessible database could be a model for sharing information across systems in a NWD initiative. A challenge to implementing this model could be the involvement of policymakers and others who see this as government overreach and intrusion into private individual information.

State Healthcare Innovation Plan (SHIP)

The Idaho State Healthcare Innovation Plan or SHIP is a multi-year effort aimed at transforming Idaho's primary care health services from fee-for-service, volume-based care to a payment system based on value and improved patient health outcomes. This effort began in 2013 with stakeholders coming together to develop a plan for transition. In 2014, the Governor established the Idaho Healthcare Coalition (IHC) which continued the stakeholders work. IHC members include private and public payers, legislators, health system leaders, primary care providers, nurses, healthcare associations and community representatives. The SHIP is aimed at primary care for ALL Idahoans. It has seven goals:

1) *Transform primary care practices* across Idaho into patient-centered medical homes (PCMHs) focusing on prevention, healthy practices, and stabilization of chronic conditions.
2) *Improve rural patient access* to PCMHs by developing virtual PCMHs, by training community health workers and using telehealth services.
3) *Establish seven Regional Collaboratives* to support the integration of each PCMH with the broader medical neighborhood. These will be convened by the public health districts with contracts starting 7/1/2015.
4) *Improve care coordination through the use of electronic health records* (EHRs) and health data connections among PCMHs and across the medical neighborhood to improve sharing of patient information among providers.
5) *Build a statewide data analytics system* to inform policy development and monitor the system transformation
6) *Align payment mechanisms across payers* to transform payment methodology from volume to value including participation by BC, Regence and Pacific Source – along with Medicaid – in a model test.
7) *Reduce healthcare costs,* with an anticipated cost reduction of $89 million over 3 years.

Idaho received a four-year grant of nearly $40,000,000 to begin this system transformation. The first year is "pre-implementation", getting staff (8 within DHW) and contractors in place and supporting the efforts of the IHC and the workgroups. They are targeting 55 clinics per year to convert to PCMHs.

SHIP will not be providing funds for direct patient care for people who are uninsured. Instead, the federal funds will be used primarily to provide training and support to primary care practices that commit to transforming their clinics to PCMHs.

Some of the aspects of the SHIP that lend themselves to collaboration with a transformed LTSS system are:

- *Regional Collaboratives* work with AAAs and CILs on preventing/mitigating gaps between PCMHs and LTSS at the local level
- *Idaho Health Data Exchange* – streamlining patient info across providers might eventually open up to LTSS providers
- *Telehealth* options could augment LTSS in rural areas
- *Patient-centered practices* could align with person-centered counseling as advocated by AAAs and CILs.

Idaho Division of Welfare, Self-Reliance Program (DHW)

The Self Reliance Program within the Division of Welfare is responsible for the application that determines eligibility for a variety of DHW services. DHW is the front door process for access to many services for many individuals. They provide information on how to become eligible, long term care, Medicare Savings Program (provides a subsidy for low income elderly to purchase their prescription medications), waivers and others. Their application includes information on both financial eligibility and service eligibility for programs ranging from Medicaid services to food stamps to subsidies for child care. The application is available to complete in person at DHWregional offices or on line; effective November, 2014, the application became accessible online for the health care portion only. This was directly related to Affordable Care Act (ACA) requirements for aligning insurance purchased through the health care exchange (Your Health Idaho, YHI) and Medicaid. When someone applies for insurance through YHI, it determines whether the person is eligible for an insurance subsidy or Medicaid or neither. If the person is eligible for Medicaid, they would be referred to that program and Self Reliance handles that application. The intent is to expand the capacity for online application submissions beyond the health care portion to the other portions over time. Go to http://healthandwelfare.idaho.gov/FoodCashAssistance/ApplyforAssistance/tabid/1554/Default.aspx for information on managing the application or reevaluation for assistance.

Area III Agency on Aging (AAAIII)

The AAA III covers southwest Idaho, which includes the counties of Ada, Elmore, Owyhee, Payette, Washington, Adams, Boise, Canyon, Gem and Valley.

Through the Information and Assistance program, AAA III distributes information on the full-range of long term care resources, with the focus is on the senior population. Examples of information provided through the I&A program are housing, SHIBA, low-income subsidy and resources, Medicare Savings Plan, transportation, home-delivered meals, Medicaid, caregiver resources, Alzheimer's information and local disability resource information. The staff have the ability to warm transfer calls and they utilize a resource data base separate from the 211 Careline.

AAA III staff provide the following services: Adult Protection, Ombudsman and Information and assistance. Homemaker, Respite, Chore, Family Caregiver, and Home Delivered Meals are all provided through contract providers.

AAA III currently implements the Veterans Directed Home and Community Based Services (VD-HCBS) program. AAA III is also the recipient of the Medicare Improvement for Patient and Providers Act (MIPPA) grant through the ICOA. This allows staff to provide outreach and distribute information on the Medicare Savings Program. Some of the staff are also certified as Transition Managers for the IHC/MFP program (Medicaid).

Since July 1, 2014, AAA III has not been under a parent organization and is being run by the state. A new contractor will be selected soon. Some time may be needed for the entity to establish an identity when the new contractor is selected.

FOCUS GROUP

Justice Alliance for Vulnerable Adults (JAVA)

The Idaho Justice Alliance for Vulnerable Adults (JAVA) is a network of organizations and individuals working to prevent elder abuse through action and education. JAVA's vision is to help its members work together towards where every vulnerable adult is visible and valued. The organization's mission is to strengthen community partnerships and resource networks to ensure the dignity, safety, and quality of life of vulnerable adults through advocacy, education, intervention, prevention, and policy development.

Highlights of JAVA activities include partnering with ILAS to develop and distribute the Idaho Senior Legal Guidebook, co-sponsoring the annual Idaho Summit on Elder Abuse and Exploitation, and working with the Idaho Crime Prevention Association and Peace Officers Standards and Training organization to provide training on prevention of abuse of vulnerable adults throughout the state. In addition, JAVA sponsors bi-monthly meetings designed to exchange information and strengthen the network of professionals working to assure that every vulnerable adult in Idaho is visible and valued.

JAVA, established in 2010 with support from the National Committee on Elder Abuse, is housed in the CSA at Boise State University. It provides a forum for sharing information on abuse and neglect among its members at meetings, during the annual summit, and via email communication.

Fifteen JAVA members served as a focus group in their meeting on March 8, 2015 to provide input into the NWD system, focusing on its potential strengths, weaknesses, obstacles and opportunities. That input is incorporated with the information gathered through the interviews.

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STAKEHOLDER RESPONSE TO NO WRONG DOOR SYSTEM ELEMENTS

Through the interviews with 26 stakeholders across Idaho, input was gathered regarding the strengths, weaknesses, obstacles, and opportunities for long-term services and supports presented in each of the components of the NWD.

NWD has four components:

A. Public outreach and links consumers to key long-term care information and resources

B. Provides Person-Centered Counseling

C. Streamline access to public programs

D. Incorporates shared governance, resources and oversight among

A. PUBLIC OUTREACH AND LINKING CONSUMERS TO LONG-TERM CARE INFORMATION AND RESOURCES

1) STRENGTHS

a) **211 CareLine Resource Database**: Many positive elements are in place for outreach and information sharing regarding long-term services and supports in Idaho. 211 Careline is frequently mentioned as a statewide resource for people to call for information. 211 Careline operates a toll-free phone line 24/7 and a website that can also be accessed for information. They are also the "call in" number for different advertising campaigns on specific health-related topics (smoking cessation, immunizations, etc.), which increases their visibility with the general public. 211 Careline's target is low-income Idahoans with a historical emphasis on families with children. It does, however, provide information for adults and can "warm transfer" callers to other resources which ensures that the referral is made. 211 Careline does require that it's organization resource listings offer free, reduced cost, or sliding-fee-schedule services.

b) **Supplemental Resources Lists from Other Organizations**: Organization resources are often supplemented by resource lists maintained by individual organizations that include information specific to their area of expertise. CILs have more in depth disability information than does 211 and often are referred to by the 211 operators. AAAs have information related to issues of concern to seniors. For those AAAs in community action agencies or Councils of Government (COGs), they have some natural linkages to communities that expand their ability to share information beyond their traditional population. 211 Careline also has many of those community resources in its data base.

> *There is a lot of good information out there and many organizations who can and want to help.*

c) **Outreach Provided by LTSS Organizations**: Nearly every organization interviewed had a public outreach and awareness component. Most have websites, use social media in some capacity, produce newsletters and other printed materials, and provide one-to-one information to callers. Some, like SHIBA and AARP, produce comprehensive guide books

while other choose to print out materials upon request because of the expense of printing a publication. DAC/NW has purchased air time on public television for public service announcements for all three of Idaho's CILs.

d) **Collaborative Efforts**: Joint meetings and conferences provide another avenue for collaboration in outreach. The ICOA, FIA, the AAAs, Boise State University and others often work together and share caregiver information. This includes an annual conference, workshops at the regional level, a federal grant to support respite, and a resolution this year seeking legislative direction for the Idaho Caregiver Alliance to convene a task force to coordinate and develop recommendations regarding support for uncompensated caregivers of family members. The ICDD is leading an effort to redesign the service system for adults with developmental disabilities through a multi-year Collaborative Work Group of more than 20 partners. In some areas of Idaho, networks of providers of long-term care services meet monthly and share information via email, reaching many individuals and organizations providing LTSS.

e) **New Partnerships**: New partnerships are developing to share information. Both federal and state Veterans programs are focusing on HCBS and participating in community outreach. ISU's TBI program is facilitating screenings for brain injuries as part of community health screening programs. AAA II is developing a partnership with pharmacists. And JAVA, coordinated through BSU's Center for the Study of Aging, brings a range of people together to share information on preventing abuse and neglect.

f) **Relationships are Key**: The strength of outreach and linking people to services is in partnerships and relationships. This is made easier in a state like Idaho with a small population, but at the same time is hampered by distance and challenging geography. Many of the NWD stakeholders have knowledge of or relationships with each other. But almost all feel that their outreach falls short of adequately reaching their constituency. They see value in coordinating their efforts with others and try to do so when possible.

2) WEAKNESSES AND OBSTACLES

a) **No Integrated System:** While Idaho has many strengths, it does not have an integrated outreach and information sharing system. Factors most often cited are not surprising – lack of resources, funding, time, and staff. But there is also lack of trust, respect, knowledge and willingness to share information and territory. There are pockets across the state where partnerships have been nurtured and processes developed, due often to long-standing relationships, a local champion, or the popularity or efficacy of a particular program.

b) **Geographic Barriers**: Geography is also a barrier to outreach and access to services. Many agencies are required to provide services in all areas but in some small rural communities it is hard to create a presence because of its remote location and/or lack of providers. AAA VI alone covers an area of 20,000 square miles and other areas of the state are similar.

c) **Lack of Awareness and Delayed Planning**: People are generally not aware of long-term services until they need them, for themselves or a family member or friend. By that time, without having done some planning, the information is overwhelming and confusing and decisions often have to be made quickly

People don't know what they don't know. It is difficult to get the right information to the right person exactly when they need it.

and under pressure. In these circumstances it is often not a lack of information that is causing the problem but too much information. Trying to navigate the various aspects of long term care options and payment methods is challenging. If the person who is attempting to do this does not have support of family or friends or the help of a case manager or care coordinator, the challenge is quickly enhanced. And if the person who is trying to navigate the system also has health problems, the difficulties are compounded.

d) **Consumers Unaware of 211 CareLine**: Many people are not aware of 211 CareLine and the information it provides. And there are others who are aware of it, but it does not provide what they need. For example, only recently did the 211 Careline staff become trained in the resources available to address dementia and Alzheimer's. Whether it is 211 Careline or another data resource, the information may be inaccurate, confusing, not current or limited. It takes time and resources to maintain accurate and timely information and that is often not available to programs.

e) **Confusion About ADRCs**: Although ADRCs have been in place, virtually and literally, for a few years, there continues to be confusion about who they are and what they do, both within the AAAs which have been designated as the regional ADRCs and the CILs who represent the D in ADRC. While the intent was to develop a one-stop resource for all aging and disability information, that has had varying degrees of success. Information sharing between the AAAs and the CILs has improved but it is still not an integrated model. The components of the ADRC – Person-Centered Counseling/Options Counseling – are confusing and staff is unclear about how these components are to be integrated into their regular AAA functions. All AAAs provide I&A but there is also the feeling that simply referring the caller to another number, while it may be a way to avoid duplication with services offered by another agency, may also fall short of meeting the caller's needs. It also may mean that the caller does not get the assistance to apply for and receive the services they need and to which they are entitled.

f) **Complex Long Term Care System**: The long-term care system is convoluted and not user-friendly. In some situations it can require legal assistance to navigate it. For example, the "spend down" information for Medicaid is not always provided to people when they go to DHW. This may be because the front line staff may not have the information. The system's complexity means many people need help to even understand the information they are given. If people do not understand and are not able to access what they need, it may result into a poor outcome.

g) **Public Outreach is not a Priority**: Public outreach is often weak or not a priority. When services are cut, outreach is often cut to manage limited services. This also eliminates the ability to demonstrate unmet needs. Once outreach and services are cut, it can be very challenging to restore them. In Idaho, public policies emphasize independence and not relying on services; instead of wanting to make sure people get the services they need, the intent becomes weeding people off of services as quickly as possible.

h) **System in Silos**: Agencies can be their own best kept secret. They talk to each other but not rarely to outside entities. And sometimes these outside entities are within another division or bureau of the same large organization. Programs operate in silos with different databases, processes, rules, restrictions, eligibility criteria, assessments and services. Few of these are shared and even when they are, agencies don't often know what is available or not in another program.

3) OPPORTUNITIES

a) **Transformation in Programs**: Various programs and systems in Idaho are undergoing transformation and this provides an opportunity for building new information avenues. The development of Regional Collaboratives through public health districts as part of the State Healthcare Innovation Plan provide an opportunity for partnering with long-term care providers, AAAs, CILs, and others to share information and build awareness of long term services and supports. These Collaboratives could also involve consumers of these services, providing the opportunity for ongoing dialogue regarding outreach and service access.

b) **Meetings on HCBS**: The ICDD is continually involved in systems enhancement efforts. This summer they are sponsoring public forums to gather and share information on the new CMS rules that define "homes" under HCBS services. This presents an opportunity for CILs, AAAs, HUD, Medicaid, Legal Aid, local governments and particularly users of long term services to learn what these proposed changes mean to them and to provide input to the federal government about the impact of these changes. It provides a great networking opportunity.

c) **Increased 211 CareLine Visibility**: 211 Careline presents opportunities in various ways. Increased visibility for the public will increase their understanding of what 211 currently is and stimulate conversation about what it could be. For those who maintain and use other database resources for the aging and disability population, there is the opportunity to discuss how these might be coordinated. As an example, Friends in Action uses an online resource for an economics benefit check up to help low income seniors connect to resources. It can be found at www.benefitscheckup.org and is provided through the National Council on Aging.

d) **Navigator Model**: 211 CareLine also provides access to voluntary, time-limited case management for low-income families identified as at risk. As these families contact 211, operators are able to ask questions and facilitate the family's access into this program. Begun around 2002 as the Any Door Initiative with a pilot in Moscow, it is now offered statewide. They have a cadre of 22 navigators who work with families to keep them together using a family-centered planning approach. There are no case loads limits and no waiting lists. In 2014, there were about 10,000 referrals and about half of that number was assigned navigators to work with them. The remainder were able to access information or services through the regular 211 referrals. The program is able to access federal Temporary Assistance for Families (TANF) funds for some families. A growing group of families receiving these services are KinCare families – grandparents raising their grandchildren. Funds for this program are being provided through a grant from Casey Family Program. While this current effort is limited in its eligibility and scope to families with children, it does provide a model for seniors and adults with disabilities to access services using Medicaid or other funding as identified.

e) **Broader and Stronger Partnerships**: Strengthening partnerships is key to sharing information. Interviewees identified a wide range of partners with whom formal and informal relationships could be built to better enhance the public's awareness of and access to LTSS. Although these will vary by locale, they include:

Tear down silos. Talk with each other.

- Local governmental entities (city and county)
- Churches

- Libraries
- Physician clinics and hospitals, particularly discharge planners
- Senior Centers
- Visitor Bureaus
- Veterans Centers
- Local community groups
- Non-profit health and social service organizations
- Long-term services and supports providers and their networks
- Independent living centers
- Community colleges and universities
- Foundations
- Paramedics
- Insurance companies (often cited is the Medicare-Medicaid Managed Care Program offered to dual eligible individuals through Blue Cross)

f) **Increased Information Sharing**: Methods for sharing information are almost endless, from printed materials placed strategically throughout communities to well-informed LTSS providers to easy-to-navigate websites to organizations with published, accurate, timely, and understandable information and personal assistance when needed. An increasing number of people are taking on the role of geriatric care managers, privately paid, to help individuals and their families navigate this complex array of important information and services.

g) **Take Advantage of Small Population:** Perhaps the greatest opportunity in Idaho is its relatively small population. Most agencies know one another and have some knowledge of programs and eligibility requirements. There is a shared commitment across human services to help people.

B. ACCESS TO AND/OR TRAINING ON PERSON-CENTERED COUNSELING

Person-Centered Counseling, as articulated by ACL for a NWD system, includes the following functions:

- ❖ Confirm the need for/interest in person-centered counseling
- ❖ Support any immediate LTSS needs, conduct personal interview, and identify strengths and preferences
- ❖ Conduct comprehensive review of private resources, informal caregiver supports and screening for public programs
- ❖ Facilitate the development and implementation of the person-centered plan[1]

[1] No Wrong Door System of Access to LTSS for all Populations and all Payers, No Wrong Door Assessment, NWD Planning Grantees Monthly Webinar, February 11, 2015, page 6

This process has its foundation in person-centered practices as defined and developed by Carl Rogers, Judith Snow, John O'Brien, Beth Mount, Jack Pearpoint, Tom Nerney, and others. It is about finding the balance between what is important *to* a person and what is important *for* a person.[2] It recognizes that the person is the expert in his/her life and should receive the supports they need to be in control and as independent as possible.

1) STRENGTHS

a) **Person Centered Counseling (PCP) as Best Practice**: There is wide variation in the details of what Person-Centered Counseling (or Person-Centered Planning) is in Idaho, but most agree that it is a quality individualized approach to gathering information and helping a person plan for the services and supports that they want and need. Done correctly, it can lay the groundwork for a long-term service plan for the whole person that takes into consideration their needs, wishes, strengths and capabilities and includes both paid and unpaid supports.

Person centered planning makes sense and it works.

b) **PCP Curriculum Developed**: The use and strength of person-centered counseling in Idaho is uneven and in pockets. In 2007, the ICDD received a CMS Person-Centered Planning Implementation grant. They contracted with the Center on Disabilities and Human Development (CDHD) at the University of Idaho to develop a curriculum to train individuals in person-centered planning/counseling. The comprehensive curriculum that was developed is primarily online with a two-day, face-to-face capstone session at the conclusion. Four different cadres of individuals received this training, including at least one ICOA staff and one AAA staff person. The curriculum is still in place although it has not been offered in recent years due to lack of funding.

c) **IHC/MFP Transition Managers Trained in PCC**: The ICOA provided funding for the SILC to develop a training curriculum for Transition Managers as part of the IHC/MFP program offered by Medicaid. This curriculum includes information on person-centered counseling/planning principles. This IHC/MFP provides case management and cash supports for individuals moving out of facilities after a minimum stay of 90 days and into settings in the community. Transition Managers provide that case management function. Many staff within the AAAs and the CILs are trained as Transition Managers or work with individuals who provide that service. This grant is expected to continue to 2020.

d) **Aligns with Independent Living Philosophy**: The CILs operate with a person-centered philosophy in their programs, assuming competence, embracing self-direction, and recognizing that this model allows people to take risks. The CILs do not use a specific curriculum for training their staff on this concept.

e) **Patient-Centered Model**: The conversion of primary clinics to PCMHs under the SHIP uses a patient-centered model. This program uses a team-based approach that encourages patient decision making and responsibility which aligns with person-centered counseling/planning. They offer RN population health managers as part of the model. As increasing numbers of clinics convert to this model, there will be greater numbers of practitioners aware of the concepts of person-centered planning/counseling

[2] This concept comes from The Learning Community for Person Centered Practices © 2012

f) **Family Group Decision Making Model**: Person-centered counseling is similar to the Family Group Decision Making that is used in Family and Community Services (FACS) within the DHW. This is done through contracts with private providers who facilitate and coordinate these services. In the Treasure Valley, Family Connections provides social workers who are skilled in family-centered practice to conduct this planning.

g) **Medicare Medicaid Coordinated Plan**: The Division of Medicaid has contracted with Blue Cross of Idaho (BCI) to provide services to Idahoans who are dually eligible for Medicare and Medicaid using a managed care model. BCI is paid a set amount per member per month to provide medical services, primary care health services, and, for those who are eligible, HCBS services under the A&D waiver. An important component of the service package is care coordination that is provided by Community Partnerships of Idaho Care Plus through a contract with BCI. The care coordinators have received training in person-centered planning and use that approach in their coordination of services as requested by members.

h) **Options Counseling is in Law**. In 2006, the Idaho Legislature passed HCR052 which encouraged the DHW (then the lead agency) to proceed with the development of long-term care options counseling as part of the planned Aging Resource Center initiative. Long-term care options counseling was defined as promoting alternatives to Medicaid-paid long-term care. The legislature requested a report back from DHW and stipulated that, except for necessary personnel and operating costs, this effort was to be paid from grant funds for this purpose.

2) WEAKNESSES AND OBSTACLES

a) **PCC Concept Not Well Understood**: Person-centered planning or counseling is a term that is frequently used but often not fully understood. Because of this and the amount of time it takes to conduct a thorough person-centered plan, organizations do not provide the service the way it's intended. In addition to the constraints of time, resources, lack of trained staff skilled in this practice, staff turnover, and lack of cross training were identified as weaknesses or obstacles. While person-centered counseling/planning is often regarded as a best practice, the cost of doing it in a fee-for-service system is not recoverable. The time needed to facilitate the process and conduct and develop the plan takes time, most or all of which is not a billable service. PCC is often not seen as medically necessary so is at odds with a system based on medical care, not long-term supports.

b) **Unclear How PCC is Used by ADRCs**: Staff of the AAAs/ADRCs have had some exposure to the concept of person-centered counseling but it is not clear if or how it is being used. With the move away from case management in the AAAs/ADRCs, there are questions about how and where PCC fits. It doesn't really work in an I & A model and, although it could be useful in Options Counseling, that terminology is also confusing. With no funding to do this and the time-intensive nature of this approach, where, when and how person-centered counseling is used in the AAAs/ADRCs remains a question.

c) **PCC is Not a Priority or Required**: For providers of LTSS, PCC is a good concept because it helps people make informed decisions. But it needs to be fully part of the framework and not just an add-on. For it to be done, it needs to be a requirement or at least a priority. The long-term care industry uses person-centered care plans, but it is uncertain about the content of the training their personnel receive. Although considerable time is spent training

staff on this and other aspects of care, high turnover among direct care staff sets everything back.

d) **Is PCC Measurable?** With increase emphasis across systems in outcome data, PCC is criticized for not being measurable. What are the goals? How is the impact measured at both the individual and system level? Although there is some information about the costs and consequences of poor or inadequate planning, it has not been recognized or understood enough by policy makers in Idaho to make this service a priority or a requirement. So, it is seen as optional and thus rarely done.

e) **Silos and Other Structural Barriers**: Adding to these barriers are those that are system structural issues. Program or organizational silos, differing eligibility criteria and planning requirements, different terminology, lack of capacity, training deficiencies, and demands of day to day required responsibilities, all impede the use of this process. An additional impediment may be the use of the term "counseling" which, particularly among members of the senior community, may connote behavioral counseling and thus not be viewed favorably.

Currently, the system is focused on what it can provide instead of what the person needs.

3) OPPORTUNITIES

a) **The ICDD/CDHD Curriculum**: Given the time and effort that was spent developing the person-centered planning curriculum with the ICDD/CCHD, it would seem advisable to look to the curriculum as a resource for training various LTSS members across the state. While its comprehensiveness may make it difficult to implement it exactly as envisioned, it presents a strong foundation for disseminating the philosophy and practice strategies. Because it is a web-based curriculum, it could be accessed by a wide array of individuals across the state. It could also serve as the platform for NWD stakeholders to discuss how they could collaborate in offering a standardized person-centered planning training across programs.

b) **Include Family Caregivers**: While providing PCC training is needed, it is also important to include unpaid caregivers when sharing this information through workshops and other venues. Families will almost certainly be part of a circle of support in the PCC process, but they need to understand the concepts behind the process (the person is in charge, not the family; the concept accommodates allowing the person to assume some risk). If the caregiver/family is not aware of these concepts (and their role in supporting the person to make their own decisions whenever possible), then their involvement in the process can work against what the planning is trying to achieve.

c) **Make PCC a Requirement**: In addition to providing training, it is critical to examine how PCC can be embedded in the practice of stakeholder agencies. As a model, person-centered planning has been part of the disability service lexicon for some time and it is still not widely used. If it is to become central to AAAs/ADRCs component then staff will need to be engaged in a conversation with system leadership on exactly what PCC is, who will do it, when, and how it is folded into the required services that they provide. As long as it is misunderstood or regarded as optional, it will not be done regularly or well.

d) **Align with System Transformations**: The transformation that is occurring in primary care provides opportunities for increasing awareness and use of person-centered planning. The team-based approach used in patient-centered medical homes could increase the awareness of PCC and present opportunities for expanding its use. BSU is working with the Family Medical Residency of Idaho on a HRSA geriatric workforce grant which will train Community Health Workers (part of the SHIP) to be trained in PCC/planning. This grant employs the use of technology via electronic badges to be awarded on completion of the training, another concept that deserves further exploration. If accepted, the grant will be effective 7/1/2015 and run for three years.

e) **Expand Opportunities**: Existing programs that use elements of the person-centered counseling concept could be examined for opportunities to enhance their use of this process, and, if needed, make adaptations for a more robust and effective training.

f) **Make PCC a Reimbursable Service**: If PCC is required, then it needs to be set up for reimbursement. Changes in laws and/or regulations at both the federal and state level will probably be required for this to become a reimbursable service. For that to occur, it will require stakeholders and advocates to assemble information about the cost/benefit of this in the planning process. This would need to be accompanied by data showing the long-term costs to the individual and the system of inadequate planning on health outcomes. Data gathered from the Blue Cross MMCP may be beneficial in this situation.

C. STREAMLINING ACCESS TO PUBLIC PROGRAMS THAT PROVIDE LONG TERM CARE

The NWD system model envisions streamlined access to public programs as collaboration in the preliminary and final determinations of both financial and functional eligibility for services.

Interview participants took a broader view of streamlining than envisioned by ACL. Interviewees considered any and all elements of cooperation toward an improved application and eligibility process as part of streamlining. This view covered both access to and provision of services and how working together could create a smoother, more customer-friendly process.

1) STRENGTHS

Get services to people quicker with less red tape.

a) **Self Reliance/Medicaid Application**: Perhaps the best example of a streamlined process as defined by ACL is the DHW's process for applying for benefits through their Self-Reliance program. Individuals can apply online or in their regional offices where staff are available to assist and answer questions. The application covers income, expenses, assets, and other financial qualifications to determine eligibility for food (food stamps), cash assistance TANF, Child Care Assistance (subsidies through the Idaho Child Care Program) and Health Coverage Assistance (eligibility for Medicaid or Tax Credits to help pay insurance premiums). If the person is financially eligible for assistance with health coverage, they are referred to Your Health Idaho (Idaho's insurance exchange) to apply for subsidized insurance coverage or to Medicaid. The services that they qualify for under Medicaid are determined by their health needs and level of disability. If the person has a disability, there are other assessments that they will need to have to determine their "functional" eligibility for certain services including long-term services and supports through HCBS waivers. People have long been able to download and print out the lengthy application (9 pages plus 2 appendices) but effective November, 2014, people can now submit the health

portion of the application on line through IdaLink (https://idalink.idaho.gov/). Through this link, Self Reliance, Your Health Idaho and Medicaid are connected and an eligibility decision can be made within a week. Sometimes it may even be able to be made in real time: "Based on _____, you may be eligible for _____. " Self Reliance and its partners are continuing to work on expanding the online application to the other components of the application.

b) **ADRC = A + D**: The ADRC system of the AAAs and, to a lesser degree the CILs, is also strength. The implementation of the ADRC model brought together two divergent but overlapping populations – seniors and people with disabilities – and began the conversation and systems change effort to build a collaborative system. Currently, the two do not share information systems although in some areas they can access one another's resources through links. In all parts of the state they share information and in most regions collaborate on trainings, community activities, and some staff meetings. They do not share an eligibility determination system as their criteria for services is driven by their federal funding authority. Now that both programs are within the Administration for Community Living in the federal Department of Health and Human Services, there may be opportunities for cutting across the criteria that now divide them. While both now are funded through ACL, the CILs draw their operating funds directly from ACL while the AAAs are funded through the ICOAwhich is authorized through the Idaho Legislature.

c) **Nampa Family Justice Center**: A good demonstration of collaboration to streamline access to services is the Nampa Family Justice Center. There is no income consideration for getting services; eligibility is based on need and circumstance – it is aimed at victims of domestic violence or sexual assault. It is primarily geared to women with children in Canyon County but seniors or people with disabilities could access the program if they found themselves in a domestic violence situation. It is a one-stop shop with everything in one place – police, legal aid, nurse, social services – all working together to help victims and their families. Funding is provided through program partners and grants. Although this program does not provide long-term services and supports, it is a resource that could be used by consumers of those services.

d) **Veterans Services**: The State Veterans Home (nursing home and assisted living) is an Idaho facility on the grounds of the Veterans Medical Center (VAMC), a federal program. The state handles the admissions and provides the facility and the VAMC provides the services. A sliding fee scale applies to the assisted living portion of the facility. Medicare and Medicaid are billed for the nursing home care.

e) **Collaboration through SHIBA:** SHIBA participates in partnerships to increase information and streamline access. SHIBA provides Medicare information and counseling to Idaho citizens; it assists people in applying for the Social Security Extra Help Program which helps seniors pay for their Part D co-pays, and the Medicare Savings Programs which can help people pay their Medicaid premiums and possibly copays and deductibles. SHIBA can access the Medicare database to help people file complaints with/to Medicare; when a complaint is filed, the provider, pharmacy and Medicare are all notified and the clock starts ticking toward a deadline for resolving the issue. SHIBA is also a partner with AARP in the publication of a comprehensive guide to LTSS and home-based services in Idaho.

f) **Care Coordination is Key**: Care coordination can streamline service access. One relatively new example is the Medicare-Medicaid Managed Care Plan (MMCP) offered by Blue Cross of Idaho. This plan is only available to people who are eligible for both programs and who live in one of 33 of Idaho's 44 counties. It covers all health and medical care as well as Medicaid

long-term services and supports (A&D waiver services) and targeted case management for individuals on the DD waiver. It provides some incentives for good health like a gym membership for $50/year. Every enrollee has a care coordinator who helps them develop a plan, explain services, acts as a guide in navigating services, and supports the member in the management of their health. This managed care plan is a partnership between the Division of Medicaid, Medicare, Blue Cross of Idaho and Community Partnerships of Idaho (the entity that is responsible for the care coordinators). Data to manage the information is shared across systems with some controls on access.

g) **Primary Care and LTSS**: Improved access and streamlined services between in-patient and primary care is expected with the SHIP that is aiming to transform primary clinics into PCMHs. The plan hopes to transform 55 clinics each year. Three of St. Alphonsus' clinics in the Treasure Valley are already operating using this PCMH model. Participating clinics are required to use electronic health records in order to share patient information among providers. This system is also intended to help with access to health care in rural and remote areas by using trained community health workers and telehealth practices. The SHIP is administratively supported through the DHW and just received a 3-year $40,000,000 grant for this transformation work. PCMHs will be supported in what are being called "medical neighborhoods" through Regional Collaboratives that will be led by the Health Districts across the state. This plan does not currently include long-term services and supports.

2) WEAKNESSES AND OBSTACLES

a) **Fragmented System(s)**: Streamlined access is made difficult due to the fragmentation of systems and the services they provide. Across public programs there are multiple databases that are not always compatible and/or sharable. Systems serving overlapping populations have differing eligibility requirements, program parameters, and funding streams.

b) **Lack of Trust and Sharing**: Organizations often do not share. Sometimes they are prevented from doing so by legal restrictions or privacy considerations. However, it is often other considerations that make cooperation and sharing a challenge. Organizations may feel that by giving away information they are giving away some of their authority and weakening their power. Sharing can mean increased transparency which may make some organizations feel vulnerable. There may be historical differences with other organizations that impede cooperation. Organizations are vested in the current system and want to see it maintained, or, if changed, see how it will benefit them. These "human" disincentives can be the biggest impediment of all.

Who has the knowledge to be the gatekeeper? Who has the capacity to provide "application advocacy" that is aimed at helping people get the services they need?

c) **Disincentives in Political Environment**: Idaho's political environment also influences streamlining access to services. The emphasis on independence and self-reliance can discourage people from seeking services, even when they need them. And this philosophy underpins a system that weeds people out of services rather than encouraging them take advantage of all they need or are entitled to. Changes in the service delivery model are often closely scrutinized by public policy makers who fear increased cost and the overreach of the federal government. Many citizens distrust government as well, fearing for their privacy when sharing of information is discussed.

d) **Geographic and Transportation Challenges**: Idaho's rural topography is a challenge to service access. "You can't get there from here" is often the mantra, and unfortunately, "there" may be where the services are. Although most Idahoans drive their own car – or pickup – there are many people with disabilities and an increasing number of seniors who do not. Without friends or family to drive them, public transportation is their lifeline to services. AAAs contract with transportation providers who have buses which are an important resource. Many long-term care facilities have their own vans. Also available are fixed route and demand-response public transit services in a few cities but, there are significant gaps between transportation resources that leave people isolated.

e) **Lack of Needed Information**: In seeking LTSS, people are unaware of what to ask and where to go. This means access to streamlined services is tied to outreach and getting information to people where they are, in plain language and user-friendly formats. If it is too difficult to use, such as mechanized phone trees which are frustrating for many, people may give up and not seek services. Web-based information is important and growing in its popularity and utility, but there are still many people, particularly seniors, who lack access and ability to understand and use these tools.

f) **Transitions Between Services Can Mean Gaps**: Transitions between types of services or levels of care are important points for streamlined services but are often weak links in the system. Hospital discharge planning is a key point for making sure people, particularly seniors and people with disabilities who tend to be super-utilizers of hospital care, have the services in place for their return home or to a facility. Patient data does not always follow the patient, presenting challenges for the person and their medical and long term care providers. Electronic health records are one way to help streamline and improve this process but not all providers use them.

g) **Lack of Resources after IHC/MFP Transitions**: The IHC/MFP provides assistance and resources to people who have lived in a facility for more than 90 days and want to and can move to the community. The Transition Managers work with the person, the facility, and resources in the community to facilitate that transition. AAAs, CILs, and some private providers have Transition Managers on staff. But challenges present themselves when the person who is being discharged lacks adequate services after the Transition Manager's hours end. If the person has family, the responsibility falls to them to pick up the process, but if they do not, there is a gap created in a well-intentioned program. If the person has challenging behaviors that require intervention and support, that may mean risk to the person or the community. These supports are often not available and not something that can be left to the family.

h) **Gaps In Behavioral Health**: The Behavioral Health system in Idaho is a combination of regional clinics used to deflect crises through emergency case management and inpatient services in two state hospitals. Their focus is on adults with severe and persistent mental illness and getting them stabilized and back out into the community where services are minimal. Behavioral Health has established some good working relationships with law enforcement, training Crisis Intervention Teams using the *Memphis Model* on how to respond appropriately to specific populations. They do not see many people over age 60 except people with dementia or health issues causing dementia, like traumatic brain injury. They try to work with the person and their family and others to provide support but Idaho has no protective custody law/capacity. They struggle with collaboration with the Adult Protection

program. Adult Protection does not have the authority/power they need to speak out and up for people in crisis and they could be better partners.

i) **Duplication in Services**: While there are gaps in the current long-term care system, there are also duplications in delivery of services or the potential for duplication. An example is home delivered meals. If a person receives services through the A & D waiver and is found to need this service, it is available to them. If they also use services through the AAA/Senior Center, they may also be eligible for and receiving home delivered meals through the AAA. It is unclear who has responsibility for coordinating and monitoring this benefit to ensure the person is getting what they need but that it is not being duplicated between the two programs.

j) **Family Caregivers Not Informed/Included**: Family caregivers and other unpaid supports for people with disabilities and seniors are a huge part of the service delivery system. They are often overlooked in terms of information sharing and overburdened by their responsibilities. Through Idaho's Lifespan Respite grant, the Idaho Caregiver Alliance, together with the AAAs and groups like FIA, provide a loose network of support for family caregivers, but this sector of caregiving needs increased attention, information, education, and support.

k) **Inadequate Provider Reimbursement**: Reimbursement for providers of long-term care is also an issue. Differing payment methodologies – both through private insurance and public programs – favor some types of providers over others and can result in conflict and lack of cooperation between them. Most providers assert that Medicaid and Medicare levels of payment do not keep pace with their costs of doing business. The result is that many providers from dentists to assisted living facilities do not accept people on Medicaid.

3) OPPORTUNITIES

a) **Technology and New Partnerships**: Partnerships and technology are most often mentioned in discussing opportunities for streamlining access to long-term services. Today's seniors are becoming much more tech savvy and using a technology portal as a virtual one-stop shop would be an asset for a large percentage of seniors. Ideally, multiple agencies would collaborate providing resources and identifying information that they would need. There could be one application, which when answered, would populate the needed forms. The system would need to be available online 24/7. The College of Innovation and Design at Boise State University could be a resource; system partners could work with students there to develop a triage-coordinated system.

b) **Enhancing Current Connections**: This is similar to what Self Reliance is doing for people applying for assistance from theDHW. Now that the health portion of that application can be submitted online, they are working on expanding that to include the other elements of assistance that they provide. Also within DHW is the 211 Careline, which serves as the gateway to navigating services for families. Expanding, enhancing and improving those inter-departmental connections could improve users service access.

c) **Don't Forget the Human Element**: Technology based resources also require a human element to explain and problem solve. Care coordination, provided as close as possible to the person, improves the chances the people will actually get the help they need and not fall

through the cracks. The care coordination service that is part of the Blue Cross MMCP plan is a good example. The navigators within Family and Community Services that assist families who are at risk who call into the 211 Careline are another example. The various volunteer-based services provided through the AAAs, CILs, and groups such as Friends in Action are a resource as well.

d) **Regional Collaboratives and LTSS**: The new players on the block at the regional level will be the Regional Collaboratives established through the implementation of the SHIP. The Behavioral Health progam is looking to establish a partnership with public health through this model by Regional Behavioral Health Boards having representation on the SHIP Regional Collaboratives. This presents the opportunity for behavioral health issues to be part of the medical neighborhoods as they develop. Long-term services could be part of that discussion as well with AAAs, CILS, and long-term care providers joining in with the Collaboratives.

e) **PACE Model**: An example of a program that is a coordinated effort is PACE (Program of All-Inclusive Care for the Elderly), a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going into a nursing home or other facility. PACE organizations provide care and services in the home, the community and at PACE centers. They have contracts with many specialists and other providers in the community to make sure the person gets the care they need. Many PACE participants get most of their care from staff employed by the PACE organization in the PACE center. PACE centers meet state and federal safety requirements. A person can have either Medicare or Medicaid or both to join PACE but it is only available in states that offer PACE under Medicaid. Qualifications require that the enrollee be 55 or older, live in the PACE organization's service area, need nursing home level of care and be able to live safely at home with assistance. More information is available at http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html.

f) **Time and Commitment Required**: The NWD initiative provides a vehicle for moving programs toward collaboration. The key players are at the table but it is important to realize that this is an effort that will take time and focus. Bringing a diverse group together to share information and resources would help to penetrate the siloed networks that exist. Annual conferences, newsletters, cross training are all ways to easily share information. Additional suggestions are:

- Have the flexibility to hire and train additional staff that have the background and commitment to improving long term services and supports
- Educate; add brochures and information so that the first point of contact people have provides the most current, accurate, and easy to understand information available
- Identify existing resources that could become easily accessible and streamlined with little effort
- Provide a centralized website – perhaps through or tied to 211 – that is very easy to use, intuitive, and is linked to key services and information.

D. SHARED GOVERNANCE AND OVERSIGHT OF THE SYSTEM

The NWD System Vision defines shared Governance and Administration as inputs from external stakeholders, including consumers and their advocates, on the design, implementation, and on-going operations of the system. Management Information System tracks clients, services, outcomes, expenditures, and organizational performance, enables information to flow with the client from initial person-centered plan through follow-up and supports on-going evaluation and continuous quality improvement.

Individuals interviewed took a narrower view of this, focusing more on existing structures rather than envisioning a coordinated pathway for users of the system(s).

1) STRENGTHS

a) **Current Stakeholder Engagement**: Most of those interviewed expressed support for this concept but recognized it as a major undertaking. They felt that the right stakeholders are at the table and the fact that key people were even having this discussion was positive. They also recognized that this kind of collaborative approach would best benefit the people who rely on the system(s) and services.

b) **ICOA Coordination**: The ICOA was recognized for its coordination of this effort and the work that has been done to date. In particular, ADRC Program Specialist Raul Enriquez was mentioned as important in this project.

c) **Opportunities with Existing Partnerships**: There are partnerships already in place that could be built on, expanded, or combined with others. These examples of collaboration include:

- *Idaho Home Choice/Money Follows the Person (IHC/MFP)*– a partnership among the ICOA, ADRCs, CILs, SILC, and Medicaid, working toward a shared goal of moving individuals out of institutions and into community settings with needed supports; IHC uses a multi-agency advisory committee
- *Medical Care Advisory Committee (MCAC),* a group of agency members, provider representatives and advocates who provide input and guidance to the Division of Medicaid on its programs and policies
- *Community Care Advisory Council (CCAC),* a group of Certified Family Home and Assisted Living providers plus advocates and consumer representatives, who provide input to the Division of Licensure and Certification about matters affecting their industries and the people they serve
- *Idaho Health Data Exchange (IHDE),* a group of primary care providers and hospitals who have joined together to share a web-based data exchange that allows sharing of patient information; this is a membership based program where organizations pay to belong
- *State Healthcare Innovation Plan (SHIP)* is a collaboration among health care providers, state agencies, the Family Medicine Residency, public health districts and other organizations working together to transform the primary care system in Idaho to one based on healthy outcomes
- *Collaborative Work Group on Services for Adults with Developmental Disabilities*, a committee of providers, agency representatives, people with developmental disabilities,

legislators and others who are researching and gathering information to make recommendations to policymakers on changes needed by the public system to better serve Idaho adults with developmental disabilities.

- *Consortium of Idahoans with Disabilities (CID),* a group of agency and organizational representatives who meet monthly and share information about activities, best practice, and public policies affecting people with disabilities in Idaho. This group sponsors Disability Advocacy Workshops across the state each fall and a Disability Advocacy Day at the Capitol each legislative session.
- *Idaho Caregiver Alliance* is a group of agency and organizational representatives, the Center for the Study of Aging at Boise State, and others who have come together to raise awareness of and support for family caregivers, their contributions to the Idaho service system, and the recognition of the importance of support and respite for them. This group originated from the ICOA's Lifespan Respite Grant and the coalition that was pulled together by ICOA staff to work on that effort.

d) **Small State Population**: People also recognized that Idaho's small population, where many people know one another and lots of informal information sharing and cooperation takes place, is a value and strength.

e) **211 CareLine**: The 211 Careline was mentioned as a strength in that it connects many organizations together. It also maintains and regularly updates its database information.

f) **ACL Reorganization**: Reorganization within the Department of Health and Human Services (HHS) at the federal level has also increased new opportunities for collaboration, particularly for ADRCs. The CILs and the Commission on Aging/AAAs,/ADRCs are now all under the Administration for Community Living. Formerly, CILs were under the Rehabilitation Services Administration within the U. S. Department of Education.

2) WEAKNESSES AND OBSTACLES

a) **Current LTSS System is Fractured**: The access to LTSS weakness exists in the fractured nature of the existing long-term care system. There is collaboration among some parts of the system but other pieces are broken. The ADRC system is not uniformly understood. What does it do, different from what the AAAs do? How does it include the disability component, with the CILs or others? Are there clear and workable agreements in place to meet the needs in a coordinated way? Is the leadership at the state level visionary, open and collaborative to bring people on board? Have the relationships been developed to make this into a system or are their unresolved historical issues that are getting in the way? All of these are weaknesses or questions that need to be addressed in a NWD system.

Partnering is one thing but sharing governance would be very difficult.

b) **Organizational Turf and Territory**: Turf and territory are big obstacles to sharing governance. Organizations have their own purpose(s) and agendas and want to see "what is in it" for them. And they have to see how the purpose and goals of this new entity align with those of their individual agency. This buy in is often not easy to achieve, particularly if it involves a commitment of resources – funds, people, time, organizational clout.

c) **Impact of Strong Personalities**: A stakeholder group of leaders means many strong personalities with individual biases, work habits, demands, etc. Sharing control for them may mean a loss of autonomy or authority or a paradigm shift to a new way of thinking or operating. At the same time, strong leaders will want to see strong leadership guiding this effort. This means a clear vision for what needs to be done and how to get there. It means leadership must have a demonstrated ability to work with others in a collaborative way to achieve common goals.

d) **Demands on Time**: Scarcity of time is an issue. People are busy with their own work and feel they cannot take on additional responsibilities. How does this fit with their current workload? They do not want to go to more meetings where nothing gets done.

e) **Uncertain Structure**: Although this model is one of shared governance, it will require someone to be in charge. Where will this governance and oversight "live"? Will it be in an existing state entity? Will it be a new state agency or commission? Will it be a non-governmental organization that is supported by multiple partners?

f) **Lack of Information Sharing**: Information sharing is critical. Right now, there is no one agency that tracks people through their access to long-term services and supports. The DHW as both a provider and a payer for these services holds a large share of this information but it is not always shared between different programs within that Department. They have agreements with many of the other stakeholder agencies but these are for specific programs.

g) **Medicare and Medicaid Differences**: Medicare and Medicaid are the largest payers for long-term services and supports and they are not designed to work together. They pay for differing services with different requirement and different payment rates but navigating this from the consumer perspective is a challenge.

3) OPPORTUNITIES

a) **Structural Management Opportunities**: Some of the questions posed as obstacles also present opportunities for solutions. Ownership for this governance and oversight does not need to be in any one agency. Perhaps there is a lead agency with all agencies having fiscal and programmatic responsibility and willingness to share resources to make it happen. Maybe it is a new agency that doesn't fall under any of the current key players. Or perhaps it is not a state agency at all but a "convener" that would do the work and be overseen by the stakeholder agencies. For example, Allumbaugh House in Boise where Ada County, DHW, hospitals, and others entered into a joint powers agreement to meet a need. The NWD system would be much broader, but the same approach might be considered.

Leadership must be on board and willing to commit the time and resources to make this happen.

b) **Improved Quality**: With shared governance and information sharing, there is an opportunity for better quality assurance planning across the long-term care spectrum with a shared database.

c) **Build on Community Capacity**: The NWD system presents all stakeholders with the opportunity to create a system with a different kind of "community capacity", one in which

we engage our sense of community with an obligation to care for one another. This approach would be based on shared values and bring together a combination of governmental and non-governmental entities that collaboratively focus on creating an environment where the whole person thrives.

d) **Public Private Partnerships** : Public and private partnerships provides opportunity for the development of new partnerships between government and the private sector. Examples are the improved access to care with the Blue Cross MMCP for people who are dually eligible for Medicaid and Medicare. Or assisted living facilities providing space for counseling by SHIBA volunteers in their facilities.

e) **ACL Configuration at State Level**: All of the system changes that are currently taking place provide an opportunity for sharing information, developing relationships, and building bridges. The new ACL reconfiguration at the federal level provides a foundation for cooperation among their partners at the state level. Collaborative leadership at the state level is critical, but Idaho's diverse landscape also means there are opportunities for shared oversight at the regional and local level. The new Regional Collaboratives in the SHIP are entities that could be partners not only with health districts, but AAAs/ADRCs, CILs, providers of long-term services and supports, Behavioral Health Centers, Senior Centers and others to build a comprehensive network that is not just focused on the person's medical needs but that takes a broad view of health including economic viability and interdependence.

The work of shared governance has begun with the Mission and Vision that the NWD stakeholders have developed. Now what is needed is to:

- Determine if there are others needed at the table
- Better define the roles and responsibilities for all involved
- Identify a lead person in each small group and support them to meet regularly around specific goals
- Develop a plan of action and put the structure (with timelines) in place, with specific steps, to achieve the plan.

CONSUMER SURVEY INPUT AND FINDINGS

The purpose of the NWDconsumer survey was to supplement the organization-level data gathered through the NWDstakeholder interviews. While interviewees were knowledgeable about their particular portion of the LTSS system (and some had broader involvement than others), their perspective was not the same as the person using or trying to access the system at the consumer level. By providing an opportunity for seniors and adults with disabilities to share their voice, it gives a balance to the structure that is intended to serve them.

The survey was developed by the Frontier Group, LLC in partnership with the ICOA staff. Time did not permit field testing the survey, but input was gathered from interview participants to ensure that the survey was easy to understand, in a font large enough for people with vision difficulties to read, included adequate white space, was absent of technical terms, and kept to a limited length. An introduction was originally included on the survey itself but was cut to keep the document to no more than three pages in its paper version. While this kept the survey short, it did not guarantee that the people filling out the survey understood the context and purpose of the survey.

The ICOA notified the AAAs and the CILs that their help was needed in distributing surveys. ICOA provided the home deliver meals and congregate site counts. Survey information was also sent to each AAA to notify their Senior Centers regarding this project and the contractor was available by phone and email throughout to respond to questions from the field.

The survey was offered in two formats, online and paper. A total of 12,963 paper surveys were mailed statewide as follows:

Organization	Number of Paper Surveys	Distribution Methods
AAA I	1,493	Mailed in packets to each of 11 Senior Center meal sites
AAA II	1,515 + 100	Mailed in packets to each of 12 Senior Center meal sites plus an additional packet sent to the AAA for In-Home Service Providers
PSA III	3,403	Mailed packets to 33 Senior Centers and HDM programs
AAA IV	2,452	Mailed packets to 16 Senior Center meal sites
AAA V	1,896	Mailed in two boxes to AAA for distribution to 13 Senior Meal sites
AAA VI	1,254	Mailed in packets to each of 13 Senior Center meal sites
LINC	200	Dropped off to distribute throughout their service area
LIFE	150	Mailed to distribute throughout their service area
DAC	100	Mailed to distribute throughout their service area
Supplemental	500	For additional surveys as needed
Total	**12,963**	

Each organization packet included the surveys (**Appendix C**), an introduction to the survey (**Appendix E**), and an addressed envelope to return to the Frontier Group. The survey deadline was March 27, 2015 although any paper surveys received by April 3, 2015 were included. Postage was not paid because of the uncertainty of the return. One site requested reimbursement for postage costs. More than 2/3 of the Senior Centers returned packets and the rate of participant response ranged from 2% to 76%, with most in the 20-40% range. On average, the more rural communities had a higher rate of return than the more populous areas.

In addition to the paper surveys, the survey was offered online using Survey Monkey. The ICOA posted the link on their website and the ICOA staff and contractor sent the link out statewide to several distribution lists on March 11, 2015. A reminder was sent on March 19, 2015. At least one of these distribution lists targeted disability organizations and it was anticipated that many of the adults with disabilities would use the online version of the survey.

The survey was translated into Spanish and paper versions were distributed upon request. See **Appendix D** for the Spanish survey. The Spanish language online version was sent out to the distributions lists with the English language link and sent to organizations that serve Spanish speakers.

The response rate was 20% (19% for paper surveys only); 2,476 paper surveys were received and there were 129 online responses. All of the paper surveys were entered into the online survey using Survey Monkey so that the data could be aggregated. The open-ended method of distributing the survey meant that, although it was intended for individuals over age 60, adults aged 18 and over with disabilities, or caregivers of either of those target groups, there was no way to guarantee that it would not be used by people outside the target populations. Based on prior surveys, a 20% return rate was considered acceptable but survey research indicated that a lower rate would be adequate since the sample was so large. Because of lack of controls, however, it is important to not characterize the findings as statistically valid.

This survey differs substantially from the prior surveys of Idahoans age 50 and older that were done by Boise State University in 2008 and 2012. Those surveys involved a much smaller statistically controlled sample with careful consideration for validity of instrument and distribution and collection methodologies. While it may be of interest to compare the BSU findings with those in this assessment, the purpose, instrument, process, population, and methods are quite different.

SURVEY RESPONSES

QUESTION 1. – I am (select all that apply): 60 years or older, over 60 with a disability, 18-60 with a disability, a caregiver to a senior or an adult with disabilities, a family member

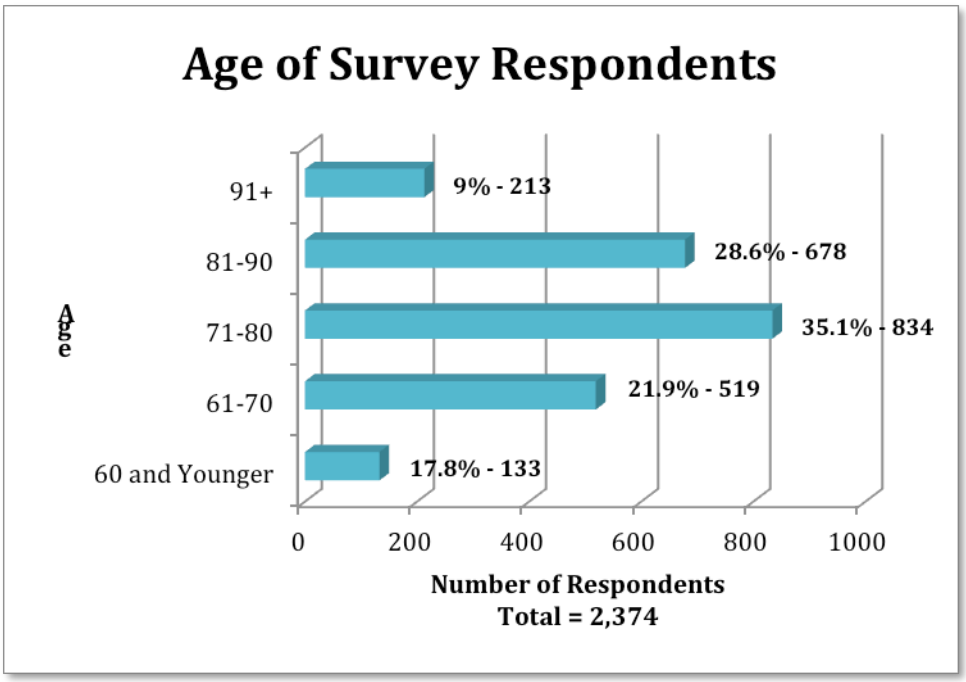
This question asked respondents to indicate to which category they belonged. Because multiple answers were allowed, there is some overlap in the numbers. Not surprisingly, more than 72% were over 60 and 27.1% were over 60 with a disability. Since disability was not defined, there is probably wide variance in what many consider – or do not consider – a disability. Only 103 or 4% of the respondents were adults with a disability under age 60, the target population for the services provided by the CILs. A total of 2,569 people responded to this question with 36 declining to answer.

The second part of the following table breaks out those responses posted online (129, with one skipping this question) from the total received. Although the numbers are much smaller, the percentages vary considerably from those in the total response population. Most notable is the smaller percentage of people over 60 with a disability responding online (56.3% vs. 72.2%) and the much higher percentage of those identifying themselves as family members (26.6% compared to 8.8%).

Category of Respondents				
	All Responses		Online Responses Only	
Answer Options	Response Count	Response Percent	Response Count	Response Percent
60 years or older	1,856	72.2%	72	56.3%
18-60 with a disability	103	4.0%	16	12.5%
A family member	226	8.8%	34	26.6%
Over 60 with a disability	695	27.1%	6	4.7%
A caregiver to a senior or an adult with disabilities	172	6.7%	37	28.9%
Answered Question	2,569		128	
Skipped Question	36		1	
Total	**2,605**		**129**	

QUESTION 2. Date of Birth

This question asked for the person's date of birth. The online survey provided a MM/DD/YYYY field, while the paper survey asked for the date but did not require a certain format. As long as the reply gave the full date, it could be converted into the required format when entering into the online version. However several respondents did not do that, simply leaving it blank, writing the person's age, or just the year. In each of these instances, the date could not be included when it was converted into an electronic format which meant it had to be excluded from the total. The responses are categorized by decade with the exception of 91 and older and 60 and younger. The oldest person completing the survey was nearly 102 and the youngest was 19. Those 60 and younger can be assumed to be either caregivers or family members or people with disabilities. The average age of all respondents is 76.5 years.

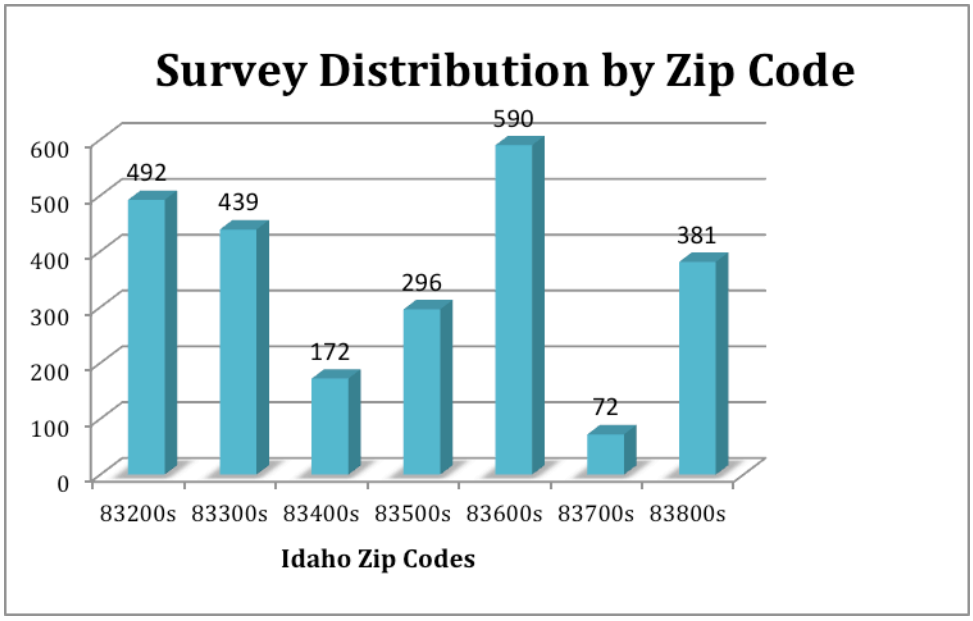


QUESTION 3. Zip Code

This question was intended to demonstrate the distribution of respondents across the seven zip codes in Idaho. The zip codes reflected the same areas as those covered by the AAAs and the CILs as shown:

DAC/NW		LINC			LIFE	
Area I	Area II	Area III		Area IV	Area V	Area VI
83800	83500	83600	83700	83300	83200	83400
381	296	590	72	439	492	172
15.6%	12.1%	24.2%	2.9%	18%	20.1%	7%

There were 53 surveys with zip codes that were incomplete, inaccurate or out-of-state. The total number of surveys with zip codes that were usable was 2,442.



The paper survey distribution methods used at each Senior Center meal site contributed to the level and completeness of the response. If people were not told the purpose of the survey or if there was no concerted effort by Senior Center staff to follow up, it was left to the respondents to decide whether it was worth their time and effort. Forty-eight surveys from AreaII were received from individuals who had received them from in-home care givers who provided support and assistance in completing them. These surveys were completed thoroughly with minimal skilled questions, indicating the importance of that assistance, support, and information.

Zip codes 83600 and 83700 include the largest and most concentrated population areas of the state. The highest number of responses in the state was from 83600 and the lowest from 83700. The 83700 zip codes are in the Boise area and the 83600 zip codes are in the surrounding areas of southwest Idaho.

QUESTION 4. Your gender

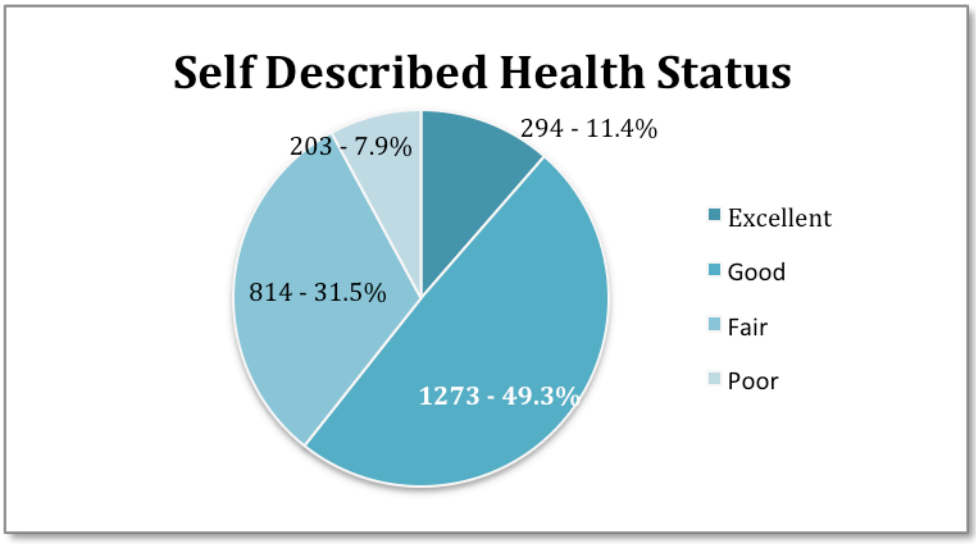
In Question 4 respondents provided gender information. Although the majority of respondents across the survey were women, among the online responses the number was more than 10% higher. In the 2010 U.S. Census, 48% of the population of Idaho over 50 was female contrasted to 64-74% of the respondents to this survey. And the Census indicated that 52% of the Idaho population over 50 was male, compared to 26-36% of this survey's respondents. The fact that this survey was targeted to people over 60 may have influenced those differences.

Respondent's Gender				
	All Responses		Online Responses Only	
Answer Options	Response Percent	Response Count	Response Percent	Response Count
Female	64.0%	1,651	74.2%	95
Male	36.0%	928	25.8%	33
answered question		**2,579**		**128**

QUESTION 5. How would you describe your health status?

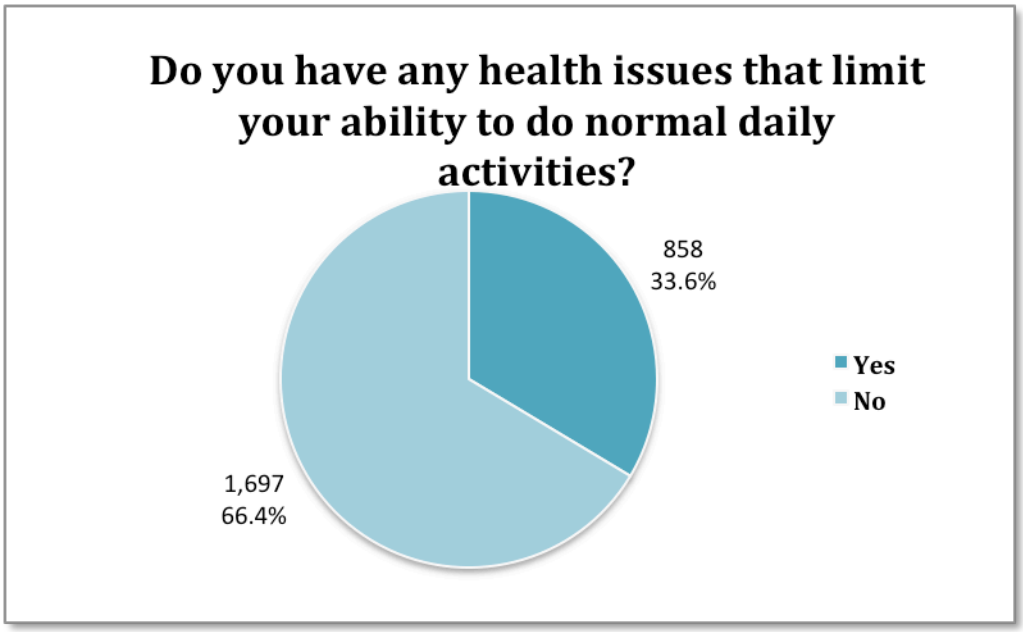
Question 5 asked people to describe their current health status. The choices were: Excellent, Good, Fair, and Poor. The answers are subjective based on the person's own perception of their health.

There were 2,584 responses to this question. Twenty-one (21) people declined to answer. Over 60% described themselves as in excellent or good health and less than 8% characterized their health as poor. Since the survey information was gathered via Senior Center lunch sites and, to a lesser degree, home delivered meals, most of the respondents are not home bound or in institutional settings where people with more fragile health would be found.



QUESTION 6. Do you have any health issues that limit your ability to do normal daily activities?

Health was also the topic of Question 6 which asked if the person had any health issues that limited their ability to do normal daily activities. Examples were given of preparing a meal, bathing, light housework, etc. Answers were limited to yes or no without opportunity for explanation. About 2/3 of the 2,555 respondents indicated that they did not have any of these limitations. Fifty-five (55) individuals did not answer this question.

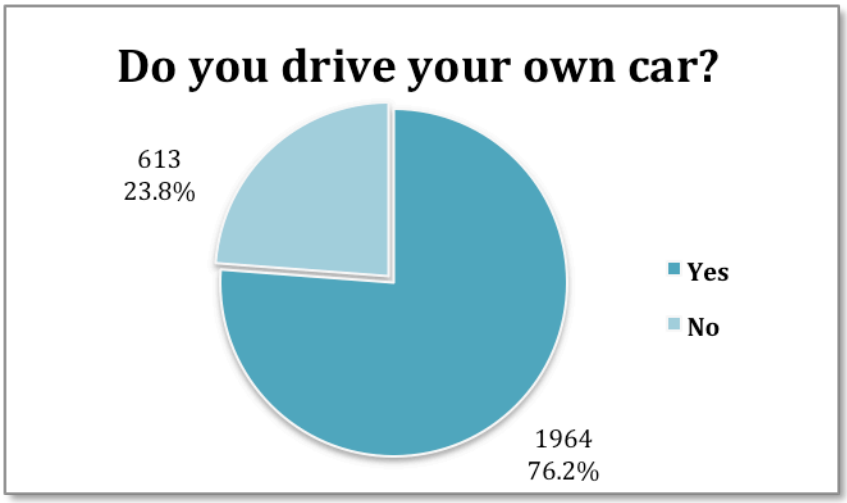


For those who indicated they did have limits in their daily abilities, we compared them to their self-described health status. Nearly 73% or 618 of the 848 respondents said their health was either fair or poor which would correspond with limits on their ability to do normal household activities. However, 15 people described their health as excellent and still were limited in their daily activities. These people may fall into the category of people with physical disabilities who are otherwise healthy but need some assistance around the house. Ten people who answered Question 6 in the affirmative did not respond to Question 5.

Limits on Daily Activities Compared to Health Conditions		
Consumers that answered 'Yes" to Question 6		
How would you describe your health status?	**Response Percent**	**Response Count**
Excellent	1.8%	15
Good	25.4%	215
Fair	52.7%	447
Poor	20.2%	171
	answered question	**848**
	skipped question	**10**

QUESTION 7. Do you drive your own car?

Mobility contributes to being able to access not only long-term services, but opportunities in the community for living a healthy and connected life. With limited public transportation in Idaho, a person's ability to drive their own car is often a lifeline to independence. Question 7 sought to find out how many of the respondents were able to drive. More than ¾ of the 2,577 people who responded indicated that they drove their own vehicle. Twenty-eight (28) people did not respond to this question.



QUESTION 8. Where do you live?

To locate where to conduct LTSS outreach, consumers were asked to identify their living circumstances. It is possible that a person could be living in a certified family home cared for by a family member. In that instance, three of the categories would apply, but participants were limited to a single response. The overwhelming number, 2,551 out of 2,591 (98.5%) of the survey respondents live in their own home or with a family member. Fourteen (14) people chose not to respond to this question.

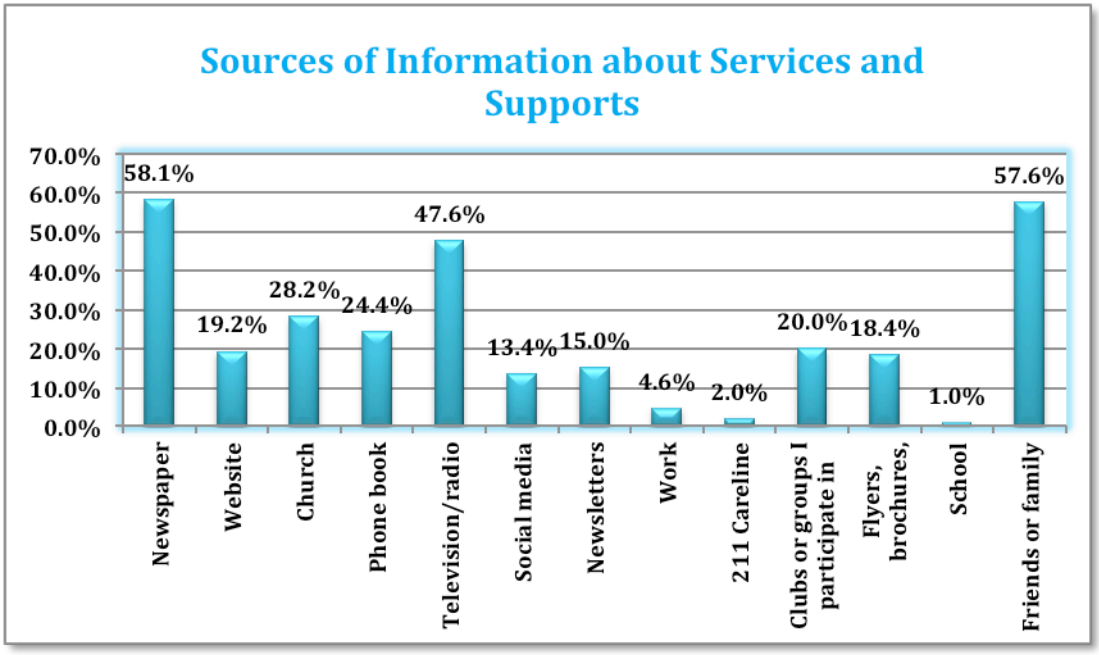
Where do you live?		
Answer Options	**Response Percent**	**Response Count**
My own home - owner of the home	76.3%	1976
My own home - renter	17.2%	445
Home of a family member	5.0%	130
Home of a care provider	0.3%	7
Congregate living facility - assisted living	1.0%	26
Congregate living facility - certified family home	0.2%	6
Congregate living facility - nursing home	0.0%	1
	answered question	**2591**
	skipped question	**14**

To confirm the relationship between a person living independently and driving, the chart below shows the high correlation between the two. Of the 1,954 people who responded to both of these questions, the percentage of people who both drive their own care and live in their own home is 95.7%.

Living Arrangements for People Who Drive Their Own Car			
	Do you drive your own car?		
Where do you live?	**Yes**	**Response Percent**	**Response Count**
My own home - owner of the home	1609	82.3%	1609
My own home - renter	261	13.4%	261
Home of a family member	70	3.6%	70
Home of a care provider	2	0.1%	2
Congregate living facility - assisted living	9	0.5%	9
Congregate living facility - certified family home	3	0.2%	3
Congregate living facility - nursing home	0	0.0%	0
		answered question	**1954**
		skipped question	**10**

QUESTION 9. Where do you get information about the services and supports that you may want or need? (check all that apply)

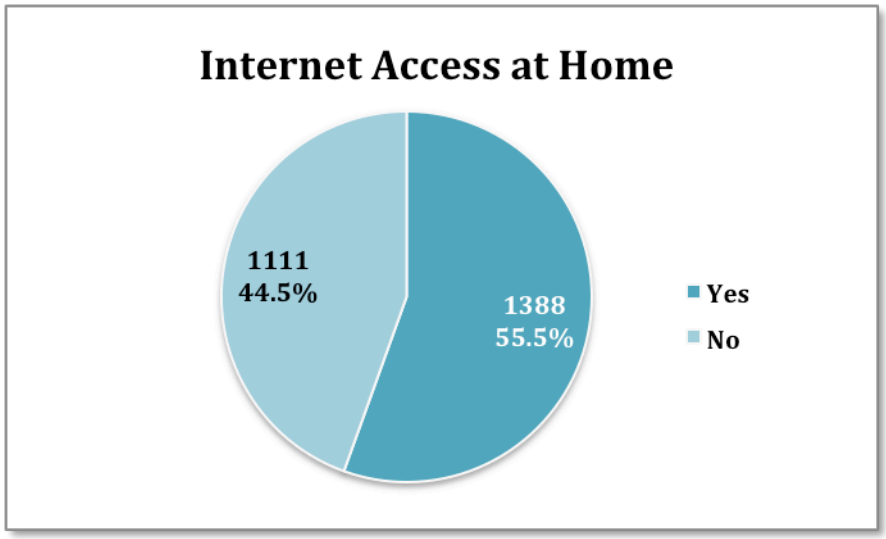
One of the questions asked of stakeholders in the interview process dealt with what information their agency provided on LTSS and the methods used for sharing that information. Question 9 was developed to illustrate where people searching for LTSS got their information. There were 13 choices plus respondents could add "other" to those choices. Multiple answers were permitted.



Not surprisingly among the senior population, the majority relied on the newspaper as their information source with family and friends a close second. Many also turned to television, church, or the phone book for information. School was the least used information source as would be expected with this target population. However, the second lowest information source, the 211 Careline, was often mentioned as the "go to" source by stakeholders. That does not appear to be the case in this survey.

QUESTION 10. Do you have access to the internet at home?

In order to gain a more accurate picture of today's seniors and people with disabilities, this question asked participants whether they had access to the internet at home. This information could also be valuable for future surveys to determine if there would be adequate response by relying on online methods of data collecting only. Two thousand four hundred ninety-nine (2,499) people answered this question and 106 skipped it. Although more than half do have access to the internet at home, the results indicate that paper surveys should probably continue for now. The data from this question may also explain the relatively low use of websites and social media as information sources as shown in Question 9.



QUESTION 11. What long-term services and supports do you receive/use?

This question was parallel to one of the questions asked of stakeholders. In the interviews, stakeholders were asked what long-term services and supports their organizations provided. In Question 11, the survey attempted to determine what long-term services and supports people used. People could choose as many as applicable and also add more services under the "other" category. Assistive technology was the most frequently cited with 587 (43.4%) and respondents circled or underlined many of the examples provided, including walker, wheelchair, hearing aids, and cane. Most of those that added under "Other" were explanations of the assistive technology or equipment that they use.

Unfortunately, without a clear explanation of these services, either on the survey instrument itself or in how it was presented to potential respondents, many did not answer this question. Nearly as many people skipped this question (1,250) as answered it (1,355). Perhaps an example of this

was that a majority of the surveys were distributed at Senior Center meal sites, but less than 30% of respondents indicated that "congregate meals" was a service they received. In all likelihood, many seniors probably regard these meals as a chance to go to lunch and visit with their friends and do not think of it as a service or support. For some of the other services and supports listed, there could well have been confusion as to what these terms meant. That is confirmed through comments at the end of some of the surveys.

In addition to congregate meals (29.2%), the most commonly mentioned services were vision care (34.1%), dental care (29.7%), homemaker (17.4%), and home health (14.2%). Options counseling was mentioned the least (7 or .5%).

What Long-Term Services/Supports do you Use?		
Answer Options	**Response Percent**	**Response Count**
Homemaker services	17.4%	236
Chore services	9.3%	126
Dental care	29.7%	402
Attendant care	5.5%	75
Physical therapy	13.4%	182
Education services	2.5%	34
Person-centered counseling	2.3%	31
Vocational support	0.8%	11
Home health services	14.2%	192
Respite for caregiver	3.5%	48
Vision care	34.1%	462
Congregate or home delivered meals	29.2%	395
Occupational therapy	2.7%	36
Options counseling	0.5%	7
Home modification for accessibility	3.5%	47
Medicaid transportation	4.1%	55
Companion services	5.5%	74
Recreational programs	7.1%	96
Help with transitioning from a hospital or nursing home to home	3.6%	49
Support groups	5.8%	79
Counseling	3.8%	52
Care management/service coordination	3.1%	42
Other public transportation	7.2%	98
Assistive technology or medical equipment (eg. wheelchair, walker, oxygen, cane, communication device, hearing aids, etc.)	43.3%	587
Other (please specify)		579
	answered question	**1355**
	skipped question	**1250**

QUESTION 12. Are there long-term services/supports you want or need that you are not getting?

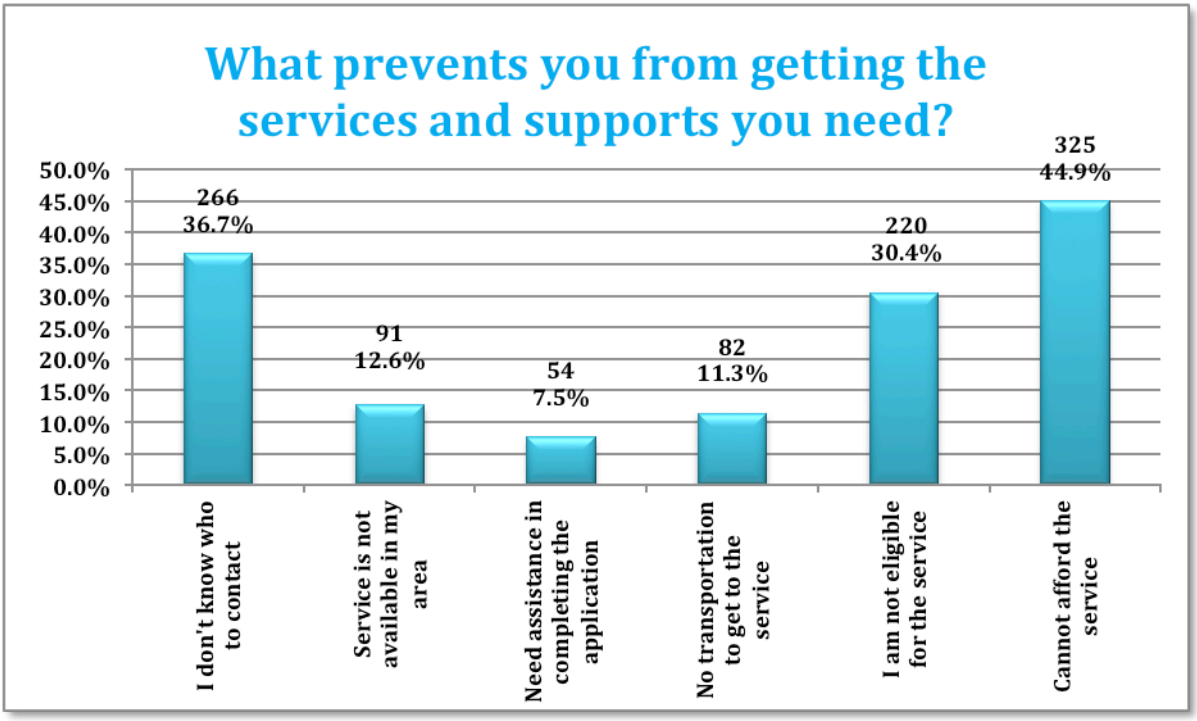
This question was a follow up to Question 11. It asked participants to share what their LTSS needs were using the same menu of services as the previous question. The same difficulties plagued this question as its predecessor. Lack of information or understanding about the terminology led people to skip this question or people did not need these services. For those that did respond, many indicated just that – they did not need most of these services. The response to this question was even less than for Question 11. Only 24.5% of the total survey participants responded. The most needed or desired services were close to the same as those services that people already received. Dental care (37.3%), vision care (28.7%), assistive technology or medical equipment (25.1%), homemaker services (12.9%), chore services (15.5%) and physical therapy (12.7%). Current meal service (congregate and home-delivered) seemed to be meeting people's nutritional needs.

What Long-Term Services/Supports do You Want or Need?

Answer Options	**Response Percent**	**Response Count**
Homemaker services	17.9%	114
Chore services	15.5%	99
Dental care	37.3%	238
Attendant care	4.4%	28
Physical therapy	12.7%	81
Education services	3.3%	21
Person-centered counseling	3.6%	23
Vocational support	1.4%	9
Home health services	7.4%	47
Respite for caregiver	7.1%	45
Vision care	28.7%	183
Congregate or home delivered meals	6.1%	39
Occupational therapy	3.0%	19
Options counseling	3.9%	25
Home modification for accessibility	6.0%	38
Medicaid transportation	5.8%	37
Companion services	8.5%	54
Recreational programs	8.2%	52
Help with transitioning from a hospital or nursing home to home	4.2%	27
Support groups	7.5%	48
Counseling	5.3%	34
Care management/service coordination	2.7%	17
Other public transportation	8.8%	56
Assistive technology or medical equipment (eg. wheelchair, walker, oxygen, cane, communication devise, hearing aids, etc.)	25.1%	160
Other (please specify)		269
	answered question	**638**
	skipped question	**1967**

QUESTION 13. What prevents you from getting the services/supports you need? (check all that apply)

Question 13 was related to the two previous questions. Participants were asked what prevented them from getting the services and supports they needed. Multiple answers were allowed. Although it is difficult to tell from the data, reviewing the individual survey responses showed that people often checked some of these obstacles even if they did not indicate that supports or services were needed. This may reflect ongoing issues they have with trying to get particular services.

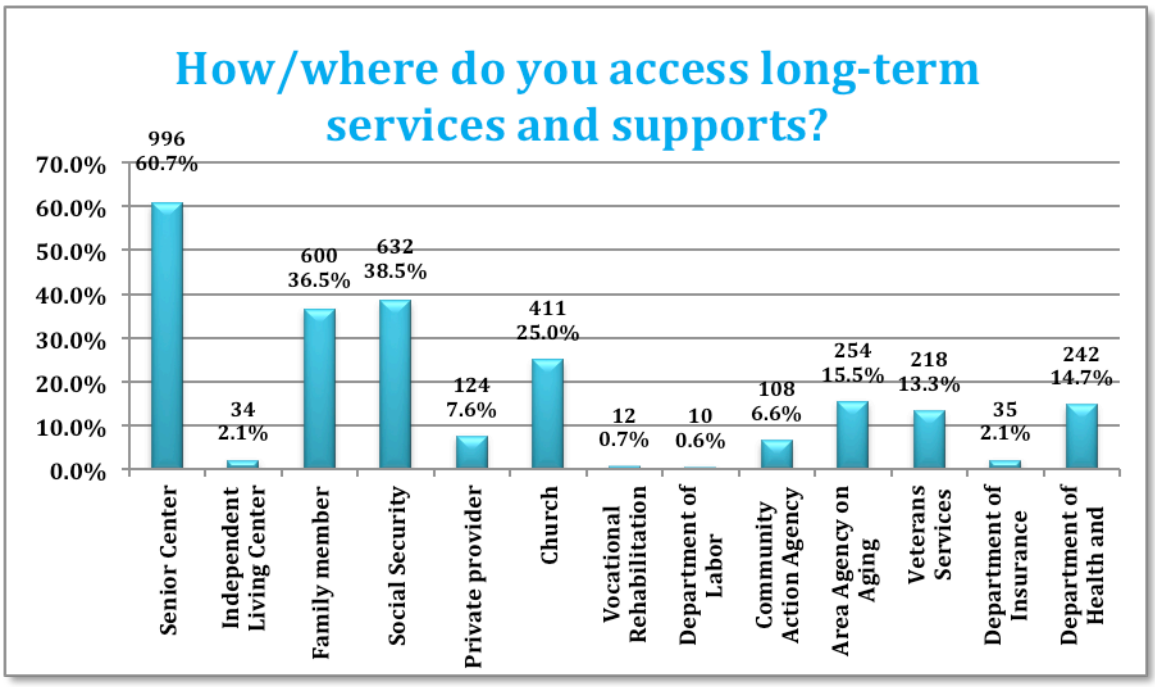


This question had a total of 724 responses. More than twice that number (1,881) did not answer this question. This is not surprising since only 638 indicated in Question 12 that they needed additional services.

Most respondents 325(44.9%) said they could not afford the service (although the service was not identified), followed by 266 (36.7%) who said they did not know who to contact and 220 (30.4%) who felt they were not eligible. It is difficult to analyze this further without knowing what service the person may need. It may be that there is a general perception about expense and eligibility that overlays any attempt to get services. Or the person may have applied for a service or at one time and been found ineligible and then generalized that experience that to other services as well.

QUESTION 14. How/where do you access long-term services and supports?

Question 14 was the final question that invited respondents to select from a menu of choices. The question asked was where the person went to get long-term services and supports. Some of the choices involved agencies where the person could apply for and receive benefits based on eligibility. Others did not have particular criteria and still others were more informal (church, family member).



This question received 1,642 responses (63%) and 963 declined (37%). Most frequently mentioned was Senior Centers (60.7%), followed by Social Security (38.5%), family members (36.5%) and church (25%). Only 34 individuals (2.1%) indicated that they received services and supports via independent living centers which were distribution points for this survey. The Department of Labor (.6%) followed closely by the Division of Vocational Rehabilitation (.7%) were the least chosen, not surprising since they are gateways to employment supports and the majority of respondents could be expected to be retired based on their age. Participants were allowed to select as many answers as applicable.

QUESTION 15. Please provide suggestions as to how we might improve access to information about long-term services and supports.

The final survey question asked participants to offer suggestions as to ways in which information about and access to long-term services and supports might be improved. Three hundred twenty (320) people commented. Some comments were suggestions, some were personal stories and requests for assistance, and some indicated that the person did not need help but appreciated being asked. Many respondents indicated how much they appreciated the Senior Centers and the activities and meals provided (including Meals on Wheels). Several people commented that they wanted to make sure the Senior Center programs were continued.

Comments could be grouped into some common areas or themes. The following are examples:

Getting Information Out:

- *Develop a master list of services and give to all home health agencies to share with their staff in the field.*
- *A newsletter through emails might help, perhaps weekly. That way I'll be more likely to know what's available, what to do to receive help, and where/to whom to turn.*
- *Flyer out through Meals on Wheels, Senior Center, newspapers; 211 could have a complete list; disability help through DAC and Aging; people have to pick this up piecemeal. They don't know what to call for the help they need.*
- *Quarterly round table workshops*
- *More specific information at doctors' offices related to long term care*
- *Commercials on TV, radio; more community events*
- *Make clear to the elderly what exactly Medicare provides in simple economic sense!*
- *By sending out a list of services available and how they can be accessed. I'm pretty much in the dark about the availability-cost-eligibility*
- *Design, launch and maintain an informative website! (Other than Facebook)*
- *Maybe you could have some seminars or classes to help people find out who to contact.*
- *Perhaps a TV channel devoted to areas of assistance for various situations and ages. Represent all programs as they become available with phone numbers and websites. Update regularly.*
- *Need a phone number similar to 911 or 211 that would access the agencies that supply long term services.*
- *I was surprised that my doctor's office had no information. Putting brochures and giving them information seems like a good place. Hospitals should also have up-to-date information and I didn't find this to be the case here. Everything I learned I had to research and ask lots of friends because none of the agencies had information about options but their own.*

Senior Centers:

- *The Senior Center is a great place for helping you! I have been helped a lot by them and they have also helped others in so many ways.*
- *Do a program at one of the Senior Center breakfasts or lunches and advertise it will ahead of time.*
- *Senior Centers should have folder filled with brochures of ALL nursing homes, retirement centers, and Alzheimers facilities available in Valley, Adams County and in Boise, Nampa area, etc. Prices to start and what that gets you for that $$.*

Veterans:

- *Qualify for Veterans benefits (WWII) but have not applied. Limited ability to get around. Spokane VA hospital lost my records when they went to computers.*
- *I am in my parent's home as often as possible. I am on Social Security Disability due to my own medical issues, however, I would like to get help for my father through Veteran's Services. My father served during World War II receiving the Bronze Star. Unfortunately, he has never taken advantage of Veteran's Services, believing that it is only for the needy. He is a very proud man, but even I can see he needs and has earned these benefits. Thank you.*
- *I am a WWII combat veteran but can't qualify for VA because I don't meet the means test. Too bad because there are many with far more money than I who got in earlier and are receiving VA services.*
- *Regarding Veterans who come to GPSC. Invite American Legion, Veterans of Foreign Wars, and Veterans Affairs service representatives to educate veterans on updates, changes and availability of benefits, resources, etc. As they are always changing and some senior members may qualify for them. Most VSO meetings are held at 7 pm and seniors may not have transportation so they are not able to get the information.*

Dental Care:

- *The local medical and dental support isn't up to par due to the rural setting of this community.*
- *I need new dentures. Medicaid, Medicare and VA don't pay for them so I eat with no teeth,*
- *Need help to pay for dental surgery to remove roots of two teeth broken off at the gum line and implants to replace the teeth.*
- *Make eye and dental insurance affordable on Medicare*

Transportation:

- *I live 2 miles from Moscow city limits. No bus service is available that I have information about, paid or free. Any help there?*
- *Provide transportation to homeless and hungry people to food banks and soup kitchens.*
- *A lot of seniors here need transportation to shopping and doctors.*
- *Desperately need transportation funding for congregate meal site and elder transportation*
- *Resume Senior Center bus services. They used to pick me up at home and I miss it.*
- *Need transportation available Monday-Friday.*

Services in general:

- *Companion service was not a match for the person to be served. Info provided on client should be shared with people providing care, not placed in the file unseen by staff who need info. People providing services should identify what they do for client specifically.*
- *Just need someone to clean my apartment once a week. I just can't do it. You were sending a housekeeper but I was informed Medicare cut me off by a letter.*

- *When my mother had dementia, the services in Los Angeles were abundant. When I brought her up here there was so much less services and I felt lost. Now for me, I broke my neck 2 years ago and the services were abundant. The hospital had a great program in post-op care and so did the Senior Center here in Hailey. The Meals on Wheels is wonderful having good food and services. It has definitely been a good experience. Far better than my mother and I experienced in 2000-2001.*
- *I don't know where to start if I qualify*
- *It would be helpful to have a resource list of activities, services and supports for those adults over 22 with intellectual or physical disabilities (or know where to access such a list). Always seeking new and different age-appropriate support activities!*
- *Not everyone who is older and needs services has access to the internet. Also many do not know how to access the internet. Most of the services that Idaho seniors really need have been cut by the State of Idaho. It is really a disgrace.*
- *We have a lot of families that call me that are desperate for help. Would be nice to have a VA gatekeeper. Would be nice to know who to call when Medicare doesn't approve a rehab to push back. Would be nice to understand with Medicare where to go for which technology, if they will pay for it, and how to get them to call you back.*

Caregivers:

- *I am a full-time caretaker for my father. I help my mother. I don't need much myself as long as I have my meds.*
- *My dad has Alzheimer's and my mom has dementia; neither of them do anything without prompts*
- *Pay caregiver's mileage*
- *Train service providers to recognize caregivers and the need for caregivers to have resources and extend those resources.*
- *List of people who provide respite care for several days at a time so caregivers can take a real vacation. List of facilities that are low cost assisted living or memory care that allow well-behaved pets.*
- *We are very thankful for home delivered meals; it is very helpful for me and my family. We need help with respite care for my daughter so she can take a break as she cares for me 24 hours.*
- *I wait on my (blind) husband 24/7. Sometime I need to get away. Sometimes I need to shop for necessities. Family members are not reliable. They have families of their own to care for. When I want to scream, I'm not so nice to my husband. And he is a wonderful person. He deserves the best! I really need to get out of the house 2-3 times a week. I need to go to church on Sundays. I need to visit my disabled daughter sometimes. Help!*

System Suggestions:

- *Don't use phone tree information lines. Make people available to speak to people. Human connections are vital to information sharing.*
- *I feel that there are not any selections in our area that are affordable. The services help with disabilities are non-existent in the State of Idaho*
- *Internet connect AAA-Senior Center with Independent Living Center and Veterans Services links. ADRC. Texting, tweeting, Facebook.*
- *If the State of Idaho would open up Medicaid, people could get the services needed. I have 2 part-time jobs and no insurance and cannot get Obamacare because I don't earn enough.*
- *While I do not need services, I suggest have a person (social worker) working with senior centers that can coordinate services and make me aware of what is available on the occasion I may need it. Many times there are so many services available that it is difficult to find them.*
- *Several years ago I had one number I could call and one person- a caseworker I believe – helped me with all info and paperwork. Now very complicated. Different numbers, names, services, associations, etc. I have short term memory loss and brain damage.*
- *Establish a website that can be accessed by the public re: services and supports that are available. This could act as a "Bulletin Board" for seniors who need assistance. Those who do not have internet access could still benefit from friends and others who would "spread the word" to those need assistance.*
- *Have guidelines for doctors dismissing patients to inform (on dismissal papers) of who to contact. Under Medicare, we are only allowed a short time in a nursing home after a hospital stay. In 2013, my husband fell and sustained a broken neck. He was also a cancer patient. He was discharged to home at 100 days after spine surgery. The cancer doctor said go home with "hospice". However there are NO hospice services on top of the Greer grade, our area. We had to contend with someone who should have still been in the hospital by ourselves. Total care is hard on backs. In the drug store one day a clerk told me to call Area Agency on Aging. Our first and only real help. This was after 3 months without help, another hospital stay for my husband, and another nursing home stay. I am trying to stay alive as the only help for my husband and our son, a diabetic since age 2 on insulin for 59 years. I really appreciate the help from the Agency on Aging and wish I had known of it sooner. Thank you.*

CONCLUSION

From the interviews and the survey findings of the 2015 No Wrong door Assessment, it is possible to identify some of the key elements that would be important or necessary to implement this system in Idaho. Those include:

- ✓ A clear, well organized plan of action developed by stakeholders and championed by leadership, that contains specific objectives, timelines and responsibilities
- ✓ Multi-faceted, collaborative outreach efforts that utilize a wide range of strategies and methods to reach seniors and people with disabilities
- ✓ Widely recognized phone number/website that people can access 24/7 and that is not limited to low-income or free provider information
- ✓ A coordinated, well maintained, comprehensive database that is sharable
- ✓ A triage approach that prioritizes inquiries for level of information or supports needed and directs people to the appropriate service
- ✓ Case management/care coordination navigation system for those who need that level of assistance
- ✓ Training for care coordinators in person-centered counseling to help individuals understand their options and develop a self-directed supports plan, as needed
- ✓ Recognition of the key role of informal caregivers and development of strategies to include them in system reforms
- ✓ Linkage, including information sharing, among the long-term services systems and providers and the evolving primary care system at both the state and regional levels
- ✓ Linkages, including information sharing, between the long-terms services systems and providers and the behavioral health care system, with an emphasis on dementia and Alzheimer's care
- ✓ Shared oversight of and responsibility for the system by key stakeholder agencies, perhaps with administrative coordination via an independent "convener" (similar to Your Health Idaho)
- ✓ Methodology for continuous quality improvement that is effective and not onerous to implement
- ✓ Recognition that systems change requires a shared vision, common goals, and a commitment of time and resources

APPENDICES

NO WRONG DOOR: Transforming State Long-Term Services and Supports Programs and Functions into A No Wrong Door System for All Populations and All Payers.

Vision: *Enhance resources and promote meaningful long care options for Idahoans*

Mission: *Empower people to make long-term care decisions by providing reliable resource information and person-centered counseling through a network of community organizations*

The NWD system is a collaborative effort of state and local organizations and agencies that partner together to provide improved access to information and services for seniors and individuals with disabilities to maintain independence. Person Centered Counseling is an important element to ensure individuals *understand and* take control of their long-term care choices. ADRC Steering Committee provides shared oversight and resources to maximize customer access and minimize duplication.

1. Tell me about your organization/agency. What long-term care **information** does your agency provide?
2. What long-term care **services and supports** does your agency provide?
3. What resources does your organization use that could be shared with NWD partners to achieve common goals?

Examples: Database, publications, web site, newsletter, meetings, eligibility process, outreach and planning efforts, funding, other .

NWD has four components:

A. Public outreach and links consumers to key long-term care information and resources
B. Provides Person-Centered Counseling
C. Streamlines access to public programs
D. Incorporates shared governance, resources and oversight among partners

From your organization's perspective, how would you view the current efforts and proposed NWD system for Idaho? (use as much space as needed)

	Strengths	Weaknesses	Obstacles	Opportunities
Public outreach and linking consumers to LTC information and resources				
Access to and/or training on Person-Centered Counseling				
Streamlining access to public programs that provide LTC				
Shared governance and oversight of the system				

APPENDIX B - ADRC Stakeholder List

Name & Title	Title	Organization	Email	Phone Number	Address
Jami Davis	Admin. Asst.	Idaho State Independent Living Council	jami.davis@silc.idaho.gov	(208) 334-3800	816 W. Bannock, Suite 202 Boise ID 83702
Sarah Toevs	Director	Boise State University Center for the Study on Aging	stoevs@boisestate.edu	(208) 426-2452	1910 University Drive, Boise ID 83725
Russ Spearman	Senior Research Associate	Idaho State University	spearuss@isu.edu	(208) 373-1773	1311 E. Central Drive Meridian, ID 83642
Jim Cook	Executive Director	Idaho Legal Aid Services	jimcook@idaholegalaid.org	(208) 336-8980 ext 1109	310 North 5th Street, Boise ID 83702
Roger Howard	Executive Director	Living Independence Network Center	Rhoward@lincidaho.org	(208) 336-3335	1878 W Overland Road Boise, ID 83705
Elizabeth Kriete	Bureau Chief	Bureau of Long Term Care. Idaho Div. of Medicaid	KrieteE@dhw.idaho.gov	(208) 287-1179	3232 Elder Street, Boise ID 83705
Christine Pisani	Executive Director	Idaho Council on Developmental Disabilities	Christine.Pissani@icdd.idaho.gov	(208) 334-2178	700 W. State St. 1st Floor Boise, ID 83702
Cathy McDougall	Associate State Director	AARP	CMcDougall@aarp.org	(208) 855-4003	3080 E. Gentry Way Suite 100, Meridian, ID 83642
Debra Mueller	Section Chief	Behavioral Health, Boise VAMC	debra.mueller@va.gov	(208) 422-1000 x7840	500 W. Fort St., Boise, ID 83702
Sister Anthony Marie Greving	Director	Southeast Idaho Council of Government (AAA V)	sister@sicog.org	(208) 233-4032	214 East Center Street Pocatello, ID 83201
Shannon Hohl	Supervisor	State Health Insurance Benefits Advisors	Shannon.hohl@doi.idaho.gov	(208) 334-4242	700 W. State Street Boise, ID 83720
Gina Westcott	SW Hub Director	Idaho Mental Health Services	westcotg@dhw.idaho.gov	(208) 334-5605	450 West State Street, Boise, Idaho 83720

Jeffery Hill	Director	North Idaho College (AAA I)	jhill@aaani.org	(208) 667-3179	2120 N Lakewood Dr Suite B Coeur d'Alene, ID 83814
Jenny Zorens	Director	Community Action Partnership (AAA II)	j.zorens@cap4action.org	(208) 743-5580	124 New 6th Street Lewiston ID 83501
Vacant	Pending	(AAA III)	Pending	Pending	Pending
Suzanne McCampbell	Director	College of Southern Idaho Office on Aging (AAA IV)	smccampbell@ooa.csi.edu	(208) 736-2122	315 Falls Avenue Twin Falls, ID 83303
Nick Burrows	Director	Eastern Idaho Community Action Partnership (AAA VI)	nburrows@eicap.org	(208) 522-5391	935 Lincoln Road Idaho Falls ID 83405
Courtney Keith	Program Manager	Health and Welfare 211 CareLine	keithc@dhw.idaho.gov	(208) 334-5771	1720 Westgate Drive, Boise ID 83704
Mark Leeper	Executive Director	Disability Action Center	mark@dacnw.org	(208) 883-0523	505 N. Main Street Moscow, ID 83843
Dean Nielson	Executive Director	Living Independence Network Center	dean@idlife.org	(208) 232-2747	640 Pershing Ave. Suite A Pocatello, ID 83201
Mary Holden	Coordinator	Justice Alliance for Vulnerable Adults (JAVA)	maryholden@boisestate.edu	(208) 850-4771	5156 E. Sawmill Way, Boise, ID 83716
Stephanie Bender-Kitz, Ph.D.	Director	Friends in Action	stephanie@fiaboise.org	(208) 333-1363	1607 W. Jefferson St., Boise, ID 83702
Jane Donnellan	Administrator	Division of Vocational Rehabilitation	Jane.Donnellan@vr.idaho.gov	(208) 287-6477	650 W. State St., Room 150, Boise, ID 83720-0096
Tammy Ray	Coordinator	Idaho Home Choice Program	RayT@dhw.idaho.gov	(208) 364-1889	3232 Elder St. Boise, ID 83705
Dr. Ted Epperley*	Chairman	Idaho Healthcare Coalition	ted.epperly@fmridaho.org	(208) 954-8744	Family Residency Prgm. 777 N. Raymond St., Boise, ID 83704
Annette Phillipp, Ph.D., MPH	Manager	St. Alphonsus Patient Centered Medical Home	phillian@sarmc.org	(208) 367-4274	1070 N. Curtis, Suite 250, Boise, ID 83706

Robert Vande Merwe	Executive Director	Idaho Healthcare Association/Idaho Residential Assisted Living Association	robert@ihca-ical.org	(208) 343-9735	1524 W. Cayuse Creek Drive, Meridian, ID 83646
Denise Chuckovich*	Deputy Director	DHW, Co-Chair State Healthcare Innovation Program (SHIP)	ChuckovD@dhw.idaho.gov	(208) 334-5500	450 W. State St. 10th Floor, Boise, ID 83702
Camille Schiller	Program Manager	Division of Health & Welfare, DHW	SchilleC@dhw.idaho.gov	(208) 334-5969	450 W. State St. 2nd Floor, Boise, ID 83702

* Dr. Epperley was invited but unable to participate in the interview; Denise Chuckovich provided the information for the SHIP

No Wrong Door Long Term Services and Support Survey

APPENDIX C

1. I am (select all that apply):

   ☐ 60 years or older ☐ Over 60 with a disability

   ☐ 18-60 with a disability ☐ A caregiver to a senior or an adult with disabilities

   ☐ A family member

2. Date of birth (focus person of this survey): _____

3. Zip code: _____

4. Your gender: ☐ Male ☐ Female

5. How would you describe your health status:
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

6. Do you have any health issues that limit your ability to do normal daily activities? (examples – preparing a meal, bathing, light housework, etc.)

   ☐ Yes ☐ No

7. Do you drive your own car?

   ☐ Yes ☐ No

8. Where do you live?

   ☐ My home ➔ ☐ Own ☐ Rent

   ☐ Home of a family member ☐ Home of a care provider

   ☐ Congregate living facility – if yes, choose which one

   ☐ Assisted living ☐ Certified Family Home ☐ Nursing facility

9. Where do you get information about the services and supports that you may want or need (check all that apply):

☐ Newspaper	☐ Television/radio	☐ 211 Careline	☐ Friends or family
☐ Website	☐ Social media	☐ Clubs or groups I participate in	
☐ Church	☐ Newsletters	☐ Flyers, brochures, posters	
☐ Phone book	☐ Work	☐ School	☐ Other, _____

10. Do you have access to the internet at home? ☐ Yes ☐ No

11. What long term services/supports do you receive/use:

☐ Homemaker services	☐ Home health services	☐ Companion services
☐ Chore services	☐ Respite for caregiver	☐ Recreational programs
☐ Dental care	☐ Vision Care	☐ Help with transitioning from a hospital or nursing home to home
☐ Attendant care	☐ Congregate or Home delivered meals	
☐ Physical Therapy	☐ Occupational Therapy	☐ Support groups
☐ Education services	☐ Options counseling	☐ Counseling
☐ Person Centered Counseling	☐ Home modification for accessibility	☐ Care management/service coordination
☐ Vocational support	☐ Medicaid transportation	☐ Other public transportation
☐ Assistive technology or medical equipment (wheelchair, walker, oxygen, cane, communication device, hearing aids, etc.)		

☐ Other? _____

12. Are there long-term services/supports you want or need that you are not getting?

☐ Homemaker services	☐ Home health services	☐ Companion services
☐ Chore services	☐ Respite for caregiver	☐ Recreational programs
☐ Dental care	☐ Vision Care	☐ Help with transitioning from a hospital or nursing home to home
☐ Attendant care	☐ Congregate or Home delivered meals	
☐ Physical Therapy	☐ Occupational Therapy	☐ Support groups
☐ Education services	☐ Options counseling	☐ Counseling
☐ Person Centered Counseling	☐ Home modification for accessibility	☐ Care management/service coordination
☐ Vocational support	☐ Medicaid transportation	☐ Other public transportation
☐ Assistive technology or medical equipment (wheelchair, walker, oxygen, cane, communication device, hearing aids, etc.)		

☐ Other? _____

13. What prevents you from getting the services/supports you need (check all that apply):

☐ I don't know who to contact ☐ No transportation to get to the service

☐ Service is not available in my area ☐ I am not eligible for the service

☐ Need assistance in completing the application ☐ Cannot afford the service

☐ Other: _____

14. How/where do you access long term services and supports (check all that apply):

☐ Senior Center	☐ Church	☐ Area Agency on Aging
☐ Independent Living Center	☐ Vocational Rehabilitation	☐ Veterans Services
☐ Family member	☐ Department of Labor	☐ Dept. of Insurance
☐ Social Security	☐ Community Action Agency	☐ Dept. of Health & Welfare (Medicaid, etc.)
☐ Private provider	☐ Other: _____	

15. Please provide suggestions as to how we might improve access to information about long-term services and supports:

_____

_____

_____

_____

Thank you for your time and assistance!

Encuesta de Servicios y Apoyo a Largo Plazo

APPENDIX D

1. Tengo (seleccione todos los que apliquen):
   ☐ 60 años o más ☐ Mayor de 60 años con una discapacidad
   ☐ 18 a 60 años con una discapacidad ☐ Un(a) cuidador(a) de una persona de la tercera edad o un adulto con discapacidades
   ☐ Un miembro de la familia

2. Fecha de nacimiento (persona con respecto esta encuesta): _____

3. Código postal: _____

4. Su género: ☐ Masculino ☐ Femenino

5. ¿Cómo describiría su condición de salud?

   ☐ Excelente ☐ Buena ☐ Regular ☐ Mala

6. ¿Tiene algún problema de salud que limita su habilidad de hacer las actividades normales diarias? (ejemplos – preparando una comida, bañándose, quehacer doméstico liviano, etc.)

   ☐ Sí ☐ No

7. ¿Maneja su propio carro?

   ☐ Sí ☐ No

8. ¿Dónde vive usted?

   ☐ Mi casa ➔ ☐ Soy Dueño(a) ☐ Rento/Alquilo

   ☐ Casa de un miembro de la familia ☐ Casa de un(a) cuidador(a)

   ☐ Lugar de cuidado y asistencia médica – sí contesta sí, escoja a cuál

   ☐ Viviendo en residencia asistida ☐ Casa Familiar Certificada ☐ Asilo de Ancianos

9. ¿De dónde obtiene información sobre los servicios y apoyos que pueda querer o necesitar (marque todos los que apliquen)?

☐ Periódico	☐ Televisión/radio	☐ 211 Careline	☐ Amigos o familia
☐ Sitio web	☐ Medios sociales	☐ Grupos en los cuales participo	
☐ Iglesia	☐ Boletines	☐ Volantes, folletos, pósteres	
☐ Guía telefónica	☐ Trabajo	☐ Escuela	☐ Otro, _____

10. ¿Tiene acceso al internet en la casa? ☐ Sí ☐ No
11. ¿Qué servicios/apoyos a largo plazo recibe/usa?

☐ Servicios de Ama de Casa	☐ Atención médica domiciliaria	☐ Servicios de Compañero
☐ Servicios de quehaceres	☐ Descanso para cuidador(a)	☐ Programas Recreativos
☐ Cuidado Dental	☐ Cuidado de Visión	☐ Ayuda de transición de un hospital o asilo a la casa
☐ Cuidado de Auxiliar	☐ Comidas entregadas a lugar o Centro de Personas de la Tercera Edad	
☐ Fisioterapia	☐ Terapia Ocupacional	☐ Grupos de apoyo
☐ Servicios educativos	☐ Consejería de Opciones	☐ Consejería
☐ Consejería Centrada en la Persona	☐ Modificación de la casa para accesibilidad	☐ coordinación de servicio
☐ Apoyo vocacional	☐ Transportación de Medicaid	☐ Otra transportación pública

☐ Tecnología Auxiliar o equipo médico (silla de ruedas, andador ortopédico, oxígeno, bastón, aparato de comunicación, audífonos, etc.)
☐ ¿Otro? _____

12.¿Hay servicios/apoyos de largo plazo que quiere o necesita y que no está recibiendo?

☐ Servicios de Ama de Casa	☐ Atención médica domiciliaria	☐ Servicios de Compañero
☐ Servicios de quehaceres	☐ Descanso para cuidador(a)	☐ Programas Recreativos
☐ Cuidado Dental	☐ Cuidado de Visión	☐ Ayuda de transición de un hospital o asilo a la casa
☐ Cuidado de Auxiliar	☐ Comidas entregadas a lugar o Centro de Personas de la Tercera Edad	
☐ Fisioterapia	☐ Terapia Ocupacional	☐ Grupos de apoyo
☐ Servicios educativos	☐ Consejería de Opciones	☐ Consejería
☐ Consejería Centrada en la Persona	☐ Modificación de la casa para accesibilidad	☐ coordinación de servicio
☐ Apoyo vocacional	☐ Transportación de Medicaid	☐ Otra transportación pública

☐ Tecnología Auxiliar o equipo médico (silla de ruedas, andador ortopédico, oxígeno, bastón, aparato de comunicación, audífonos, etc.

☐ ¿Otro? _____

13. ¿Qué le impide obtener los servicios/apoyos que necesita (marque todos los que apliquen)?

☐ No sé con quién comunicarme ☐ Falta de transportación para obtener el servicio

☐ Servicio no está disponible en mi área ☐ No califico para el servicio

☐ Necesito ayuda para llenar la aplicación ☐ No puedo pagar por el servicio

☐ Otro: _____

14. ¿Cómo/dónde accesa los servicios y apoyos a largo plazo (marque todos los que apliquen)?

☐ Centro de Personas de la Tercera Edad	☐ Iglesia	☐ Agencia de Área de Envejecimiento
☐ Centro para Vivir Independiente	☐ Rehabilitación Vocacional	☐ Servicios de Veteranos
☐ Miembro de la Familia	☐ Departamento de Trabajo	☐ Depto. de Seguro
☐ Seguro Social	☐ Agencia de Acción Comunitaria	☐ Depto. de Salud y Bienestar (Medicaid, etc.)
☐ Proveedor Privado	☐ Otro: _____	

15. Por favor provea sugerencias de cómo podríamos mejorar el acceso a la información sobre los servicios y apoyos de largo plazo:

_____

_____

_____

_____

¡Gracias por su tiempo y ayuda!

APPENDIX E

Idaho Commission On Aging

No Wrong Door Network

The Idaho Commission on Aging is partnering with health and human service organizations to implement a No Wrong Door (NWD) Network. The goal of this network is to improve access to long term information and services for seniors and adults with disabilities. Examples of these services are nutrition, transportation, housing, planning for long term services, and Social Security benefits to name a few. In order to build this NWD network in a way that is accessible to all, **we need to hear from you**.

Following is a survey that will take approximately 10 minutes to complete. Individual responses are anonymous and confidential. Survey responses will be used to make improvements to the Idaho's Long Term Services and Supports Network.

Please respond to this survey by **Friday, March 27, 2015**.

If you have any questions, please contact Marilyn Sword, Project Consultant, at 208-344-8585 or email her at frontiergroupidaho@gmail.com.

Thank you very much.

Instructions for distributing this survey

AAA - Congregate Meal Sites – Please distribute this survey sometime the week of March 16-20. You may want to pick the day when the largest number of people come in for lunch. Encourage individuals to complete them that day and leave them at the meal site. If they do take the survey home, ask that they bring them back by no later than Friday, March 20. The following week, please send the completed surveys to Frontier Group in the addressed envelope(s) or hold them for pick up by your AAA staff. You will be advised by them as to how they plan to collect the surveys. Please keep track of your postage costs so that you can be reimbursed.

AAA – Home Delivered Meals – Please include a survey with each home delivered meal early in the week of March 16-20 and collect them by the end of the week. Return them to me in the addressed envelope provided or hold them to be picked up by AAA staff. They will work with you to gather the surveys in whatever way is easiest for all.

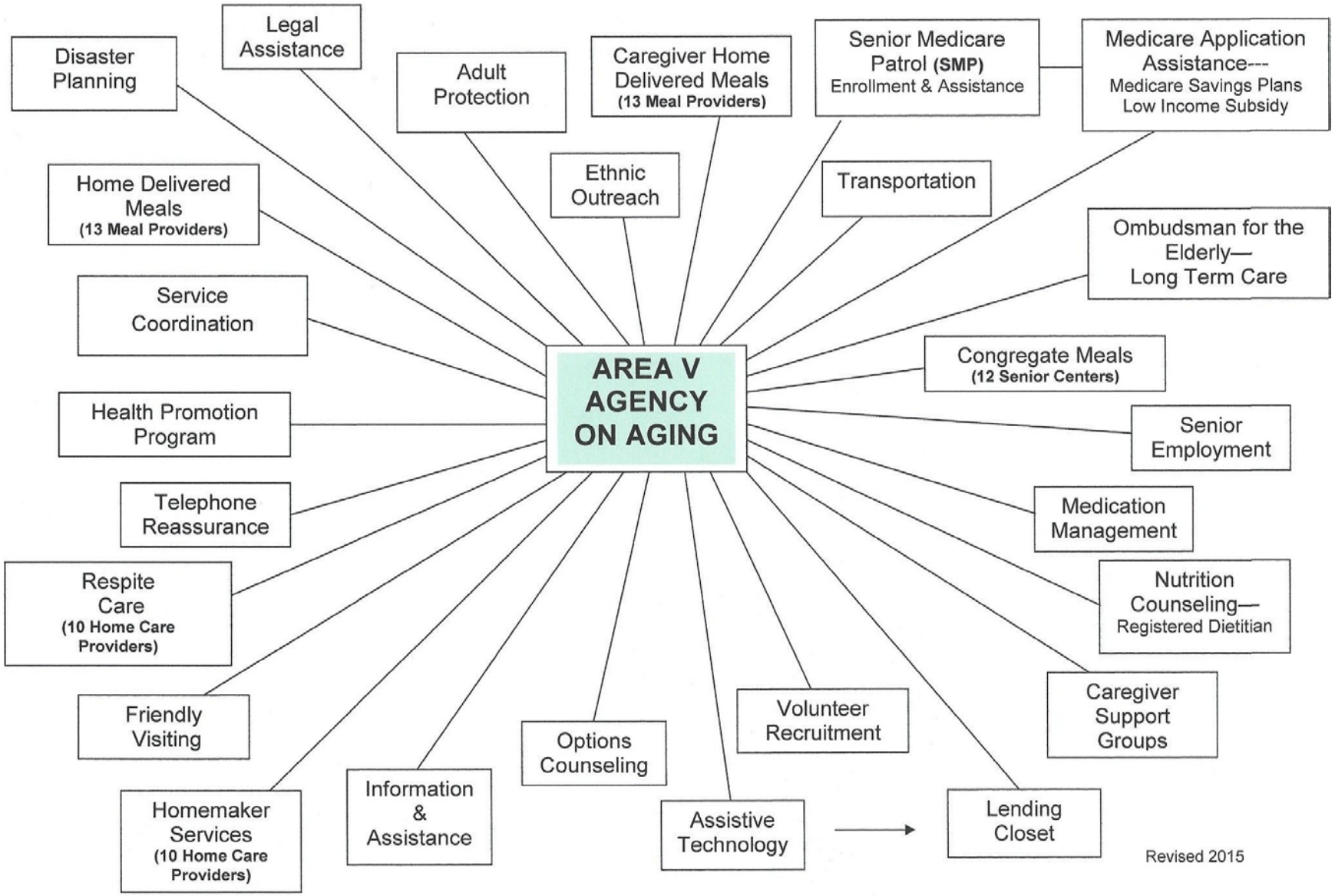
All stakeholders – The survey, in both English and Spanish, will be posted in early March, on the home page of the Idaho Commission on Aging website. I ask that you encourage people to use the web-based survey if at all possible as it means one less step in combining the data. If people get a paper survey and also have internet access, it would be best if they would complete it on line if they are comfortable doing so.

Thank you so much for your help in distributing these surveys and gathering the information. This is the voice for the people that your programs serve and it is critical for us to have that input.

Area Agency on Aging Services for Southeast Idaho

APPENDIX F

Mission: To promote independence, dignity and protection of individuals through advocacy and services.



Revised 2015

APPENDIX G

ACRONYMS

ACL	Administration for Community Living
ADRC	Aging and Disability Resource Center
A&D	Aged and Disabled (Waivers)
AARP	Formerly the American Association for Retired Persons – now just AARP
ADA	Americans with Disabilities Act
AAA	Area Agency on Aging
AT	Assistive Technology
BH	Behavioral Health
BSU	Boise State University
CAC	Community Action Agency
CAP	Community Action Partnership
CCAC	Community Care Advisory Council
CDHD	Center on Disabilities and Human Development
CDHH	Council for the Deaf and Hard of Hearing
CFH	Certified Family Home
CIL	Center on Independent Living (same as Independent Living Center)
CIT	Crisis Intervention Team
CLC	Community Living Centers (part of the VA network)
COG	Council of Governments
CSA	Center for the Study of Aging at Boise State University
CSI	College of Southern Idaho
CWG	Collaborative Work Group on Adult Developmental Disabilities Services
DAC/NW	Disability Action Center Northwest (North Idaho CIL)
DD	Developmental disabilities
ICDD	Developmental Disabilities Council
DHW	Department of Health and Welfare
DME	Durable Medical Equipment
DRI	Disability Rights Idaho
FACS	Family and Community Services, a division within DHW
FIA	Friends in Action, a program of Jannus (formerly Mountain States Group)
HBPC	Home Based Primary Care
HCBS	Home and Community Based-Services
HUD	Housing and Urban Development

I & A	Information and Assistance
I & R	Information and Referral
IATP	Idaho Assistive Technology Project
ICDE	Idaho Center on Disability Evaluation (through ISU, provides the assessment for the DD Waiver)
ICOA	Idaho Commission on Aging
ICH	Idaho Healthcare Coalition
IHC/MFP	Idaho Home Choice (Idaho's Money Follows the Person or MFP Program)
IHCA	Idaho Health Care Association
IHDE	Idaho Health Data Exchange
ILC	Independent Living Center (same as Center on Independent Living)
ISU/IRH	Idaho State University Institute of Rural Health
ITD	Idaho Transportation Department
JAVA	Justice Alliance for Vulnerable Adults
LIFE	Living Independently for Everyone (Southeast Idaho CIL)
LINC	Living Independence Network, Corp. (Southwest Idaho CIL)
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCAC	Medical Care Advisory Committee
MMCP	Medicare Medicaid Care Plan (through Blue Cross of Idaho)
NH	Nursing Home
NIC	North Idaho College
NWD	No Wrong Door
OT	Occupational Therapy
PCC/PCP	Person-Centered Counseling/Person-Centered Planning
PCMH	Primary Care Medical Home
PT	Physical Therapy
RALF	Residential Assisted Living Facility
SDE	State Department of Education
SHIBA	State Health Insurance Benefit Advisors
SHIP	State Healthcare Innovation Plan
SIB-R	Scales of Independent Behavior – Revised (the assessment tool used for people applying for developmental disabilities services)
SILC	State Independent Living Council
SNF	Skilled Nursing Facility
SPIL	State Plan for Independent Living

SR	Self Reliance
SS	Social Security
SSA	Social Security Administration
TBI	Traumatic Brain Injury
UAI	Uniform Assessment Instrument (the assessment tool used to determine eligibility for nursing home placement or the A&D waiver)
VAMC	Veterans Administration Medical Center
VHA	Veterans Hospital Administration
VR	Vocational Rehabilitation