Administration for Community Living

National Study of Aging and Disability Resource Centers

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Process and Outcome Study Report

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FOREWORD BY THE ADMINISTRATION FOR COMMUNITY LIVING

The Administration for Community Living (ACL) and the Centers for Medicare & Medicaid Services (CMS) came together in 2003 to create a joint funding opportunity to support state efforts to create "one-stop-shop" access programs for people seeking long term services and supports. This initiative, known as the Aging and Disability Resource Center (ADRC) Program, was designed to provide consumers with "visible and trusted" sources of information, one-on-one counseling, and streamlined access to services and supports.

Finding and accessing the right long-tern supports and services (LTSS) can be a daunting task for individuals and their families. The current LTSS System involves numerous funding streams administered by multiple federal, state and local agencies using different, often fragmented and duplicative, access processes involving screening, intake, needs assessment, service planning, and eligibility determination. Individuals trying to access LTSS frequently find themselves confronted with a bewildering maze of organizations and bureaucratic requirements at a time when they are vulnerable or in crisis. This often results in people making decisions based on incomplete, and sometimes inaccurate, information about their options. This can lead to decisions to purchase and/or use LTSS options that are less than optimal for the individual and more expensive than necessary, including decisions to use expensive options such as nursing facility care that can quickly exhaust an individual's personal resources and result in their spending down to Medicaid. The consequences of an LTSS System that makes it difficult for people to make informed decisions about their LTSS options has a direct impact on the health, well-being and financial status of our citizens, and it also has a direct impact on our state and federal budgets. This situation will only be compounded as the number of people who need LTSS increases and more and more LTSS products come onto the market. Currently, about 11 million Americans need some form of LTSS each year, and about 70% of all the people now turning age 65 will need LTSS at some point during their life.

Recognizing that the LTSS System will always involve multiple payers and providers, and therefore always have some degree of fragmentation, the ADRC Program was a "system change" initiative to help states better coordinate and integrate their access functions and create a new "interface" between consumers and the LTSS System in order to make it easier for people to learn about and quickly access the LTSS options that would best meet their needs. The ADRC grant program was based on the most promising practices being implemented at the time by states, including Washington, Oregon and Wisconsin. ADRC grants were awarded to 12 states which were jointly funded across ACL and CMS in 2003, and each year the number of states participating in the program grew and eventually almost all states and several of the territories received funding to develop ADRC Programs. As the number of participating states grew, the ADRC initiative started to evolve, and several key functions were strengthened. For example, in 2007 CMS made special

Hospital Discharge Planning grants available to 10 state ADRC programs to strengthen their involvement in hospital to home care transitions. Then in 2009, supporting care transitions was recognized as a functional component of the ADRC initiative. This work expanded again in 2010 when the Administration on Aging (AoA), now a part of ACL, made special grants available to 16 states to partner with hospitals to build evidence-based care transition programs into their ADRC programs. The capacity of ADRCs to help nursing home residents transition back to the community was significantly bolstered when state Medicaid agencies started to invest in ADRCs to assist with Money Follows the Person transitions, and, then, under the new CMS guidance for minimum data set (MDS) Section Q, many Medicaid agencies designated ADRCs to serve as a Local Contact Agency to assist nursing home residents expressing a desire to return home.

Another major development in the evolution of the ADRC model occurred in 2008 when the Veterans Health Administration (VHA) – the nation's largest health care system - recognized the value of ADRCs in helping consumers develop person-centered plans and direct their own care. In that year, the VHA entered into formal funding agreements with ADRCs to serve as the VHA's designated entity for delivering the Veterans-Directed Home and Community Based Services Program (VD-HCBS). Another development in 2008 included Nursing Home Diversion/Community Living grants to states to strengthen the role of the ADRC in serving non-Medicaid eligible individuals in an effort to reduce the rate that they spend down to Medicaid by diverting them from higher cost LTSS. Then, in 2010 the Affordable Care Act provided $50 million dollars over five years to support the further development of the ADRC Program. The Affordable Care Act also funded the CMS Balancing Incentive Program to incentivize states to rebalance their Medicaid LTSS spending and required participating states to make changes to their LTSS Systems, including developing statewide "No Wrong Door" (NWD) programs.

In 2012, recognizing the accomplishments and lessons learned of both the ADRC and Balancing Incentive Program initiatives, ACL, CMS and the VHA decided to work with a select number of high performing ADRC states to develop national standards for ADRCs going forward. With the 2012 Funding Opportunity, ACL officially adopted the "No Wrong Door" System for the ADRC Part A grants. Part A grants were awarded to 8 states to develop an NWD System in their state so the federal partners could leverage the experience and models emerging in these states. Key deliverables from these 8 states and national partners by the end of 2015 will include:

- Draft National Standards for a No Wrong Door System
- Specification for a data management tool to document the capacity of the No Wrong Door System to carry out its functional responsibilities
- A model Person Centered Counseling Training Program
- A strategy for implementing a National Credentialing Program for Person Centered Counseling

- A Medicaid Claiming Guide for the No Wrong Door System
- A web based catalog of No Wrong Door System/ADRC best practices
- A draft Toolkit to expand Veterans access to Veteran Directed Home and Community Based Services through the No Wrong Door System

To date, the federal government and states have invested over $100 million in the development of the Aging & Disability Resource Centers. Since the program started, state innovations, feedback from key stakeholders, and consumer experiences have shaped the ongoing development of the Aging & Disability Resource Center and the national vision for a No Wrong Door System for all populations and all payers. This study is part of the continuous quality improvement approach that ACL, CMS and VHA have always used to strengthen the program's design. The findings in this report support the current direction and vision that ACL, CMS and VHA are advancing for the program.

CHAPTER 1. EXECUTIVE SUMMARY

1.1 Background

The Aging and Disability Resource Center (ADRC) program, a funding initiative jointly launched in 2003 by the Administration on Aging (AoA) and Centers for Medicare & Medicaid Services (CMS), was initially designed around a vision of providing consumers in every community with a single point of access to long-term services and supports (LTSS). Specifically, this program encouraged states to implement ADRCs to act as "visible and trusted" sources of information and referral, provide one-on-one options counseling, assist with Medicaid eligibility determination, and streamline access to the full range of services and supports that older individuals, persons with disabilities, and family caregivers need, in the settings they prefer. As part of the larger "systems change" effort, ADRCs were intended to be coordinated systems for public- and private-pay clients that minimized confusion while supporting informed decision-making. They were also envisioned to prevent or delay spend-down and enrollment into Medicaid and other public programs.

Initial awards were granted to 12 states in 2003; over the past decade, the ADRC program has grown to 525 ADRC sites established in 53 states and territories. With this growth, the program has also evolved in important ways. Special grants have been funded to encourage partnerships with hospitals to provide discharge planning, to encourage diversion from high-cost LTSS, and to formalize consumer-directed programming with the Veterans Health Administration. Most recently, funding has been awarded toward the establishment of true "No Wrong Door" systems characterized by coordinating and integrating access to LTSS for all age and disability populations, across all payers through full partnership of state and local agencies involved in ADRCs' networks.

1.2 Overview of the National Process and Outcome Studies

Throughout the evolution of the ADRC program, data on aspects of operations and performance have been regularly collected through the Semi-Annual Reporting Tool (SART), but there have been no systematic national studies to examine how ADRCs provide access to LTSS, the environments within which they operate, or outcomes of individuals who use them. In order to understand how well ADRC sites are facilitating access to LTSS and whether clients report positive experiences, the Administration for Community Living (ACL) contracted with IMPAQ International, LLC, and Abt Associates, Inc., to conduct a national process and outcome study of the ADRC program.

Both state- and local-level ADRCs participated in this research. The primary goals of the process study were to explore the motivations of state and local ADRCs for seeking ADRC grants and the effect of the grants on local sites' performance; understand contextual factors (e.g., level of community service capacity) identified from a local perspective; learn about the operational characteristics of ADRCs from state and local perspectives; and capture aspects of LTSS service delivery that influence participant experience that may not be captured in the outcome study. These data were collected through an online survey that was administered through the spring 2013 version of the SART.

The outcome study was conducted using a smaller sample of ADRC sites from which the study team recruited individuals who had utilized the ADRC to access LTSS. These individuals were administered a telephone-based participant experience survey (PES). The PES was designed to capture how well ADRCs helped older adults and persons with disabilities access needed LTSS, factors that led clients to seek information from ADRCs, the type of access and services that ADRCs provided, challenges that clients faced in accessing LTSS through ADRCs, and, finally, client satisfaction with ADRCs.

1.3 Implementation of Process and Outcome Studies

All state- and local-level ADRCs were invited to participate in the process study, with the exception of three states and one U.S. territory that either did not have ADRC grants or were not required by ACL to report data through the SART. Forty-eight state-level and 472 local-level sites participated. Data collection occurred from April 1 through September 15, 2013, via a web-based survey.

For local-level ADRCs, the survey had a total of 60 items grouped into five sections:

- Section A – Baseline Characteristics
- Section B – Populations Served
- Section C – Service Provision
- Section D – Organizational Characteristics
- Section E – LTSS Environment

The survey given to state-level ADRCs was shorter, with 15 questions in three sections:

- Baseline Characteristics
- Organizational Characteristics
- LTSS Environment

A smaller sample of 18 local and two statewide ADRC sites participated in the outcome study. Staff from each of these sites were trained to screen their clients for participation in the PES.

Eligible clients from each site were identified by staff based on age, disability status, and receipt of specific services. Eligible clients were invited to participate in the study and asked to provide contact information in order to be contacted to complete the telephone-based PES. A total of 552 ADRC clients completed the PES.

The PES instrument contained 60 questions regarding:

- Experience with initial contact
- Agency efficiency
- Agency effectiveness
- Institutional diversion
- Assistance with services
- Assistance with Medicaid eligibility determination
- Assistance with one-on-one counseling
- Care transition services
- Support received from the agency
- Health and demographic information

1.4 Highlights of Process and Outcome Study Findings

Descriptive analyses were used to examine process and outcome study data. Bi-variable cross-tabulations and chi square tests were used to examine a number of subgroup differences at both the ADRC level and the client level. Data from the outcome study were assigned a sampling weight, based on the sampling design used in the larger study. Details on the sample and weighting approach are provided in Chapter 3. A number of interesting and relevant results were found in both the process and outcome studies that highlight the success of the ADRC program as well as some challenges and areas that may be improved as the ADRC program continues to evolve in the future.

1.4.1 Process Study

Overall, ADRCs appear to be making progress towards their mission of providing seamless access to LTSS and strengthening sustainability by increasing funding sources. For example:

- Nearly all local ADRCs reported improvement in their ability to provide integrated, comprehensive access to LTSS since the start of the ADRC program.
- The majority of state ADRCs reported that ADRC program funding enabled them to increase the number of partnerships and the skills of staff members. Local ADRCs said that ADRC funding enabled them to increase the level of coordination with aging and disability network organizations and improve staff training opportunities.
- There was an increase in the number of funding sources reported by ADRCs from prior fiscal years.

Most ADRCs were found to provide options counseling and to conduct initial screenings for Medicaid eligibility—two services deemed key to the original vision of ADRCs. In addition, the majority of local ADRCs said they always use a standard consumer needs assessment procedure, and over one-half reported utilizing a standard tool to provide options counseling. However, fewer indicated that these tools are shared across partners. Although a majority of ADRCs appear to be moving in the direction of a common assessment instrument, more progress needs to be made to ensure that these tools and the information they inventory are shared efficiently across all agencies with which individuals interact to obtain LTSS.

ADRCs understand the importance of aging, disability, and other organizations in providing integrated and streamlined access to LTSS. They reported an average of four core operating organizations and 16 partners. The most frequently identified partnerships were between ADRCs and state units on aging (SUA), centers for independent living (CIL), area agencies on aging (AAA), state Medicaid agencies, and local veterans administration (VA) offices. In general, most indicated that these partnerships were highly functional; a notable exception, however, was found in partnerships with the local VA. While nearly half of local ADRC sites reported having formal partnerships with their local VA, fewer considered this partnership as highly functional. This was seen at the state level as well, as less than one-quarter of state-level respondents reporting a highly functional relationship with the VA. Given the increasing partnerships between the Veterans Health Administration (VHA) and the federal ADRC program, understanding reasons for this discrepancy and determining strategies for improving partnerships, through technical assistance or another means, may be vital to ensuring success of these recent initiatives.

Local ADRCs seem to be located in service areas with a disproportionate number of White and non-Hispanic populations. Further, an average of nearly 20 percent of the population is living at or below the poverty level, and, for many ADRCs, a significant portion of their population does not have health insurance coverage. Not surprisingly, ADRCs serve more clients over age 60 than younger persons with disabilities. In addition, they serve more persons with physical disabilities and their caregivers than other disability groups. The disproportion of populations served by the ADRC indicates a potential disparity in access to ADRC services, underscoring an area in need of improvement. Enhancing the ability of ADRCs to reach and appropriately serve diverse communities around the country is an ADRC goal that should be soundly reinforced by ACL.

1.4.2 Outcome Study

The outcome study provided a glimpse into the experiences of older adults and adults with disabilities when they contact an ADRC. The results revealed many positive aspects of the program, illustrating that the ADRCs are meeting their goal of providing seamless access to and information about needed LTSS. On the other hand, results also identified a number of consistently challenging aspects of delivering integrated access to LTSS.

Overall, clients were positive about their interactions with the ADRC. For example, they were very satisfied that the ADRC met their needs and said they would contact an ADRC in the future to obtain LTSS. A vast majority of clients indicated that the ADRC representative was professional, knowledgeable, paid close attention, correctly assessed their LTSS needs, and provided clear and understandable information. Further, clients were satisfied with the completeness and accuracy of the information that they received, and the vast majority indicated that they would recommend the ADRC to friends or family.

However, important challenges were also observed in the data. Of particular importance is the fact that more than one-half of respondents said that they had not received the services requested by the time of the survey, which was conducted approximately three to four weeks after contact with the ADRC. However, it is important to note that most of the services requested by clients—transportation, housing, and the like—are not provided directly by the ADRC. The ADRC instead serves to provide integrated *access* to these services. This finding may reflect a lack of availability of needed services, as discussed earlier, or a longer duration of time may be needed to determine whether services were indeed eventually received. Notwithstanding, this is an area that requires further review to determine what technical assistance or potential future initiatives may be provided to more fully explore the reasons for non-receipt of requested services and to ensure that ADRC consumers are able to access LTSS.

Similarly, as discussed earlier, diversion from public programs, including Medicaid, has been a central aspect of the ADRC program vision. Delaying or preventing individuals from having to spend-down to meet Medicaid eligibility requirements or to rely on more expensive LTSS options by helping them learn about low-cost options and make better use of their own resources has been a focus of ADRC grants since their inception in 2003. Although ADRC respondents indicated that diversion from nursing homes or other residential settings is an outcome their agency sought to achieve, ADRC representatives helped less than one-third of responding clients understand their options for staying in the community and, thereby, avoiding or delaying a move into a nursing home or another long-term care setting. It may be that ADRC representatives did not have reason to assist in this way, but further work is needed in this area to determine if a mismatch exists between citing diversion as a goal and providing information and assessments accordingly.

Finally, a number of interesting subgroup differences were observed in the outcome study:

- Individuals with disabilities were less likely to report that the ADRC staff paid close attention to what they said, but more likely to report that the ADRC staff talked to them about options for staying in the community.
- Individuals with disabilities were more likely to report that services were not accessible, that the information they received from the ADRC was not helpful, and that they had difficulty filling out the paperwork.
- Individuals who rated their health as poor were more likely to say that ADRC staff talked with them about options for staying in the community.
- Individuals with disabilities and those who rated their health as poor were less likely to report that service was unavailable.

These subgroup results are mixed in nature. On one hand, persons with disabilities and poorer health were more likely to report that ADRC staff discussed community options. This is a positive finding, as these groups may be at increased risk for institutionalization. On the other hand, it appears that ADRC staff may need to be more attentive to these groups and their needs and to provide additional support in completing necessary paperwork. Again, service availability for these groups is likely to be dependent not on what the ADRC can provide, but on what is available in the community; while ADRCs may not have direct control over solutions to this problem, it is still in the interest of ADRCs at the local, state, and federal level to advocate for increased LTSS and outreach to help persons with disabilities and poorer health remain in the community as long as possible.

1.5 Conclusion

Overall, findings from the process and outcome study of ADRCs suggest that local and state ADRC programs are, at their foundation, true systems change initiatives and that they are achieving their goal of providing seamless access to LTSS. There is evidence that ADRCs are increasing partnerships; standardizing and sharing information, including assessment tools, across stakeholders; and providing highly satisfactory access even in the environment of inadequate LTSS. ADRC clients feel that they are listened to, that their care plans reflect their needs and desires, and that the ADRCs are providing the core aspects of integrated access to LTSS, including information and referral, options counseling, and Medicaid eligibility determination. However, there is still room for progress in many areas, including increasing care transition service provision, improving aspects of participant satisfaction for specific groups of people, expanding the reach of ADRCs to underserved populations, and solidifying partnerships with key stakeholders such as local VAs.

As evidenced from this study and other sources, the ADRC program is continuing to evolve. ACL, CMS, and VHA have created funding opportunities to encourage a high-performing ADRC options counseling program with the capacity to serve persons of all ages, disabilities, and income levels; build stronger partnerships between health and LTSS systems; develop financially sustainable ADRC models with multiple revenue streams; and adopt a set of national performance and outcome standards. These efforts demonstrate the progress made since the inception of the ADRC program, which began with 12 states in 2003. The ADRC program has strengthened and grown into a national model of integrated access to LTSS; it is successfully moving toward seamless access to comprehensively meet the needs and desires of individuals in communities across the country.

CHAPTER 2. INTRODUCTION

The Aging and Disability Resource Center (ADRC) program, launched in 2003, encourages states' efforts to integrate the full range of long-term supports and services (LTSS) into a single streamlined, coordinated No Wrong Door (NWD) system. The ADRC program was initially a collaborative effort of the Administration for Community Living (ACL; formerly the Administration on Aging)[1] and the Centers for Medicare & Medicaid Services (CMS) in response to a mandate in the 1965 Older Americans Act (OAA). The effort is now also supported by the Veterans Health Association (VHA).

As amended in 2006,[2] the OAA defines the ADRCs as entities established by a state as part of the state system of long-term care to provide:

> ‘‘(A) comprehensive information on the full range of available public and private long-term care programs, options, service providers, and resources within a community, including information on the availability of integrated long-term care;
>
> (B) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; and
>
> (C) consumers access to the range of publicly-supported long-term care programs for which consumers may be eligible, by serving as a convenient point of entry for such programs.” (PUBLIC LAW 109–365—OCT. 17, 2006, Title I, Section 101[44]).

Title II, Section 206, of the OAA specifies that the Assistant Secretary for Aging “shall measure and evaluate the impact of all programs authorized by this Act…. Evaluations shall be conducted by persons not immediately involved in the administration of the program or project evaluated.”[3] Although ADRC program grantees are required to include a local program evaluation in their grant activities, there has not been a national program study since the program's inception in 2003. The collection of information through a national study was deemed necessary to determine the overall effect of ADRCs on LTSS and individuals and to show whether or not ADRCs are fulfilling their mission.

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[1] As of April 2012, the Administration on Aging, the Office on Disability, and the Administration on Developmental Disabilities were combined into a single agency, the Administration for Community Living (ACL), which supports both cross-cutting initiatives and efforts focused on the unique needs of individual groups, such as children with developmental disabilities or seniors with dementia. For more information see https://federalregister.gov/a/2012-9238 or http://hhs.gov/acl

[2] http://www.doleta.gov/seniors/other_docs/PublicLaw109-356.pdf; accessed on 10/5/14

[3] http://infousa.state.gov/government/branches/docs/oldamact.pdf, accessed on 10/6/2014

Motivated by the OAA mandate and a strong commitment to the ADRC program and its essential role in the future of fully integrated, coordinated NWD systems across states, the ACL contracted with IMPAQ International, LLC, and Abt Associates, Inc., to implement a rigorous national study of the ADRC program. Through this study, ACL sought to understand how well ADRCs are supporting members of the aging and disability populations in making informed choices and accessing LTSS. ACL was also interested in understanding whether consumers who access ADRCs report positive experiences and issue resolution.

The national study has two components: a process study and an outcome study. This report presents the results and discussion based on the analyses of the data collected as part of the national ADRC process and outcome studies. Specifically, the report presents the findings outlined below.

Process study

- The motivation to become an ADRC and institutional diversion as an outcome sought
- Funding sources and the effects of funding
- The profile of the communities in which ADRCs operate such as their service capacity and availability; population race, medical insurance, and poverty level; and consumer demographics
- Organizational structure such as staffing levels and services provided (i.e., options counseling, care transitions, and Medicaid eligibility); number and quality of ADRC partnerships
- Assessment of the level of service provision, extent of site integration, and Medicaid integration status

Outcome study

- The profile of agencies and respondents participating in the participant experience survey (PES)
- ADRC consumer respondents' perspectives on the efficiency and effectiveness of the ADRC
- The types of services for which ADRC consumer respondents request assistance
- Consumer respondents' experiences when accessing the requested services
- Consumer respondents' satisfaction with their ADRC experience
- Key outcomes by each of the three ADRC dimensions: service provision, site integration, and Medicaid integration

2.1 ADRC Program Background

Over 10 million community-dwelling Americans currently need or receive LTSS to help them remain independent and avoid placement in institutional settings such as nursing homes.[4] LTSS can include a range of assistive services provided to individuals who have limitations in performing activities of daily living, such as eating, bathing, or transportation; instrumental activities of daily living, such as shopping, food preparation, or managing finances; and medication management. Receiving these supports and services is often essential to an individual's ability to live in the community. Ensuring that individuals can easily access these services in a coordinated and integrated manner is, therefore, fundamental to LTSS delivery systems.

Unfortunately, the multiple and separate public funding streams and disparate assessment and tracking systems for determining LTSS eligibility complicate the coordination and delivery of LTSS. Those with multiple or complex needs may have to reach out to a number of different agencies or organizations to ensure that their needs are met. They may also have to go through multiple eligibility screenings to access services and benefits. Streamlining these systems and integrating access to LTSS allows LTSS users and their caregivers to connect to a broad and comprehensive range of services more easily and efficiently.

The ADRC grant program is one vehicle for achieving integrated access to LTSS in response to these challenges facing persons in need of LTSS. Designed as a "systems change" initiative to help states better coordinate and integrate access functions, ACL and CMS envision ADRCs to be highly visible and trusted places, available in every community across the country, where all people, regardless of their age, income, or disability, can go to obtain information on the full range of long-term support options. Initially, ADRCs were required, at a minimum, to target older adults and at least one additional subpopulation, including people with physical disabilities, serious mental illness, and/or developmental/intellectual disabilities. They were also envisioned to reach people before they became Medicaid-eligible to prevent or delay spend-down and enrollment into Medicaid and other public programs.

Initial awards were granted to 12 states in 2003; over the past decade, the ADRC program has grown to 525 ADRC sites established in 53 states and territories. With this growth, the program has also evolved and expanded in important ways. Special grants have been funded to encourage partnerships with hospitals to provide discharge planning, to encourage diversion from high-cost LTSS, and to formalize consumer-directed programming with the Veterans Health Administration. Most recently, funding has been awarded toward the establishment of true "No Wrong Door"

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[4] Kaiser Commission on Medicaid and the Uninsured (Kaiser) (2009). Medicaid and long-term services and supports. The Henry J. Kaiser Family Foundation, CA.

systems characterized by coordinating and integrating access to LTSS for all age and disability populations, across all payers through full partnership of state and local agencies involved in ADRCs' networks. Due to the timing of this study, it does not measure the effects of this effort started with the 2012 awards, but rather documents the ADRCs as they were based on the 2010 funding. Exhibit 2.1 visually depicts this evolution of the ADRC program.

As stated by ACL and CMS in program funding announcements, three key services should be provided to facilitate integrated access to LTSS:

1) Visible and trusted information and referral (I&R) to available and appropriate programs, supports, and services
2) One-on-one options counseling to support LTSS decision-making
3) Streamlined linkages to available LTSS across multiple funding streams

Since the first grants were awarded in 2003, ADRC programs have grown nationwide, evolving to include innovative models linking hospital discharge planning with ADRCs, supporting care transitions as functions of ADRCs, and forming consumer-directed and person-centered planning partnerships with the VHA through the Veterans Directed-Home and Community Based Services program. NWD systems are actively serving older adults and persons with disabilities across the nation, and, since the inception of the program, NWD systems have made over 25 million contacts, helping to answer questions related to health and LTSS.[5]

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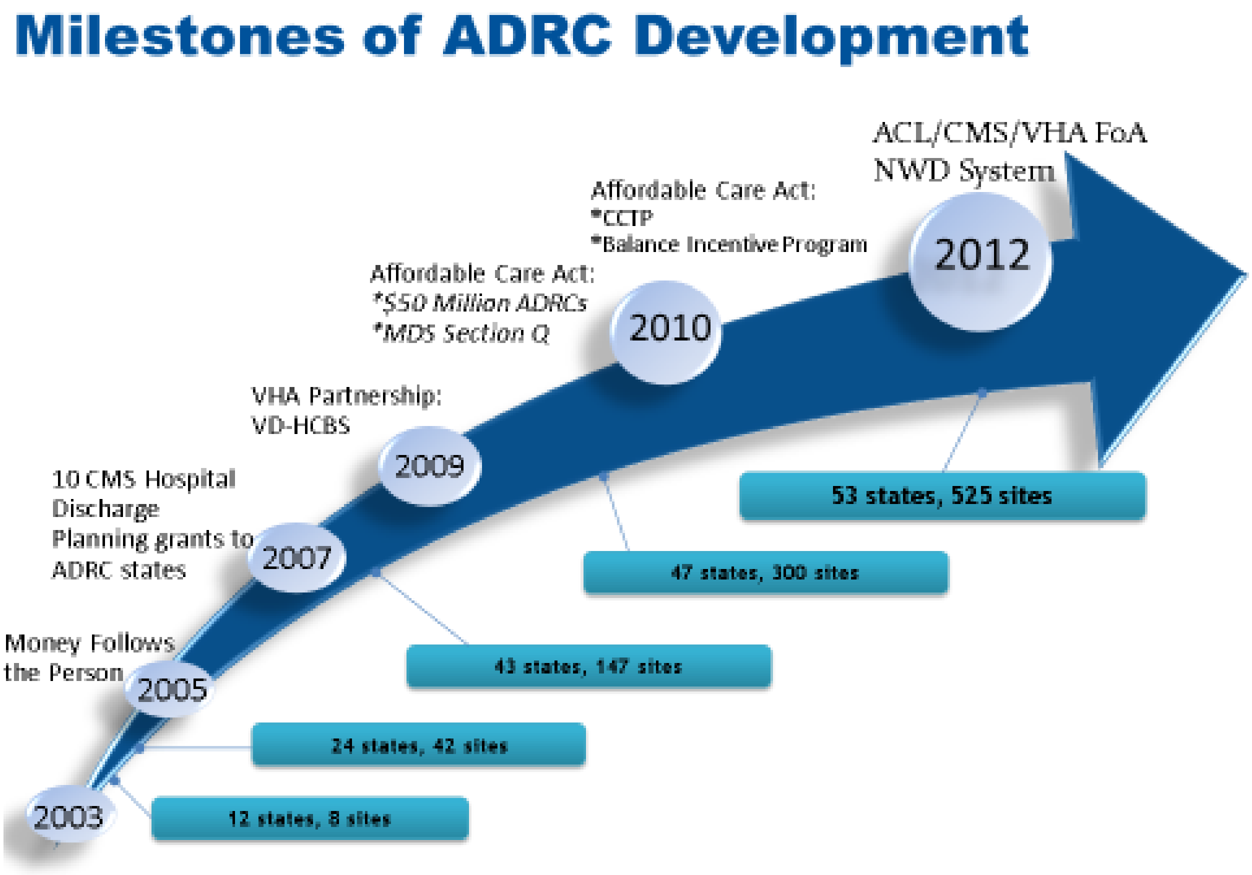
[5] http://www.acl.gov/Programs/CDAP/OIP/ADRC/index.aspx, accessed on 10/5/2014

Exhibit 2.1: The Evolution of the ADRC Program



Source: Administration for Community Living, 2014

Looking toward the future, ACL and its federal partners are working to develop a set of national standards, tools, and metrics for states to use as they continue to improve their ADRC programs and create high-performing, streamlined access systems for all populations in need of LTSS. To be successful in this mission, ACL needs the information obtained from the national ADRC study to understand the current landscape of the program, including the degree to which ADRCs have integrated and simplified access to LTSS, and to identify best practices that will lead to program refinement and continuous quality improvement.

2.2 Overview of the National ADRC Study

The purpose of the national ADRC study is to understand how well ADRCs are facilitating access that meets the LTSS needs of the aging and disability populations and to determine whether clients who access ADRCs report positive experiences. Specifically, the goals of the study are to:

- Identify strategies that ADRCs are implementing that help to efficiently and effectively integrate access to LTSS in the communities they serve
- Reveal approaches that may lead to program refinement and continuous quality management
- Enable ACL to more accurately report on the effectiveness of the ADRC program to governmental agencies and to the public

The national ADRC study received the Office of Management and Budget's approval under the Paperwork Reduction Act of 1995 and Abt Institutional Review Board approval; data collection was conducted between 2013 and 2014. The process study included representatives of all state and local ADRCs; the outcome study included a convenience sample of consumers of ADRCs selected with intention. A matched sample of AAAs was also selected for inclusion in the process and outcome study, but a low response rate among AAA consumers prevented meaningful analytic comparison.

2.2.1 Overview of the Process Study

The process study data were collected from state and local ADRCs and recruited AAAs, as described above. The data were obtained using the web-based tool that is currently used by ADRC grantees for submission of their semi-annual grant reports (i.e., the Semi-Annual Reporting Tool or SART); the tool is HIPAA compliant. Responses were analyzed using descriptive statistics as well as bivariate and chi-square analyses to explore subgroup differences. From the process study data, we also created three core measures to assess the ADRC program's degree of provision of core services, site integration, and Medicaid integration.

2.2.2 Overview of the Outcome Study

Data for the consumer-level outcome study were collected using a participant experience survey (PES). These data were analyzed in aggregate form to determine the overall impact of ADRCs regarding access to services and respondent experiences in contacting ADRCs. Outcome data were analyzed in conjunction with the process study data to determine whether there are certain types of ADRC approaches that are most beneficial to consumers overall or that are best suited to specific types or subpopulations of consumers or to certain community characteristics. As in the process study, descriptive statistics were used to analyze the data collected via the PES. In addition, bi-variable analyses were performed to identify statistically significant differences among subgroups, and regression analyses were employed to estimate the associations among respondent, ADRC, and community characteristics and outcomes of interest. Note that because we did not have a viable comparison group, we were unable to conduct an impact estimation of ADRCs on client experience or make causal inferences. The core measures developed from the process study data were also used in analyses and interpretation of the findings from the outcome study data.

2.3 Organization of the Report

In the remainder of this report, we present the methodology, findings, and discussion of the national ADRC process and outcome studies. Specifically, Chapter 3 provides the methodological approach followed for the process and outcome studies, including the development of the three core ADRC measures. We describe our sample selection, data collection tools, recruitment of survey participants, administration of the survey, and analytic approach. We then discuss the approaches utilized to analyze the process and outcome study data. Chapter 4 focuses on the process study. We first present the research questions addressed by the process study and then present the results of the process study analyses and a discussion of the implications of the findings. Chapter 5 begins with an introduction to the outcome study research questions. It then presents a summary of findings from the outcome study data and their implications. Finally, in Chapter 6 we offer a discussion of the synthesized results of the process and outcome studies and place these findings in the context of the evolving ADRC program.

CHAPTER 3. PROCESS AND OUTCOME STUDY METHODOLOGY

This chapter presents the methodology followed for the process and outcome studies. It describes the sample selection, recruitment, surveys, data collection, and analytical approach for each study. We also describe the technical specifications of the three core measures developed using the process study data.

3.1 Agency Sample Selection and Recruitment

This section describes the sample selection and recruitment of ADRCs and AAAs participating in the process and outcome studies. We describe the agency sample selection and recruitment strategies at the outset because some of the methodology is common to both the ADRC process and outcome studies. Specifically, the sample of AAAs is used in both studies, and since participating AAAs were matched to selected ADRCs, the selection and recruitment of the ADRCs and AAAs are described below. We note, however, that due to the small sample size and the similarity of service delivery between the ADRCs and AAAs, selected AAAs were not used as a comparison group in either the process or outcome study analyses.

3.1.1 Agency Sample Selection and Recruitment for the Process Study

All the state and local ADRCs were invited to participate in the process study survey. ADRCs from three states and a U.S. territory were the only exceptions. Mississippi, Missouri, Wyoming, and Northern Mariana Islands were not expected to participate in the process study survey, as they are not required by ACL to participate in the ADRC SART. In addition to the state and local ADRCs, 14 AAAs agreed to participate in the survey. The sampling and recruitment of these AAAs and ADRCs are described in Sections 3.1.2 and 3.1.3.

3.1.2 Agency Sample Selection for the Outcome Study

The sampling strategy followed for the selection and recruitment of a sample of ADRCs and AAAs for the outcome study is described below.

Drawing a Sample of ADRCs. Power calculations were conducted and revealed that a sample of 40 agencies (20 ADRCs and 20 AAAs) would result in an adequate sample size to detect statistically significant group differences, if they existed. As a result, we attempted to draw a sample of 23 ADRCs from the population of all ADRCs. At the time that the study was initiated, three large statewide ADRCs were identified in the population (i.e., Arkansas, Minnesota, and New Mexico). Since statewide ADRCs are likely to be different from non-statewide ADRCs with regard to characteristics of interest, we included these statewide ADRCs in the sample with certainty. A probability sample of 20 ADRCs was then selected from the remaining population.

For selection of the sample, the population of ADRCs was stratified by 10 geographic regions. Within each region, the population of ADRCs was further stratified into two groups, rural or urban, based on the urbanicity ratio of the population in their service areas. Per the urbanicity ratio, an urban ADRC is one that has over 50 percent of the population in its service area residing in urban areas, according to the 2010 U.S. Census. Similarly, rural ADRCs are ADRCs that have less than 50 percent of the population in their service area residing in urban areas. Since there were not enough rural ADRCs in Region IX, the urbanicity ratio was relaxed from 50 percent to 60 percent. For each of the resulting 20 strata, one ADRC was selected at random and a second was designated as reserve to be used in case the first selected ADRC turned out to be a non-respondent, as was often the case. Since it was found that some strata had no respondents, agencies from adjacent regions were recruited (see Appendix A, Exhibit 1) and the strata collapsed. The assumption was that ADRCs in adjacent regions are likely to be more similar with regard to characteristics as compared to other regions. In some cases, the collapsed stratum consisted of regions that were not adjacent to the responding region.

Drawing a Sample of AAAs. In January 2013, the research team obtained updated data on AAAs and their coverage areas from the ACL’s www.eldercare.gov web site. At that time, the total number of AAAs was 634. Working with this dataset and the ADRC dataset, the research team compared the coverage areas of AAAs and ADRCs in order to come up with a list of AAAs whose coverage areas did not overlap with the coverage areas of ADRCs. The result was a total of 134 AAAs that did not have overlapping coverage areas with ADRCs. Exhibit 2 in Appendix A displays these AAAs by region and urban/rural status. Since there was only one AAA each in Regions IX and X that could be classified as rural based on a 50 percent threshold for urbanicity, we raised the threshold to 60 percent. This yielded five rural AAAs in Region IX and eight rural AAAs in Region X.

Because of the inadequate number of AAAs in Regions I and III and their geographic proximity to Region II, we selected all three rural and all three urban AAAs available in Regions II and III into the sample with certainty (see Appendix A, Exhibit 3). From the remaining AAAs, the research team selected a probability sample of AAAs using a similar design to the one used for the selection of ADRCs. Two AAAs were randomly selected from each of the remaining seven regions (one rural and one urban AAA from each region) as primary AAAs, for a total number of 14 AAAs. Back-up AAAs were randomly selected from among the remaining AAAs in each strata. To select back-up sites for Regions I – III, three AAAs were selected from the rural stratum and three AAAs were selected from the urban stratum in Region IV.

3.1.3 Agency Recruitment for the Outcome Study

First, electronic letters of support from ACL (see Appendix B), signed by the project officer, Susan Jenkins, were emailed to the directors of ADRCs and AAAs to encourage their participation in the study. Within a week or two of sending the letters from ACL, the research team made recruitment calls to the directors of the selected agencies, providing them with background about the study and asking for their agreement to participate. In order to track these communications, team members developed a detailed spreadsheet where they recorded the date and content of each call.

If an agency agreed to participate, the team obtained the contact information for designated primary and secondary site coordinators. The recruiter then sent a brief follow-up email to the proposed agency coordinator thanking him/her for agreeing to fill that role. Agency coordinators were also asked to provide the names and email addresses of staff who would be involved in screening and recruitment of clients. This contact information would enable the team to invite staff to sign up for a webinar presentation on screening and recruiting clients.

The study team conducted follow-up calls to site coordinators to confirm their commitment during the agency recruitment. These calls entailed sharing further details of the role of study sites and answering any questions site coordinators had. This step was particularly important if the designated site coordinator was not the agency director and therefore had not yet received communication from ACL or the IMPAQ recruitment team. In such cases, these individuals required an initial introduction to the study and had questions about what their agency's involvement would entail. Several sites decided that they did not wish to participate in the study, and no further communication ensued. For sites that agreed to remain involved, a follow-up email was sent to the site coordinator. The email reviewed the main points covered in the phone conversation and encouraged the site coordinator to contact the research team at any time during the study should she/he have any questions or concerns.

At the start of data collection, in mid-June 2013, 40 agencies agreed to participate. However, numerous sites dropped out during the first few months, primarily as a result of limited resources. Also, one agency that initially did not respond to the team's communications ultimately joined and began sending data in early October 2013. Exhibit 4 in Appendix A provides a list of sites that dropped out of the study. The final sample of participating agencies was 33, with two statewide ADRCs, 18 local ADRCs, and 13 AAAs agreeing to participate in the outcome study. To recruit 18 local ADRCs, we contacted 33 ADRCs for a response rate of 55 percent. The response rate for AAAs was 41 percent, with 13 out of 32 AAAs agreeing to participate. Exhibits 3.1 and 3.2 show the distribution of participating ADRCs and AAAs by region and rural versus urban status.

Exhibit 3.1: Final Distribution of ADRCs Stratified by Region and by Rural Versus Urban Status

Region	Selected with Certainty	Rural	Urban
I: CT, NH	0	1	1
II: NJ	0	0	1
III: VA, WV	0	1	1
IV	0	0	0
V: IN, MN	1	1	1
VI: AR, OK, TX	1	2	1
VII: IA, MO	0	1	1
VIII: CO, MT	0	2	1
IX: CA	0	1	0
X: ID, OR	0	0	2
Total	**2**	**9**	**9**

Exhibit 3.2: Final Distribution of AAAs by Region and by Rural Versus Urban Status

Region	Rural	Urban
I	0	0
II	0	0
III	0	0
IV: MS, NC	3	2
V	0	0
VI: TX	2	2
VII: IA, NE	1	2
VIII: MT	1	0
IX	0	0
X	0	0
Total	**7**	**6**

3.2 Process Study Methodology

3.2.1 Survey

We collected the data for the process study through a web-based survey administered to all state and local ADRCs. Three versions of the survey were administered:

- State-level survey (one survey per state)
- Local-level survey (one survey per site)
- AAA survey (those selected for the outcome study)

The state ADRC directors or their representatives were the respondents of the state-level survey. Similarly, the respondents of the local-level survey were the local ADRC directors or their representatives.

The agencies participated in the process study survey through the SART that is administered on a semi-annual basis by the Lewin Group, ACL's technical assistance contractor for the ADRC program. The SART is an online tool that allows ADRCs to create and submit their required semi-annual performance reports through one integrated system. The process study survey replaced the spring 2013 version of the SART semi-annual performance report survey.

The data collection period for the process study survey was from April 1, 2013, through September 15, 2013. ACL invited the agencies to participate in the survey and periodically sent follow-up letters to encourage participation. Three webinars were held to familiarize the ADRCs with the survey administration. Lewin and IMPAQ also operated a help desk to address questions from the agencies throughout the data collection period.

The process study survey was a modification of the semi-annual performance report survey regularly administered through the SART. The process study survey was designed to (1) provide an understanding of LTSS programs from state and local perspectives, (2) inform the analysis of client outcomes, and (3) collect information that will guide recommendations for continuous quality improvement for the LTSS field.

The local ADRC survey had 60 questions grouped into five sections:

Section A – Baseline Characteristics
Section B – Populations Served
Section C – Service Provision

Section D – Organizational Characteristics

Section E – LTSS Environment

The survey questions in Section A collected ADRCs' perspectives on their motivations for applying for an ADRC grant and the impact of ADRC funding on resources, services, and outcomes. Section B questions were designed to collect information on the barriers and facilitators for LTSS in the community, as well as the types of consumers ADRCs serve. Section C delved into the types of services provided by the agencies. In Section D, information on the organizational characteristics and operational processes of the agencies was gathered. Section E included an open-ended question on the LTSS environment. The AAAs were administered the local ADRC survey with slight modifications.

The state ADRC survey was shorter than the local survey, with 15 questions in three sections:

Section A – Baseline Characteristics

Section B – Organizational Characteristics

Section C – LTSS Environment

The survey questionnaires are provided in Appendix C (local survey) and Appendix D (state survey).

3.2.2 Response Rates

The process study survey achieved a high response rate for both the state and local ADRC surveys. The state ADRC survey had a 100 percent response rate among the states and territories expected to participate in the process study, which excluded Mississippi, Missouri, Wyoming, and Northern Mariana Islands, as noted earlier.

As shown in Exhibit 3.3, the local ADRC survey also achieved a high response rate. Twenty-seven states had a 100 percent response rate. Twelve states had a response rate between 75 and 99 percent, and Guam's single ADRC did not respond to the survey (i.e., it had a zero response rate). The overall response rate for the local ADRC survey was 83 percent, with 472 out of 567 local ADRCs participating in the survey. Appendix E provides the complete state-specific response rates for the local ADRC survey. Thirteen out of the 14 AAAs that agreed to participate in the survey responded, achieving a response rate of 93 percent.

Exhibit 3.3: Response Rate on the Local ADRC Process Study Survey

Response Rate	Number of States/Territories
100%	27
99% – 75%	12
74% – 50%	5
49% – 25%	3
24% – 1%	0
0%	1

3.2.3 Analytic Approach

The process study findings are presented primarily as descriptive statistics. We also conducted bi-variable analyses and chi-square tests to explore subgroup differences. Following is a detailed description of our analytic approach.

Tabulation. We tabulated the responses to the survey questions and generated frequencies and percentages. For questions with continuous numbers as responses (e.g., number of consumers served), we grouped the responses into logical categories and generated frequencies and percentages. In addition, we summarized the responses and generated the minimum, maximum, mean, median, and mode. We provide the results of the tabulations in Appendix F (local survey) and Appendix H (state survey).

Free-text survey responses were coded and summarized. These summaries and the verbatim responses are provided in Appendix G (local survey) and Appendix I (state survey). Selected examples are presented in Chapter 4.

Closed-ended and open-ended survey responses from AAAs are provided in Appendix J and Appendix K, respectively. Note that survey findings specific to AAAs are not discussed in this report, as they were collected for use as covariates in the outcome regression analyses and not to serve as a comparison group in the process study.

Bi-Variable Analysis. In addition to tabulating the survey data, we conducted bi-variable analyses to gain a deeper understanding of the performance of ADRCs in the context of their organizational and community characteristics. This involved conducting subgroup analyses of key questions using cross-tabulations to see whether survey responses varied by subgroups (e.g., whether the types of services offered varied by urban or rural local ADRCs). We employed chi-square tests for identifying statistically significant differences in survey response among subgroups. We used one set of subgroup variables that represented ADRC characteristics and a second set of variables based on the environment in which ADRCs operate.

The subgroups examined in the process study include:

- Categories based on the number of ADRC consumers
- Government or independent non-profit ADRCs
- Rural versus urban ADRC service areas
- ADRCs from centralized, decentralized, or mixed-model states
- Level of core service provision categories
- Extent of site integration categories
- Status of Medicaid integration categories

Below we provide the definitions and distributions (see Exhibit 3.4) of the various subgroup analysis categories. The distribution is from the process study dataset with ADRCs that have non-missing data.

Number of ADRC consumers. This is the only subgroup variable that is based on a continuous variable, the total number of older adults and individuals with disabilities served by a local ADRC. For the purposes of subgroup analysis, we created a categorical variable of ADRC size based on the number of consumers. We split the ADRCs into those serving 0 to 500 (small), 501 to 2500 (medium), or 2500+ (large) consumers. These categories were defined based on having a comparable number of ADRCs in the various categories.

Exhibit 3.1: Distribution of Local ADRCs by Subgroup Analysis Categories

	Number	Percentage
Size		
0 – 500	84	20.90
501 – 2500	171	42.54
2500 +	147	36.57
Organizational Structure		
Government	265	56.14
Independent Non-Profit	207	43.86
Urbanicity*		
Rural	129	27.98

	Number	Percentage
Urban	332	72.02
Operational Model		
Centralized	72	15.25
Decentralized	85	18.01
Mixed	315	66.74

Note: ADRCs with missing data on a variable were excluded from the related categorization. For example, an ADRC with missing information on number of consumers served is excluded from the size categorization.
*Statewide ADRCs were excluded from the urbanicity-based categorization.

Government or independent non-profit ADRCs. This variable is based on the organizational structure of ADRCs, that is, whether they were part of a government (e.g., county or city) or an independent non-profit agency.

Rural or urban ADRC service areas. An urban ADRC is one that has over 50 percent of the population in its service area residing in urban areas, according to the 2010 U.S Census. Similarly, a rural ADRC is an ADRCs that has less than 50 percent of the population in its service area residing in urban areas.

Centralized, decentralized, or mixed-model states. ADRCs were categorized as centralized, decentralized, or mixed-model ADRCs based on the number of operating organizations. This categorization was provided by the ACL. ADRCs were defined as centralized if they had only one operating organization, whereas ADRCs were defined as decentralized if they had more than one operating organization. The largest proportion of states (24 states) had a mix of centralized and decentralized ADRCs. Seventeen states or territories had only centralized ADRCs, and 12 states or territories had only decentralized ADRCs.

The findings from the subgroup analyses are discussed in the corresponding sub-sections of this report if they were found to be statistically significant. The cross-tabulations are provided in Appendices L – O, with a separate appendix for each major subgroup category.

Item Non-Response. The survey response tabulations indicated high levels of item non-response on certain questions, such as those requiring specific numbers as responses. For example, non-response ranged from 45 to 95 percent on questions asking local ADRC representatives to provide the number of consumers with disabilities by type. Similarly, on questions asking local ADRC representatives to report funding amounts by type, non-response ranged from 51 percent to 97 percent. Therefore, we did not consider imputation of missing values as an appropriate method to address item non-response. The survey response tabulations provided in the appendices include a "No response" row or column, as applicable.

3.3 Outcome Study Methodology

In this section of the report, we describe the methodological approach utilized in the outcome study for the sample selection, survey development, and collection of ADRC client experience data using the PES. Thereafter, we discuss our analytic approach for the outcome study data analysis.

3.3.1 Staff Screening and Recruitment Training

Once agencies were recruited and designated site coordinators were determined, agency staff were sent an email inviting them to attend a webinar presentation on how to screen and recruit clients to participate in the study by responding to a 20-minute telephone PES. The one-hour training was offered on four different days (May 28, June 3, June 6, and June 10) at different times to accommodate staff availability. Attendance was strongly encouraged in order to ensure that all staff were properly trained on how to accurately screen and recruit clients. If staff were not available for any of the four sessions, they were asked to view the recorded webinar that was posted on the ACL website. They were also encouraged to review the Reference Guide (see Appendix P) that all agency staff received via email with instructions on how to register for the webinar.

3.3.2 Client Screening and Recruitment

Concurrently with the training sessions, the research team mailed to each participating agency a packet of data collection forms and pre-paid FedEx envelopes in which to return completed forms to Abt. Additional forms and envelopes were shipped to agencies as needed throughout the recruitment period, approximately June 1, 2013, through March 31, 2014. Immediately following the training, staff were asked to begin client screening to determine eligibility of clients and recruit eligible clients. Clients and client proxies were eligible for the study. Staff were asked to complete a client screening tool (see page 41 of Appendix P) to determine eligibility. In general, client eligibility was determined by age, disability status, receipt of certain information or counseling services, and the professional status of the caregiver. Details on screening including eligibility requirements and recruitment procedures can be found in the Reference Guide (Appendix P). Individuals who were deemed eligible were invited to participate in the study. Clients who agreed were read an agreement-to-participate statement (see page 46 of Appendix P) and then were asked to provide contact information, which was recorded by staff on a data collection tool (see page 48 of Appendix P). Every week or so, agencies forwarded to Abt the three agency data collection forms for data entry and tracking. Forms were sent whether or not clients were deemed eligible and whether or not all data fields were complete. Data were entered into an Access database and saved to a secure FTP system, Move-It DMZ. Abt SRBI retrieved the data from the secure server to conduct the administration of the PES (described below).

Efforts to Improve Client Recruitment. In mid-July 2013, six weeks after recruitment had commenced, sites that had sent data were sent an email thanking them for their participation and encouraging them to continue to screen and recruit clients and send data on a weekly basis. Sites that had not sent data were thanked for their participation and strongly encouraged to send their data and to let the research team know if they had any questions or concerns. Approximately two months after client recruitment had commenced, several sites had sent only 10 or fewer data collection forms. These sites were contacted over the phone to ensure that they understood the process, to answer any questions they had, and to facilitate data collection. Reasons for sending limited amounts of data varied, from some sites being in rural locations and seeing very few clients, to being understaffed or having to meet competing demands. Then, approximately a month later, in mid-September, all sites were sent postcards (see Appendix Q), which thanked them for their involvement in the study and also served as a reminder to continue with data collection. They also received personalized letters from the ACL, signed by the project officer, thanking them for their valuable contribution to the study and requesting that they send data on a regular basis.

Because the number of clients eligible for the PES continued to be lower than expected, eligibility criteria were relaxed as of October 1, 2013. Agencies were sent an email asking them to screen clients even if they were seeking services such as basic information and referral, Meals on Wheels, or transportation. By loosening eligibility criteria, the team hoped to increase the number of clients able to participate in the PES.

In addition to frequent phone contact by the co-principal investigator and an additional mailing of the thank-you postcard, a final effort to increase the number of eligible clients recruited into the study was to extend the data collection period by three months from December 31, 2013, to March 31, 2014.

3.3.3 Participant Experience Survey

The research team led by Abt Associates developed the PES to capture consumers’ experiences when contacting an ADRC or AAA to inquire about LTSS. The survey received approval from Abt’s IRB. The PES can be found in Appendix R. Because respondents in this study are more likely than the general population to experience cognitive challenges including limited attention, it was preferable to keep the questions brief and easy to answer and the overall survey short so that it took no more than 20 minutes to complete. Every effort was taken to make the wording of the questions clear and simple and to avoid colloquialisms that might be unique to one culture or even to one part of the country. The survey was designed so that either the recipient of the services or a caregiver could answer. As described below, the survey instrument underwent cognitive and pilot testing and was revised based on the results of these tests.

The survey began with a statement of informed consent that was read to the respondent and required a verbal agreement to continue. The instrument contained 60 questions prompting yes/no, short answer, multiple choice, or Likert scale responses. Skip patterns were built into the survey so that questions irrelevant to a specific respondent could be avoided (e.g., "Did you request one-on-one counseling?"). The multiple choice and Likert scale responses were designed to be exhaustive, and all included the options "don't know" and "refused to answer." The questions covered by the survey include the following nine domains:

- Experience with initial contact
- Agency efficiency
- Agency effectiveness
- Institutional diversion
- Assistance with services
- Assistance with Medicaid eligibility determination
- Assistance with one-on-one counseling
- Care transition services
- Services received from the agency
- Health and demographic information

3.3.4 Administration of the Participant Experience Survey

The outcome study used a telephone survey whose development involved three stages: a cognitive test to refine the questionnaire design, a pre-test to assess timing and further design issues, and a main telephone survey. It was conducted using a fully overlapping dual (landline and cell phone) frame sample, with approximately half of the completed surveys originating from the cell phone frame and half from the landline frame. As noted earlier, respondents were either clients or client proxies of ADRCs and AAAs. Most clients were adults, with the exception of two who were under-18 clients; only adults were interviewed.

3.3.5 Response Rates

The interviewers dialed a total of 1,169 telephone numbers and achieved an interview completion rate of 54 percent. Of the 625 telephone interviews completed, 330 were landline respondents and 295 were cell phone respondents. The completion rate for ADRCs was 88 percent (552 respondents), while the completion rate for AAAs was 12 percent (73 respondents). For more detail about the administration of the PES, please see Appendix S.

3.3.6 Analytic Approach

The approach to analyzing the outcome study data that were collected via the PES is described in the following sections.

Sample Weighting. Each responding ADRC and AAA was assigned a sampling weight. This weight was used for all population-based estimates and for all statistical analyses. The sampling weight combines a base weight and an adjustment for non-response. The determination of weights followed the sampling design used for the outcome study.

For the selection of the sample, the population of ADRCs was stratified by 10 regions, and, within each region, the ADRCs were further stratified by rural or urban status, creating 20 strata for sample selection. The same design was followed for the selection of AAAs. An equal-probability sample of two ADRCs was selected in each stratum. The base sampling weight for each selected ADRC is the ratio of the number of ADRCs in the stratum population to the number selected in the sample.

For data collection, one ADRC was selected at random from the two in the stratum, and the other was designated as reserve in case the first selected ADRC turned out to be a non-respondent. At the end of the survey period, it was found that some strata had no respondents. First, the base weight was adjusted for non-response within a stratum. Since there was total non-response in some regions, for weighting purposes these regions were merged with adjacent regions to form a collapsed stratum, and the weights were based on the total number of ADRCs in the combined or collapsed stratum and the number responding in the collapsed stratum. The assumption was that ADRCs and AAAs in adjacent regions are likely to be similar with regard to characteristics in the survey as compared to other regions. In some cases, the collapsed stratum consisted of regions which are not adjacent to the non-responding region. This was done to avoid very large sampling weights. Since the samples of ADRCs and AAAs were selected with equal probability in each stratum, the base weight adjusted for non-response is essentially the ratio of the number of ADRCs in the population to the number responding in the sample. The sum of the sampling weights in each of the four groups—ADRC rural, ADRC urban, AAA rural, and AAA urban—is equal to the total population in each of these groups.

Tabulation. We tabulated the survey questions, and the relevant tables for ADRCs are provided in Appendix T (tabulations of questions) and Appendix U (free-text responses). These tables report the actual frequencies of the survey responses. However, all the percentages reported are weighted using the sample weights generated to account for selection probability and non-response.

We discuss a selection of these tabulations in the various sections of Chapter 5. We codified and summarized the free-text responses. Key findings from the open-ended responses are also discussed in this report.

The corresponding tables for AAAs are available in Appendices V and W. We do not discuss findings from the survey respondents who represented AAAs. As mentioned earlier, the fact that only 73 AAA clients responded to the outcome study survey limits their usefulness as a viable comparison group.

Bi-Variable Analysis. As in the case of the process study, we implemented bi-variable subgroup analyses in addition to tabulating individual survey questions. These analyses identified statistically significant differences among subgroups in relation to respondent experience with ADRCs. The bi-variable analysis was conducted using cross-tabulations, and statistical significance of differences was assessed using chi-square tests.

The subgroups of interest are categorized into client characteristics and ADRC characteristics.

The ADRC client characteristics used in the outcome study cross-tabulations include:

- Gender
- Education
- Income
- Type of client: older adult or adult with a disability

The ADRC characteristics used in the outcome study cross-tabulations include:

- Statewide or local ADRC
- Number of consumers served
- Number of full-time equivalent (FTE) staff
- Rural or urban ADRC service areas

- Level of core service provision categories
- Extent of site integration categories
- Status of Medicaid integration categories

In Exhibit 3.5, we provide the definitions of the various subgroup analysis categories and their distributions at the respondent level. The ADRC characteristics are generated from the process study survey data, and the client characteristics are from the outcome study survey data. The frequencies and percentages presented below are un-weighted.

Statewide versus local ADRC. A variable that we included to capture the organizational structure of ADRCs was whether the ADRC operated statewide or at the local level. Two of the ADRCs that participated in the survey, Choices in Living Resource Center in Arkansas and MinnesotaHelp Network™: A Network of Aging & Disability Resource Centers in Minnesota, are statewide ADRCs with their operations covering the entire states of Arkansas and Minnesota, respectively.

Exhibit 3.5: Distribution of Survey Respondents by Subgroup Analysis Categories

	Number	Percentage
ADRC Characteristics		
Organizational Type		
Local	252	46.65
Statewide	300	54.35
Number of Consumers		
0 – 500	34	6.16
500 – 2500	265	48.01
2500 +	253	45.83
Number of FTEs		
0 – 5	60	10.87
6 – 15	243	44.02
16 +	249	45.11
Urbanicity*		
Rural	93	16.85
Urban	159	28.08
Client Characteristics		
Gender		
Male	160	29.04
Female	395	70.96
Education		
Less than High School	109	20.88
High School Diploma	208	39.85
More than High School	205	39.27
Income		
≤ $40,000	454	90.26
> $40,000	49	9.74
Type**		
Older Adult	401	72.64
Adult with Disability	441	79.89

*Percentages for rural and urban ADRCs do not add up to 100 as they are generated from the universe of ADRCs, which comprised rural, urban, and statewide ADRCs.

**Older adults with a disability are counted in both categories. Therefore, percentages do not add up to 100.

Number of ADRC consumers. To understand how client experience varies with the capacity of ADRCs, we used the total number of clients (aged and disabled) served by the ADRC in the most recent six months. The same three categories used for the process study subgroup analysis was used here: small (0 – 500 consumers), medium (501 – 2,500 consumers), and large (2,500+ consumers).

Number of FTEs at ADRC. Another variable used in the analysis to capture ADRC capacity was the total number of FTEs at the agency. The total number of FTEs was split into three categories: 0 – 5, 6 – 15, and 16+.

Rural versus urban ADRC service areas. To understand whether respondent experience varies with the urbanicity of the service areas of ADRCs, we used the categorical variable rural or urban ADRC, defined as in the process study subgroup analysis. Statewide ADRCs were not assigned rural or urban status.

Client gender. Subgroup analysis also explored gender differences in responses.

Client education. Client education was coded into three categories: less than high school education, high school graduate, and more than high school education.

Client income. Income, a continuous variable from the survey, was recoded as a binary variable with the categories income over $40,000 and income less than or equal to $40,000.

Client type. ADRC clients are categorized into two groups: older adults and adults with a disability. Older adults and adults with a disability are not mutually exclusive categories. Older adults are individuals who are aged 60 or above, irrespective of disability status. Adults with a disability comprise all individuals 18 years of age or older who have a disability.

The analyses of the three core measures generated for this study are presented together in Section 5.2.6. The findings from the remaining subgroup analyses are discussed in the corresponding sub-sections of this report if they were found to be statistically significant. The cross-tabulations are provided in Appendices X – HH, with a separate appendix for each major subgroup category.

Regression Analysis. We used regression analysis as an additional exploratory tool to help understand the associations between various client, ADRC, and community characteristics and our outcomes of interest after controlling for factors that might influence the outcomes. As mentioned earlier, we originally intended to use AAA clients as a comparison group for impact estimation under the outcome study. However, the number of AAA respondents to the outcome study survey was too low (73 respondents) for them to be used as a comparison group in the regression analysis.

Since we did not have a viable comparison group, we were unable to conduct an impact estimation of ADRCs on respondent experience in order to make causal inferences or focus on the effect of a single policy variable such as the receipt of assistance from an ADRC. Therefore, our regression findings can only be considered as associations of certain client, ADRC, and community characteristics with the outcomes of interest.

In this section, we first discuss the outcome variables studied in the regression analysis, then the covariates, and, finally, the specification of the regression model.

Outcome variables. We conducted regression analysis on key outcomes of interest including:

- Efficiency of ADRC staff in service provision
- Reasons for respondent contact with ADRCs
- Challenges faced by respondents in resolving their issues
- Usefulness of ADRC services
- Respondent satisfaction with ADRCs

All the above outcomes of interest were coded as binary variables taking a value of 0 or 1 for the regression analysis. For example, if the outcome is whether the respondent was able to speak with an ADRC representative on his or her first contact with the ADRC, a value of 1 implied that the respondent was able to speak with an ADRC representative and a value of 0 implied that he or she was unable to speak with an ADRC representative.

In our list of outcomes of interest, in addition to survey questions with binary response options such as “Yes” and “No,” we also had outcomes, such as respondent satisfaction, with ranked categories for response options. Some of the response categories for these outcomes had a small number of observations, necessitating the recoding of these categorical variables into binary variables. For example, the satisfaction-related outcomes had ordered response options such as “very satisfied,” “somewhat satisfied,” “somewhat dissatisfied,” and “very dissatisfied.” We recoded these categorical variables into binary variables so that “very satisfied” and “somewhat satisfied” constituted one category, “satisfied.” Similarly, we combined the response categories of “somewhat dissatisfied” and “very dissatisfied” into a single category, “dissatisfied.” With this recoding, the satisfaction variables took a value of 1 if the respondent was satisfied with the services or interaction that she or he had with the ADRC and a value of 0 if the respondent was not satisfied.

Covariates. We used a variety of client, ADRC, and community characteristics as covariates in the regression. Appendix II provides the specifications and sources of data of the covariates included in the regression analysis. Note that all the demographic, health, and economic status variables were those of the client who needed LTSS and not of the respondent to the survey. The survey respondents are the individuals who contacted ADRCs for services; they may or may not have been the clients on whose behalf the ADRC contact was made. Age of the client is the only continuous variable at the client level. All the other client-level variables are indicator variables such as whether the client was married, lived alone, was more than 60 years old, or had a disability. We also included indicators for a White, non-Hispanic client and three education indicators capturing whether the client was a high school graduate, had education beyond high school, or had less than a high school education. Other client-level explanatory variables included indicators for income below $40,000 and self-reported health status at the time of the survey as “poor.” We also included variables to indicate whether the client was an older adult (with or without disability) or an individual with disability (irrespective of age).

For some of the outcomes of interest, respondents’ reasons for contacting the ADRC were also included in the regression models. In addition, for outcomes measuring satisfaction, we controlled for respondent type, that is, whether the client him- or herself contacted the ADRC with a service request or someone else called on the client’s behalf.

To understand whether respondent experience varied with ADRC characteristics, we included two variables. The first one was an indicator of whether more than 50 percent of the population in the service area of an ADRC resided in urban areas. The second one indicated whether the respondent sought assistance from a statewide ADRC or a local ADRC.

In order to account for community characteristics, we included variables capturing the education, race, ethnicity, and poverty status of the population in the service areas of ADRCs. We also included the number of older adults and individuals with disabilities in the community, the two populations to which ADRCs cater. To capture community-level health infrastructure directly relevant for ADRC services, the number of home health agencies per 10,000 older adults (60 years and above) and the number of nursing home beds per 1,000 older adults (60 years and above) were also included in the regression models.

Regression model specification. Since all the outcome variables were dichotomous, we used probit regression for estimation. All analyses were weighted using sample weights. Standard errors were clustered by ADRC to adjust for any correlation across individuals who contacted the same agency.

The regression coefficients reported are the average marginal effects of the covariates.[6] A positive average marginal effect coefficient on a covariate means that the variable increases the likelihood of the outcome of interest taking a value of 1. The coefficients are reported in percentage points. The interpretation of a coefficient depends on whether the variable is continuous or dichotomous. For example, in the case of an outcome variable measuring respondent satisfaction, if a continuous variable such as age had a coefficient of –0.05 percentage points, it may be interpreted that a one-year increase in age is associated with a 0.05 percentage point lower probability of respondents being satisfied, after controlling for the effect of all other covariates. In the case of a dichotomous variable such as the indicator for statewide ADRCs, a coefficient of 5 percentage points means that respondents contacting statewide ADRCs for assistance have a 5 percentage point higher probability of being satisfied compared to respondents contacting a local ADRC.

In our discussion of findings from the regression analysis, we report only coefficients that were statistically significant at the 95 percent confidence level or higher ($p \leq .05$). However, in the regression results tables presented in Appendix JJ, we also indicate those coefficients that are significant at the 90 percent confidence level ($p \leq .10$).[7] In addition, when describing the effects in the report, we focus on client and ADRC characteristics, though the coefficients on community characteristics are also included in the regression output in Appendix JJ.

We estimated several model specifications—in terms of the covariates included in the regression—for each outcome, depending on the nature of the outcome. For example, in some regression specifications we included the reasons for contacting ADRCs as covariates, whereas in others we did not. However, in this report, we present findings only from the model specification that we considered to be the one that best accounted for the variation in the outcome of interest. Furthermore, we restricted our analysis to outcomes with sufficient variation.[8]

Below is the specification of the probit regression model that we implemented:

$$Probability\ (Y_i = 1|Z_{ADRC}, X, C) = F\ (\alpha + \beta Z_{ADRC} + \gamma X + \delta C + u_i)$$

The dependent variable in the above model (Y) is the probability of the outcome of interest occurring, for example, the client being satisfied with the direct services received. The control

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[6] The marginal effect of a covariate is the change in the likelihood of the occurrence of the outcome of interest with respect to a small change in that covariate, holding all other covariates in the model at some fixed value. Instead of calculating the marginal effect of a covariate at some fixed value of all the other covariates, we calculated the marginal effect of the covariate at every observed value of all the covariates and then averaged those values to get the average marginal effect of that covariate.

[7] We use asterisks to indicate statistically significant results as *$p \leq .10$, **$p \leq .05$, or ***$p \leq .01$.

[8] Binary outcomes variables that had very few (less than 5 percent) 1s or 0s were not analyzed using regression models.

variables in the above regression equation include *ADRC* (Z_{ADRC}), client (X) and community characteristics (C). The probit function follows a normal (cumulative) distribution.

Z_{ADRC} includes variables that capture the characteristics of ADRCs, such as whether the ADRC is a statewide or local ADRC. Inclusion of ADRC characteristic variables help us understand their association with the different measures of respondent experience after controlling for client and community characteristics. For example, we can analyze the model below to focus on the association of the type of ADRC and the outcome of interest, Y.

$$Probability\ (Y_i = 1 | Z_{ADRC}, X, C) = F\ (\alpha + \mu Rural\ ADRC + \beta Z_{ADRC} + \gamma X + \delta C + u_i)$$

The variable *Rural ADRC* takes a value of 1 if the ADRC serves a rural area. We show this variable separately from Z_{ADRC} only as an illustrative example. If Y_i is a variable that represents, for example, whether difficulty reaching ADRC staff was a challenge in the way of issue resolution, this model shows how the service area of ADRCs being rural is associated with the likelihood of respondents' facing difficulty in reaching ADRC staff, after controlling for other ADRC, as well as client and community, characteristics.

Imputation of missing values. Several client characteristics had missing values. The number of observations with missing data ranged from one observation for the gender variable to 44 observations for the income variable. To prevent the loss of observations due to missing data when implementing the regression analysis, we imputed the missing values. Since the number of observations was small and all the client characteristics were binary, we imputed these values based on the proportion of subgroups in the sample. For example, for the income variable, we coded all missing values as "income less than $40,000," since over 85 percent of the clients who reported income in the dataset had income less than $40,000. For the education variable, we coded all missing values as "high school graduate," since this was the most frequent education category.

3.4 Core Integration Dimensions

Using data from the process study, we developed three core measures to assess the range of services provided by ADRCs and their level of integration. The core measures capture the following three dimensions of ADRC operations:

- Level of core service provision
- Extent of site integration
- Status of Medicaid integration

The core measures also contribute to a better understanding of the process and outcome study findings. Specifically, they were used in the process study to:

- Describe the level of core service provision, the extent of site integration, and the status of Medicaid integration across local ADRCs
- Determine if the level of integration was associated with other organizational characteristics (e.g., differences between urban and rural service areas)
- Assess whether key outcomes of interest varied across categories (e.g., by site integration)

In the outcome study, the core measures were used to:

- Assess whether key outcomes of interest varied across categories (e.g., differences in the challenges faced when receiving services by level of site integration)
- Assess whether client satisfaction with ADRC services varied by the level of core service provision, extent of site integration, or status of Medicaid integration

3.4.1 Level of Core Service Provision

The level of core service provision is intended to assess the provision of core services by ADRCs. To construct this measure, we counted the number of core services: information and referral (I&R); options counseling; eligibility determination, referral, and enrollment; and care transitions. We then grouped the ADRCs into three categories according to the comprehensiveness of those services.

ADRCs that provided I&R and either options counseling or eligibility determination, referral, and enrollment, but not both, were categorized as low core service providers. Those that offered I&R plus both options counseling and eligibility determination, referral, and enrollment were categorized as medium core service providers. ADRCs that provided all four services were categorized as high core service providers. This grouping allowed us to distinguish ADRCs that were providing relatively basic levels of service from those that were offering more comprehensive services.

Information and referral. The process study survey did not include questions that directly collected data on whether ADRCs offered I&R or information and assistance (I&A). However, since all consumers contact an agency to request some type of information or referral, for the purpose of generating the measure of core service provision, we assumed that all ADRCs offer I&R/I&A.

*Options counseling***.** To construct this measure, we counted the number of "Yes" responses to the local-level process study survey Question 33 regarding the provision of options counseling, "Does your organization/network provide 'Options Counseling'?" (See Appendix C for full item.)

Eligibility determination. Similarly, there was no direct question regarding whether or not an ADRC provided eligibility determination services. As a result, we inferred from the eligibility determination questions (i.e., Questions 48, 51, 52, and 54; see Appendix C). An ADRC was categorized as providing the service if it met any one of the following criteria:

- Responded "Yes" to Question 48 about administering a screening questionnaire
- Did not select the response "We do not assist clients with financial eligibility applications" for Question 51
- Did not select the response "We do not assist clients with financial eligibility applications" for Question 52
- Responded "Yes" or "No, but in development" to Question 54 about using a universal, comprehensive instrument to determine eligibility

Care transition services. ADRCs that responded "Yes" to whether or not the organization provided transition services were considered as providing transition services to consumers discharged from an acute care setting (i.e., Question 24, see Appendix C).

Degree of Missing Data. ADRCs were categorized as having a low, medium, or high level of core service provision only if they answered all applicable questions on all the core services.

Exhibit 3.6 displays the number of core services on which ADRCs had missing information. The level of core service provision measure was generated only for the 436 local ADRCs that had information on all four core services.

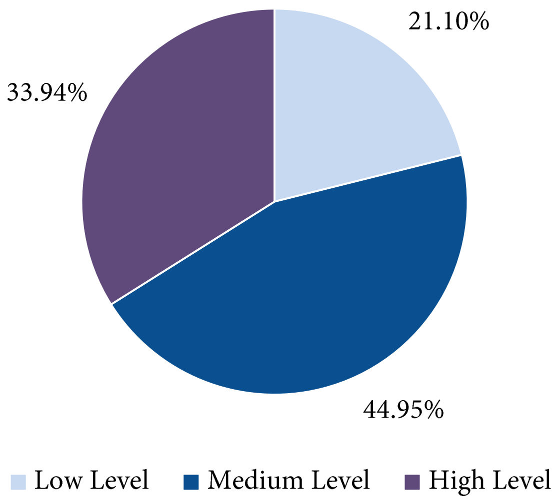
Exhibit 3.6: Number of Core Services for Which ADRCs Had Missing Information

Number of Services with Missing Information	Number of ADRCs
0	436
1	19
2	17
3	0

Note: Twenty-six ADRCs had missing information on the options counseling items; 27 had missing information on the eligibility determination items.

Distribution of ADRCs by Level of Core Service Provision. Exhibit 3.7 presents the level of core service provision of local ADRCs. One-third of local ADRCs met the requirements to be considered a high core service provider. While almost half of the local ADRCs provided a medium level of core services, one-fifth of ADRCs provided only a low level of core services.

Exhibit 3.2: Distribution of ADRCs by Level of Core Service Provision



3.4.2 Extent of Site Integration

The measure of site integration was developed to capture the level of comprehensiveness of the services and supports offered by a local-level ADRC, as well as the operational processes and number of partnerships within and across agencies that facilitate these services.

Six domains with multiple sub-measures within each domain were scored and aggregated into an overall measure of site integration. Local ADRCs were categorized into low, medium, or high categories according to the extent of their site integration.

Domains. Following are the six domains that comprise the site integration measure, with respective measurable elements and an explanation of scoring.

1. **Populations served** assessed the range of older adults, persons with a disability, and specific populations, such as those with limited English proficiency, served by the ADRC. We counted the consumers in each category listed below based on responses to

Questions 14a and 14b (i.e., the number of consumers of each type served; see Appendix C).

- Over age 60
- Under age 60
- Physical disability
- Mental disability
- Intellectual/developmental disability
- Paid and unpaid caregivers
- Health and human services professionals
- Traumatic brain injury
- Emergency cases
- Low income
- Limited English proficiency

An ADRC received one point for the domain if the ADRC answered question 14a but not question 14b. If the ADRC provided any information for question 14b, it received one point; if the ADRC served four or fewer types of consumers, *including at least one disability group*, it scored one point; if the ADRC served more than four types of consumers, it scored two points.

2. ***Eligibility determination*** evaluated the comprehensiveness of the assistance provided by ADRCs for financial and functional eligibility determination.

    - Assist with Medicaid and other public LTSS financial eligibility determination applications
    - Assist with other public LTSS financial eligibility determination applications
    - Conduct screening eligibility for diverse populations
    - Assist with functional assessment (level of care) for LTSS
    - Conduct functional assessment for diverse populations

An ADRC received one point if it provided at least one of the following: (a) assist with Medicaid and other public LTSS financial eligibility determination applications, (b) assist with other public LTSS financial eligibility determination applications, or (c) assist with functional assessment (level of care) for LTSS. If an ADRC provided three or more of the above financial and functional eligibility determination services, it received two points. An ADRC was excluded from scoring for this domain if it did not answer any one of questions 49a, 51, 52, 54, and 55d (see Appendix C).

If an ADRC gave an affirmative answer to response categories 3, 4, 5, 6, or 7 for Question 51, we counted it as offering assistance to consumers with their Medicaid LTSS financial eligibility determination application. Similarly, based on the response to Question 52, we determined whether an ADRC assisted consumers with financial eligibility applications for publicly funded LTSS other than Medicaid. If an ADRC administered the eligibility screening instrument to consumers aged 65 and older and at least one type of consumer with disability, under Question 49a, it was considered as offering eligibility determination services to diverse populations. If an ADRC responded "Yes" or "No, but in development" to Question 54, we assumed that it assisted with functional assessment for LTSS. Finally, if an ADRC used functional assessment for consumers aged 65 and older and consumers with at least one type of disability (Question 55d), it was considered as offering functional assessment services to diverse populations.

3. ***Options counseling*** assessed whether the ADRC provided options counseling to clients and the setting(s) where options counseling took place.
    - Options counseling provided
    - Options counseling provided under multiple settings

Those ADRCs that respond "Yes" to Question 33 regarding the provision of options counseling (see Appendix C) were considered as providing options counseling to consumers and received one point. ADRCs received a second point if they provided options counseling to clients in two or more settings such as the ADRC, a hospital, or residences, per Question 35c (see Appendix C). An ADRC was excluded from scoring in this domain if it did not answer Question 33.

4. ***Person-centered transition support*** measured whether or not the ADRC provided transition support from acute care settings and to which population and health insurance types.
    - Care transition services provided from acute care setting
    - Care transition services to all ages
    - Care transition services to all insurance types

Those ADRCs that responded “Yes” to Question 24 regarding the provision of transition services (see Appendix C) were considered as providing transition services to consumers discharged from an acute care setting and received one point. They got a second point if they offered care transition services to all ages per Question 27 or all health insurance types per Question 28 (see Appendix C). An ADRC was excluded from scoring in this domain if it did not answer Question 24.

5. ***Integrated processes*** assessed the integrated processes in place at the ADRC for the coordination of assistance within and across agencies such as data sharing and “warm transfers.[9]”
    - Shared consumer needs assessment tool common across partners
    - Standardized tool/process for options counseling
    - Comprehensive database/management of information systems (MIS)
    - Staff follow Alliance of Information and Referral Systems (AIRS) standards
    - Data sharing with operational partners
    - Data sharing with service providers
    - Follow up with consumers
    - Follow up with providers
    - Warm transfers

If an ADRC had between one and four of the above processes, the ADRC received one point. Those ADRCs that reported five or more of the processes received two points. An ADRC was excluded from scoring for this domain if the respondent did not answer any one of Questions 32, 36, 39, 40, 41, 42, 42a, 43, and 44 (see Appendix C).

An ADRC whose representative reported that the ADRC shared common consumer needs assessment tools across all or some partners (Question 32) was considered as sharing common consumer needs. Whether or not an ADRC had a standardized tool /process for options counseling was assessed based on its response to Question 36, and a “Yes” response to Question 39 determined whether an ADRC’s staff followed AIRS standards. The database/MIS of an ADRC was counted as comprehensive if the ADRC selected at least three of the response options for Question 40 that queried whether or not the ADRC had a database for specific tracking purposes. ADRCs answering “Yes” or “No with plans to develop capacity” to Questions 41 and 42 were considered as having the capacity for data sharing with operational partners and service providers,

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[9] A warm transfer is a simultaneous transfer of a telephone call and its associated data from one agent to another agent or supervisor.

respectively. ADRCs answering “Always” or “Sometimes” to Questions 42a and 43 were considered to follow up with consumers after their initial contact with the ADRC and with providers after consumers are referred to them, respectively. Finally, response to Question 44 told whether an ADRC provided warm transfers to consumers referred to other organizations.

6. ***Partnerships*** explored whether or not the ADRC had developed strong partnerships with organizations representative of aging, disability, and mental health service networks.
    - Strong partnerships with organizations representing the aging population
    - Strong partnerships with organizations representing individuals with disabilities
    - Strong partnerships with government agencies at the federal, state, and local levels
    - Strong partnerships with organizations providing direct services, such as 211 call centers and community health clinics

A partnership was considered strong if the ADRC representative chose the response option “highly functional” to Question 63 (see Appendix C). ADRCs that indicated at least one strong partnership among the above types received one point. ADRCs mentioning strong partnerships with both organizations representing older adults and organizations representing persons with disabilities, as well as strong relationships with at least one of the remaining two partnership types, received two points. To be considered as having a strong partnership with government agencies, an ADRC had to have strong partnerships with at least two levels of government agencies (i.e., federal and state, federal and local, or state and local). To be considered as having a strong partnership with organizations providing direct services, an ADRC had to have a strong partnership with at least two organizations. An ADRC was excluded from scoring for this domain if it did not answer Question 63.

Scoring Mechanism. The measure of site integration was scored on a 12-point scale. An ADRC could score up to two points on each of the six domains. We aggregated the scores received under each domain to arrive at the total score. It should be noted that all six domains were weighted equally, because they are considered of equal importance in offering integrated services. ADRCs were categorized into the following groups based on their total number of points:

- High level of site integration: 10 – 12 points
- Medium level of site integration: 6 – 9 points
- Low level of site integration: 0 – 5 points

Degree of Missing Data. Only ADRCs with scores on all six domains were categorized into the low, medium, or high categories of the extent of site integration. As seen in Exhibit 3.8, Domain 1, Populations Served, was the domain with the largest number of ADRCs without domain scores.

Exhibit 3.2: Number of ADRCs without Scores on the Site Integration Domains

Domain	Number of ADRCs without Scores on the Domain
1 – Populations Served	64
2 – Eligibility Determination	28
3 – Options Counseling	26
4 – Person-Centered Transition Support	0
5 – Integrated Processes	14
6 – Partnerships	43

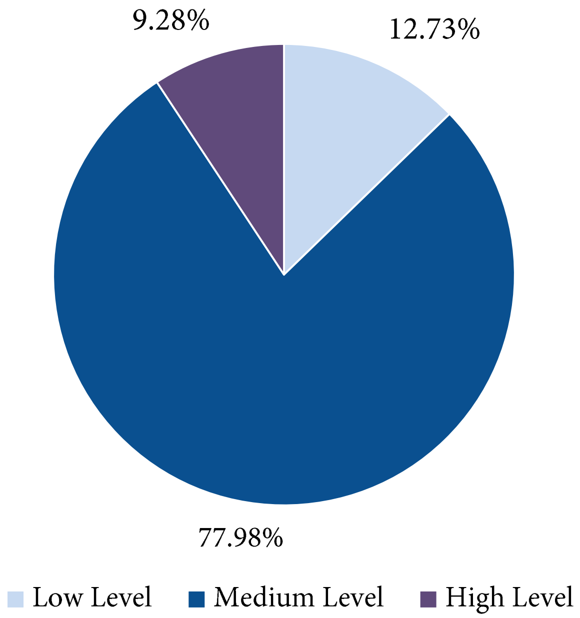
In Exhibit 3.9, we present the number of site integration domains for which ADRCs did not have scores. The exhibit shows that 377 local ADRCs had scores on all six domains of site integration and could be categorized on their extent of site integration.

Exhibit 3.3: Number of Site Integration Domains for Which ADRCs Had No Score

Number of Domains without Score	Number of ADRCs
0	377
1	60
2	14

Distribution of ADRCs by the Extent of Site Integration. Exhibit 3.10 indicates that more than three-quarters of local ADRCs were moderately integrated, whereas around 13 percent had a low level of site integration. Only 9 percent of the local ADRCs were found to have a high extent of site integration.

Exhibit 3.5: Distribution of ADRCs by Extent of Site Integration



3.4.3 Status of Medicaid Integration

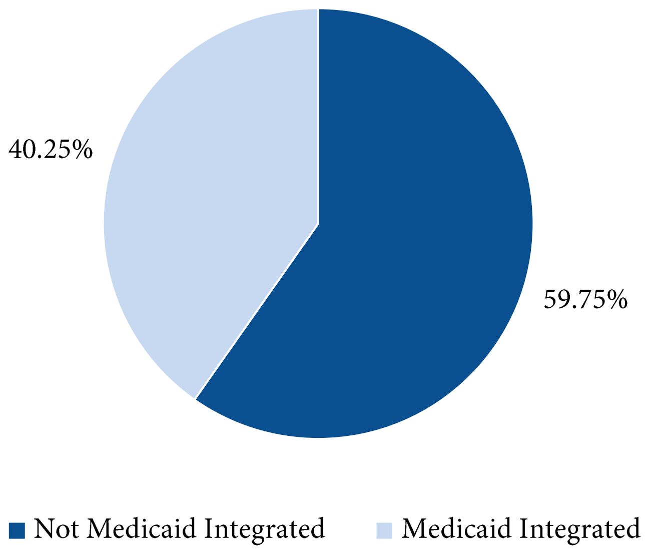
Local ADRCs receiving funding during fiscal year 2013 from any of the following six Medicaid-related sources were considered to be Medicaid integrated:

- CMS Real Choice Systems Change Grants
- CMS Person-Centered Hospital Discharge Planning Grant
- Money Follows the Person Demonstration
- Program of All-Inclusive Care for the Elderly (PACE)
- Medicaid for Direct Services (state and federal)
- Medicaid for Federal Financial Participation

Degree of Missing Data. For the purpose of this analysis, if a local ADRC did not report a positive amount of funding from at least one of the above Medicaid funding sources, it was assumed that the ADRC was not Medicaid integrated. Based on this definition of Medicaid integration, we were able to identify the Medicaid integration status of all 472 local ADRCs that participated in the process study.

Distribution of ADRCs by Status of Medicaid Integration. Exhibit 3.11 shows that 40 percent of local ADRCs were Medicaid integrated.

Exhibit 3.6: Distribution of ADRCs by Status of Medicaid Integration



CHAPTER 4. PROCESS STUDY FINDINGS AND IMPLICATIONS

In this chapter, we present the results of the process study. Section 4.1 describes the key research questions. Section 4.2 presents key process study findings by research domain. It also explores the differences among ADRCs across the three dimensions of service provision, site integration, and Medicaid integration. Lastly, Section 4.3 presents conclusions and implications based on the process study findings.

4.1 Process Study Purpose, Research Questions, and Research Domains

4.1.1 Purpose

The main goals of the process study were to:

- Explore the motivations of state and local ADRCs for seeking ADRC grants and the effect of the grants on local sites' performance
- Understand contextual factors (e.g., level of community service capacity) identified from a local perspective
- Learn about the operational characteristics of ADRCs from state and local perspectives
- Capture aspects of LTSS service delivery that influence participant experience that may not be captured in the outcome study
- Collect and analyze information that will guide improvements of the ADRC program

4.1.2 Research Questions

To achieve the above goals, the process study specifically explored the following key research questions:

- What motivated states and local sites to seek ADRC funding?
- What effects did ADRC funding have on the resources, services, and outcomes of local ADRCs?
- Are there community characteristics or programs that support, facilitate, or create barriers to ADRCs?
- What types of consumers contact ADRCs for services?
- What types of services do ADRCs provide?
- What are the organizational structure and operational processes of ADRCs?

- What types of resources and staffing do ADRCs have?
- Is there a uniform eligibility determination process, or are there standard operating procedures, for ADRCs?
- To what extent do ADRCs use data for decision-making?
- How do state and local agencies collaborate to provide access to LTSS at ADRC sites? Are there interagency agreements or other collaborative efforts in place?

4.1.3 Research Domains

This report groups the above research questions into the following five domains, each of which will form a section in the process study findings part of this report below:

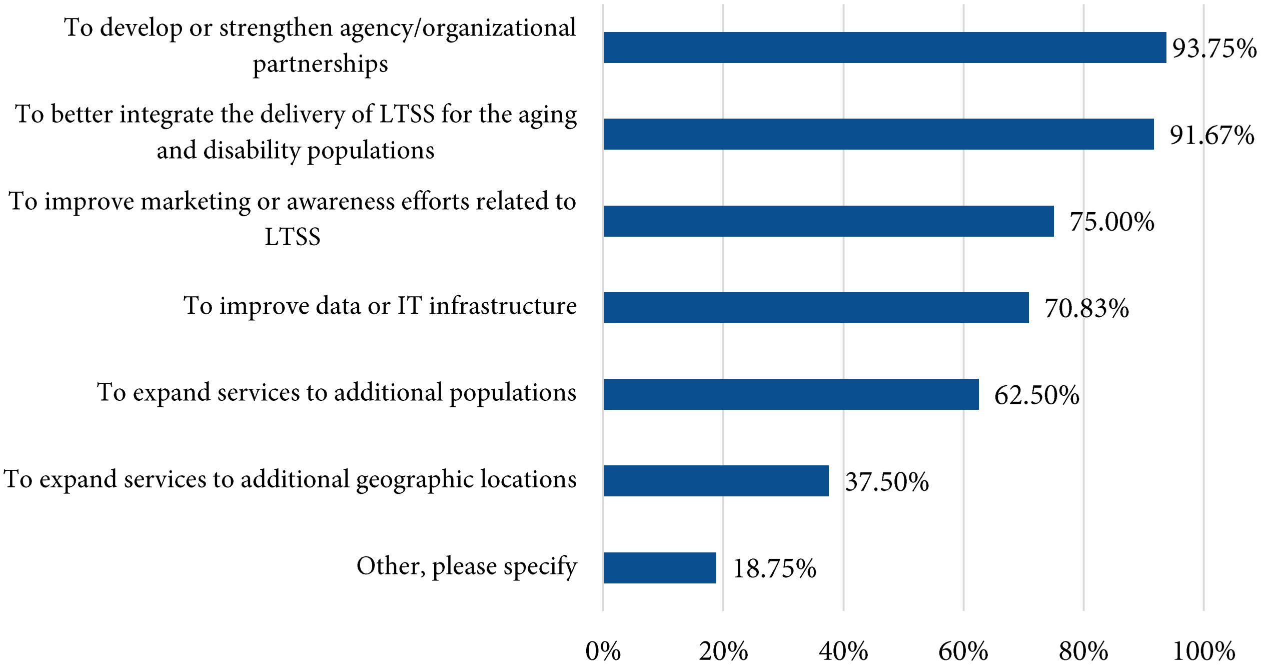
- Motivation and objectives
- Funding
- Community and consumer information
- Organizational information
- Partnerships

4.2 Process Study Findings

4.2.1 Motivation and Objectives

State ADRCs' Reasons for Becoming an ADRC. When asked to indicate their goals when first applying for an ADRC grant, more than 90 percent of state ADRC respondents cited that they intended to better integrate the delivery of LTSS for older adults and persons with disabilities and to develop or strengthen agency/organizational partnerships (see Exhibit 4.1). Nearly 63 percent cited that they aimed to expand services to additional populations. Approximately three-quarters of state ADRCs selected improving data or information technology (IT) infrastructure and improving LTSS marketing/awareness efforts as goals.

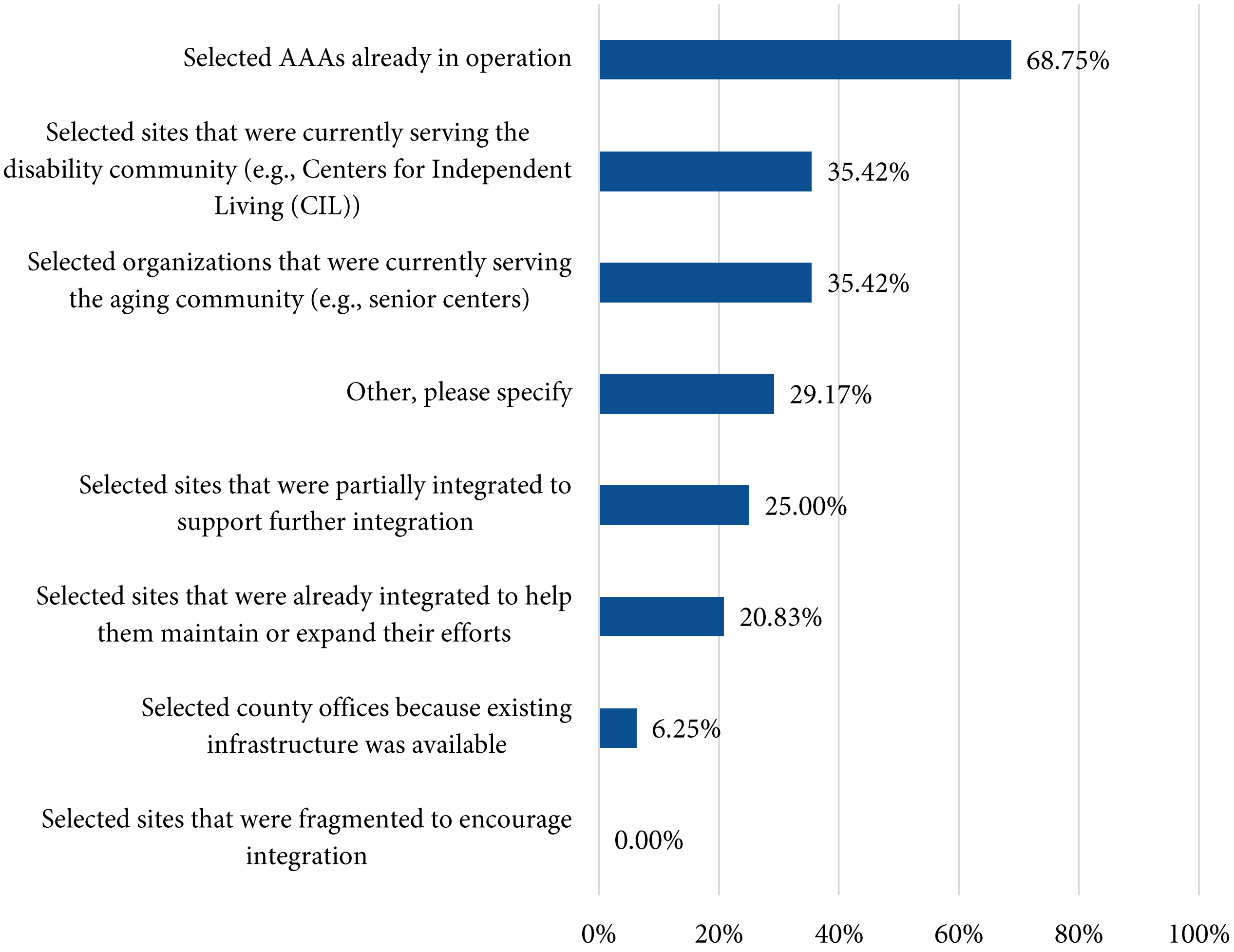
Exhibit 4.1: Reasons for Becoming a State ADRC



Notes: Response rate was 100%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Criteria for Selecting Local Sites for ADRC Funding. State ADRCs indicated the criteria they followed in selecting local sites initially for ADRC funding. We see, from Exhibit 4.2, that the most common criterion established by state ADRCs was whether the organization already operated as an AAA (69%). More than one-third of state ADRCs considered whether the organization was currently serving the aging community (35%) or the disability community (35%) when selecting local ADRCs for funding.

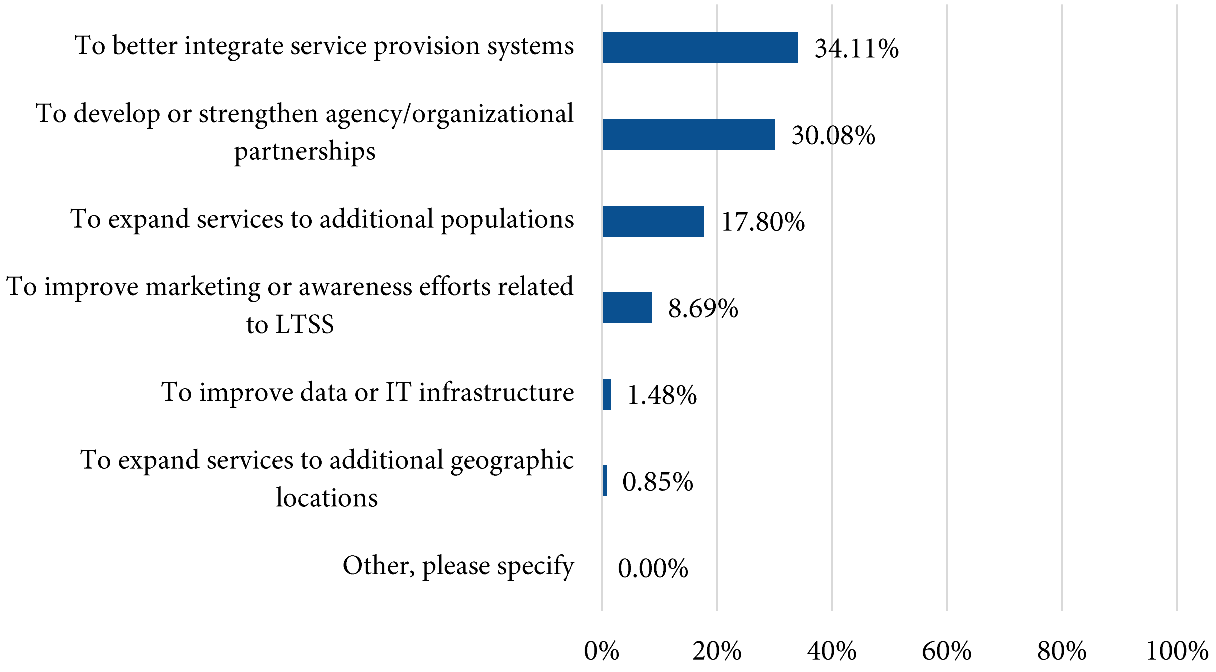
Exhibit 4.2: State ADRCs' Criteria for Selecting Local ADRCs for Funding



Notes: Response rate was 100%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Local ADRCs' Reasons for Becoming an ADRC. As shown in Exhibit 4.3, descriptive statistics indicate that the most frequently selected reason chosen by local ADRC respondents for becoming an ADRC was to better integrate the delivery of LTSS for the aging and disability populations. Chosen nearly as frequently was the opportunity to develop or strengthen agency /organizational partnerships. While state ADRCs could choose multiple response options, local ADRCs could choose only one. Therefore, the two sets of findings are not directly comparable.

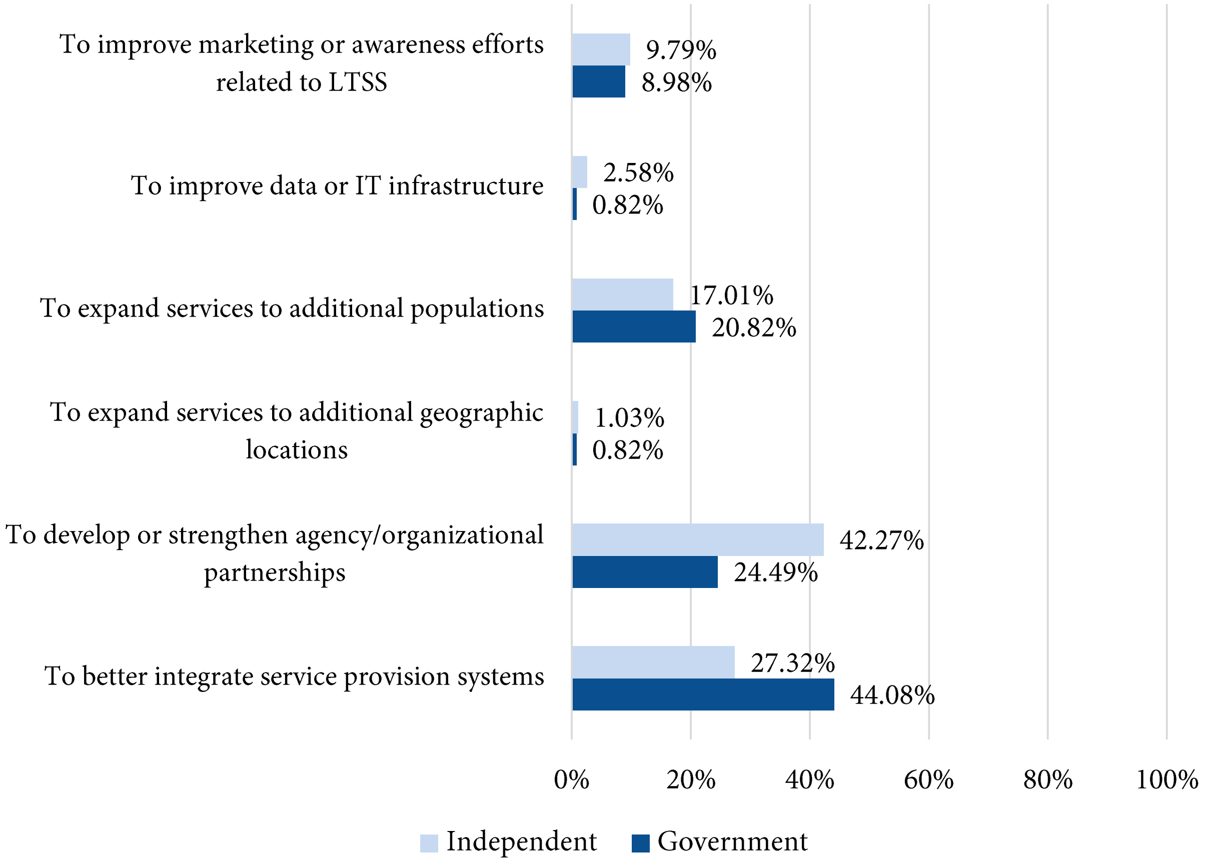
Exhibit 4.3: Reasons for Becoming a Local ADRC



Note: Response rate was 93%.

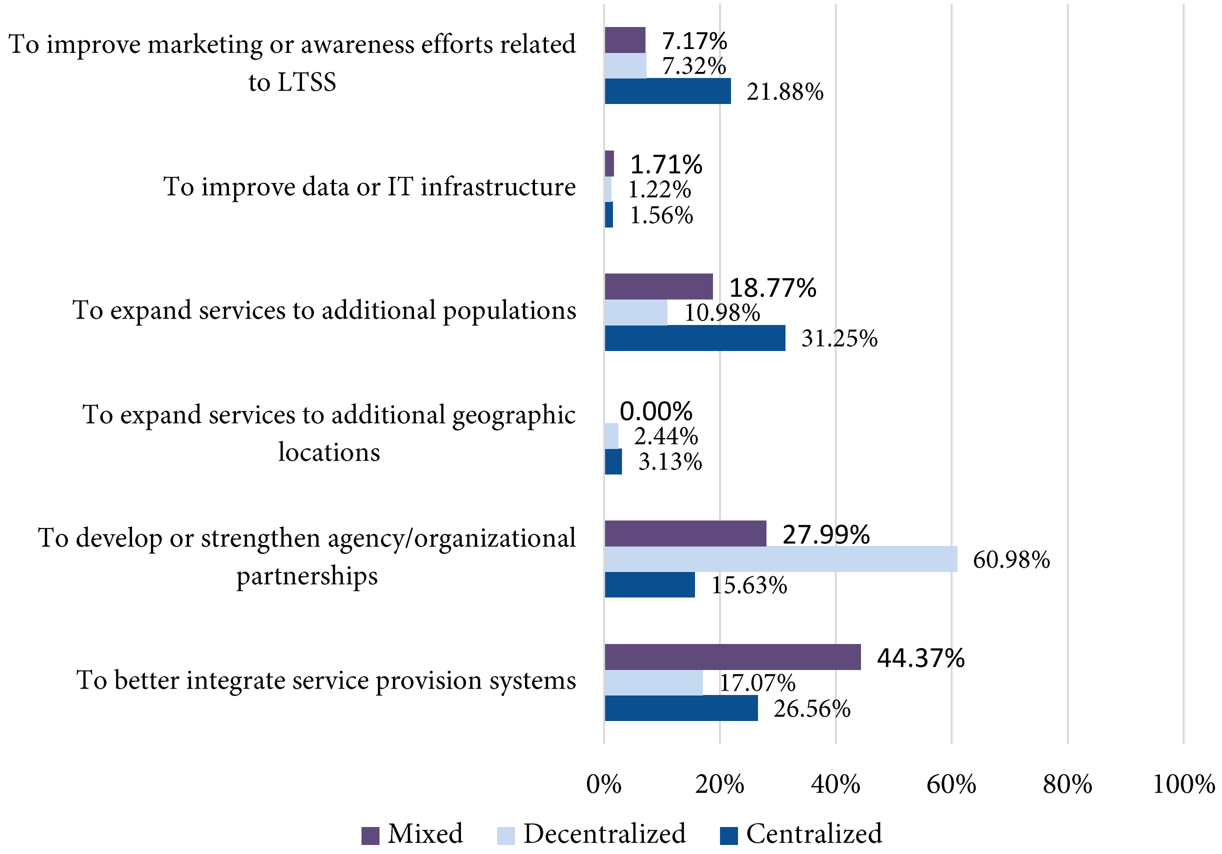
The subgroup analyses failed to reveal a statistically significant difference between rural and urban local ADRCs among any of the options for becoming an ADRC. In contrast, we did find statistically significant differences by organizational structure ($p \leq .01$). As presented in Exhibit 4.4, compared to independent non-profit local ADRCs, government-operated local ADRCs were more likely to report that their primary reason for becoming an ADRC was to better integrate service provision systems (44% and 27%, respectively). However, independent non-profit ADRCs, compared to government local ADRCs, were more likely to report that they became an ADRC to develop or strengthen agency/organizational partnerships (42% and 24%, respectively). See Appendix M, Exhibit 1 for more detail.

Exhibit 4.4: Reasons for Becoming an ADRC by Organizational Structure



We also found statistically significant differences by operational structure ($p \leq .01$). Centralized local ADRCs (31%), compared to decentralized (11%) and mixed (19%) sites, were more likely to indicate that their primary reason for becoming an ADRC was to expand services to additional populations (see Exhibit 4.5). Decentralized sites (61%), compared to centralized (16%) and mixed sites (28%), were more likely to report that they became an ADRC to develop or strengthen partnerships. Mixed sites (44%) were more likely than centralized (27%) and decentralized (17%) local ADRCs to indicate that they became an ADRC to better integrate service provision systems (See Appendix N, Exhibit 1 for more detail).

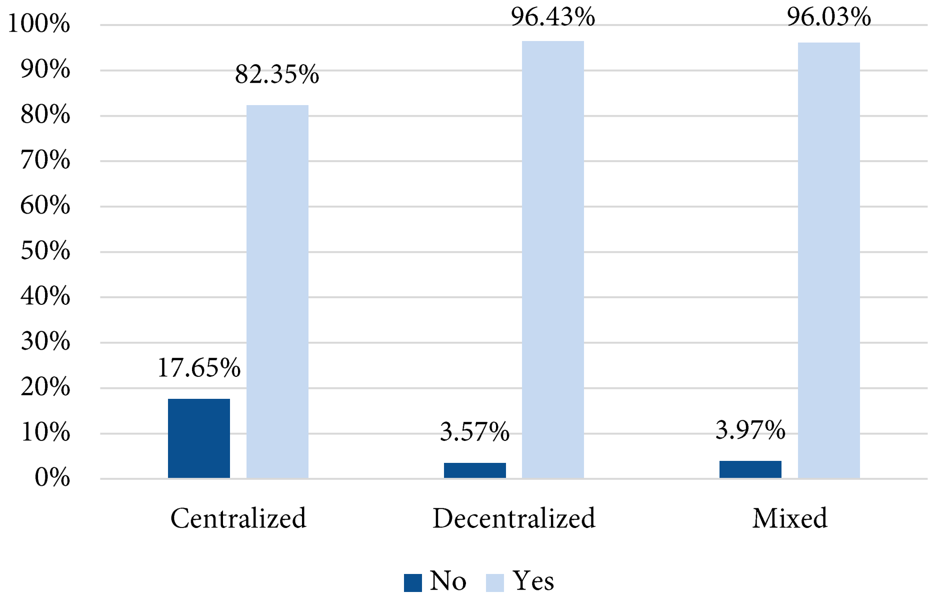
Exhibit 4.5: Reasons for Becoming an ADRC by Operational Structure



The most common reason for becoming an ADRC was similar for varying sizes of local ADRCs and did not demonstrate statistically significant differences. Large, medium, and small local ADRCs similarly indicated that their primary reason for becoming an ADRC was to better integrate service provision systems.

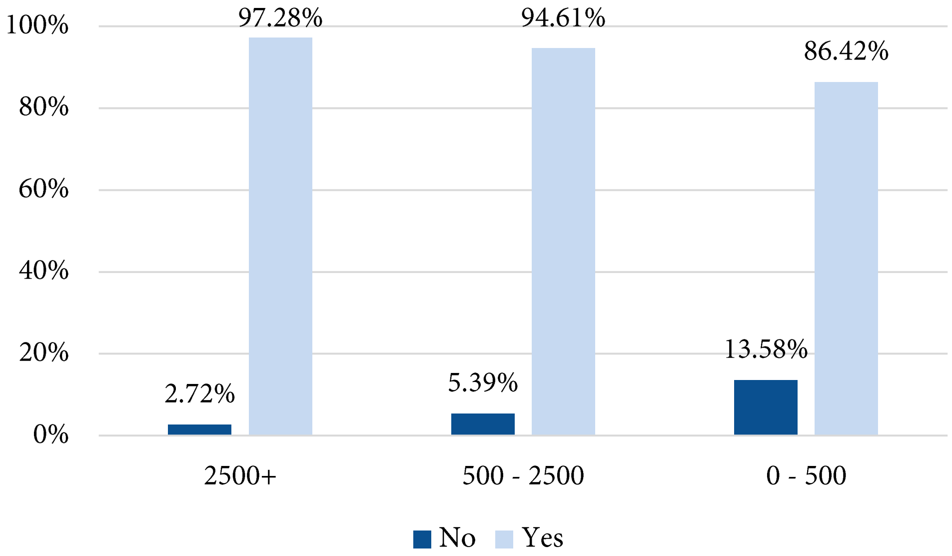
Diversion as an Outcome Sought. Respondents from most local ADRCs (91%) indicated that diversion from nursing homes or other institutional residential facilities was an outcome that their agency sought to achieve. Subgroup analyses failed to show statistically significant differences between rural and urban or government and non-governmental agencies on this item. However, statistically significant group differences were found based on operational structure and size. As presented in Exhibit 4.6, respondents from decentralized and mixed (96%) local ADRCs were more likely than those from centralized (82%) local ADRCs to report diversion from institutional residential facilities as a desirable outcome ($p \leq .01$).

Exhibit 4.6: Diversion as an Outcome Sought by Operational Structure



Similarly, large (97%) and medium (95%) ADRCs were more likely than small ADRCs (86%) to indicate that diversion was desirable (*p* ≤ .01) (Exhibit 4.7). (See Appendix N, Exhibit 2, and Appendix O, Exhibit 1, for more detail).

Exhibit 4.7: Diversion as an Outcome Sought by Number of Consumers Served



4.2.2 Funding

Sources of Funding

The local ADRC survey included questions regarding funding sources in fiscal year 2013 as well as in prior fiscal years.[10] As seen in Exhibit 4.8, local ADRCs reported an average of 3.8 funding sources in the prior fiscal years and 4.4 funding sources in fiscal year 2013, with the most common funding source being state units on aging in prior fiscal years and in 2013 (see Exhibit 4.9). As shown, local ADRCs indicated the same top five sources of funding in prior fiscal years and in fiscal year 2013. It is noteworthy that the percentage of local ADRCs receiving funding from "other" sources (e.g., Older Americans Act Title III-B, state health funds, and state transportation departments) and state general revenue increased in fiscal year 2013 compared to prior fiscal years (28% to 34% and 25% to 28%, respectively).

Exhibit 4.8: Number of Funding Sources for Local ADRCs

	Mean	Median	Mode	Range	
				Min	Max
Prior years' funding sources*	3.80	3	1	1	27
Current (FY13) funding sources**	4.37	4	1	1	18

*Response rate is uncertain since "not checked" may indicate no response or no prior funding.
**Response rate was 76%.

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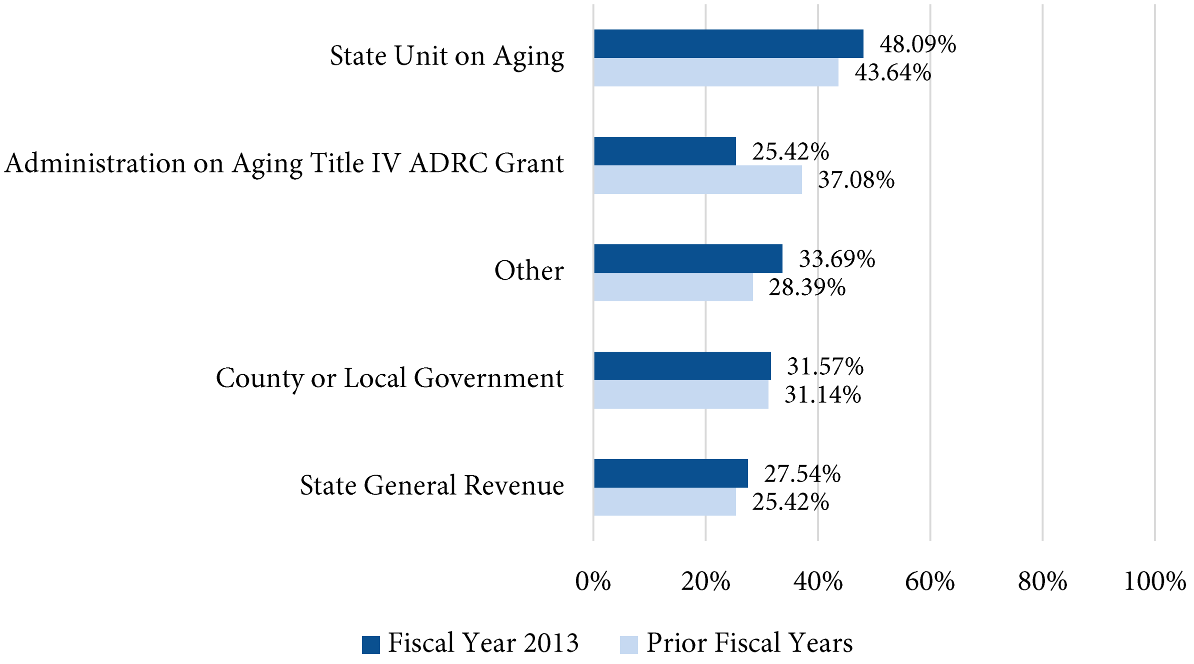
[10] Local and state ADRCs were asked to provide their fiscal year 2013 budget as well as the amount of funding received from various sources. Due to high levels of non-response and lack of certainty about the accuracy of the figures (which included wide variations and several improbable values), we do not discuss the budget and funding amounts in this report. See Appendix F, Question 58, for the local figures and Appendix H, Question 9, for the state figures.

Exhibit 4.9: Sources of Local Funding Prior to and in Fiscal Year 2013

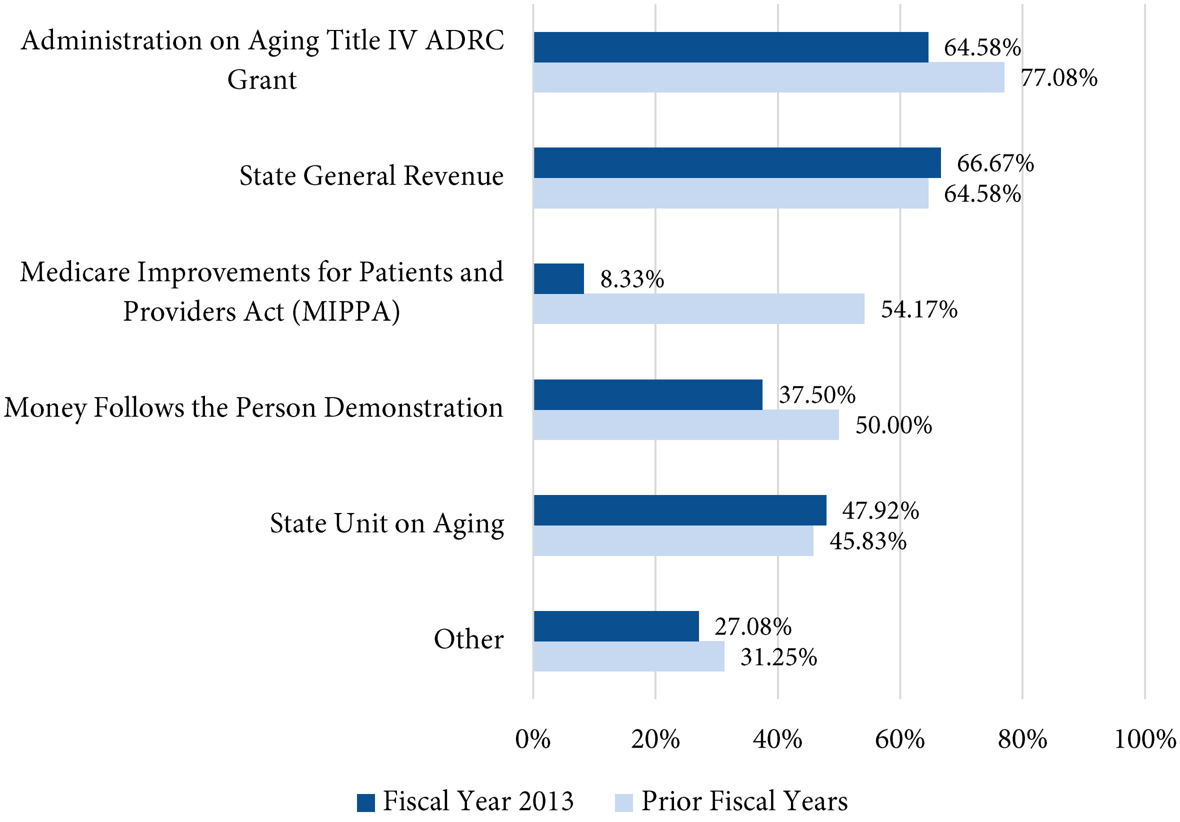


*Percentages do not add up to 100 because ADRC respondents could choose multiple options.

The state ADRC survey also included questions regarding the sources of funding in both prior fiscal years and in fiscal year 2013. Interestingly, state ADRCs relied more heavily on federal funds than local ADRCs (see Exhibit 4.10).

Note that while 54 percent of state ADRCs reported receiving Medicare Improvements for Patients and Providers Act (MIPPA) funds prior to fiscal year 2013, only 8 percent reported receiving MIPPA funds in fiscal year 2013. Furthermore, "other" sources (e.g., CMS State Health Insurance Assistance Program, Older Americans Act Title III-B, and local grants) ranked in the top five most common sources in fiscal year 2013 but not in prior years.

Exhibit 4.10: Sources of State Funding Prior to and in Fiscal Year 2013

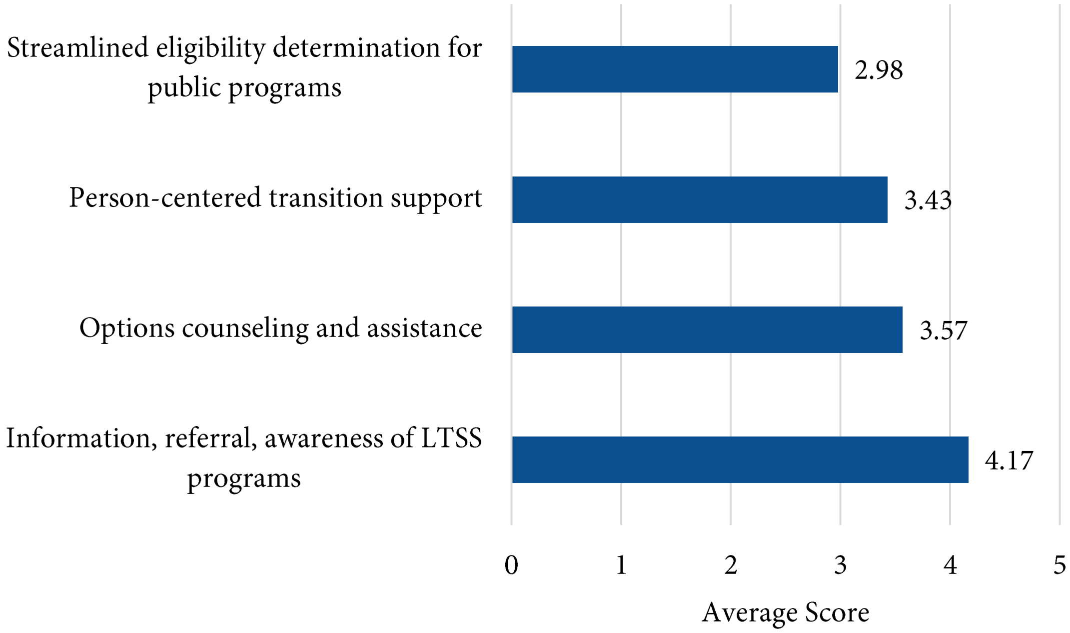


*Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Impact of ADRC Funding

Impact on Services. Almost all of the local ADRCs (95%) reported that their organization realized an improvement in the ability to provide integrated, comprehensive access to LTSS since the start of the ADRC grant. For more details on this finding, see Appendix F, Question 1. State ADRCs indicated, on a scale from 1 to 5, with 1 being "poor" and 5 being "excellent," how they rated their state's progress on improving access to services since receiving federal funding for the development of ADRCs. Exhibit 4.11 presents the average score on each of four services listed. As shown, all services were reported showing greater than average improvement, with information, referral, and information showing nearly excellent improvement, on average. Appendix H, Question 1, presents these findings in more detail.

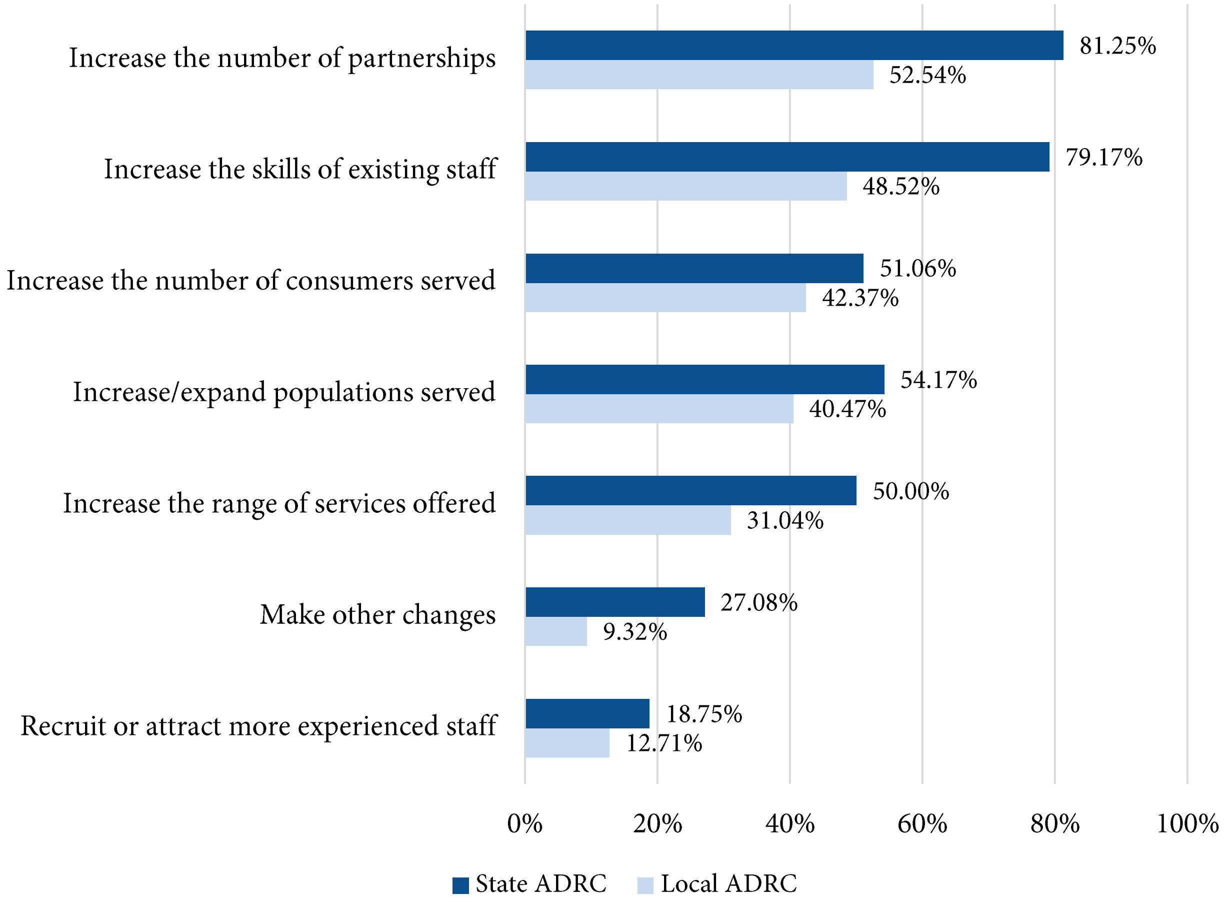
Exhibit 4.11: Effect of ADRC Funding on Services: Average Scores of State ADRCs



Note: Response rate was 98%.

Impact on Outcomes. As presented in the following exhibit (see Exhibit 4.12), the most frequently selected option among both state and local ADRC respondents for the ways in which ADRC grants impacted operational outcomes was enabling them to increase their number of partnerships (approximately 82% and 53%, respectively). The second most frequently selected option among both state and local ADRC respondents was the ability to increase the skills of existing staff (79% and 49%, respectively).

Exhibit 4.12: Outcomes Improved at the Local and State Levels by ADRC Funding



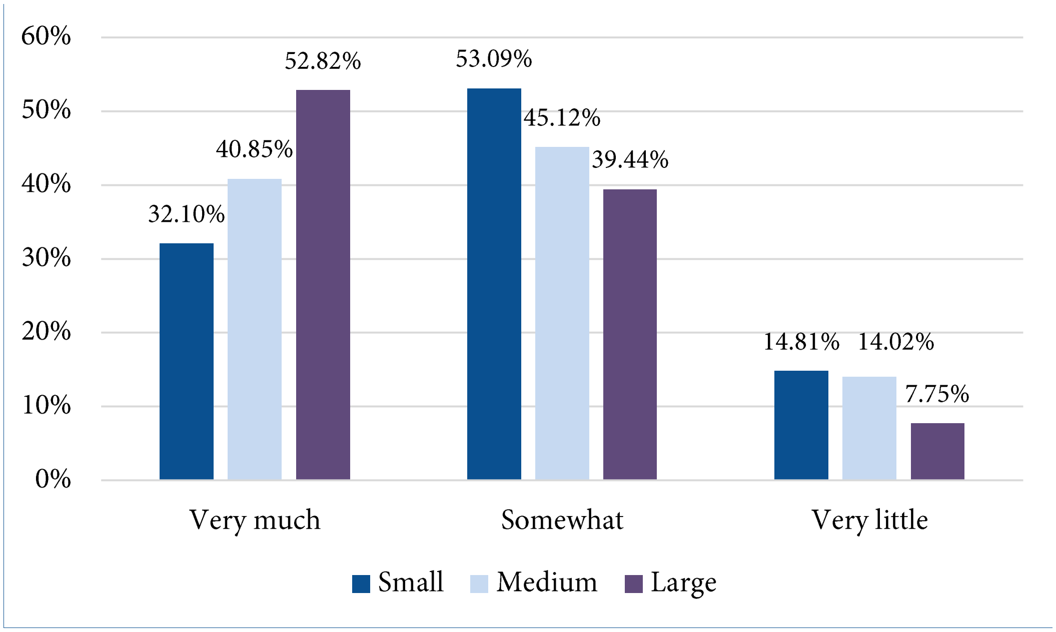
Notes: Response rate for local survey was 99%; response rate for state survey was 100%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Subgroup analyses indicated statistically significant differences on the following outcomes:

- Increase or expand populations served
- Increase the number of consumers served
- Increase the number of partnerships

We found statistically significant differences among small, medium, and large local ADRCs on the option that the grant enabled them to increase and/or expand populations served ($p \leq .05$). As shown in Exhibit 4.13, medium and large local ADRCs were significantly more likely than small sites to indicate that federal grants enabled them to increase and/or expand populations served. See Appendix O, Exhibit 2, for more detail.

Exhibit 4.13: Extent to Which Federal Grants Increased or Expanded Populations Served by Number of Consumers Served



As presented in Exhibit 4.14, the subgroup analyses also indicated statistically significant differences among centralized, decentralized, and mixed local ADRC respondents on their response to the option that funding helped to increase the number of consumers served ($p \leq .01$). A quarter of the centralized local ADRCs, compared to approximately one-tenth each of decentralized and mixed sites, indicated that grants had very little impact on their ability to increase the number of consumers served. See Appendix N, Exhibit 3, for more detail. Further, as illustrated in Exhibit 4.15, there were statistically significant differences among small, medium, and large local ADRC representatives on their response to the option that federal grants enabled them to increase the number of consumers served ($p \leq .05$). Nearly 33 percent of small, 46 percent of medium, and 51 percent of large local ADRCs indicated that grants enabled them to increase the number of consumers served. In contrast, 18 percent of small, 11 percent of medium, and 63 percent of large sites reported that federal grants did very little to increase the number of consumers served. See Appendix O, Exhibit 3, for more detail.

Exhibit 4.14: Extent to Which Federal Grants Increased the Number of Consumers by Operational Structure

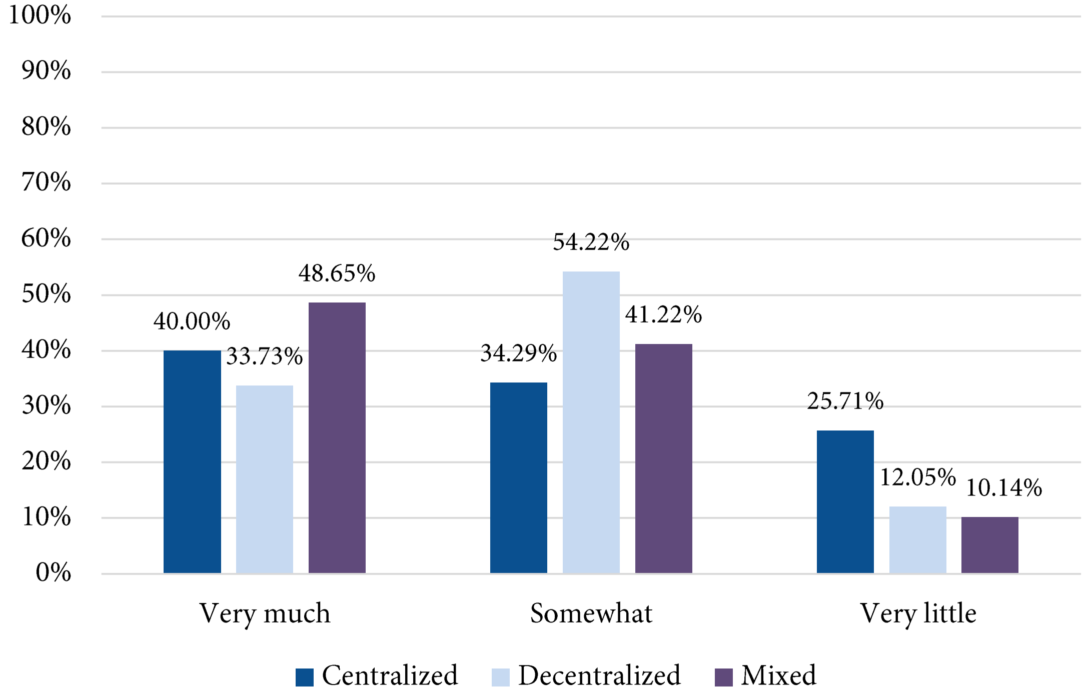
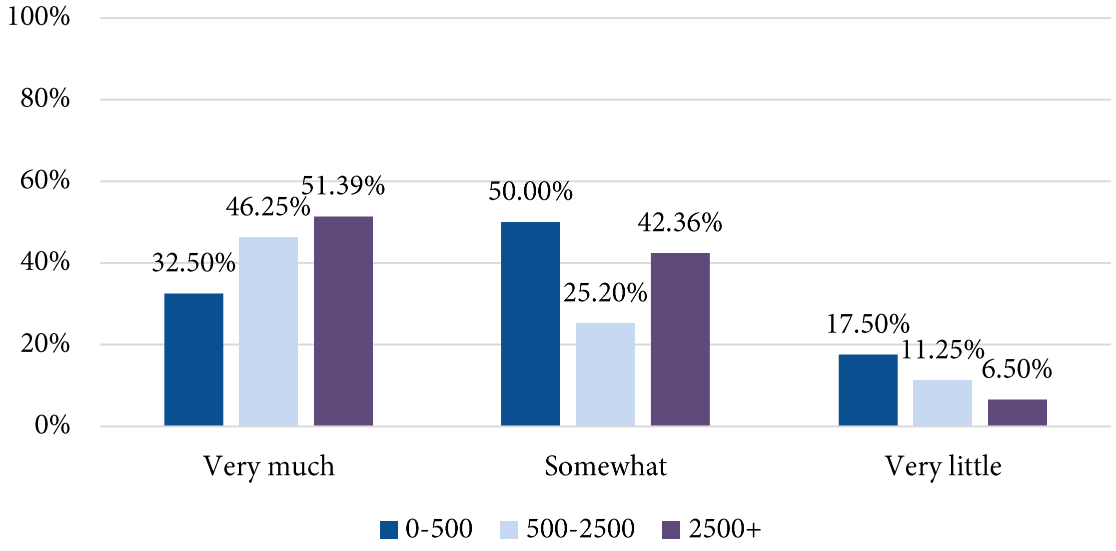
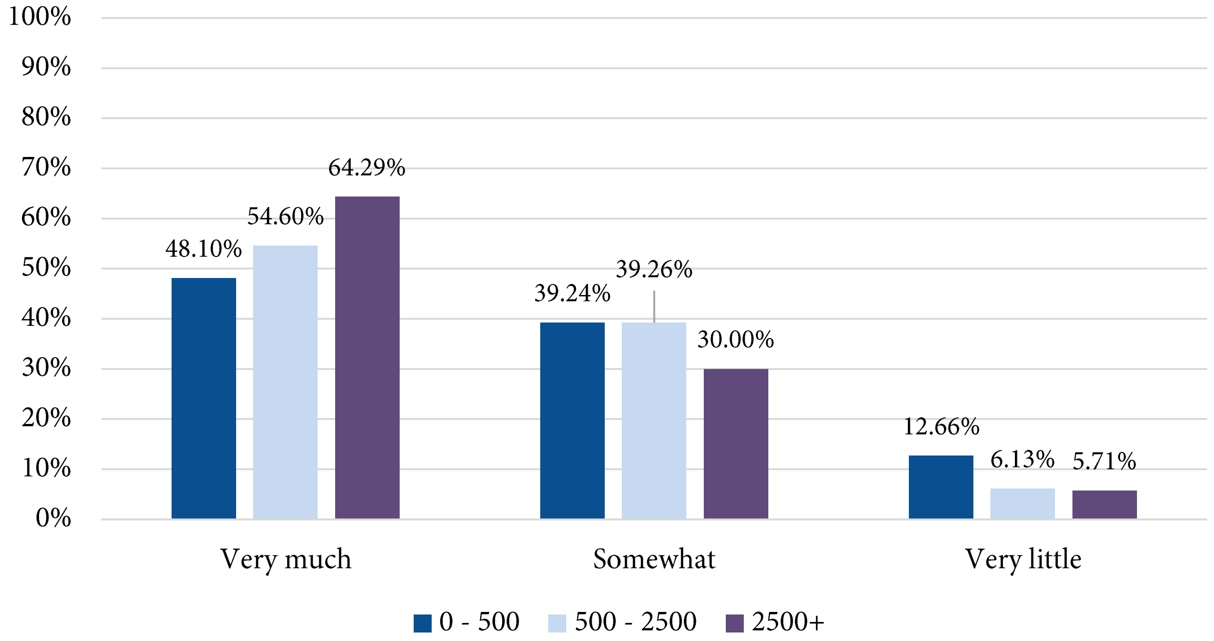


Exhibit 4.15: Extent to Which Federal Grants Increased Number of Consumers by Number of Consumers Served



Lastly, as shown in Exhibit 4.16, there was a trend toward significance in differences among ADRCs of different sizes in the impact that federal grants had on the number of partnerships. Small (compared to medium and large) local ADRCs were more likely to report that federal grants had little impact on their number of partnerships ($p \leq .10$). See Appendix O, Exhibit 4, for more detail.

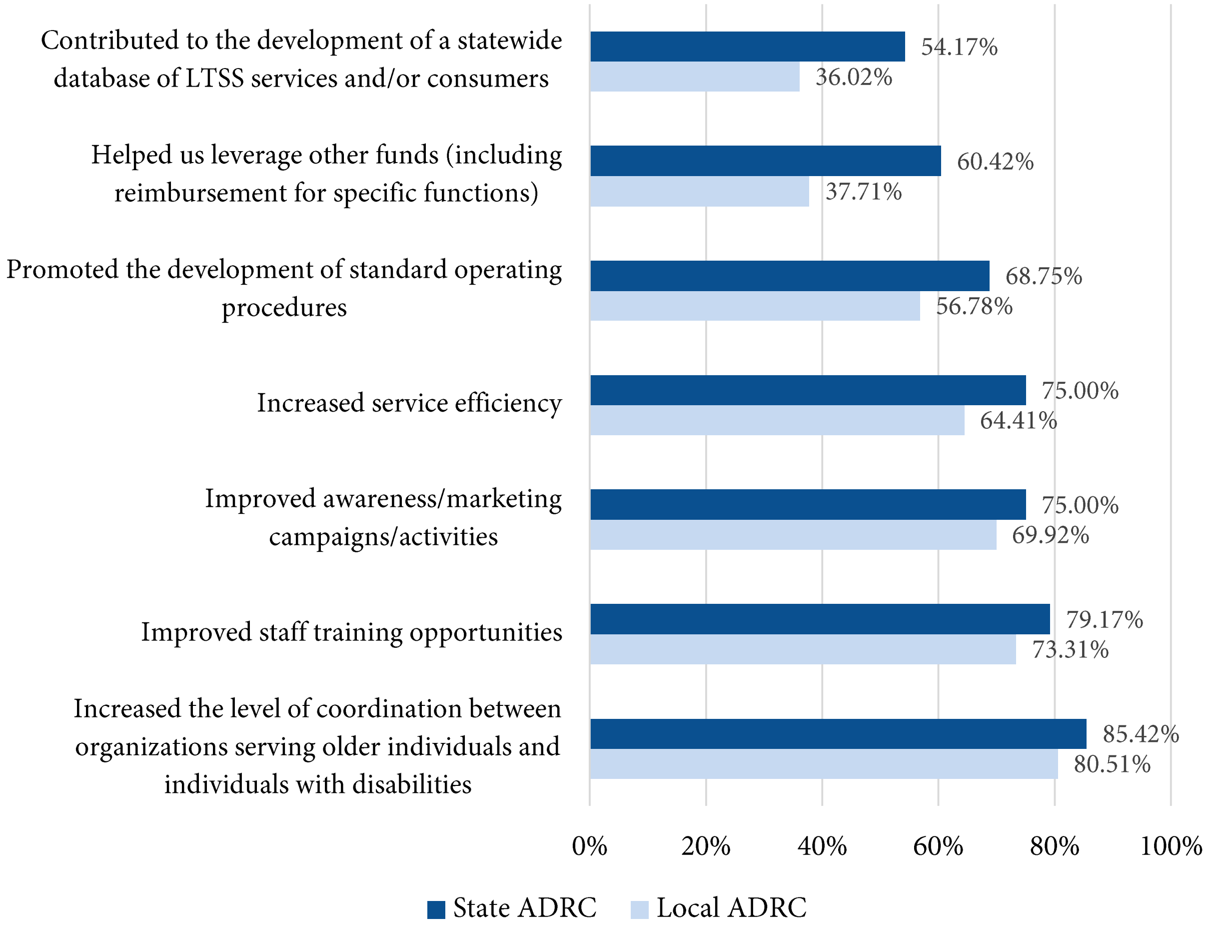
Exhibit 4.16: Extent to Which Federal Grants Increased the Number of Partners by Number of Consumers Served



Impact on Resources. Descriptive analyses were conducted to assess how ADRC grants affected resources or resource allocation at the local level. As shown in Exhibit 4.17, representatives of local and state ADRCs selected responses in the same order. The most common response was that ADRC grants allowed local sites to increase the level of coordination between organizations serving older individuals and individuals with disabilities (81% of local ADRCs and 85% of state ADRCs).

When asked to provide additional thoughts about local ADRC resources, local-level respondents mentioned two challenges: limited funding and staffing reductions (due to funding cuts). Respondents pointed out that the same forces leading to funding and staffing cuts (e.g., the economic climate) were also increasing demand for services, leaving remaining staff challenged to provide additional support. See Appendix G for details.

Exhibit 4.17: Local Resources Impacted by ADRC Funding

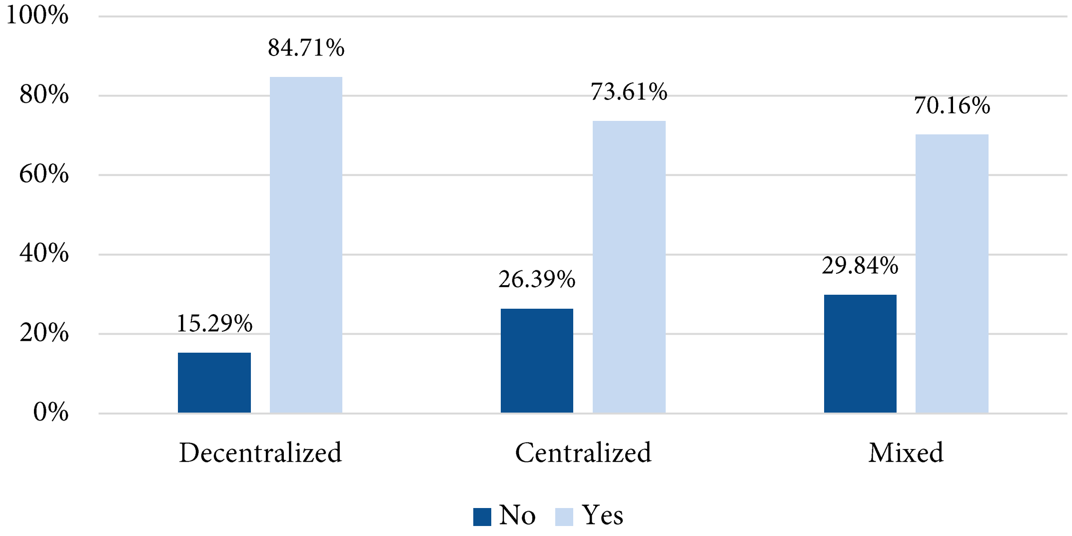


Notes: Response rate for local survey was 97%; response rate for state survey was 100%. Percentages do not add up to 100 because ADRCs could choose multiple options.

The results showed statistically significant differences in effects among subgroups on improved staff training opportunities and contributing to the development of a statewide database of LTSS consumers.

Exhibit 4.18 shows that decentralized local ADRCs (85%) were more likely than centralized (74%) and mixed (70%) local sites to report that ADRC grants improved staff training opportunities. This difference was statistically significant (*p* ≤ .05). See Appendix N, Exhibit 4, for more detail.

Exhibit 4.18: Impact of ADRC Grants on Improving Staff Training Opportunities by Operational Structure



Rural (compared to urban), and large (compared to small and medium) local ADRCs were significantly more likely to indicate that ADRC grants had contributed to the development of a statewide database of LTSS services and/or consumers. Forty-three percent of rural local ADRCs, compared to 33 percent of urban local ADRCs, reported that ADRC grants contributed to the development of a statewide database of LTSS services and/or consumers ($p \leq .05$, Exhibit 4.19). In addition, 39 percent of government local ADRCs, compared to 32 percent of independent sites, indicated that grants contributed to the development of a statewide database ($p \leq .10$, Exhibit 4.20), as did 26 percent of small, 36 percent of medium, and 44 percent of large local ADRCs ($p \leq .05$, Exhibit 4.21). See Appendix L, Exhibit 1; Appendix M, Exhibit 2; and Appendix O, Exhibit 5, respectively, for details.

Exhibit 4.19: Impact of ADRC Grants on Contributing to the Development of Statewide Database of LTSS Services or Consumers by Agency Location

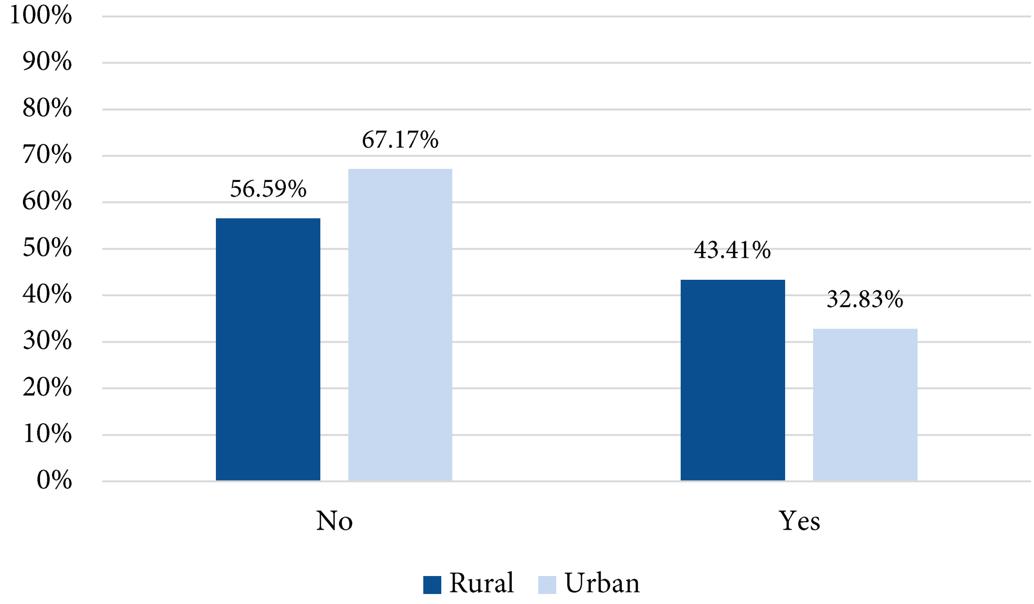


Exhibit 4.20: Impact of ADRC Grants on Contributing to the Development of Statewide Database of LTSS Services or Consumers by Organizational Structure

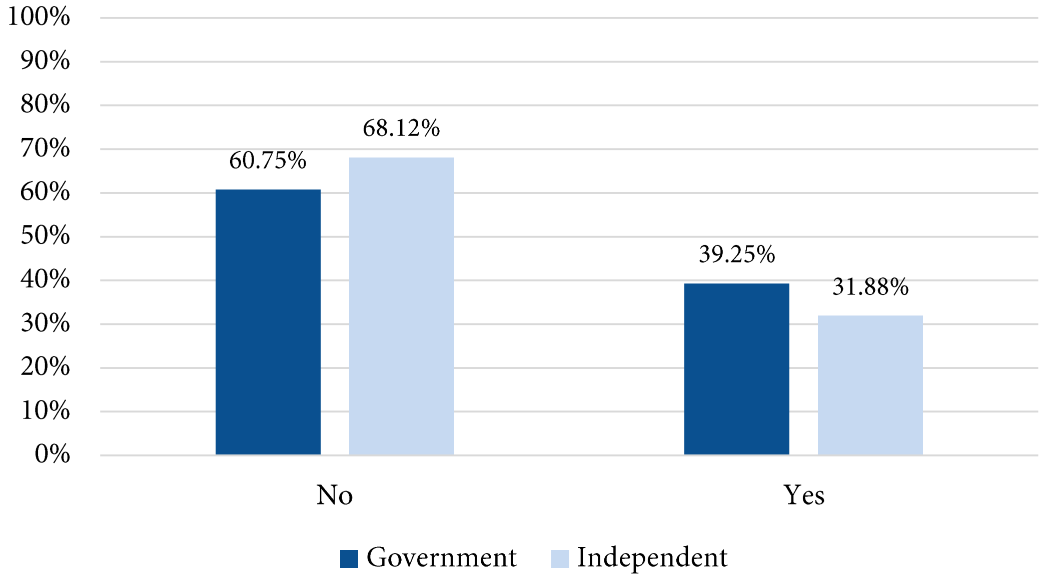
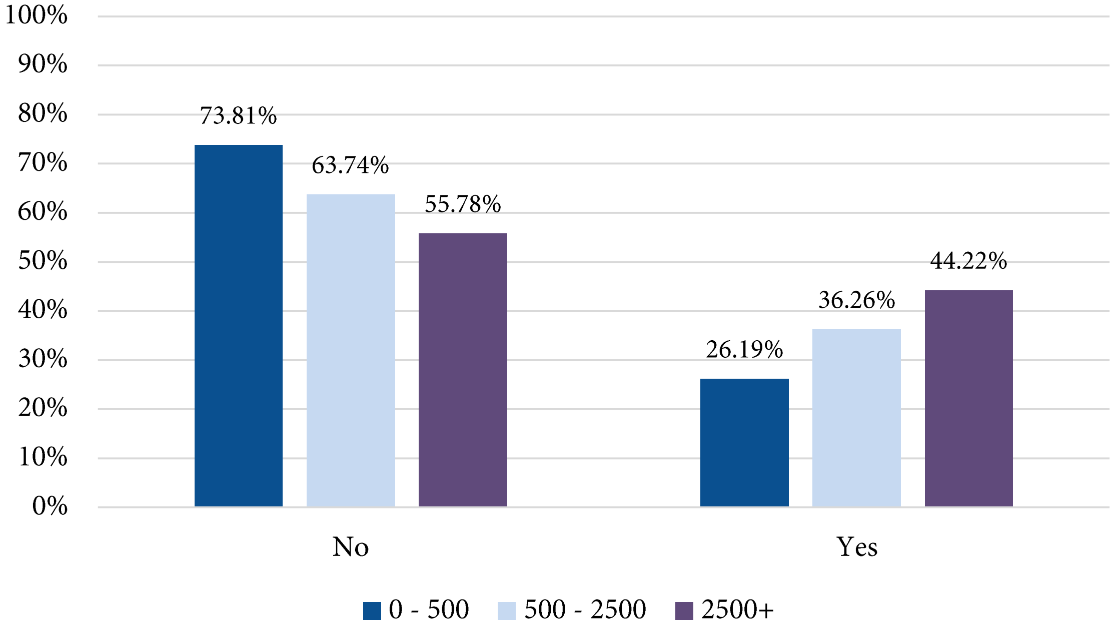


Exhibit 4.21: Impact of ADRC Grants on Contributing to the Development of Statewide Database of LTSS Services or Consumers by Number of Consumers Served



Impact on LTSS. Most local ADRC respondents reported positive impacts on LTSS and home- and community-based services (HCBS) in their communities since the organizations began serving consumers. As shown in Exhibit 4.22, of the 80 percent of local ADRC sites that responded to this question, 71 percent reported that there was an increase in the number of LTSS providers since the organization started serving consumers. Similarly, 73 percent of responding local ADRCs believed that there was an increase in the quality of LTSS services provided in the community since they started serving consumers. See Appendix F, Question 68.

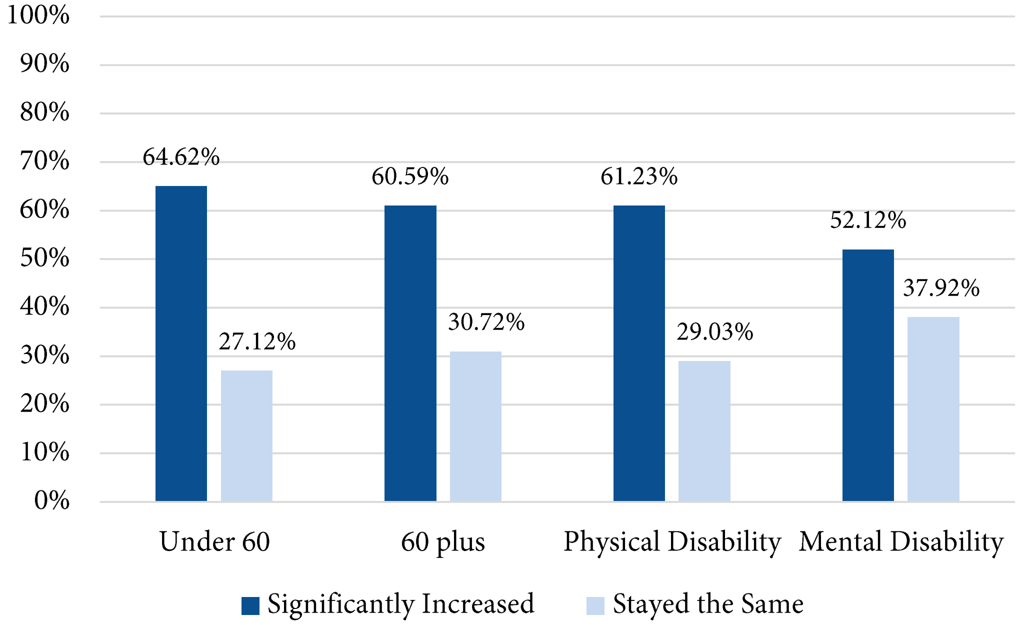
Exhibit 4.22: Improvements in LTSS and HCBS Since Local ADRCs Started Serving Consumers

Change	Frequency	Percentage
Increase in the number of LTSS providers	335	70.97
Increase in the quality of LTSS services	346	73.31

Note: Response rate was 79%.

Impact on Consumers Served. Descriptive statistics presented in Exhibit 4.23 indicate that two-thirds of ADRC respondents indicated that, since the initiation of the ADRC grant, there was an increase in consumers served, including the number of adults both over and under 60 years old and the number of consumers with physical disabilities. Among the ADRC respondents, 50 percent reported that the number of consumers with mental and emotional disabilities also significantly increased. Very few ADRCs (less than 1 percent) showed a significant decrease in the number of consumers of the above types.

Exhibit 4.23: Change in the Number of Consumers Served by Local ADRCs Since the Start of the ADRC Grant

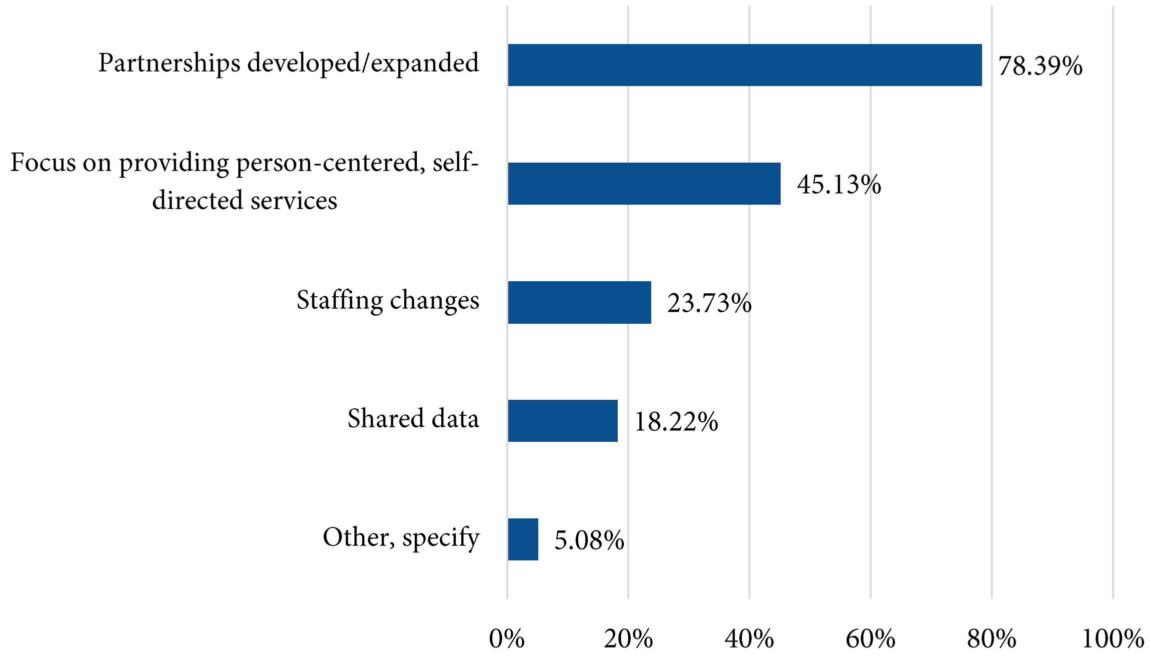


Factors Contributing to Positive Outcomes

Seventy-eight percent of local ADRC respondents stated that developed and/or expanded partnerships had the most positive impact on their ability to provide integrated, comprehensive access to LTSS. In open-ended responses, respondents reported that strengthening the effectiveness of their ADRC, despite the challenges, was possible through creating partnerships with state, healthcare, and service organizations. Respondents were asked to select up to two options that indicated the factors that had the most impact on their ability to provide LTSS.

As presented in Exhibit 4.24, almost half (45%) counted their focus on providing person-centered, self-directed services as one of the two factors. In addition to the choice responses, some respondents noted additional factors that contributed to positive impact on their ability to provide integrated, comprehensive access to LTSS including increased staff education and training, additional marketing and outreach, increased awareness of LTSS options, infrastructure improvements (e.g., telephone, IT), and enhanced ability to expand the service population (Appendix F, Question 2).

Exhibit 4.24: Operational Factors with Most Positive Impact on LTSS Provision at Local Level



Notes: Response rate was 95%. Percentages do not add up to 100 because ADRC respondents could choose up to two options.

In subgroup analyses, we found statistically significant differences among the following factors:

- Partnerships developed/expanded;
- Focus on providing person-centered, self-directed services;
- Staffing changes; and
- Shared data.

Exhibit 4.25 shows a statistically significant difference between urban and rural local ADRCs with 81 percent of urban versus 71 percent of rural ADRCs indicating that partnerships have had the most positive impact on their organization's ability to provide LTSS ($p \leq .05$). As shown in Exhibit 4.26, 82 percent of independent local ADRCs indicated that partnerships had the most positive impact on LTSS provision compared to 75 percent of government-operated local ADRCs ($p \leq .10$). See Appendix L, Exhibit 2 and Appendix M, Exhibit 3, respectively, for details.

Exhibit 4.25: Impact of Partnerships on Ability to Provide LTSS by Agency Location

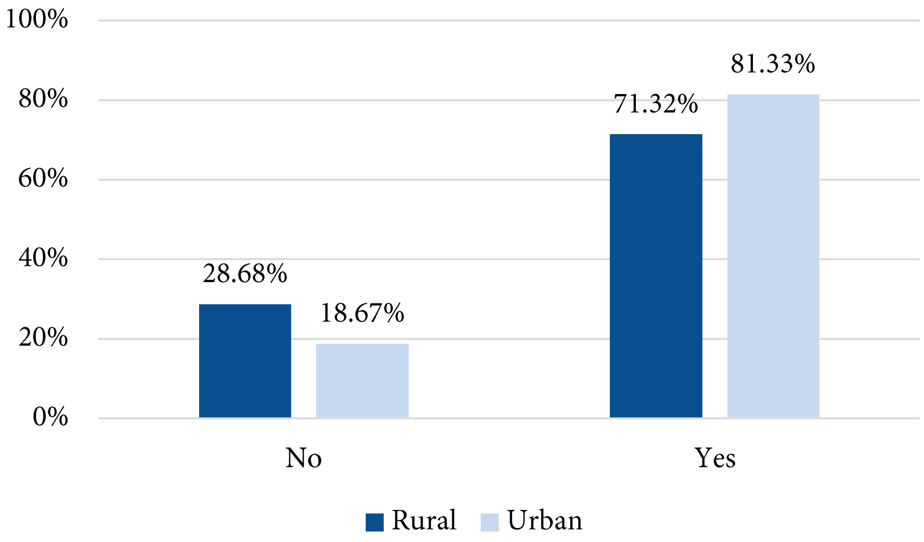
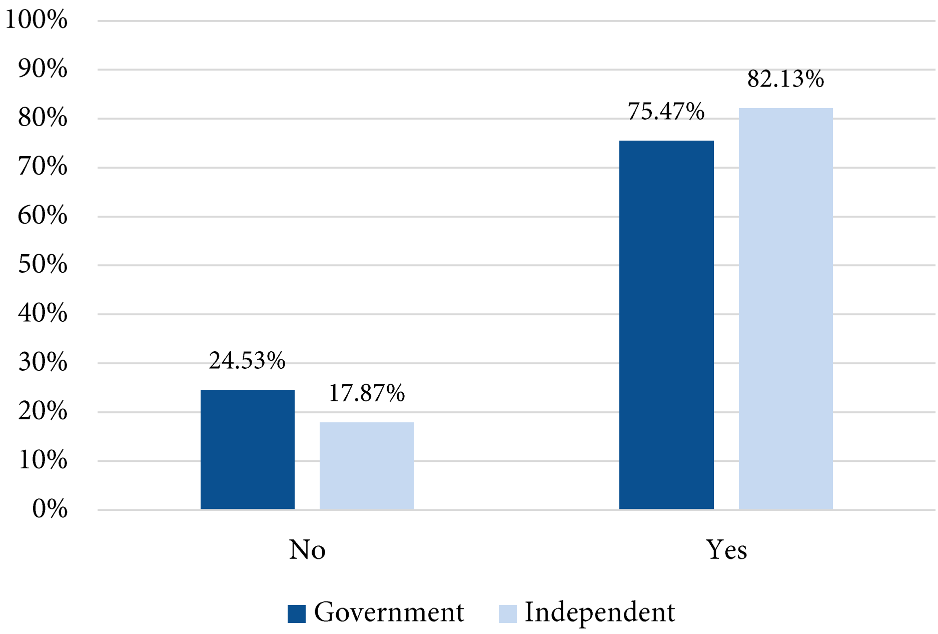


Exhibit 4.26: Impact of Partnerships on Ability to Provide LTSS by Organizational Structure



There were also statistically significant differences in the effect of partnerships based on operational structure and number of consumers served. Respondents from decentralized local ADRCs (89%) were more likely to report that partnerships had the most positive effect on their organization's ability to provide integrated, comprehensive access to LTSS compared to mixed

(77%) and centralized (72%) local ADRC respondents ($p \leq .05$, Exhibit 4.27). Additionally, large local ADRCs (86%) were more likely than medium (77%) and small (71%) sites to report that partnerships had the most positive impact on their organization's ability to provide LTSS ($p \leq .05$, Exhibit 4.28). For detailed results, see Appendix N, Exhibit 5, and Appendix O, Exhibit 6, respectively.

Exhibit 4.27: Impact of Partnerships on Ability to Provide LTSS by Operational Structure

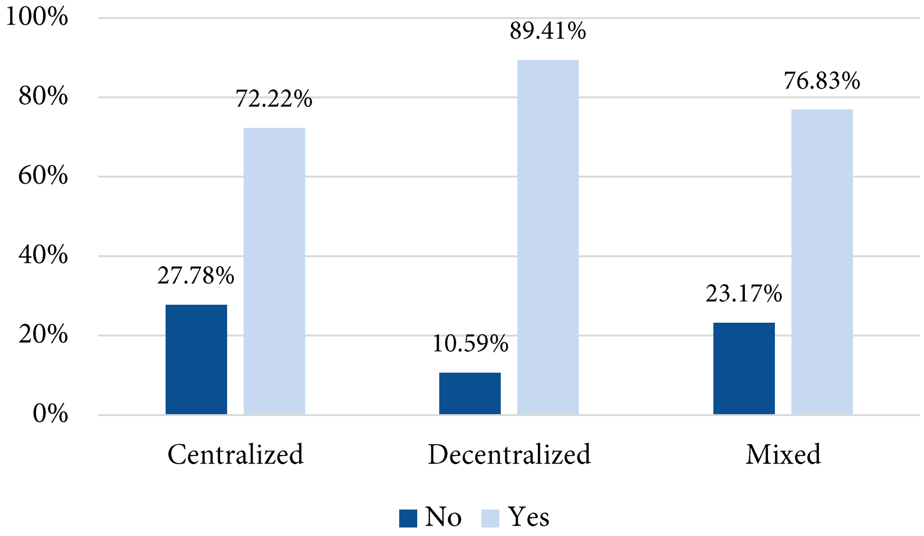
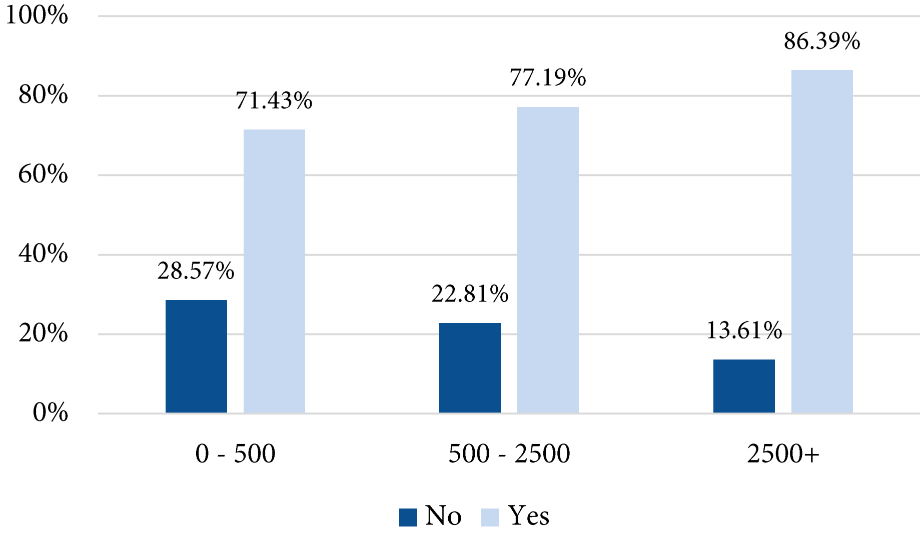
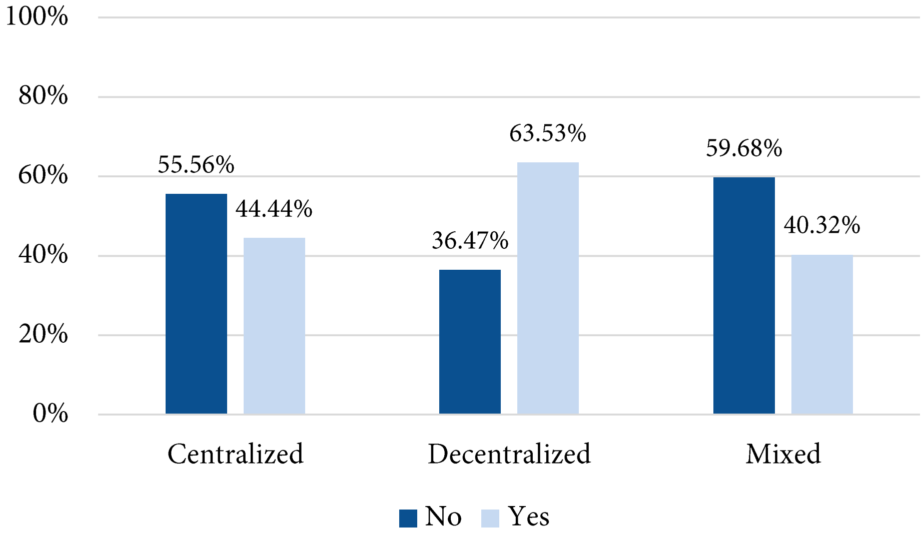


Exhibit 4.28: Impact of Partnerships on Ability to Provide LTSS by Number of Consumers Served



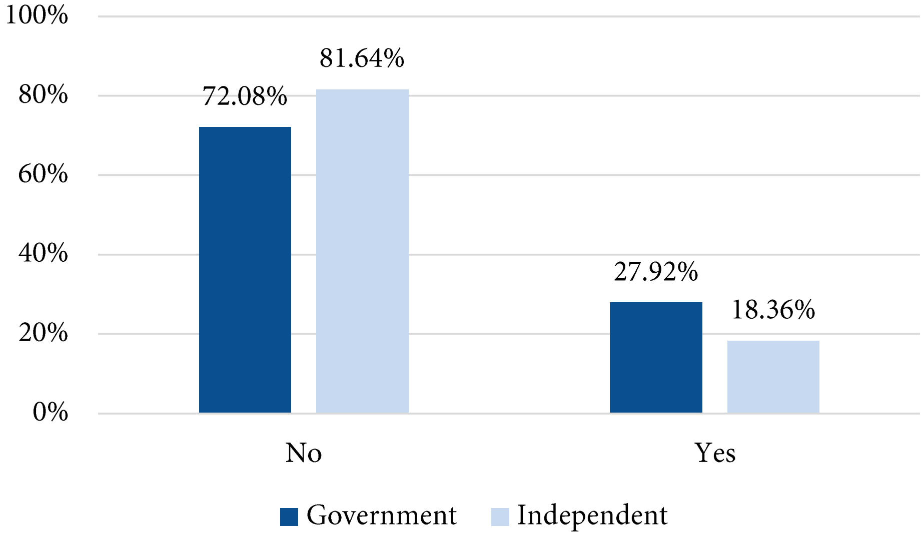
Decentralized local ADRCs (64%), compared to centralized (44%) and mixed (40%) local sites, were significantly more likely to report that their focus on providing person-centered, self-directed services had the most positive impact on their organization's ability to provide integrated, comprehensive access to LTSS ($p \leq .01$, Exhibit 4.29). See Appendix N, Exhibit 6, for detailed results. There were no statistically significant differences by geographic location of site, organizational type, or size of site.

Exhibit 4.29: Impact of Person-Centered Services on Ability to Provide LTSS by Operational Structure



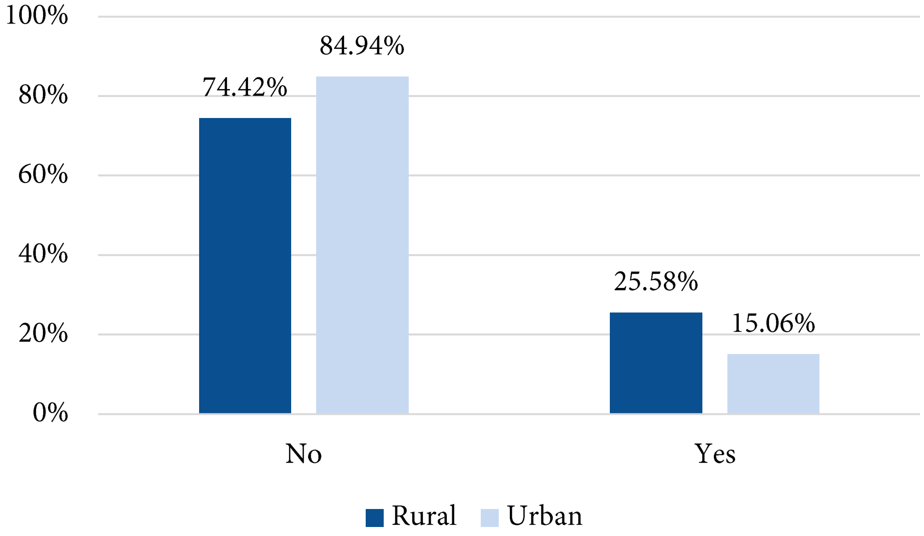
Government-operated local ADRCs (28%) were significantly more likely than independently operated sites (18%) to report that staffing changes had the most positive impact on their organization's ability to provide integrated, comprehensive access to LTSS ($p \leq .05$, Exhibit 4.30). See Appendix M, Exhibit 4, for detailed results. There were no statistically significant differences by geographic location, operational structure, or size of ADRC.

Exhibit 4.30: Impact of Staffing Changes on Ability to Provide LTSS by Organizational Structure



Lastly, as shown in Exhibit 4.31, rural local ADRCs (26%) were significantly more likely than urban sites (15%) to report that shared data had the most positive impact on their organization's ability to provide integrated, comprehensive access to LTSS ($p \leq .01$). See Appendix L, Exhibit 3, for detailed results. There were no statistically significant differences by organizational structure, operational structure, or size of site.

Exhibit 4.31: Impact of Shared Data on Ability to Provide LTSS by Agency Location



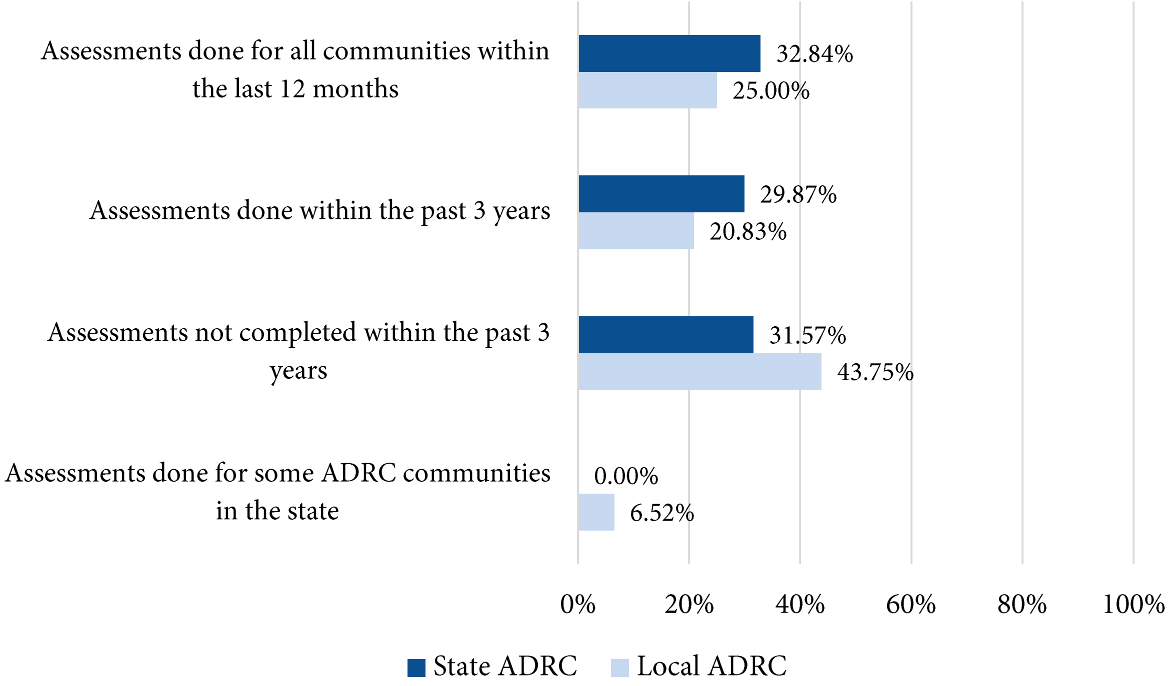
In an attempt to assess the degree of importance of specific factors in improving access to LTSS, state ADRC respondents were asked to rank, on a five-point scale where 1 = not important at all and 5 = very important, the degree of importance of specific factors in improving access to LTSS in their states (for details, see Appendix H, Question 2). Ninety-four percent of the respondents indicated that partnerships were important or very important in improving access to LTSS. Similarly, 79 percent and 65 percent of the respondents, respectively, rated staffing and shared data systems as important or very important in improving access to LTSS.

4.2.3 Community and Consumer Information

Community Characteristics

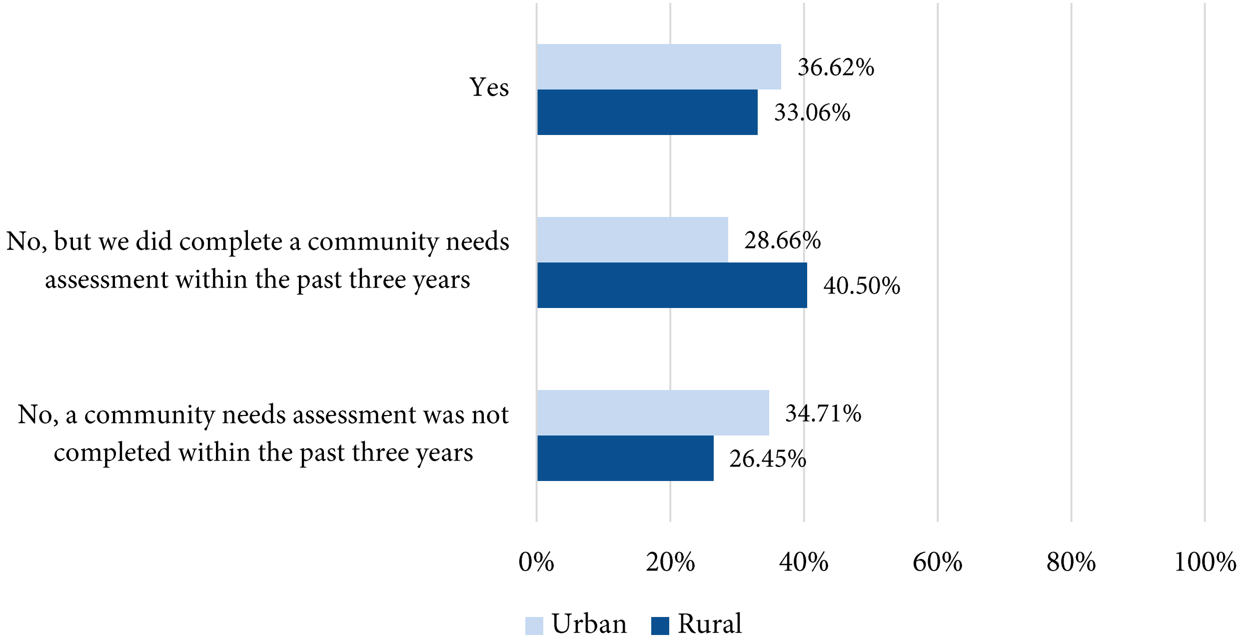
LTSS Needs Assessment. Exhibit 4.32 shows that approximately 33 percent of local ADRCs reported that they had assessed the LTSS needs of their communities within the last 12 months. In contrast, only one-fourth of the state ADRCs reported that they had assessed the LTSS needs of all of their communities within the last 12 months. One-third of the local ADRCs and almost half of the state ADRCs indicated that no LTSS needs assessment had been done in their coverage areas in the past three years.

Exhibit 4.32: Community LTSS Needs Assessment Conducted at Local and State Levels



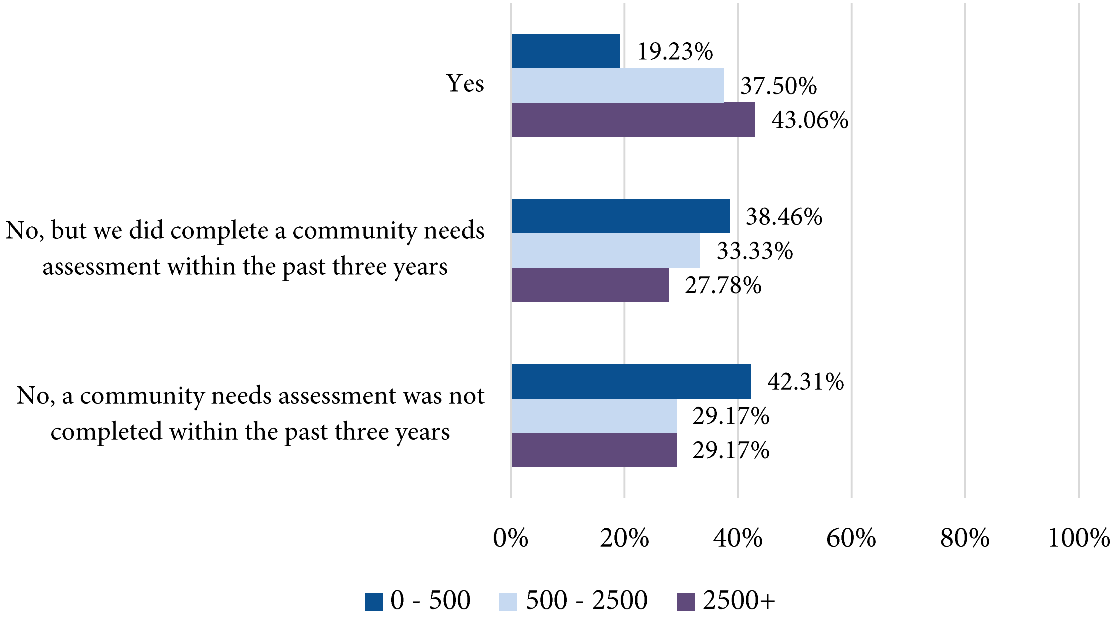
Subgroup analyses indicated that nearly 35 percent of urban local ADRCs had not conducted a needs assessment in the past three years, while only 26 percent of rural ADRCs had not done so ($p \leq .05$, Exhibit 4.33). See Appendix L, Exhibit 4, for detailed results.

Exhibit 4.33: Community LTSS Needs Assessment Conducted within the Last 12 Months by Agency Location



There were also statistically significant differences based on the size of the site. As presented in Exhibit 4.34, most small sites (42%), compared to medium (29%) and large sites (29%), indicated that they had not conducted a needs assessment within the last three years ($p \leq .01$). See Appendix O, Exhibit 7, for detailed results.

Exhibit 4.34: Community LTSS Needs Assessment Conducted within the Last 12 Months by Number of Consumers Served



LTSS Availability in the Community. Local and state ADRC participant responses on the top five LTSS services' current availability are presented in Exhibit 4.35. See Appendix F, Question 13, and Appendix H, Question 8a, for more information on LTSS service availability at the local and state levels. Local ADRC respondents reported ombudsman services as being adequately available most often (70%), while 54 percent of state ADRC respondents selected this option, so that it ranks third. The second LTSS that was reported by both local and state ADRC respondents is nursing home services (77% and 60%, respectively).

Exhibit 4.35: Services Most Frequently Reported as Adequate to Meet Consumer Need at Local and State Levels

Service	Adequate Availability	
	Frequency	Percentage*
Local ADRCs		
Ombudsman services	329	69.70
Opportunities to develop advance directives	293	62.08
Nursing home/residential beds	283	59.96

Service	Adequate Availability	
	Frequency	Percentage*
Education services	242	51.27
Nutrition programs	237	50.21
State ADRCs		
Nursing home services	37	77.08
Assisted living services	28	58.33
Ombudsman services	26	54.17
Socialization/recreation programs	23	47.92
Peer support services/groups	22	45.83

Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

In Exhibit 4.36, we show the top five services reported as being inadequately available at the local and state levels. It is noteworthy that three services (i.e., transportation, housing, and mental health services) were reported by both local and state ADRC respondents.

Exhibit 4.36: Most Inadequately Available LTSS Services at Local and State Levels

Service	Inadequate Availability*	
	Frequency	Percentage
Local ADRCs		
Transportation services	414	87.71
Safe and affordable housing options	396	83.90
Income assistance	380	80.51
Mental health services	375	79.45
Energy assistance	348	73.73
State ADRCs		
Safe and affordable housing options	45	93.75
Transportation services	43	85.98
Hospital transition programs	41	85.42
Mental/behavioral health services	41	85.42
Shared living programs	37	77.08

*Inadequate availability includes response options “Not available” and “Available but inadequate to meet the need.”
Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

There were a few additional notable services that were reported in the open-ended response as being inadequately available. Some examples include affordable integrated housing, adult day care, homemaking services for clients younger than 60 years old, dental services, weekend emergency assistance for the elderly, services for the mentally ill, VA services, and job coaching. See Appendix G, Question 13b, for more information.

There were statistically significant differences between rural and urban local ADRCs on transportation and mental health services being inadequately available. A higher proportion of rural ADRCs considered transportation services as inadequate ($p \leq .01$), whereas a higher proportion of urban ADRCs considered mental health services as inadequate ($p \leq .05$). See Appendix L, Exhibits 5 and 6, for details.

Barriers to LTSS. Exhibit 4.37 presents the five most common prior and current barriers to receiving LTSS reported by local ADRC representatives. No changes were reported in the five most common barriers between the period prior to receiving the ADRC grant and the current period. Lack of transportation continued to be the most common barrier to consumers seeking LTSS services from ADRCs, with 92 percent of local ADRC representatives reporting transportation as a barrier in the prior and current periods. More details on the results of the analyses of barriers to receiving LTSS are provided in Appendix F, Question 13. In subgroup analyses, there was a trend toward statistically significant differences between rural and urban local ADRCs on barriers to LTSS. Rural ADRC respondents (25%) were more likely than urban ADRC respondents (22%) to report lack of health insurance as a current barrier to LTSS ($p \leq .10$, Exhibit 4.38). See Appendix L, Exhibit 7, for detailed results.

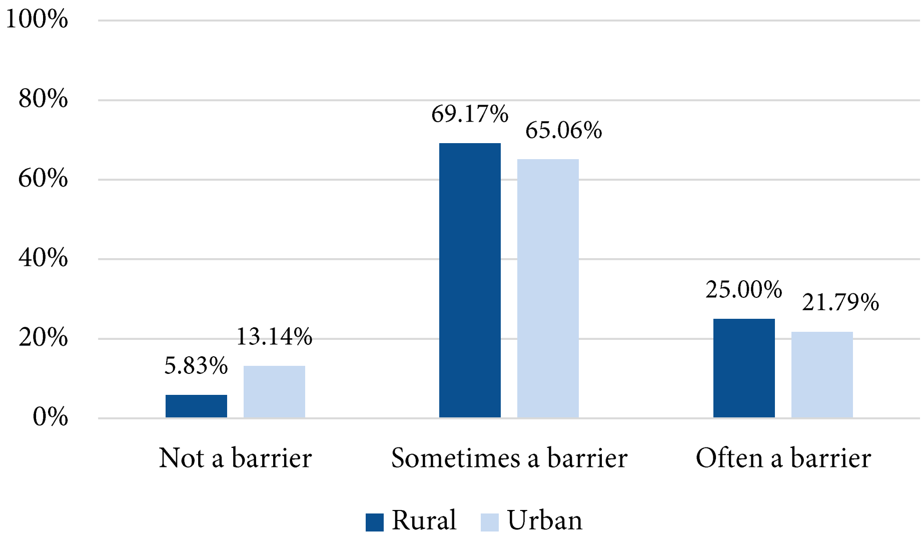
Exhibit 4.37: Most Common Barriers to Seeking LTSS Currently and Prior to Receiving ADRC Grants: Local ADRCs

Prior Barriers*	Freq.	%	Current Barriers*	Freq.	%
Consumers lack transportation	435	92.16	Consumers lack transportation	432	91.53
Lack of health insurance	397	84.11	Lack of health insurance	391	82.84
Lack of LTSS-needed services	395	83.69	Lack of LTSS-needed services	375	79.45
Lack of available LTSS slots (i.e., long waiting lists)	389	82.42	Lack of available LTSS slots (i.e., long waiting lists)	373	79.03
Providers have high staff turnover	365	77.33	Providers have high staff turnover	367	77.75

*Barrier includes response options “Sometimes a barrier” and “Often a barrier.”

Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Exhibit 4.38: Lack of Health Insurance as a Barrier to LTSS by Agency Location



Organizational structure also affected whether a local ADRC representative reported current barriers due to lack of health insurance. As shown in Exhibit 4.39, nearly 27 percent of government-operated local ADRC respondents, compared to 17 percent of non-government local ADRC respondents, reported that lack of health insurance was often a barrier for individuals seeking LTSS ($p \leq .01$). See Appendix M, Exhibit 5, for details. Similarly, Exhibit 4.40 illustrates that centralized local ADRCs (36%), compared to mixed (23%) and decentralized (12%) sites, were more likely to indicate lack of health insurance as a current barrier to LTSS ($p \leq .01$). See Appendix N, Exhibit 7, for details.

Exhibit 4.39: Lack of Health Insurance as a Barrier to LTSS by Organizational Structure

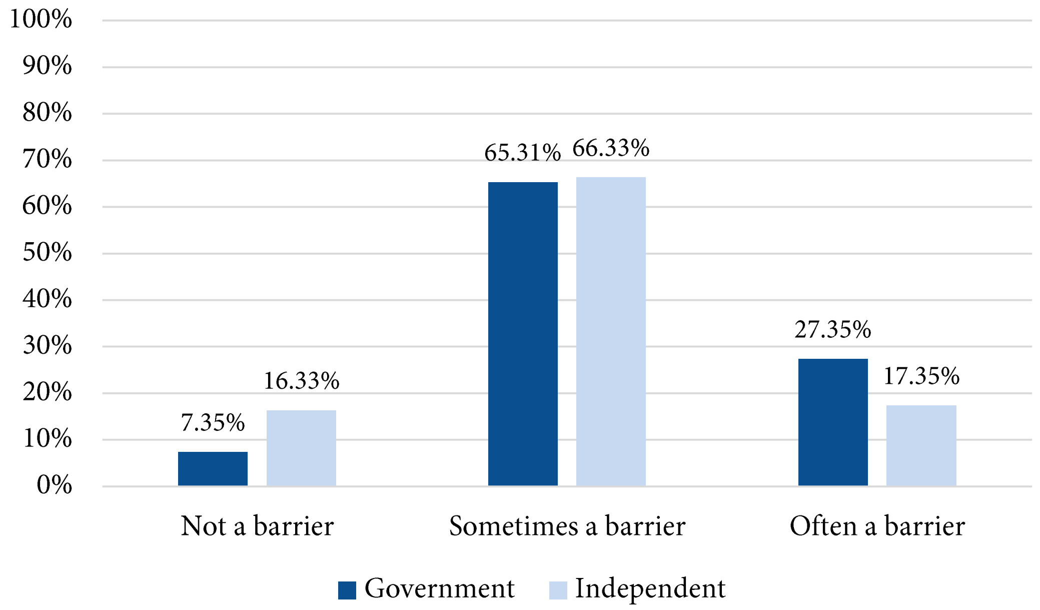
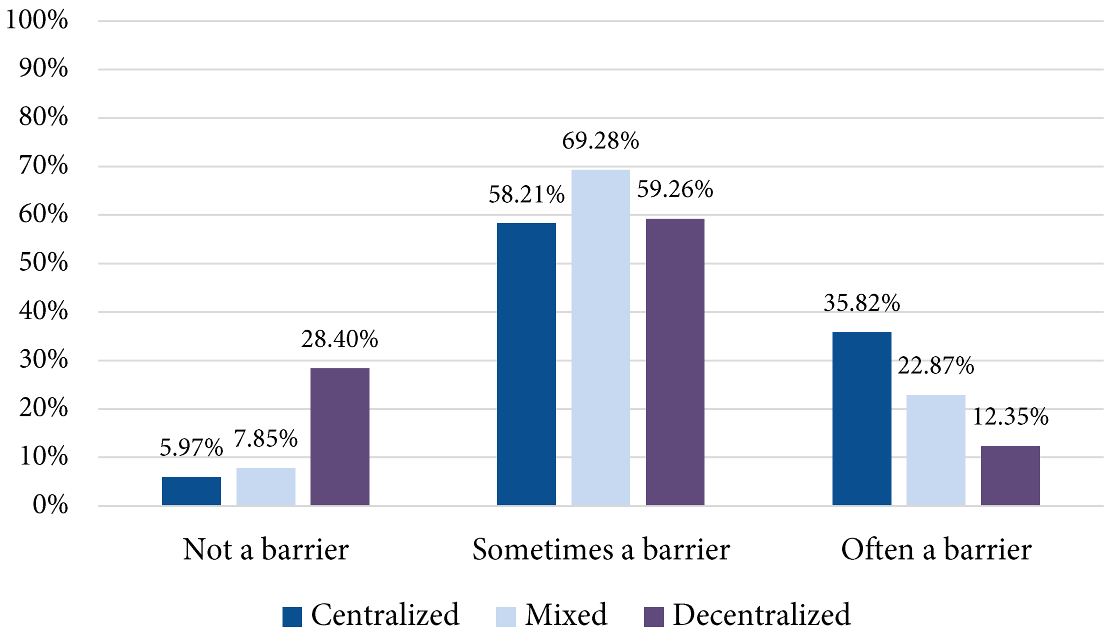


Exhibit 4.40: Lack of Health Insurance as a Barrier to LTSS by Operational Structure



In Exhibit 4.41, we explore the five most common prior and current barriers to receiving LTSS reported by state ADRCs (see Appendix H, Question 7, for more details). As reported, four of the five most common barriers were the same prior to receiving ADRC grants and in the current period. These barriers also are similar to the ones reported by local ADRCs. However, the fifth most common barrier to receiving LTSS in the prior period, “Providers lack appropriately trained staff” was replaced in the current period by “Limits on enrollment in state-only funded LTSS.” Seventy-nine percent of state ADRC representatives reported limits on enrollment in state-only funded LTSS as one of the most common barriers to seeking LTSS services currently.

Exhibit 4.41: Most Common Barriers to Seeking LTSS Currently and Prior to Receiving ADRC Grants: State ADRCs

Prior Barriers*	Freq.	%	Current Barriers*	Freq.	%
Non-availability of needed services and supports	46	95.83	Consumers lack transportation	46	95.83
Consumers lack transportation	46	95.83	Non-availability of needed services and supports	45	93.75
Lack of health insurance	43	89.58	Lack of health insurance	42	87.50
Providers have high staff turnover	42	87.50	Providers have high staff turnover	42	87.50
Providers lack appropriately trained staff	42	87.50	Limits on enrollment in state-only funded LTSS	38	79.17

*Barrier includes response options “Sometimes a barrier” and “Often a barrier.”
Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Provider Choice. Exhibit 4.42 shows the five most adequately available provider choices in the community as reported by local ADRCs in the years prior to receiving the ADRC grant and currently. More information on provider choice is available in Appendix F, Question 13. The only service that was reported as one of the top five adequately available provider choices in both the prior and current periods was opportunities to develop advance directives.

Exhibit 4.43 shows the most common provider choices reported as inadequately available in the community by local ADRCs. There are not many changes in the list from the years prior to receiving ADRC grants to the current period. Transportation service continued to be the most commonly reported provider choice. However, transition programs, which were reported as inadequately available in the prior period, were not reported as commonly in the current period. Emergency services/crisis intervention was reported as inadequate in the current period but not prior to receiving the grant.

Exhibit 4.42: Most Common Adequately Available Provider Choices Currently and Prior to Receiving ADRC Grants: Local ADRCs

Prior Provider Choice	Freq.	%	Current Provider Choice	Freq.	%
Nursing home/residential beds	229	48.52	Opportunities to develop advance directives	266	56.36
Ombudsman services	223	47.25	Nursing home/residential beds	259	54.87
Nutrition programs	179	37.92	Ombudsman services	248	52.54
Education services	177	37.50	Education services	206	43.64
Opportunities to develop advance directives	170	36.02	Opportunities for socialization/recreation	196	41.53

Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Exhibit 4.43: Most Common Inadequately Available Provider Choices Currently and Prior to Receiving ADRC Grants: Local ADRCs

Prior Provider Choice*	Freq.	%	Current Provider Choice*	Freq.	%
Transportation services	402	85.17	Transportation services	405	85.81
Transition programs (from hospitals, nursing homes, etc.)	387	81.99	Income assistance	384	81.36
Safe and affordable housing options	386	81.78	Safe and affordable housing options	373	79.03
Mental health services	375	79.45	Mental health services	372	78.81
Income assistance	372	78.81	Emergency services/crisis intervention	359	76.06

*Inadequate availability includes response options “Not available” and “Available but inadequate to meet the need.”

Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

In Exhibit 4.44, we explore the five most frequently reported areas with adequate provider choice at the state level (see Appendix H, Question 8b, for details). There is only one change in the list of five most commonly reported areas with adequate provider choice between the prior and current periods. Educational services were added in the current period, replacing socialization/recreation programs from the period prior to the ADRC award.

Exhibit 4.45 shows the top five inadequately available provider choices reported by state ADRC representatives in prior and current periods. Inadequate provider choice in transportation services continued to be the most commonly reported area of concern at the state level.

Exhibit 4.44: Most Common Adequately Available Provider Choices Currently and Prior to Receiving ADRC Grants: State ADRCs

Prior Provider Choice	Freq.	%	Current Provider Choice	Freq.	%
Nursing home services	30	62.50	Nursing home services	31	64.58
Assisted living services	24	50.00	Assisted living services	28	58.33
Ombudsman services	22	45.83	Education services	20	41.67
Socialization/recreation programs	20	41.67	Ombudsman services	20	41.67
HCBS Medicaid waiver programs	15	31.25	HCBS Medicaid waiver programs	19	39.58

Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Exhibit 4.45: Most Common Inadequately Available Provider Choices Currently and Prior to Receiving ADRC Grants: State ADRCs

Prior Provider Choice*	Freq.	%	Current Provider Choice*	Freq.	%
Transportation services	43	89.58	Transportation services	42	87.50
Hospital transition programs	42	87.50	Mental/behavioral health services	39	81.25
Safe and affordable housing options	41	85.42	Safe and affordable housing options	38	79.17
Nursing home transition	40	83.33	Hospital transition programs	38	79.17
Independent living	40	83.33	Shared living programs	37	77.08

*Inadequate availability includes response options “Not available” and “Available but inadequate to meet the need.”

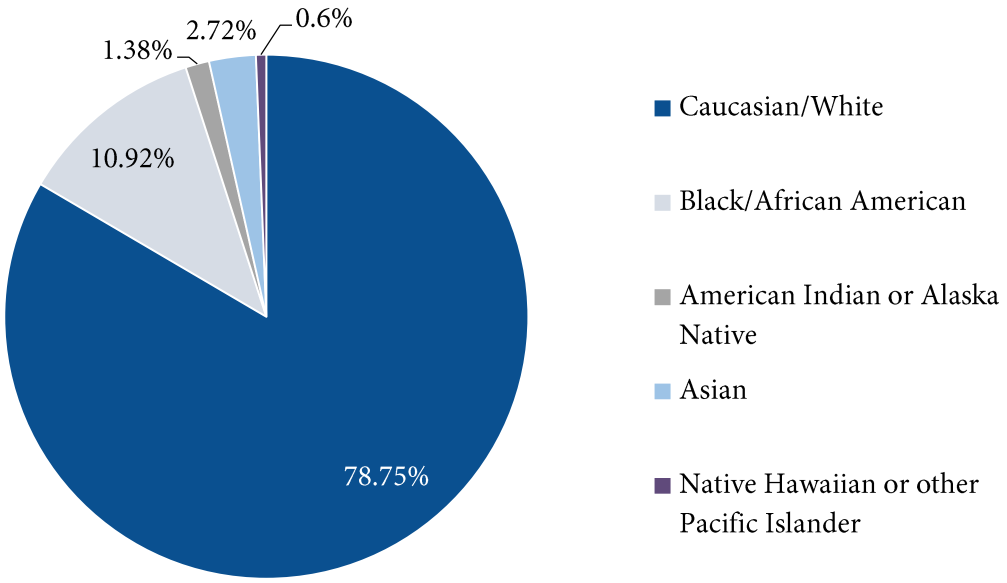
Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Community Populations

The local ADRC survey contained questions to collect data on the demographic composition of ADRC service areas in terms of race, ethnicity, poverty status, and insurance status. The complete tabulations of the demographic survey questions are available in Appendix F, Questions 7 – 10a.

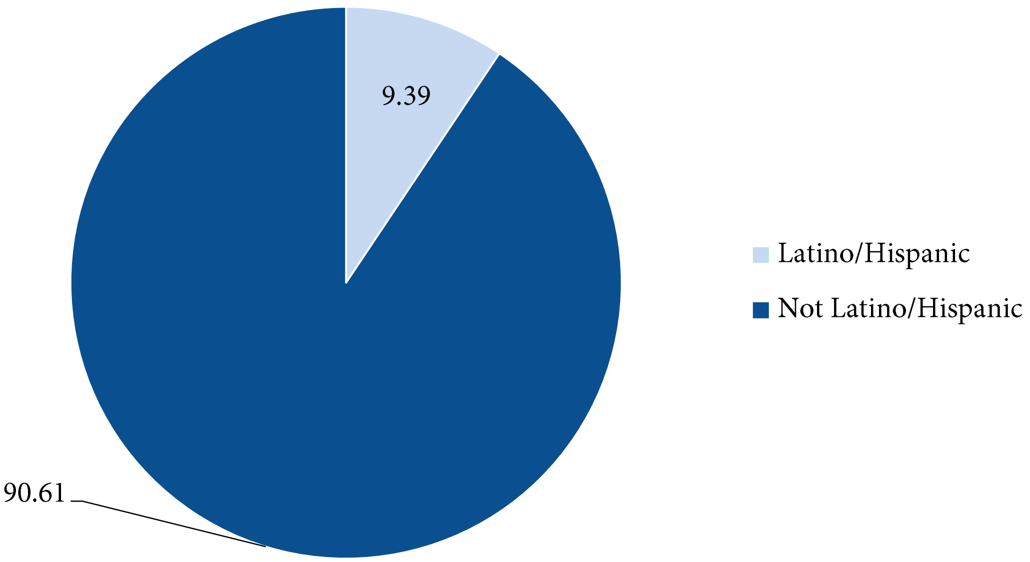
Racial and Ethnic Composition. Exhibit 4.46 illustrates the average racial composition of local ADRC service areas. It should be noted that there was a fairly high non-response rate on some of the items (i.e., 10 – 51% non-response) and that Exhibit 4.46 represents only those ADRCs for which there was a response to the item. As shown, on average, 79 percent of ADRC service areas were Caucasian/White, while 11 percent were Black/African American. Local ADRC respondents identified 18 cultural groups, such as Hmong, Middle Eastern, and Amish, as subpopulations (see Appendix G, Question 8, for details). Across all local ADRC service areas, an average of 9 percent of the population was of Latino/Hispanic ethnicity (see Exhibit 4.47).

Exhibit 4.46: Racial Composition of Local ADRC Service Areas



Note: Response rate for sub-categories varied between 49% and 90%.

Exhibit 4.47: Ethnic Composition of Local ADRC Service Areas



Note: Response rate was 82%.

Poverty Status. Fifty-nine percent of the local ADRC respondents responded to the poverty item; they reported that, on average, 17 percent of their population was living at or below the poverty line. A little over 31 percent indicated that they were not sure about the poverty status of their population but believed that a significant proportion of their population lived below the poverty line. Only 4 percent of local ADRCs reported that the population living below the poverty line in their service areas was small or negligible.

Medical Insurance Status. The mean uninsured rate was reported to be 15 percent, although only 25 percent of ADRC representatives responded to this item. Fifty percent of local ADRC respondents indicated that, while they were not sure of the exact percentage, they believed that a significant portion of the population did not have health insurance coverage. Nineteen percent of local ADRC respondents reported that the uninsured population in their service areas was negligible.

We also explored the differences in the demographic composition of ADRC service areas by subgroups and did not find any statistically significant differences.

Consumer Characteristics

The local ADRC survey also contained questions about the characteristics of ADRC consumers, including demographics and most frequently requested services.

Consumer Demographics. Appendix F, Question 14, displays the number of older adults, persons with disabilities, caregivers, and other sub-populations served by local ADRCs during the six months preceding the survey (October 2012 to March 2013). They also present the minimum, maximum, mean, median, and mode of these categories. As the exhibits indicate, there is wide variation in the number of consumers served by ADRCs. Appendix F, Question 14, shows that local ADRCs served an average of 3,961 consumers aged 60 or older during the six-month period (median = 1,444, maximum = 58,388).

Exhibit 4.48 shows the number of individuals with disabilities, both under 60 years of age and 60 years and older, who were served by local ADRCs. The largest numbers of consumers in both age groups were adults with physical disabilities. The exhibit also provides caregiver types by consumer age group. As shown, informal/family caregivers were the largest group of caregivers served by local ADRCs.

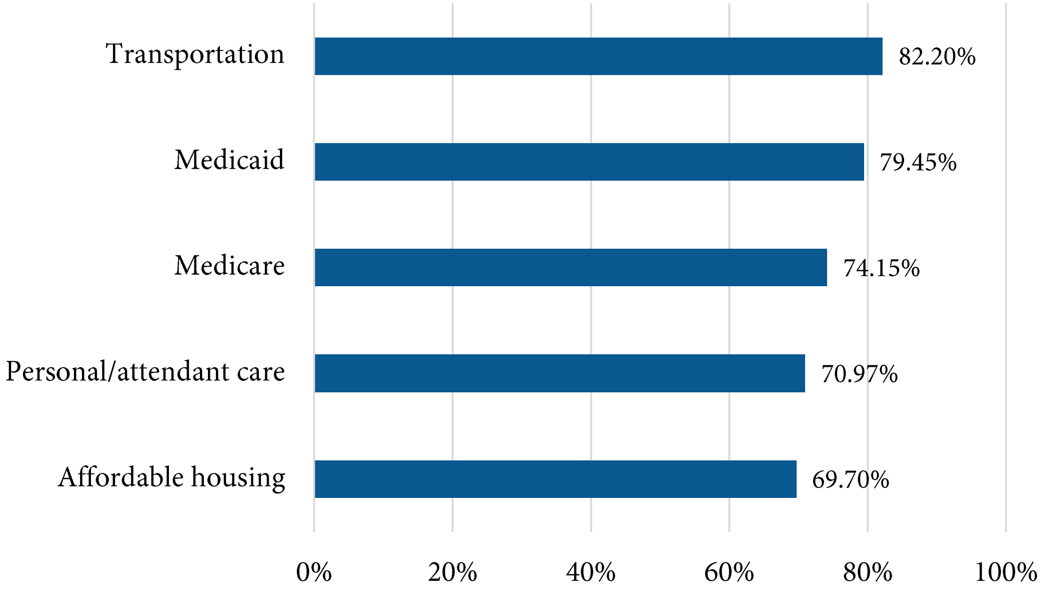
Exhibit 4.48: Number of Consumers with Disabilities and Caregivers Served by Local ADRCs

	Under 60	60 and over
Consumers with Disabilities		
Physical disabilities	59,071	204,709
Cognitive impairment	6,904	26,387
Intellectual disabilities	4,184	4,308
Developmental disabilities	9,455	7,260
Mental illness	12,447	14,253
Multiple disabilities	37,566	78,143
Caregivers		
Informal/family caregiver	25,224	86,871
Paid caregiver	3,589	14,111
Health and human services professional	13,877	48,288

Appendix F, Question 14, presents the number of consumers who belonged to other disability groups, such as those with a traumatic brain injury, and those with limited English proficiency.

Most Frequently Sought Services by Consumers. Items on the local ADRC questionnaire were designed to collect data on how frequently consumers inquired about certain types of services (see Appendix F, Question 20, for details). As shown in Exhibit 4.49, the most frequently requested service was transportation (82%). Medicaid and Medicare eligibility determination and services were the second and third most frequently sought services at 79 percent and 74 percent, respectively.

Exhibit 4.49: Most Frequently Requested Services by Consumers at Local Level



Notes: Response rates to the sub-questions varied between 89% and 90%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Interestingly, in multiple cases the most frequently sought services were also the ones that were most frequently cited by local ADRCs as being inadequately available in the communities they served. For example, transportation ranked first on services sought and services inadequately available. Affordable housing also appeared as a service sought and a service inadequately available. There were statistically significant differences between subgroups in the types of services that were most frequently sought by consumers, except in the case of transportation, which was frequently sought in all subgroups (responses ranged from 87% to 95%).

Large local ADRCs (97%), compared to medium (89%) and small (77%) sites, were significantly more likely to report that consumers frequently asked about Medicaid eligibility and services ($p \leq .01$, Exhibit 4.50). See Appendix O, Exhibit 8, for details. Further, geographic location, organizational structure, and operational structure of an ADRC were linked to frequency of consumer inquiry on Medicare eligibility and services. Exhibit 4.51 shows a trend toward statistical significance, with more rural than urban local ADRCs reporting that consumers frequently asked about Medicare eligibility and services (89% and 81%, respectively, $p \leq .10$). Similarly, as illustrated in Exhibit 4.52, significantly more government than independent local

ADRCs reported that they had consumers who frequently asked about Medicare eligibility and services (87% and 78%, respectively; $p \leq .05$), and more centralized (90%) local ADRCs, compared to decentralized (71%) and mixed (85%) sites, reported that consumers frequently asked about Medicare eligibility and services ($p \leq .01$; see Exhibit 4.53). See Appendix L, Exhibit 8; Appendix M, Exhibit 6; and Appendix N, Exhibit 8, respectively, for details.

Exhibit 4.50: Frequency of Consumer Requests about Medicaid Eligibility by Number of Consumers Served

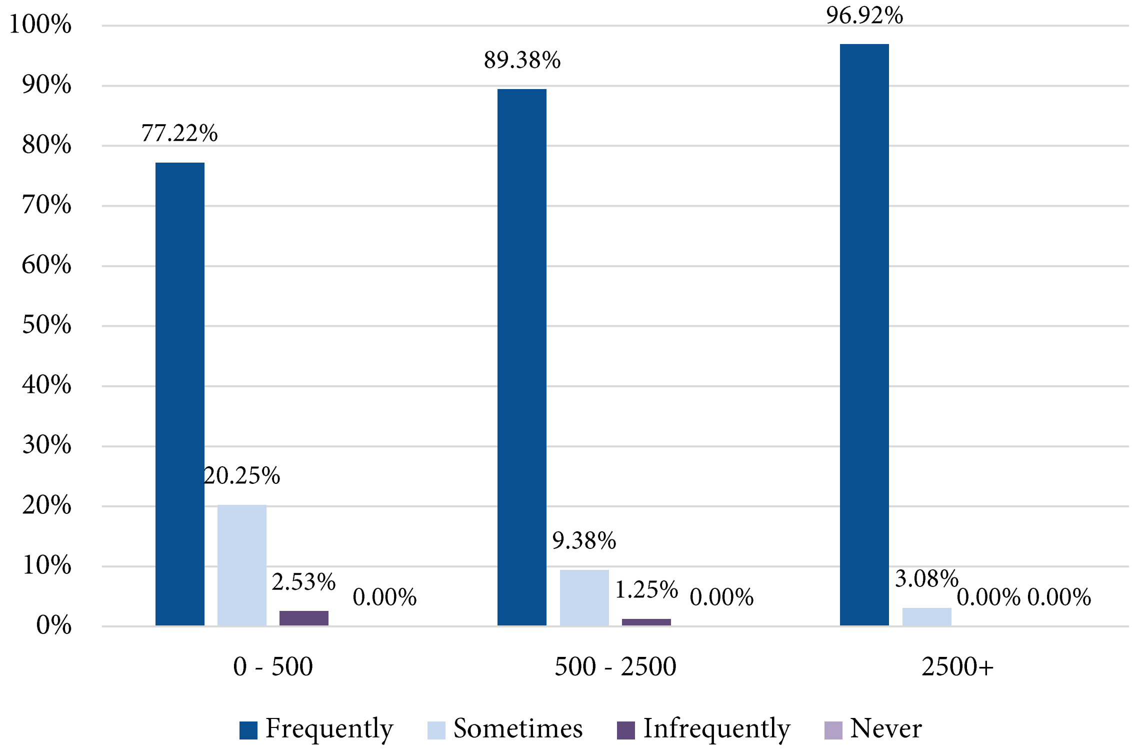


Exhibit 4.51: Frequency of Consumer Requests about Medicare Eligibility by Agency Location

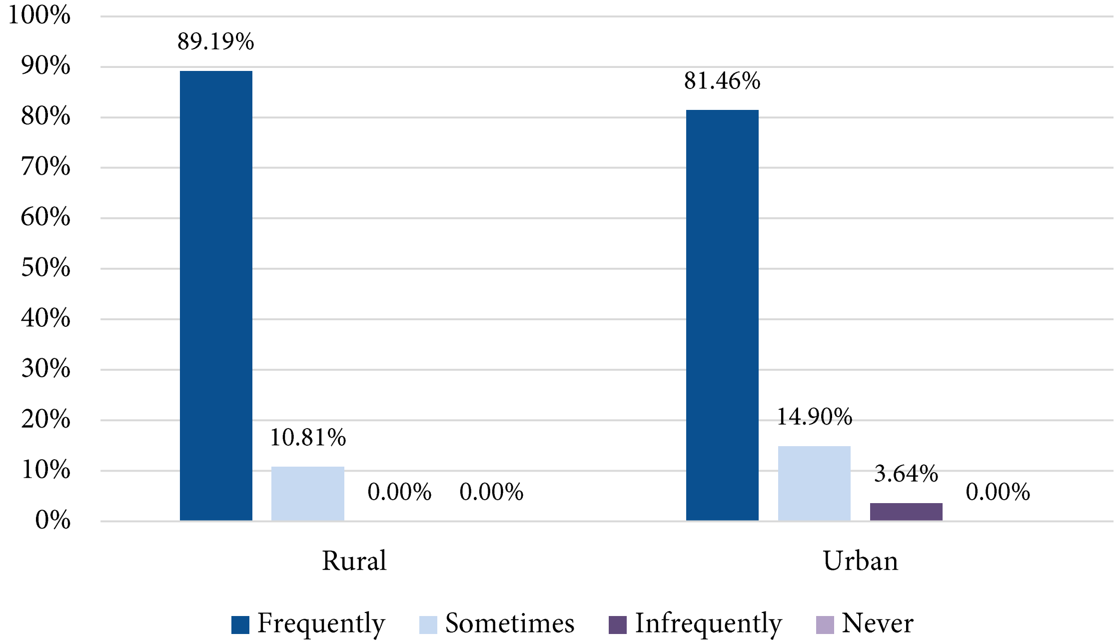


Exhibit 4.52: Frequency of Consumer Requests about Medicare Eligibility by Organizational Structure

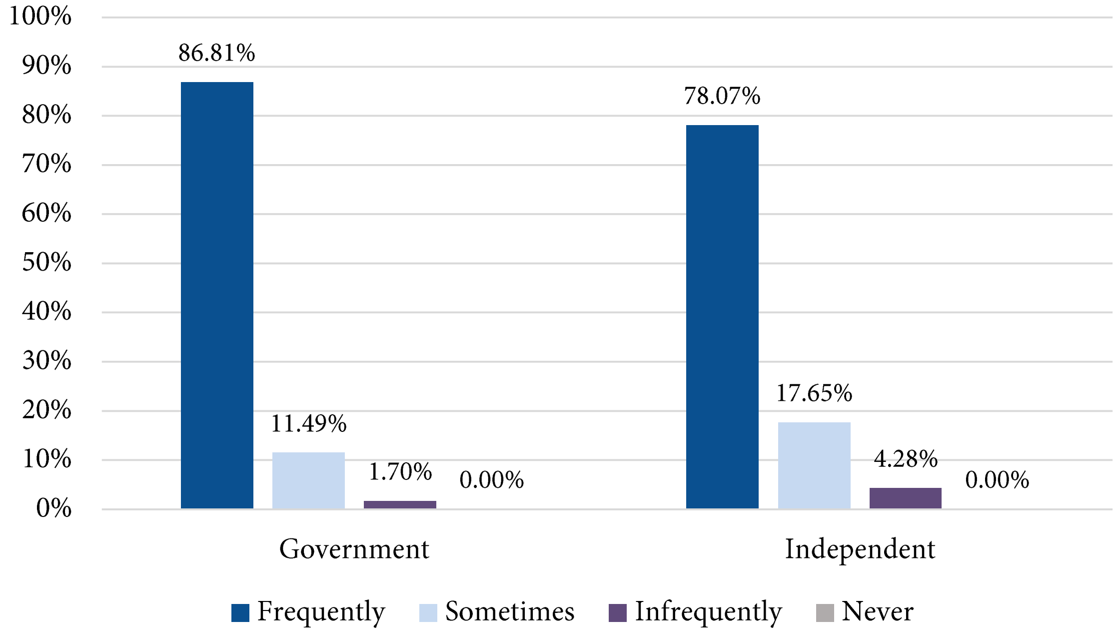
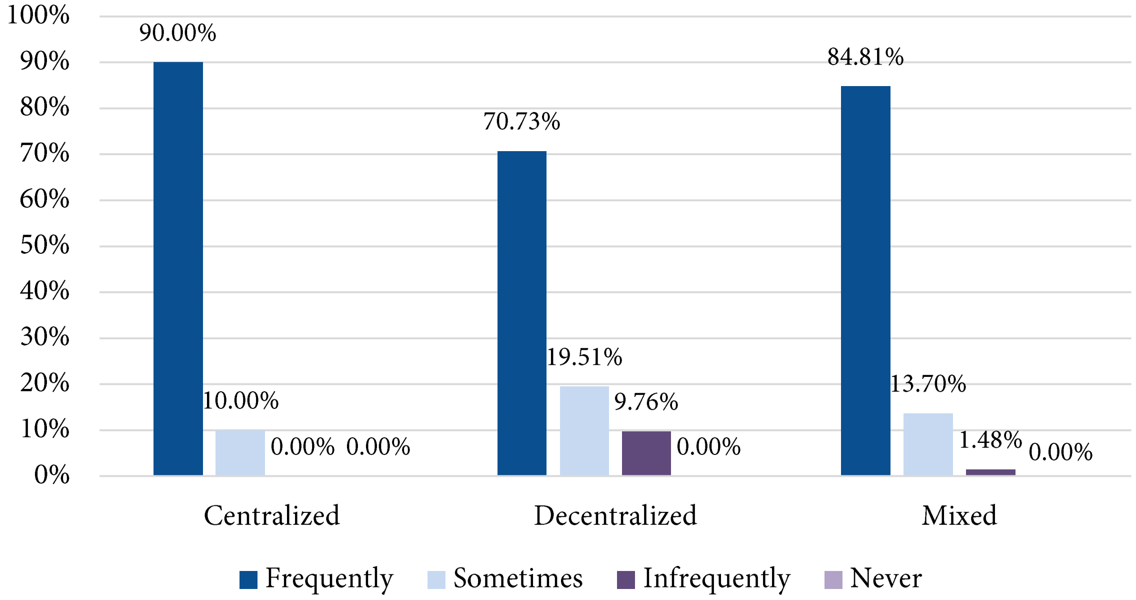


Exhibit 4.53: Frequency of Consumer Requests about Medicare Eligibility by Operational Structure



Additional analyses demonstrated a trend toward significance in that more urban (83%) than rural (72%) local ADRCs reported that consumers frequently asked about personal care and attendant care services ($p \leq .10$, Exhibit 4.54). Larger ADRCs (82%) reported inquiries about affordable housing significantly more frequently than medium (77%) and small (71%) ADRCs ($p \leq .05$; see Exhibit 4.55). For detailed results, see Appendix L, Exhibit 9, and Appendix O, Exhibit 9, respectively. Similarly, more decentralized local ADRCs (87%) than centralized (64%) and mixed (79%) ADRCs and more urban (85%) than rural (57%) local ADRCs reported that consumers were significantly more likely to ask about affordable housing options ($p \leq .05$ and $p \leq .01$, respectively; Exhibits 4.56 and 4.57). See Appendix N, Exhibit 9, and Appendix L, Exhibit 10, respectively, for details.

Exhibit 4.54: Frequency of Consumer Requests about Personal Care and Attendant Care Services by Agency Location

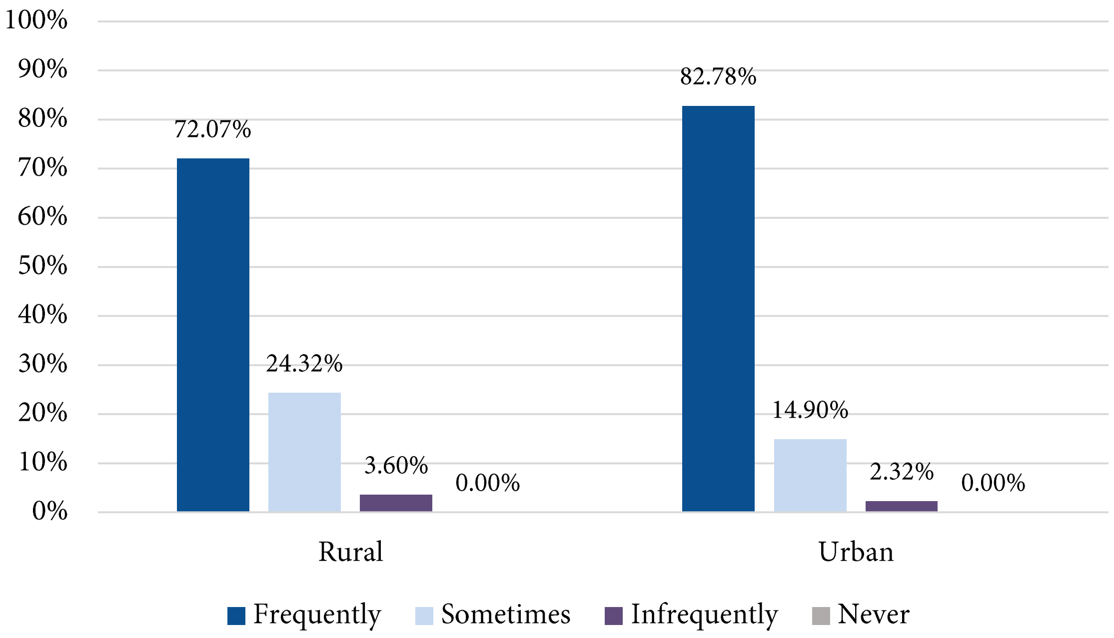


Exhibit 4.55: Frequency of Consumer Requests about Affordable Housing Services by Number of Consumers Served

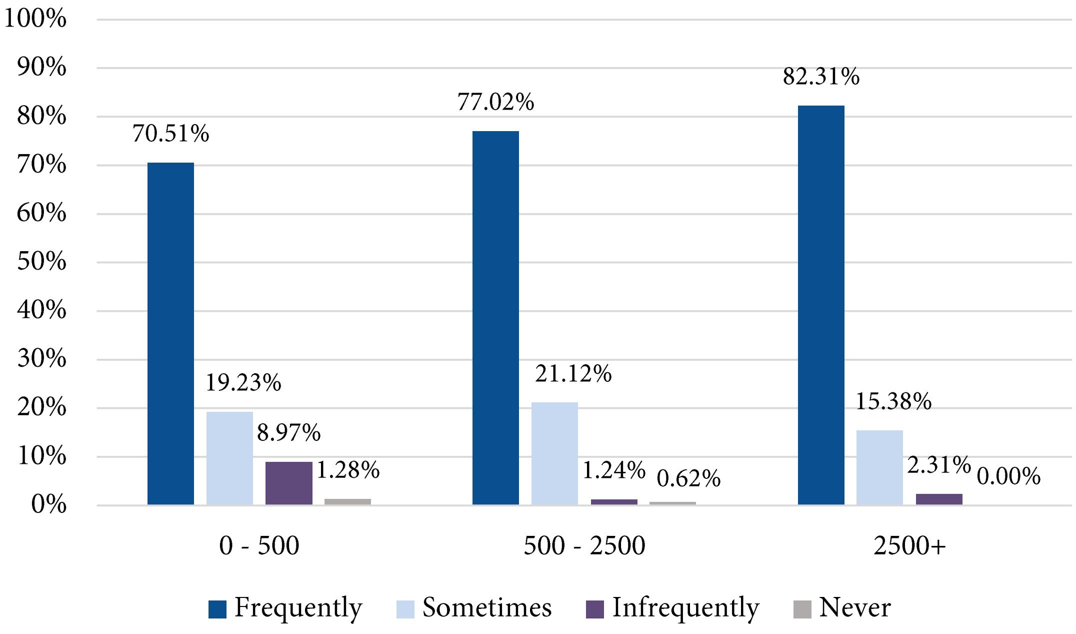


Exhibit 4.56: Frequency of Consumer Requests about Affordable Housing Services by Operational Structure

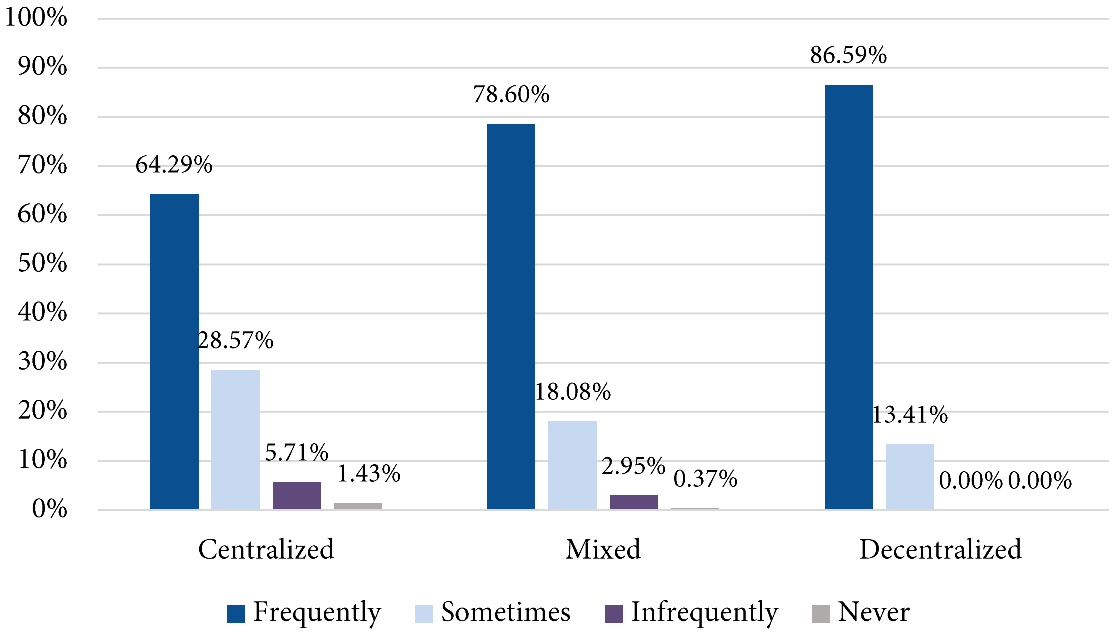
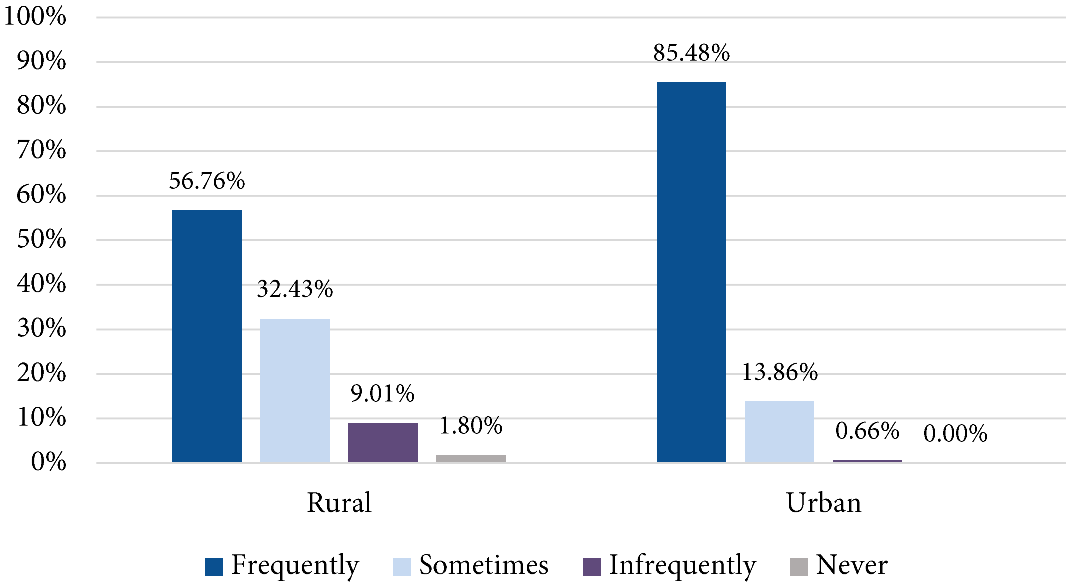


Exhibit 4.57: Frequency of Consumer Requests about Affordable Housing Services by Agency Location



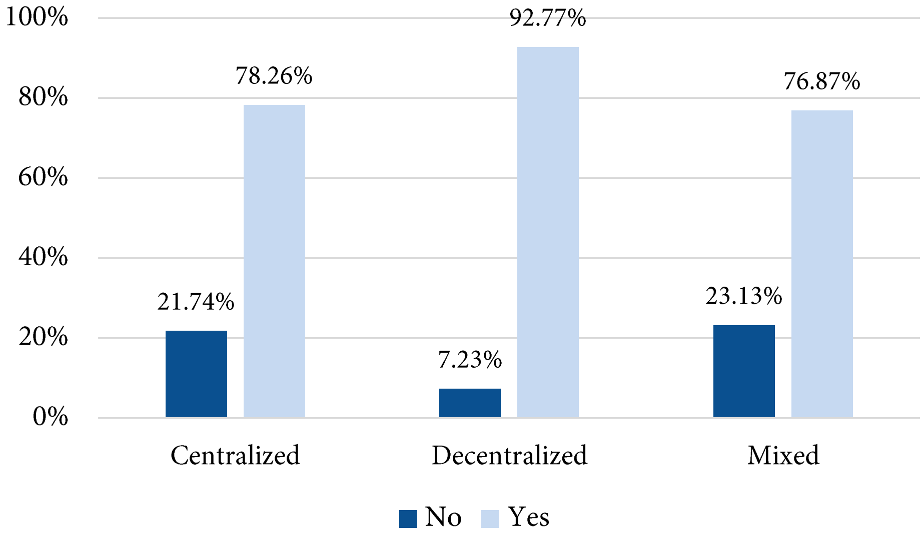
4.2.4 Organizational Information

Services Provided by ADRCs

Options Counseling. A majority of local ADRC respondents (76%) indicated that they provided options counseling or other one-on-one counseling designed to support consumers' ability to make informed decisions about their long-term care. Additional detail about this finding can be found in Appendix F, Question 33.

Nearly 77 percent of rural and 81 percent of urban local ADRCs provided options counseling, and 79 percent of government and 81 percent of independent sites provided options counseling. However, as shown in Exhibit 4.58, there was a statistically significant difference between decentralized local ADRCs (93%) and centralized (78%) or mixed (77%) sites ($p \leq .01$). Lastly, significant differences between rates of options counseling among small (83%), mid-size (81%), and large (80%) local ADRCs were not found. See Appendix N, Exhibit 10, for details.

Exhibit 4.58: Provision of Options Counseling or One-on-One Counseling to Support Consumers by Operational Structure



Findings from analyses on the number of clients by age, method, and setting who received options counseling during the same six-month period from October 2012 to March 2013 can be found in Appendix F, Question 35. Note that the response rates to optional categories were relatively low (ranging from 16% to 58%).

As shown in Exhibit 4.59, respondents reported providing options counseling to a larger number of clients aged 60 and older (mean = 1,268) compared to other age groups. During the six-month period, local respondents provided counseling to a total of 298,647 older adults age 60 and above, compared to 62,819 clients under the age of 60.

Exhibit 4.59: Clients Provided Options Counseling at Local Level by Age

Age	Mean	Median	Mode	Range	
				Min	Max
Under 60	297	58	2	1	8,234
60 and older	1,268	170	7	1	74,000
Unknown age	686	69	1	1	10,192

Note: Response rates to the sub-questions varied between 45% and 67%. Summary statistics are based on ADRCs that served at least one client in that particular age group.

Exhibit 4.60 presents the findings on the analyses of modes of options counseling. Telephone was the most common method used to contact local ADRCs (*N* = 229,653, mean = 1,256). During this period, it was reported that staff at local ADRCs provided in-person options counseling to a total of 90,648 clients (mean = 438). The least common method for offering options counseling was through electronic means, such as email and website chats.

Exhibit 4.60: Clients Provided Options Counseling at Local Level by Method

Method	Mean	Median	Mode	Range	
				Min	Max
In person	438	85	3	1	12,521
Phone	1,256	133	12	1	48,935
Electronic communication	241	19	1,3,5	1	9,650

Note: Response rates to the sub-questions varied between 32% and 60%. Summary statistics are based on ADRCs that provided options counseling to at least one client using that particular method.

The most common setting in which local ADRCs provided options counseling was on-site at the ADRC facility. A total of 124,030 clients received options counseling in-house at the local ADRC. As shown in Exhibit 4.61, staff at local ADRCs provided in-house counseling to an average of 725 clients. The second most common setting was at the client's community residence (*N* = 33,614, mean = 242). In addition, 16,930 clients received options counseling at a nursing home or other institutional setting over the six-month reporting period (mean = 154), and only 5,488 clients received options counseling at a hospital over this same period (mean = 96).

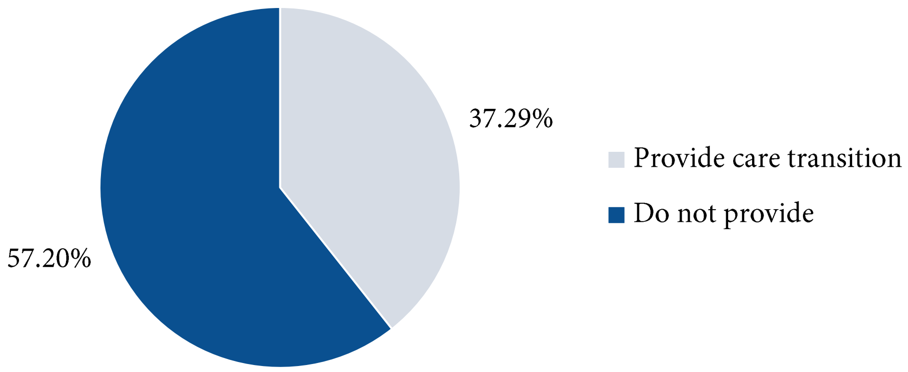
Exhibit 4.61: Clients Provided Options Counseling at Local Level by Setting

Setting	Mean	Median	Mode	Range	
				Min	Max
Local ADRC	725	137	24	1	9,480
Hospital	96	18	1	1	1,021
Client’s community residence	242	50	10	1	6,019
Nursing home/institution	154	19	1	1	2,980

Note: Response rates to the sub-questions varied between 34% and 50%. Summary statistics are based on ADRCs that provided options counseling to at least one client at that particular setting.

Care Transitions. Results of analyses of survey items addressing whether or not local ADRCs provided transition services to consumers discharged from an acute care setting and the types of care transition services they provided can be found in Appendix F, Questions 24–30. Thirty-seven percent of local ADRCs provided transition services to these consumers, as seen in Exhibit 4.62, and geographic location, organization structure, and operational structure were each significantly related to whether an organization provided transition services to consumers. Exhibit 4.63 shows that nearly 44 percent of urban, compared to 29 percent of rural, local ADRCs provided transition services ($p \leq .01$). Additionally, 47 percent of independent, compared to 33 percent of government, local ADRCs provided transition services ($p \leq .01$, Exhibit 4.64), and decentralized ADRCs (58%), compared to mixed (37%) and centralized (27%) ADRCs, were more likely to provide transition services ($p \leq .01$, Exhibit 4.65). See Appendix L, Exhibit 11; Appendix M, Exhibit 7; and Appendix N, Exhibit 11, respectively, for detailed results.

Exhibit 4.62: Consumers Provided Care Transition Services



Note: Response rate was 94%.

Exhibit 4.63: Provision of Transition Services to Consumers Discharged from an Acute Care Setting by Agency Location

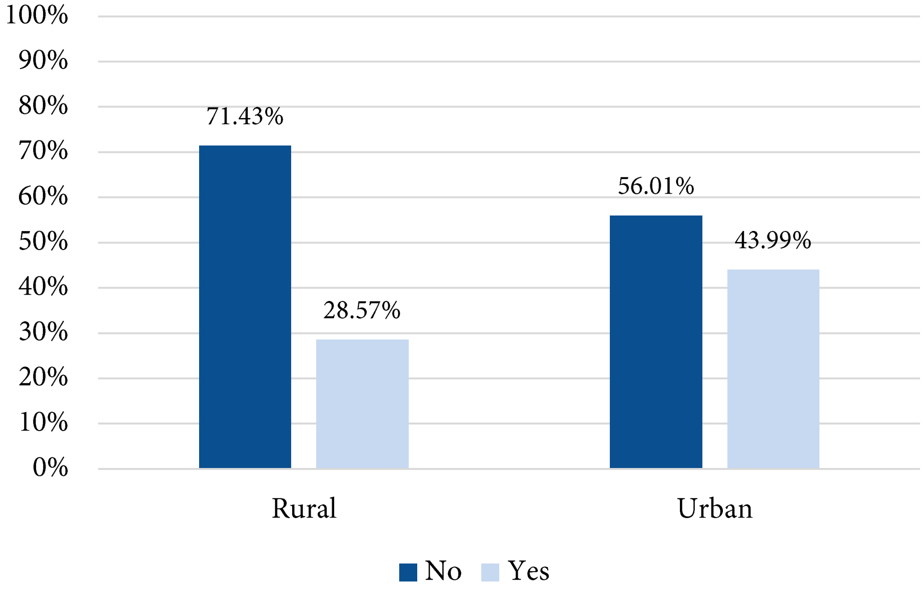


Exhibit 4.64: Provision of Transition Services to Consumers Discharged from an Acute Care Setting by Organizational Structure

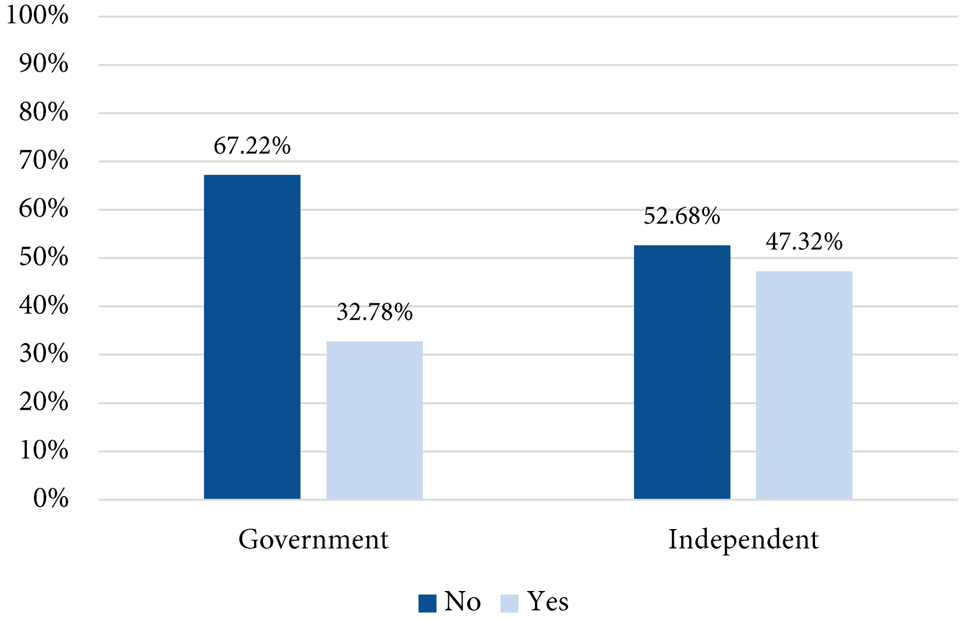
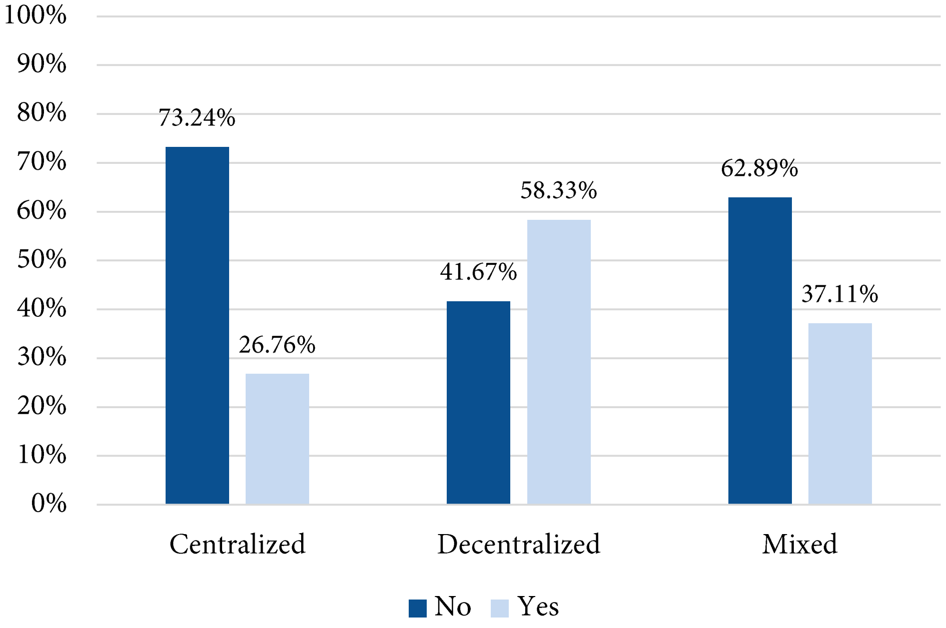


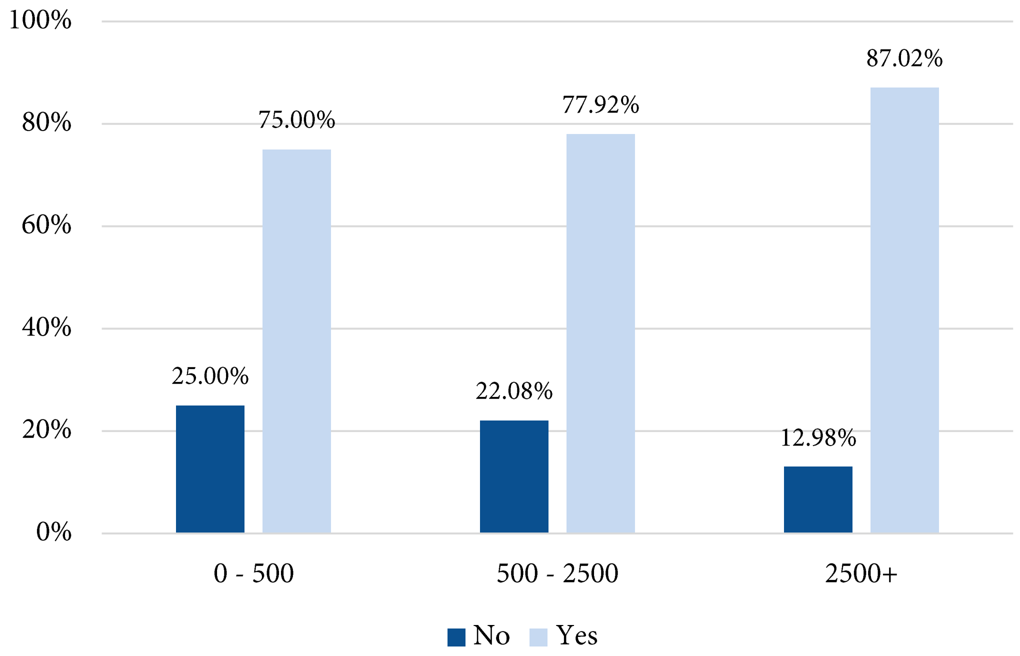
Exhibit 4.65: Provision of Transition Services to Consumers Discharged from an Acute Care Setting by Operational Structure



Medicaid Eligibility. Items on the local ADRC survey addressed whether or not ADRC staff administered a screening questionnaire to make a preliminary determination of eligibility and the need for publicly funded LTSS. Approximately 76 percent of local ADRC respondents reported that they conducted an initial screening, and 17 percent reported that they did not (see Appendix F, Question 48).

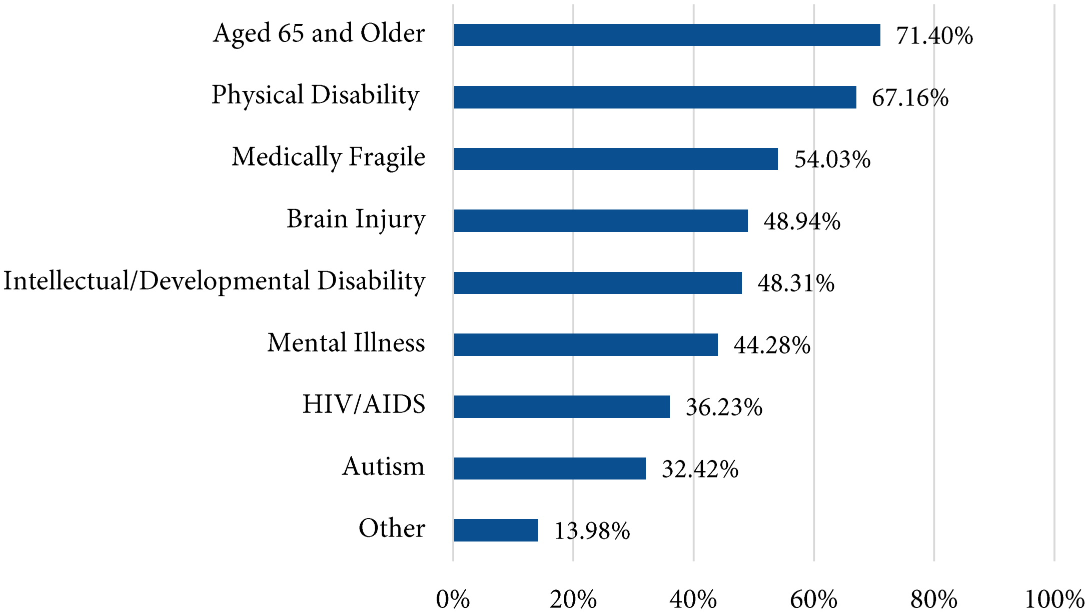
There was a trend toward significance in the relationship between ADRC size and whether or not a site administered a screening questionnaire. Large local ADRCs (87%) were more likely than medium (78%) and small (75%) sites to administer a screening questionnaire to make a preliminary determination of eligibility and need for publicly funded LTSS ($p \leq .10$, Exhibit 4.66). For detailed results, see Appendix O, Exhibit 10.

Exhibit 4.66: Use of Screening Questionnaire to Make a Preliminary Determination of Eligibility and Need for Publicly Funded LTSS by Number of Consumers Served



Descriptive statistics in Exhibit 4.67 indicate that 71 percent of local ADRCs administered a screening instrument to consumers aged 65 and over to make a preliminary determination of eligibility for publicly funded LTSS. More than two-thirds of local ADRCs reported screening consumers with physical disabilities, and about half reported screening those with intellectual or developmental disabilities for a preliminary determination of eligibility for publicly funded LTSS.

Exhibit 4.67: Types of Consumers Provided Preliminary Eligibility Screening



Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options

At the time of the survey, 28 percent of local ADRCs, or their state agencies, permitted presumptive financial eligibility in order to expedite the provision of LTSS to clients while their financial eligibility applications were being processed. Just over half (56%) reported that neither they, nor their state agency, permitted presumptive financial eligibility. Nearly 4 percent were in the process of permitting presumptive financial eligibility. [11]

Findings demonstrated that nearly all local ADRCs assisted clients in some capacity with financial eligibility applications for Medicaid (93%) and other publicly funded (90%) LTSS programs. Exhibit 4.68 presents the top four ways in which local ADRCs assisted with financial eligibility applications for Medicaid and other publicly funded LTSS programs (see Appendix F, Question 51, for more detail). As shown, the most common way in which local ADRC staff assisted with Medicaid LTSS program applications was to advise the client where he or she could obtain an application (71%).

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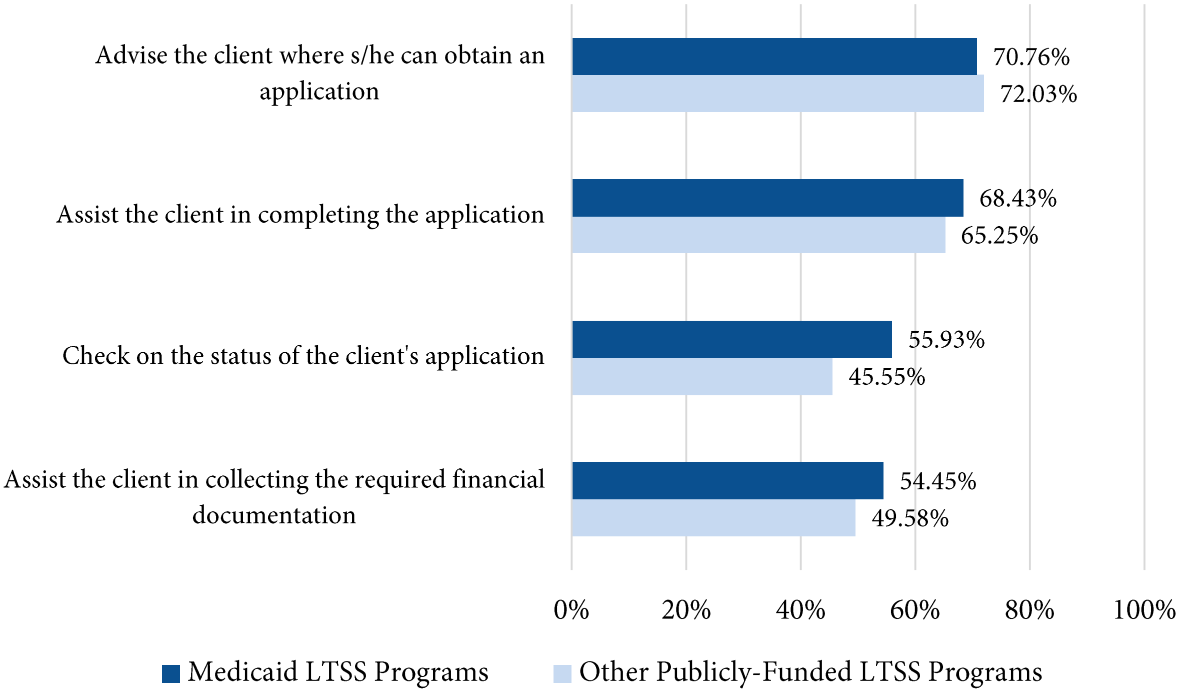
[11] Response rate was 87 percent.

Exhibit 4.68: Ways of Assisting with Financial Eligibility Applications

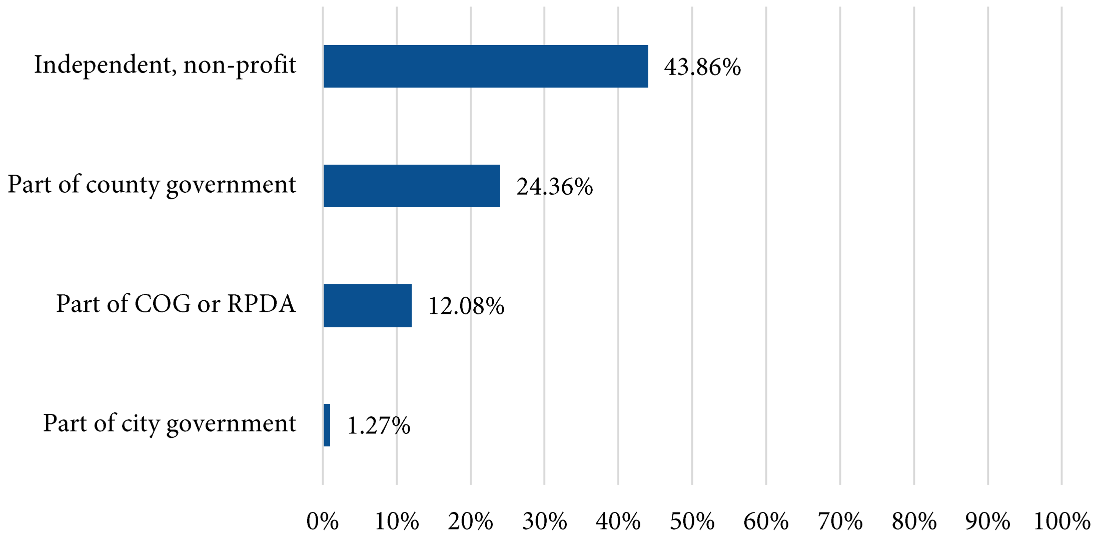


Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Provision of ADRC Services

Organizational Structure. Exhibit 4.69 summarizes the organizational structure of the 82 percent of local ADRC participants that responded to the question. As illustrated, a number of local ADRCs were independent non-profit organizations (44%).

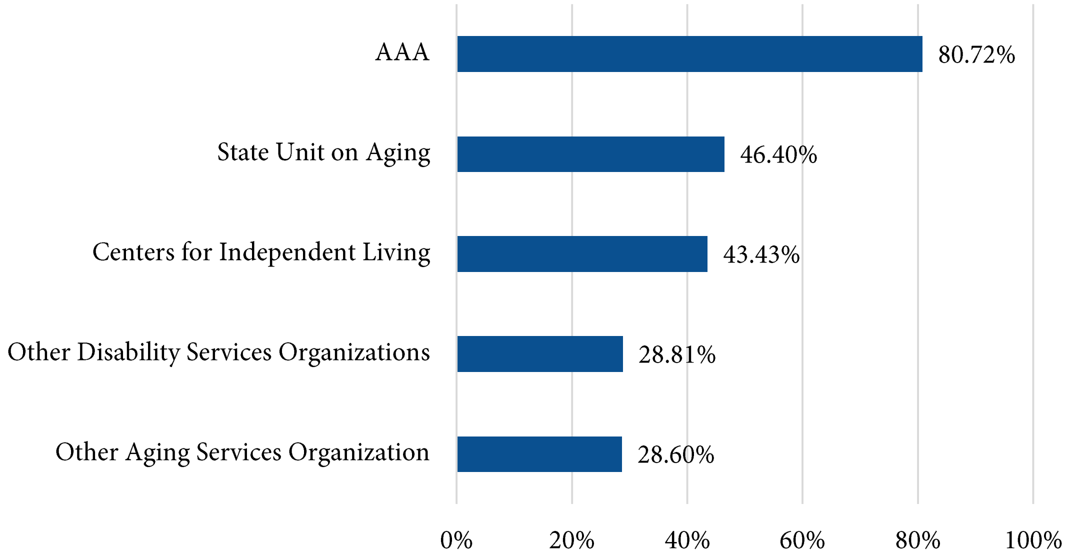
Exhibit 4.69: Structure of Local ADRCs



Note: Response rate was 82%.

Core Operating Organizations. Local ADRC respondents reported that their ADRC was composed of an average of four core operating organizations (range = 1 – 15). In Exhibit 4.70, we present the top five agencies that were cited as a core operating organization by local ADRCs. The most common core operating organization was AAAs, with nearly 81 percent of local ADRCs reporting that AAAs served as one of their core operating organizations. Approximately 46 percent of local ADRCs reported that their state unit on aging (SUA) was one of their core operating organizations, and 43 percent reported a center for independent living (CIL) as a core operating organization. More information about core operating organizations is provided in Appendix F, Question 61.

Exhibit 4.70: Most Frequently Reported Core Operating Organizations



Notes: Response rates to sub-categories varied between 50% and 88%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Overall, the local ADRC respondents reported having "positive" and "solid" relationships with their core operating organizations. In addition to identifying their core organizations, most of the sites provided specific information about the resources that these organizations provided. Many organizations provided the ADRCs with resources such as a physical space and connections to community resources. In addition, many of the sites signed formal memorandums of understanding to officially establish use of resources, staff, information, and coordination. A few local ADRC representatives commented about plans to improve the LTSS they offer by working more closely with their partners and core operating organizations. Respondents from none of the sites reported having a negative relationship with their core operating organizations (see Appendix G, Question 61a).

Staffing. Local ADRC respondents reported the number of full-time equivalent staff (FTE) that performed various functions at their site. It should be noted that response rates to sub-questions varied from 25 percent to 74 percent, thus compromising the accuracy of estimates. Exhibit 4.71 presents the average number of local ADRC FTEs by function (see Appendix F, Question 64 for details).

Exhibit 4.71: Full-Time Equivalents at Local Level by Position Type

Position	Mean	Median	Mode	Range	
				Min	Max
Independent living services	6.30	2.00	1.00	0.05	171
Advocacy services	5.39	2.00	1.00	0.10	92
I&R/I&A	5.07	3.00	1.00	0.14	75
Benefits counseling/ eligibility determination	5.07	2.00	1.00	0.10	150
Options counseling/ counseling to provide in-depth support	4.70	2.00	1.00	0.10	65
Crisis intervention services	4.46	2.50	1.00	0.05	30
Administrative support	3.29	2.00	1.00	0.14	91
Care transition services	3.17	2.00	1.00	0.05	40

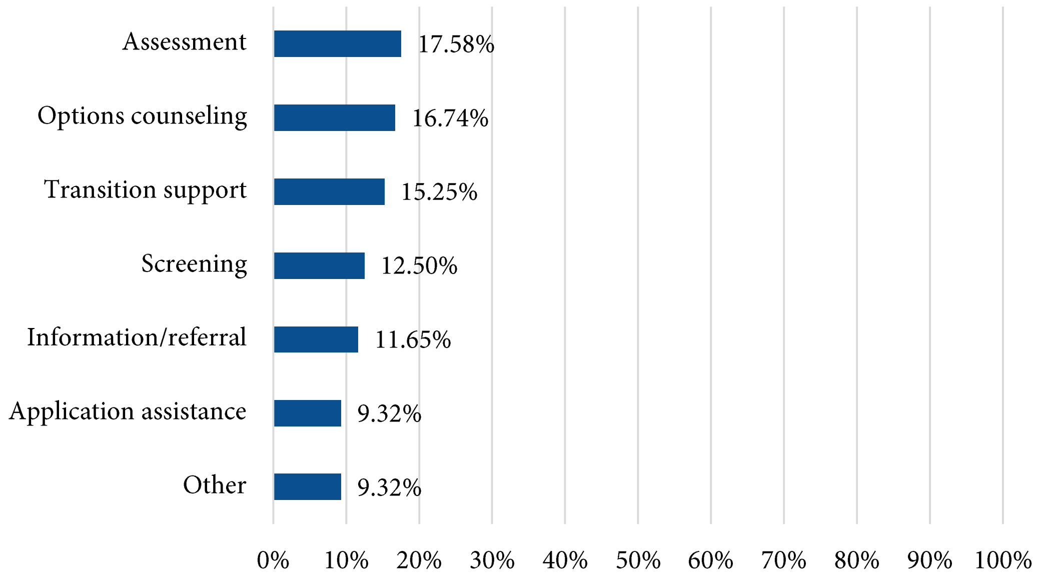
Note: Response rates to the sub-questions varied between 25% and 74%. Summary statistics are based on ADRCs that indicated greater than 0 FTE for the position.

Among the 313 responses, local ADRC participants indicated a total of 2,077 front-line staff at their organizations with an average of six staff (range = 0.50 – 161; response rate = 66%) performing front-line functions at local ADRCs. See Appendix F, Question 65, for details.

Among the 38 state ADRC responses, participants reported a total of 153 state-level FTEs, with an average of four FTEs (range = 0.50 – 21; response rate = 79%) working with local ADRCs at each state ADRC. See Appendix H, Question 12, for details.

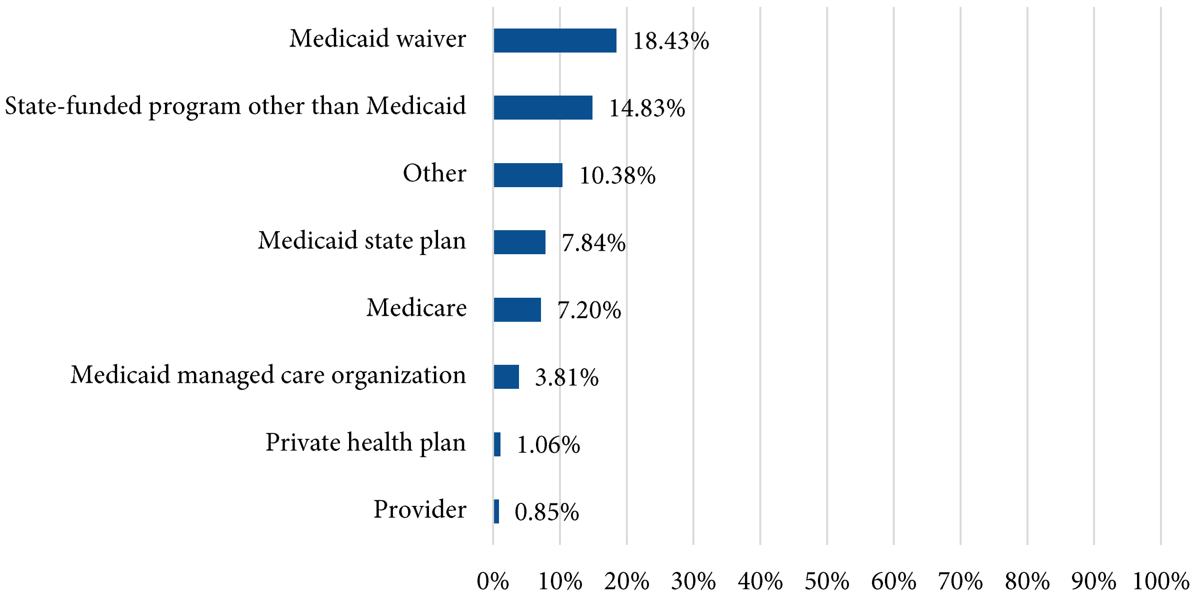
Fee-for-Service Activities. As shown in Exhibit 4.72, 18 percent of local ADRCs indicated that their organizations were paid on a fee-for-service basis for assessment services, 17 percent mentioned options counseling as a fee-for-service activity, and almost 15 percent mentioned that they were paid fee-for-service for transition support services. Exhibit 4.73 shows that 18 percent of local ADRCs indicated Medicaid waiver as the most common source of fees for services provided, followed by state-funded programs other than Medicaid (15%).

Exhibit 4.72: Local ADRC Services Provided on a Fee-for-Service Basis



Notes: Response rate was 38%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

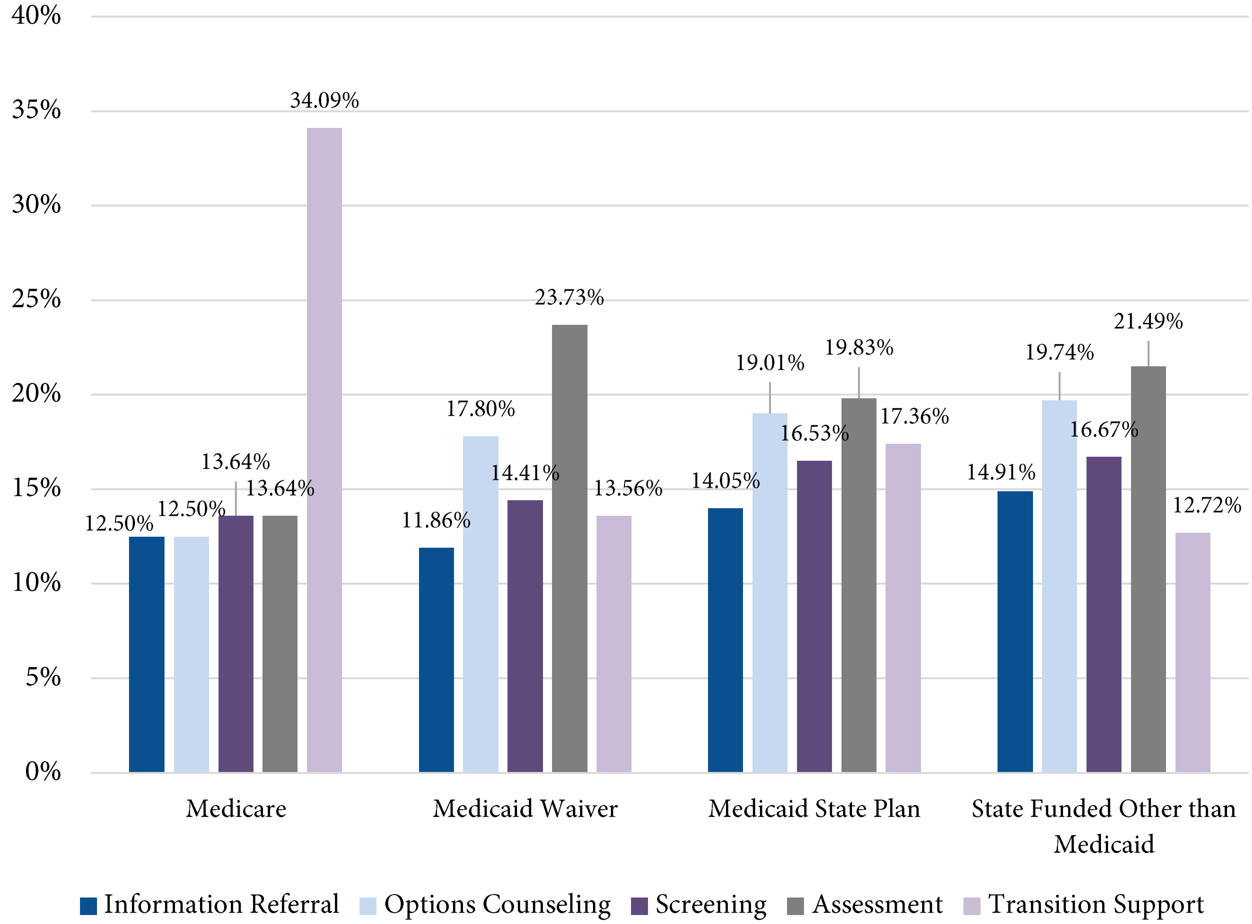
Exhibit 4.73: Local ADRC Source of Fee-for-Service



Notes: Response rate was 37%. Percentages do not add up to 100 because ADRC respondents could choose multiple options.

Exhibit 4.74 shows the findings from the cross-tabulation of the most commonly reported sources of funds for fee-based services reported by local ADRCs and the most commonly reported fee-based services offered by them. Out of the ADRC representatives who reported Medicare as one of the source of funds for fee-based services, 34 percent reported providing fee-based care-transition support services. Among the ADRC representatives reporting Medicaid waiver as one of the fee-for-service funding sources, 24 percent provided fee-based assessment services, and 18 percent provided options counseling services as fee-for-service assistance.

Exhibit 4.74: Fee-for-Service Activities and Sources of Funding



AIRS Standards. As shown in Exhibit 4.75, nearly 44 percent of local ADRCs indicated using Alliance of Information and Referral Systems (AIRS) standards for data collected on consumers. In subgroup analyses, decentralized local ADRCs (75%) were more likely than mixed (58%) and centralized (57%) sites to require staff to follow AIRS standards with all consumers ($p \leq .05$). Similarly, large local ADRCs (71%) were significantly more likely than medium (63%) and small

(45%) sites to require staff to use AIRS standards with all consumers ($p \leq .01$). For detailed results, see Appendix N, Exhibit 13, and Appendix O, Exhibit 11, respectively.

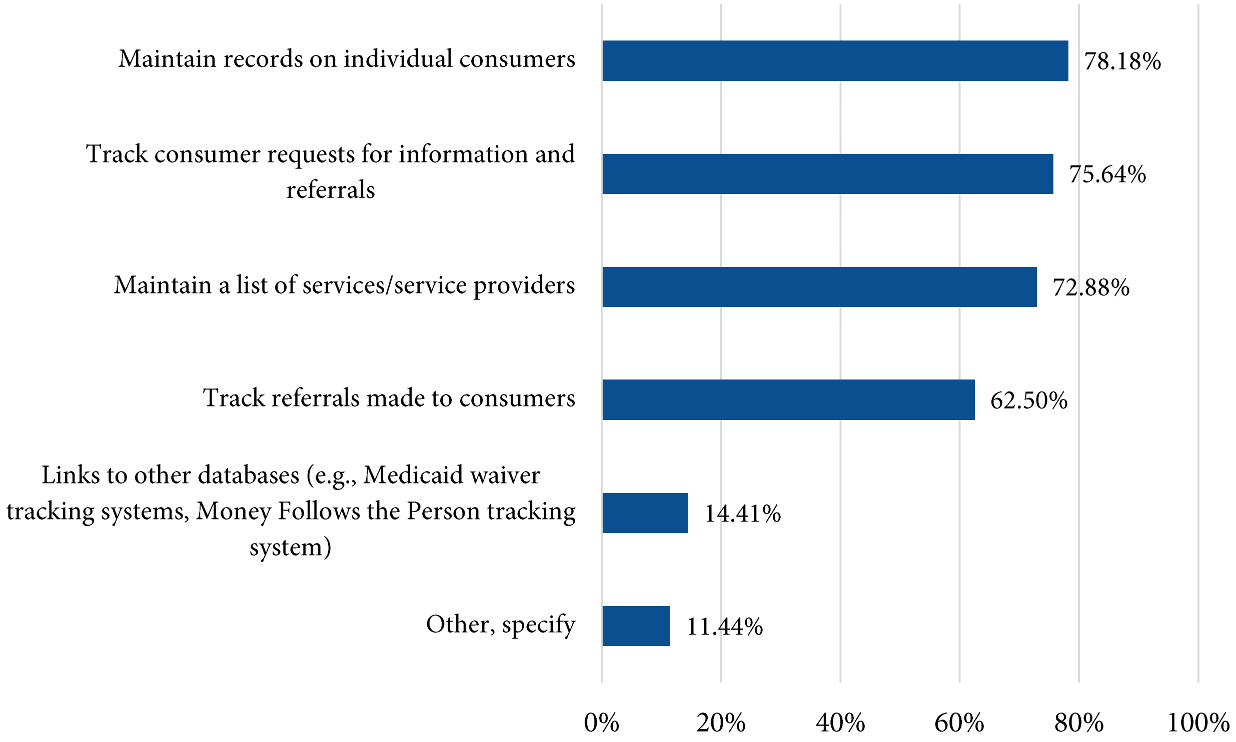
Exhibit 4.75: Use of Alliance of Information and Referral Systems (AIRS) at Local Level

Common Process	Frequency	Percentage
AIRS Standards		
Yes, with all consumers	208	44.07
Yes, with specific groups of consumers	0	0.00
No	129	27.33

Note: Response rate was 71%.

Management of Information Systems (MIS)/Databases. As presented in Exhibit 4.76, the most common use for databases/MIS at local ADRCs was to maintain records on individual consumers, at 78 percent. However, nearly as many local ADRC respondents (76%) indicated that they used databases/MIS to track consumer requests for information and referrals. Eleven percent of local ADRCs reported that their databases/MIS performed “other” functions, such as linking to their state’s Medicaid eligibility system, statewide ADRC database, and 211 system.

Exhibit 4.76: Database/MIS Functionalities at Local Level



Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

When asked about additional technical assistance topics they desired, local ADRC representatives most commonly identified guidance on improving data and systems (see Appendix G, Question 47). Some examples included the need for a standardized database and a desire for training on data collection. One responded stated:

> *"It would be most helpful if the technical assistance provider would be able to assist local ADRCs in establishing a data collection system that reflects the information expected to be reported on within the SART and/or the local National Study Survey."*

There also was a concern about cost and resources required for data collection at the local level. One local-level ADRC respondent said:

> *"We do not track all data the same way it is being asked for in this report. If data needs to be collected differently going forward for accurate reporting, data collection should be designed using this reporting tool as the basis to pull data when needed and data entry should be standardized across the country. The cost borne to make these changes at the local level would be astronomical."*

Standardized Tool for Needs Assessment. Approximately 67 percent of local ADRC representatives reported that they always utilized a standard operating procedure to assess consumer needs, while 20 percent said that they sometimes did (see Appendix F, Question 31b, for details). Similarly, 58 percent of local ADRCs reported having a standardized process or tool to provide options counseling (Appendix F, Question 36). As indicated in Exhibit 4.77, almost 23 percent of local ADRCs reported using the same consumer assessment tools across all partners, and one-fourth mentioned using the same consumer assessment tools across some partners.

Geographic location, organization structure, and operational structure were all significantly linked to whether a consumer assessment tool or process was common across partner organizations. Exhibit 4.78 shows that there was a trend toward significance based on geographic location, with representatives of urban local ADRCs being more likely than representatives of rural sites to report that their consumer assessment tool or process was common across all partners (28% and 19%, respectively; $p \leq .10$). For detailed results, see Appendix L, Exhibit 12. Independent local ADRCs (31%), compared to government sites (24%), were significantly more likely to use the same consumer assessment tools/processes across all partners ($p \leq .01$, Exhibit 4.79), and Exhibit 4.80 illustrates that centralized local ADRCs (64%) were significantly more likely to report that each partner used their own assessment tool/process, compared to mixed (48%) and decentralized (32%) sites ($p \leq .01$). See Appendix M, Exhibit 8, and Appendix N, Exhibit 12, respectively, for details.

Exhibit 4.77: Use of Consumer Assessment Tools at Local Level

Common Process	Frequency	Percentage
Consumer Assessment Tool		
Yes, common across all partners	109	23.09
Yes, common across some partners	118	25.00
No, each partner organization uses their own assessment tool/process	207	43.86

Note: Response rate was 92%.

Exhibit 4.78: Use of Common Consumer Assessment Tool and/or Basic Consumer Needs Assessment across Partner Organizations by Agency Location

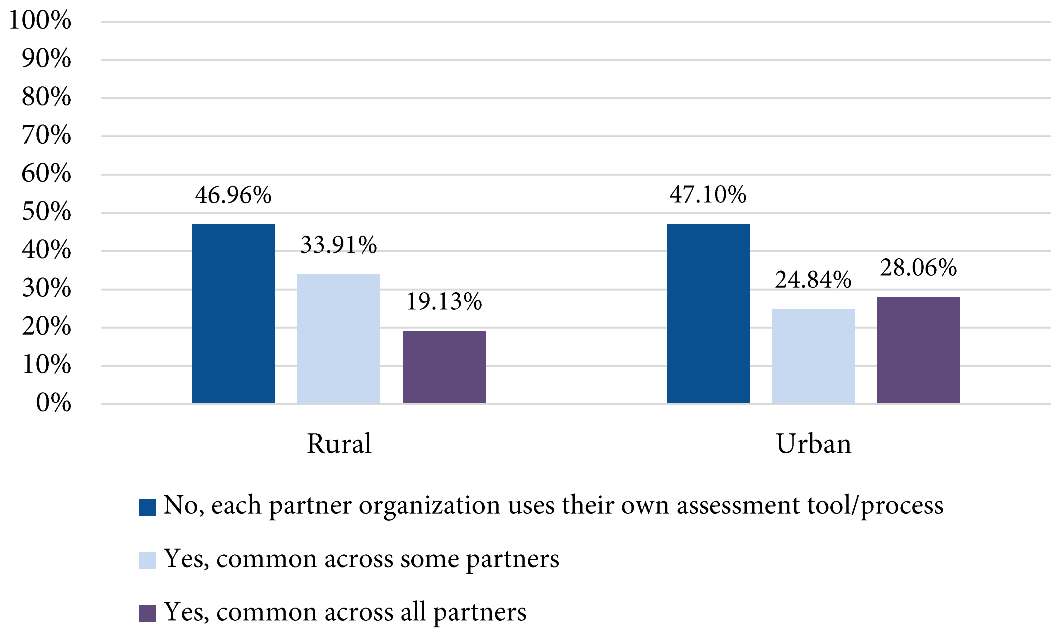


Exhibit 4.79: Use of Common Consumer Assessment Tool and/or Basic Consumer Needs Assessment across Partner Organizations by Organizational Structure

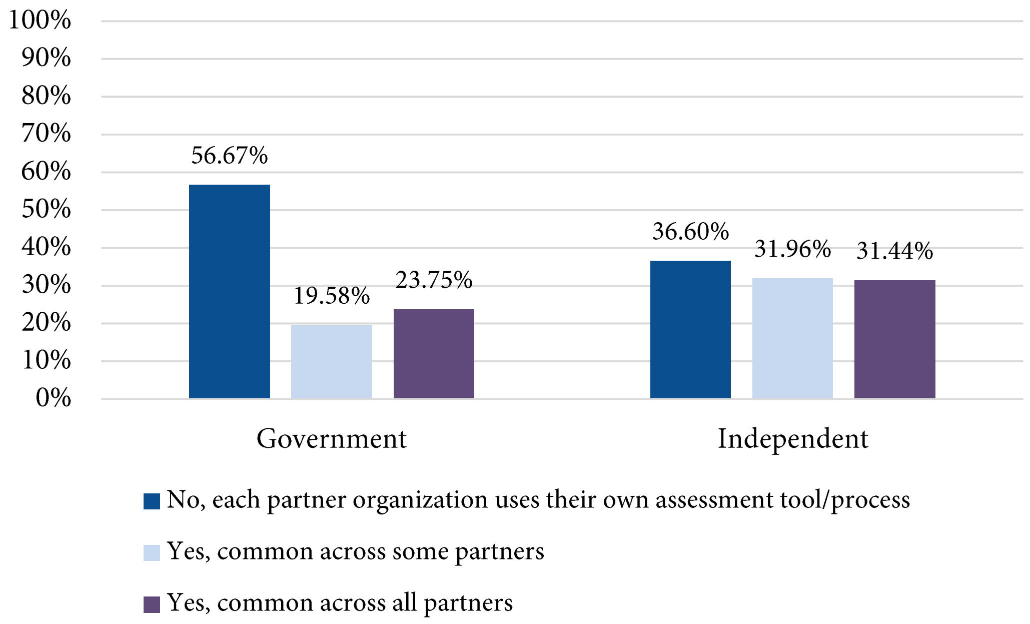
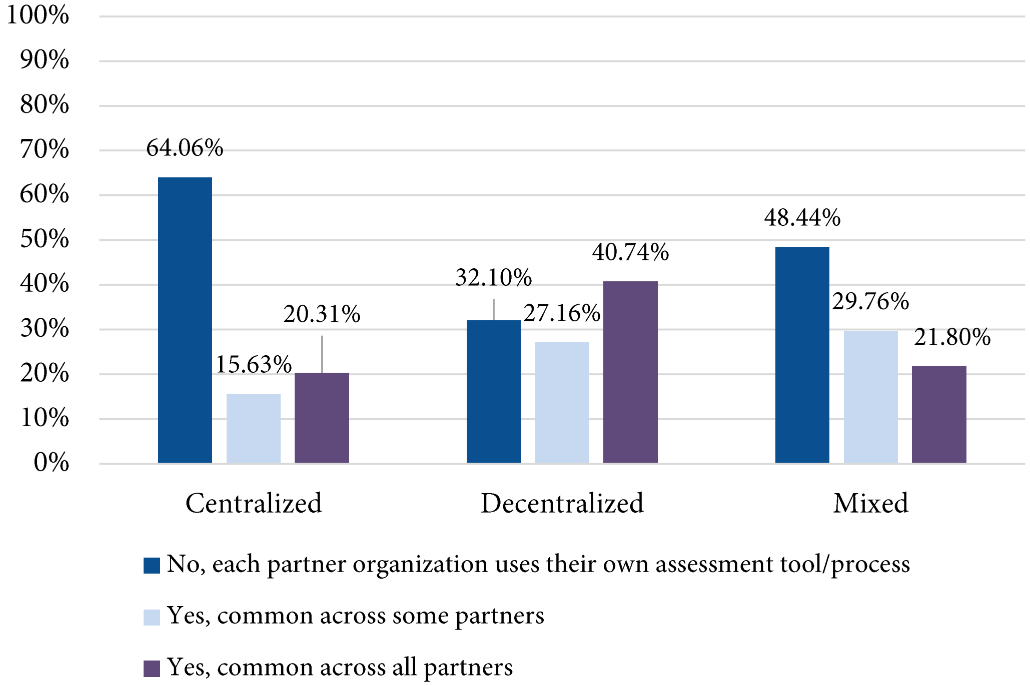


Exhibit 4.80: Use of Common Consumer Assessment Tool and/or Basic Consumer Needs Assessment across Partner Organizations by Operational Structure



Care Plan. Of the 54 percent of local ADRC participants who responded to care plan items, approximately 23 percent said that their agency worked with consumers to develop a care plan, while 31 percent reported that they did not develop care plans with their consumers, as this was not part of their service provision (see Appendix F, Question 55c).

Referrals and Follow Up. Local ADRCs referred a total of 481,797 consumers to public programs such as Medicare, Medicaid, Food Stamps, TANF, and Social Security in the six-month period prior to survey administration. Over the same period, they referred a total of 236,385 consumers to non-public programs and services. Exhibit 4.81 provides the mean, median, mode, and range of both referral types. See Appendix F, Exhibit 34 for additional information. Over the six-month period, local ADRCs referred more clients to public programs than to non-public ones (response rates ranged from 54% to 58%).

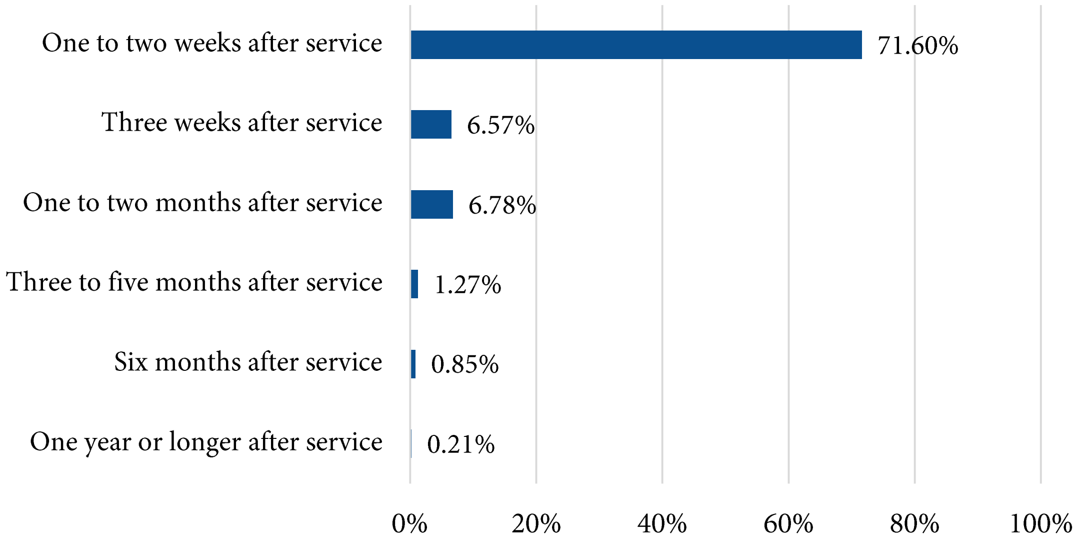
Exhibit 4.81: Consumers Provided Referrals at Local Level by Referral Type

Referral Type	Mean	Median	Mode	Range	
				Min	Max
Public program	1,788	719	500	0	30,864
Non-public program	955	246	10	0	15,968

Note: Response rates to the sub-questions varied between 54% and 58%.

Almost 90 percent of local ADRC respondents reported that the ADRC followed up with consumers (Appendix F, Question 42a). As shown in Exhibit 4.82, 72 percent of them said they had their first follow-up with clients within one to two weeks of service.

Exhibit 4.82: First Follow-up with Consumers at Local Level



Note: Response rate was 87%.

Fifty-eight percent of local ADRC respondents responded to the survey item regarding receiving a "warm transfer"[12] when transferred to another agency. Of the 275 responses, it was revealed 37 percent provided a "warm transfer" on average (range = 0 – 100), and 22 local ADRCs (8%) provided "warm transfers" to all clients (see Appendix F, Question 44 for detail).

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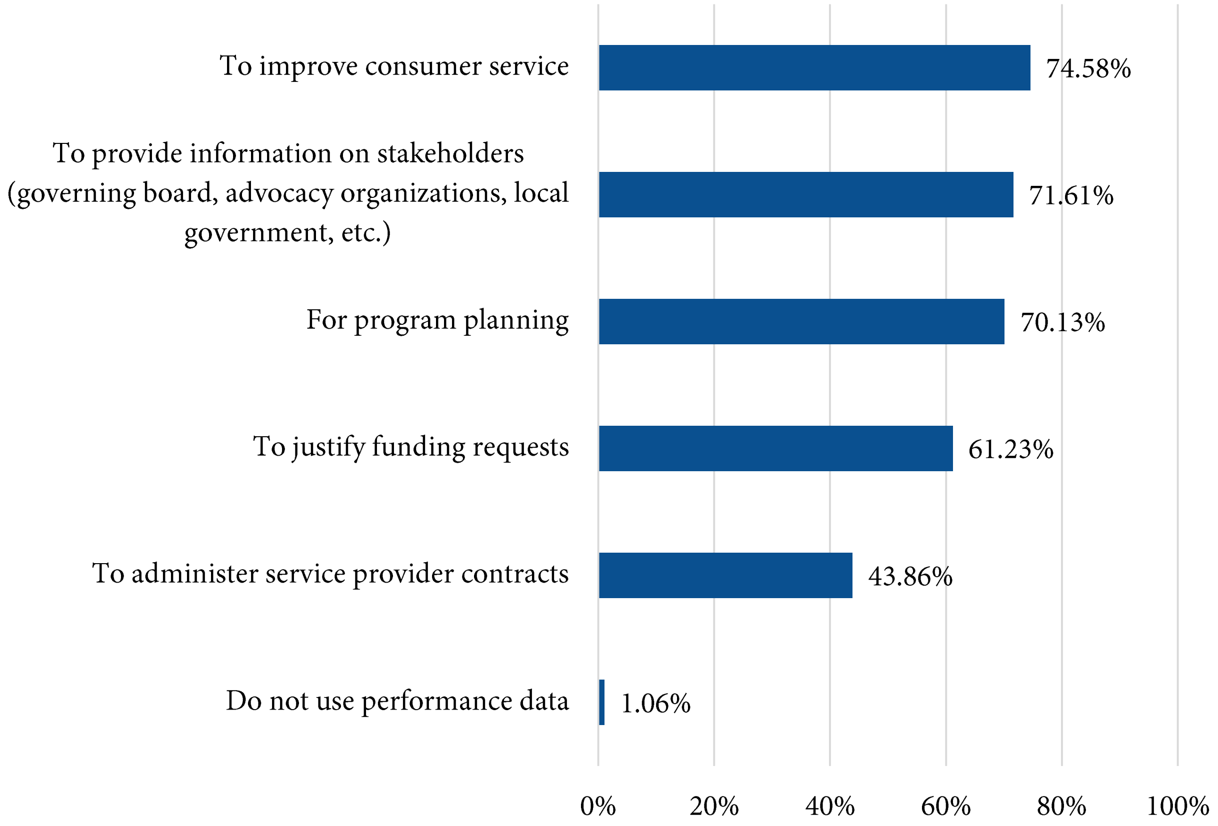
[12] A warm transfer is a simultaneous transfer of a telephone call and its associated data from one agent to another agent or supervisor.

Performance Data. More than two-thirds of respondents from local ADRCs (77%) reported that they routinely collected performance data about their services and consumers (Appendix F, Question 45); they noted several uses for the data. As shown in Exhibit 4.83, respondents most frequently indicated that they used performance data to improve consumer services (75%); only 1 percent reported that they did not use performance data at all.

Exhibit 4.83: Use of Performance Data at Local Level



Notes: Response rate was 79%. Percentages do not add up to 100 because ADRCs could choose multiple options.

4.2.5 Partnerships

Type of Partnerships

Number of Partnerships. Local and state ADRCs have developed a broad range of partnerships including those with federal, state, local, and non-public organizations (for detailed results, see Appendix F, Question 63, and Appendix H, Question 10a, respectively). As reported by respondents, local ADRCs had an average of 16.3 partners (Exhibit 4.84). In addition to indicating the entities with whom they had a partnership, respondents also reported on the functionality of these relationships (see Appendix F, Question 63, and Appendix H, Question 10b, respectively, for detail). Respondents indicated that local ADRCs had an average of 6.4 highly functional partnerships. When comparing this relationship to the mean number of partnerships (16.3), it appears that approximately one-third of the local ADRC partnerships can be considered highly functional.

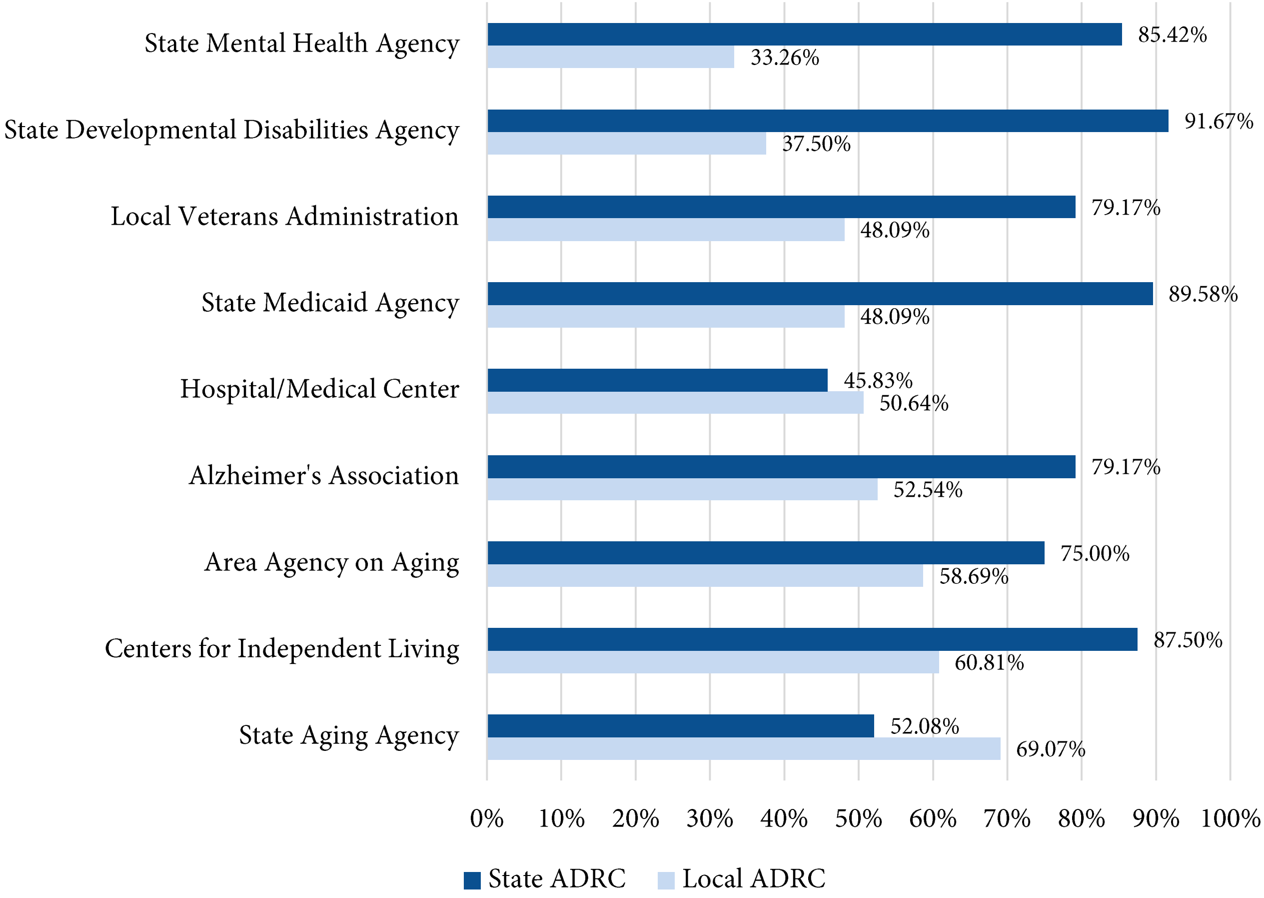
Exhibit 4.84: Number of Partners of Local ADRCs

	Mean	Median	Mode	Range	
				Min	Max
Partnerships*	16.27	15	10	1	42
Highly functional partnerships**	6.38	5	3	0	40

*Response rate is uncertain since “not checked” may indicate no response or no partnership.
**Response rate was 93%.

Common Partnerships. Exhibit 4.85 presents the most frequently cited partnerships among local and state ADRCs. While local and state ADRC respondents reported common partnerships, state ADRC participants reported more partnerships with disability-related organizations, such as state developmental disabilities agencies and state mental health agencies, compared to local ADRCs.

Exhibit 4.85: Most Frequently Cited Partnerships at Local and State Levels



Note: Percentages do not add up to 100 because ADRC respondents could choose multiple options.

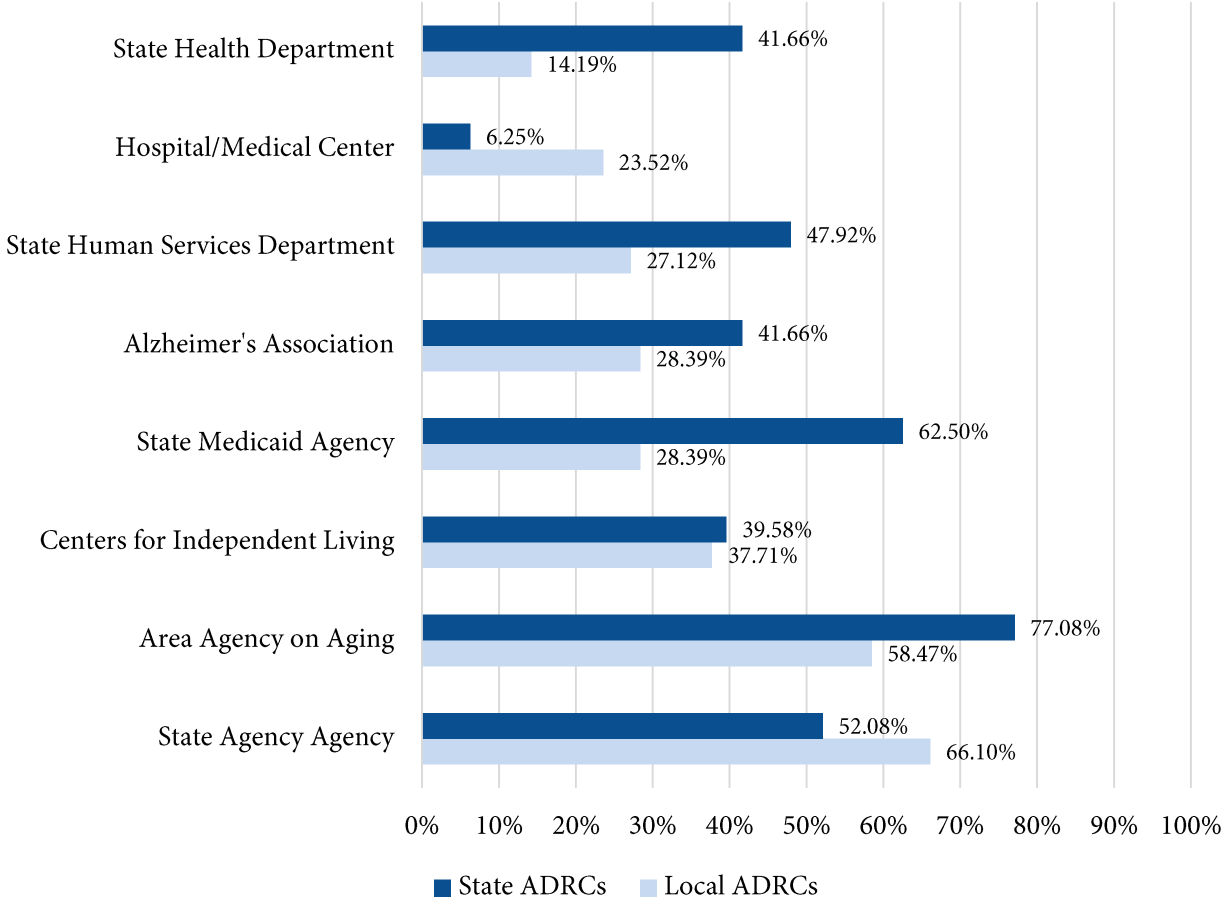
Quality of Partnerships

Exhibit 4.86 shows the most common partnerships with high functionality. Response rates for the sub-questions on functionality varied between 52 percent and 76 percent for local ADRCs and between 54 percent and 96 percent for state ADRCs on the functionality questions.

In general, the most frequently cited partnerships reported by local and state respondents were also the most highly functional. The notable exception was the local Veterans Administration (VA) office. Although both groups reported the local VA as a common partnership, only 16 percent of local ADRCs and 23 percent of state ADRCs considered the partnership with the VA as highly functional. Most local and state sites (28% and 42%, respectively) reported that their relationship with the local VA was functioning at a moderate level.

Interestingly, while respondents did not indicate state human services departments as a common partnership, this partnership ranked in the top seven high functioning partnerships among local and state ADRCs.

Exhibit 4.86: Partnerships with High Functionality at Local and State Levels



Note: Response rates to the local ADRC sub-questions varied between 52% and 76%. Response rates to the state ADRC sub-questions varied between 54% and 96%.

Partnerships by Type of Core Operating Organizations

The most common core operating organization types reported by states were AAA, SUA, and CIL (see Exhibit 4.70). Additional analyses on partnerships were conducted to examine partnership types and quality by these three core operating organization types. Specifically, these additional analyses answered three main questions:

1. Do local ADRCs rate partnerships with their core operating agency as strong, highly functional partnerships?

2. What other organizations do local ADRCs identify as partners outside of their core operating agencies?
3. What is the quality of these partnerships?

To address the first question, Exhibit 4.87 displays the percentage of local sites who rated the partnership with their core operating agency as highly functional and the percentage who rated this partnership as either moderately functional or weak. Results are mixed. The highest percentage of strong partnerships was reported by ADRC sites with SUAs identified as a core operating agency (76% rated partnerships with SUAs as highly functional), followed by sites with AAAs as core operating organizations (66%). Slightly more than half of sites with CILs as core operating partners indicated that this relationship was strong.

Exhibit 4.87: Percentage of Local ADRCs Reporting Highly Functional Relationships with Core Operating Organizations by Core Operating Organization Type

	Strong Relationship with Core Operating Organization	
Core Operating Organization	**Yes**	**No**
Area Agency on Aging	65.9%	34.1%
State Unit on Aging	76.3%	23.7%
Centers for Independent Living	54.6%	45.6%

To address the next two questions, we examined non-core operating organizations identified as partners by local ADRC sites and the percentage of respondents that rated each partnership as highly functional. Exhibit 4.88 presents these results. Overall, a wide range of partnerships was reported. Across all core operating organization types, a majority of respondents identified partnerships with local VAs, SUAs, state and county Medicaid agencies, AAAs, United Way, Alzheimer's associations, and CILs. Those organizations identified as partners by the fewest number of ADRCs included state and county housing offices and county departments on aging. County and state housing offices were also the organizations most commonly rated as moderate or low functioning partnerships. Few strong partnerships were also reported with state mental health agencies, state developmental disability agencies, and vocational or rehabilitation service organizations. Results specific to each type of core operating organization are presented next.

AAA Core Operating Organization Sites. Among ADRCs that identified AAAs as a core operating partner, at least half reported partnerships with nearly all the organizations listed in Exhibit 4.88. The most commonly identified partners included SUAs (85%), CILs (77%), Alzheimer's associations (68%), hospitals/medical centers (67%), and VAs (65%). With the exception of SUA partners, with whom 72 percent of respondents rated partnerships as highly functional, the quality of these partnerships was relatively low. For example, only 30 percent rated partnerships with Alzheimer's associations as highly functional, about a quarter identified hospital partnerships as strong, and only 14 percent reported strong partnerships with the VA. Partners with the lowest percentage of sites rating the partnership as high quality included state departments of mental health (9%), state housing departments (10%), and county housing offices (11%).

SUA Core Operating Organization Sites. The most commonly identified partners for SUA core operating organization sites included CILs and VA (each identified by 78% of local ADRCs), hospitals/medical centers (67%), and state Medicaid agencies (66%). With respect to the quality of these partnerships, less than 40 percent of respondents rated partnerships as highly functional, with the most striking result noted with VAs: Only 19 percent of sites rated the partnership as strong. Partnerships with AAAs were the most commonly reported strong partnership for this group, rated highly functional by 66 percent of local ADRC respondents. Low partnership quality ratings were also seen with mental health agencies (9%) and state and local housing offices (11% and 12%, respectively).

CIL Core Operating Organization Sites. Partnerships with SUAs, AAAs, VAs, and Alzheimer's associations were the most frequently identified among ADRCs with a CIL as a core operating organization. Over 60% of these sites rated partnerships with SUAs and AAAs as highly functional, but far fewer indicated strong partnerships with VAs (15%) and Alzheimer's associations (26%). Of the 50 percent of sites that identified state mental health agencies as a partner, only 9 percent rated this partnership as highly functional; partnerships with state and local housing agencies were also rated poorly by this group.

Exhibit 4.88: Percentage of Organizations Identified as ADRC Partners and Percentage of Partnerships Rated as “Highly Functional” by Core Operating Organization Type

Partners	Core Operating Organizations Identified by ADRCs					
	AAA *N* = 381		SUA *N* = 219		CIL *N* = 205	
	% partner	% strong partnership	% partner	% strong partnership	% partner	% strong partnership
Federal Agencies						
Local Veterans Administration	65.1%	14.4%	77.6%	18.7%	67.3%	15.0%
State Agencies						
Health	46.5%	13.9%	53.0%	16.9%	54.2%	16.1%
Human Services	52.5%	4.5%	61.2%	32.4%	60.5%	30.2%
State Unit on Aging	85.0%	71.7%	86.8%	76.3%	81.0%	64.9%
Developmental Disabilities	51.4%	13.9%	55.7%	17.3%	57.1%	14.6%
Mental Health	46.7%	8.7%	50.7%	9.1%	50.2%	8.8%
Medicaid	61.2%	28.3%	65.8%	34.2%	61.5%	26.8%
Housing	44.9%	9.7%	49.8%	10.5%	51.2%	11.7%
Local Government Agencies						
Area Agency on Aging	74.0%	65.9%	73.1%	65.8%	74.6%	63.9%
County Health Department	60.6%	18.9%	60.7%	20.1%	56.1%	16.6%
County Medicaid Office	58.5%	22.6%	61.2%	29.2%	57.1%	19.0%
County Department on Aging	27.6%	21.8%	27.9%	22.4%	29.3%	23.9%
County Housing Office	37.0%	10.5%	37.0%	11.9%	42.0%	12.7%
Direct Service Organizations						
211 or Other Call Center	54.3%	19.4%	54.8%	19.2%	55.6%	20.4%
Hospital/Medical Center	66.9%	25.5%	67.1%	26.5%	45.4%	25.4%
United Way	55.1%	21.5%	58%	21.5%	57.6%	19.5%
Vocational/Rehabilitation Services	45.1%	14.2%	52.1%	16%	54.6%	19.5%
Advocacy/Referral Organizations						
Alzheimer’s Association	67.7%	30.4%	68.0%	32.4%	65.4%	26.3%
Centers for Independent Living	76.6%	39.9%	77.6%	38.4%	90.7%	54.6%

Data Sharing with Partners

Exhibit 4.89 depicts local ADRCs' current plans to share data with their operational partners and service providers. Almost 23 percent of local ADRC respondents indicated that they shared data with their operational partners, and 24 percent indicated that they shared data with their service providers. Twenty-nine percent and 24 percent indicated that they had plans to share data with their operational partners and service providers, respectively.

Exhibit 4.89: Data Sharing with Partners and Providers at Local Level

	Frequency	Percentage
Operational Partners*		
Yes	107	22.67
No, but there are plans to develop that capacity	135	28.60
No, and there are no current plans to do this	182	38.56
Service Providers**		
Yes	114	24.15
No, but there are plans to develop that capacity	111	23.52
No, and there are no current plans to do this	214	45.34

*Response rate was 89%.
**Response rate was 93%.

Local ADRCs shared data with their operational partners for multiple purposes. Most commonly, respondents indicated that ADRCs provided access to client tracking and demographic information, and some local ADRCs indicated that their service providers had access to consumer data for billing purposes. For details on these analyses, see Appendix G, Question 42a.

4.2.6 Comparison by Core Integration Dimensions

In each of the three sub-sections below, we explore the distribution of the ADRC core measures by subgroups of interest such as location, organizational structure, operational structure, and number of consumers served. We then assess whether or not there are statistically significant differences in the three measures based on key process study variables of interest.

Level of Core Service Provision

Exhibit 4.90 indicates the level of core service provision by ADRC characteristics. Urban ADRCs were more likely than rural ADRCs to have a high level of core provision ($p \leq .05$). Independent ADRCs were much more likely to have a high level of core provision when compared to governmental ADRCs ($p \leq .01$). Further, decentralized ADRCs were significantly more likely than centralized or mixed ADRCs to have a high level of core provision ($p \leq .01$). There was no statistically significant difference among small, medium, and large ADRCs in the level of core service provision.

Exhibit 4.90: Level of Core Service Provision by ADRC Characteristics

	Low Level	Medium Level	High Level
Agency Location**			
Rural	23.93	52.14	23.93
Urban	19.81	42.21	37.99
Total	20.94	44.94	34.12
Organizational Structure***			
Government	21.37	52.56	26.07
Independent	20.79	36.14	43.07
Total	21.10	44.95	33.94
Operational Structure***			
Centralized	22.06	52.94	25.00
Decentralized	12.05	32.53	55.42
Mixed	23.51	46.67	29.82
Total	21.10	44.95	33.94
Number of Consumers*			
0 – 500	20.00	55.00	25.00
500 – 2500	20.00	47.88	32.12
2500+	20.98	40.56	38.46
Total	20.36	46.65	32.99

Note: Results are reported as percentages. *$p \leq .10$, **$p \leq .05$, ***$p \leq .01$.

There were also significant differences in the impact of partnerships based on core service provision, shared data, person-centered services, and federal grants. Specifically, ADRCs with a high level of core service provision were significantly more likely to have partnerships that had an impact on their ability to provide LTSS than ADRCs with low or medium levels of core service provision ($p \leq .01$, Exhibit 4.91). Exhibit 4.92 shows that ADRCs with a high level of core service provision were less likely to indicate that shared data had an impact on their ability to provide

LTSS ($p \leq .01$), while ADRCs with a low level of core provision were statistically significantly less likely to indicate that person-centered services had an impact on their ability to provide LTSS when compared to ADRCs with a medium or high level of core service provision ($p \leq .01$, Exhibit 4.93). Finally, as seen in Exhibit 4.94, ADRCs with high and medium levels of core service provision were statistically more likely than those with low levels to indicate that federal grants had very much or somewhat of an impact on increasing or expanding populations served compared to ADRCs with a low level of core service provision ($p \leq .01$).

Exhibit 4.91: Impact of Partnerships on Ability to Provide LTSS by Level of Core Service Provision

Impact of Partnerships	Low Level	Medium Level	High Level	Total
No	23.91	26.02	12.16	20.87
Yes	76.09	73.98	87.84	79.13
Total	100	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

Exhibit 4.92: Impact of Shared Data on Ability to Provide LTSS by Level of Core Service Provision

Impact of Shared Data	Low Level	Medium Level	High Level	Total
No	70.65	81.63	88.51	81.65
Yes	29.35	18.37	11.49	18.35
Total	100	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

Exhibit 4.93: Impact of Person-Centered Services on Ability to Provide LTSS by Level of Core Service Provision

Impact of Person Centered Services	Low Level	Medium Level	High Level	Total
No	72.83	46.43	53.38	54.36
Yes	27.17	53.57	46.62	45.64
Total	100	100	100	100

Note: Results are reported as percentages. Results are significant at $p \leq .01$.

Exhibit 4.94: Extent to Which Federal Grants Increased/Expanded Populations Served by Level of Core Service Provision

Impact on Populations	Low Level	Medium Level	High Level	Total
Very much	33.73	41.88	50.00	43.03
Somewhat	39.76	46.60	42.96	43.99
Very little	26.51	11.52	7.04	12.98
Total	100	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

Exhibit 4.95 shows that ADRCs with a low level of core service provision were more likely to indicate that they had conducted a community LTSS needs assessment within the past year when compared to ADRCs with a medium or high level of core service provision ($p \leq .10$), and, as seen in Exhibit 4.96, ADRCs with a low or medium level of core service provision were more likely than ADRCs with a high level to indicate that lack of health insurance was a barrier to accessing LTSS ($p \leq .01$).

Exhibit 4.95: Conducted Community LTSS Needs Assessment within the Last 12 Months by Level of Core Service Provision

Conducted Community LTSS Needs Assessment	Low Level	Medium Level	High Level	Total
No, a community needs assessment was not completed within the past three years	28.26	40.53	28.47	33.89
No, but we did complete a community needs assessment within the past three years	30.43	27.89	35.77	31.03
Yes	41.30	31.58	35.77	35.08
Total	100	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .10$.

Exhibit 4.96: Lack of Health Insurance as a Barrier by Level of Core Service Provision

Barrier Level	Low Level	Medium Level	High Level	Total
Often a Barrier	21.43	21.58	22.46	21.84
Sometimes a Barrier	69.05	72.11	58.70	66.99
Not a Barrier	9.52	6.32	18.84	11.17
Total	100	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

In Exhibit 4.97, we see that ADRCs with a high level of core service provision were more likely to indicate that diversion from a nursing home was sought and that ADRCs with a high level of core service provision were more likely to provide care transition services when compared to ADRCs with a low or medium level ($p \leq .05$, $p \leq .01$, respectively). Also, representatives of ADRCs with medium and high levels of core service provision were significantly more likely to indicate that their ADRC provided options counseling when compared to ADRCs with low levels of core service provision ($p \leq .01$, Exhibit 4.97).

Exhibit 4.97: Provision of Diversion, Transition Services, and Options Counseling by Level of Core Service Provision

	Low Level	Medium Level	High Level	Total
Diversion from Nursing Home**				
No	6.52	8.85	2.04	6.03
Yes	93.48	91.15	97.96	93.97
Total	100.00	100.00	100.00	100.00
Transition Services***				
No	80.90	100.00	0.00	61.18
Yes	19.10	0.00	100.00	38.82
Total	100.00	100.00	100.00	100.00
Options Counseling***				
No	93.48	0.00	0.00	19.72
Yes	6.52	100.00	100.00	80.28
Total	100.00	100.00	100.00	100.00

Note: Results are reported as percentages.
$^{**}p \leq .05$, $^{***}p \leq .01$

Extent of Site Integration

Statistically significant differences were not found for the extent of site integration based on geography, organizational type, operational structure, or ADRC size. Exhibit 4.98 provides descriptive statistics for each of these domains.

Exhibit 4.98: Extent of Site Integration by ADRC Characteristics

	Low Level	Medium Level	High Level
Agency Location			
Rural	16	76	8
Urban	11.57	78.36	10.07
Total	12.77	77.72	9.51
Organizational Structure			
Government	12	79.5	8.5
Independent	13.56	76.27	10.17
Total	12.73	77.98	9.28
Operational Structure			
Centralized	12.07	81.03	6.9
Decentralized	8.7	73.91	17.39
Mixed	14	78.4	7.6
Total	12.73	77.98	9.28
Number of Consumers			
0 to 500	20	55	25
500 to 2500	20	47.88	32.12
2500+	20.98	40.56	38.46
Total	20.36	46.65	32.99

Note: Results are reported as percentages. No results are statistically significant.

In contrast, staffing changes, data sharing, and person-centered services were significantly related to the extent of site integration. Exhibit 4.99 shows that ADRCs with a low level of site integration were statistically more likely to indicate that staffing changes did not have an impact on their ability to provide LTSS, as compared to ADRCs with a medium or high level of site integration ($p \leq .05$). Further, ADRCs with a high level of site integration were statistically less likely to answer that shared data had an impact on their ability to provide LTSS ($p \leq .05$) than those with a low or medium level (Exhibit 4.99), and ADRCs with a low level of site integration were statistically less likely to indicate that person-centered services had an impact ($p \leq .05$, Exhibit 4.99).

Exhibit 4.99: Factors Contributing to Provision of LTSS by Extent of Site Integration

	Low Level	Medium Level	High Level	Total
Impact of Staffing Changes**				
No	89.58	72.79	74.29	75.07
Yes	10.42	27.21	25.71	24.93
Total	100	100	100	100
Impact of Shared Data**				
No	68.75	82.31	91.43	81.43
Yes	31.25	17.69	8.57	18.57
Total	100	100	100	100
Impact of Person-Centered Services**				
No	70.83	52.04	40.00	53.32
Yes	29.17	47.96	60.00	46.68
Total	100	100	100	100

Note: Results are reported as percentages.
**$p \leq .05$

Statistically significant relationships were demonstrated between the effect of federal grants on populations served by ADRCs and the extent of site integration. For example, ADRCs with medium and high levels of site integration were more likely than those with a low level to indicate that federal grants helped to expand the populations served "very much" or "somewhat" ($p \leq .05$, Exhibit 4.100). Exhibit 4.100 shows that ADRCs with a low level of site integration were much less likely to indicate that federal grants had "very much" increased the number of consumers when compared to ADRCs with a high or medium level of site integration ($p \leq .05$), and ADRCs with a high level of site integration demonstrated a trend toward significance in that they were more likely to respond that grants "very much" increased the number of partners when compared to responses from ADRCs with medium and low levels of site integration ($p \leq .10$, Exhibit 4.100).

Exhibit 4.100: Impact of Federal Grants by Extent of Site Integration

	Low Level	Medium Level	High Level	Total
Impact on Populations**				
Very much	31.11	43.11	64.71	43.65
Somewhat	53.33	43.82	35.29	44.2
Very little	15.56	13.07	0.00	12.15
Total	100	100	100	100
Impact on Number of Consumers**				
Very much	27.27	46.32	53.13	44.6
Somewhat	61.36	41.75	46.88	44.6
Very little	11.36	11.93	0.00	10.8
Total	100	100	100	100
Impact on Number of Partners*				
Very much	55.56	55.52	64.71	56.39
Somewhat	44.44	34.88	35.29	36.11
Very little	0.00	9.61	0.00	7.5
Total	100	100	100	100

Note: Results are reported as percentages.
$*p \leq .10$, $**p \leq .05$

In the final set of site integration analyses, results showed that ADRCs with a low level of site integration were less likely to indicate that diversion was sought when compared to ADRCs with either a medium or high level ($p \leq .10$, Exhibit 4.101), and ADRCs with a high level of site integration were more likely to provide care transitions services than those with low and medium site integration ($p \leq .01$, Exhibit 4.101). Further, ADRCs with medium and high levels of site integration were statistically more likely to indicate that they provided options counseling compared to ADRCs with low levels of site integration ($p \leq .01$, Exhibit 4.101).

Exhibit 4.101: Provision of Diversion, Transition Services, and Options Counseling by Extent of Site Integration

	Low Level	Medium Level	High Level	Total
Diversion from Nursing Home*				
No	12.77	4.81	2.94	5.65
Yes	87.23	95.19	97.06	94.35
Total	100	100	100	100
Transition Services***				
No	95.83	64.69	2.86	62.87
Yes	4.17	35.31	97.14	37.13
Total	100	100	100	100
Options Counseling***				
No	66.67	12.93	0	18.57
Yes	33.33	87.07	100	81.43
Total	100	100	100	100

Note: Results are reported as percentages.
*p ≤ .10, ***p ≤ .01

Status of Medicaid Integration

In the following exhibit, we present the findings from the analyses of Medicaid integration by the key domains of interest. From Exhibit 4.102, we see that the urbanicity of the service areas of ADRCs was not significantly associated with their Medicaid integration status. However, independent ADRCs were more likely to be Medicaid integrated, compared to government run ADRCs, at a statistically significant level (*p* ≤ .05). Further, decentralized ADRCs were more likely to be Medicaid integrated than centralized or mixed ADRCs, with mixed ADRCs being the least likely to be Medicaid integrated (*p* ≤ .01). Exhibit 4.102 shows no statistically significant association between Medicaid integration and the number of ADRC consumers.

Exhibit 4.102: Status of Medicaid Integration by ADRC Characteristics

	Not Medicaid Integrated	Medicaid Integrated
Agency Location		
Rural	62.79	37.21
Urban	58.43	41.57
Total	59.65	40.35

	Not Medicaid Integrated	Medicaid Integrated
Organizational Structure**		
Government	63.77	36.23
Independent	54.59	45.41
Total	59.75	40.25
Operational Structure***		
Centralized	54.17	45.83
Decentralized	45.88	54.12
Mixed	64.76	35.24
Total	59.75	40.25
Number of Consumers		
0 – 500	61.9	38.1
500 – 2500	56.73	43.27
2500+	51.7	48.3
Total	55.97	44.03

Note: Results are reported as percentages.
**$p \leq .05$, ***$p \leq .01$

Respondents from ADRCs that were Medicaid integrated were less likely to respond that shared data had an impact on their ability to provide LTSS ($p \leq .10$, Exhibit 4.103), and, as seen in Exhibit 4.104, respondents from ADRCs that were Medicaid integrated were more likely to indicate that person-centered services had an impact on the provision of LTSS than ADRCs that were not Medicaid integrated ($p \leq .01$).

Exhibit 4.103: Impact of Shared Data on Ability to Provide LTSS by Level of Medicaid Integration

Impact of Shared Data	Not Medicaid Integrated	Medicaid Integrated	Total
No	78.01	87.37	81.78
Yes	21.99	12.63	18.22
Total	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

Exhibit 4.104: Impact of Person-Centered Services on Ability to Provide LTSS by Level of Medicaid Integration

Impact of Person Centered-Services	Not Medicaid Integrated	Medicaid Integrated	Total
No	60.64	46.32	54.87
Yes	39.36	53.68	45.13
Total	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

Exhibit 4.105 shows that, compared to ADRCs that were not Medicaid integrated, ADRCs that were integrated were significantly more likely to indicate that federal grants had “very much” of an impact on expanding populations they served ($p \leq .01$), and they said that their consumers requested services pertaining to Medicare eligibility “sometimes” ($p \leq .10$, Exhibit 4.106). Respondents from Medicaid integrated ADRCs were slightly more likely to indicate that diversion was sought compared to those who were not Medicaid integrated ($p \leq .10$, Exhibit 4.107), while they were significantly more likely to offer care transition services when compared to ADRCs who were not Medicaid integrated ($p \leq .01$, Exhibit 4.107). Finally, Exhibit 4.107 shows that respondents from integrated ADRCs were also much more likely to indicate that they provided options counseling services compared to non-integrated ADRCs ($p \leq .01$).

Exhibit 4.105: Extent to Which Federal Grants Increased/Expanded Populations Served by Level of Medicaid Integration

Impact on Populations	Not Medicaid Integrated	Medicaid Integrated	Total
Very much	36.60	51.09	42.54
Somewhat	46.04	40.22	43.65
Very little	17.36	8.70	13.81
Total	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .01$.

Exhibit 4.106: Frequency of Consumer Requests about Medicare Eligibility by Medicaid Integration

Medicare Eligibility and Services	Not Medicaid Integrated	Medicaid Integrated	Total
Frequently	83.62	82.11	82.94
Sometimes	12.07	16.84	14.22
Infrequently	4.31	1.05	2.84
Never	0.00	0.00	0.00
Total	100	100	100

Note: Results are reported as percentages. Results are statistically significant at $p \leq .10$.

Exhibit 4.107: Provision of Diversion, Transition Services, and Options Counseling by Status of Medicaid Integration

	Not Medicaid Integrated	Medicaid Integrated	Total
Diversion from Nursing Home*			
No	7.52	3.72	5.95
Yes	92.48	96.28	94.05
Total	100	100	100
Transition Services***			
No	66.92	51.61	60.54
Yes	33.08	48.39	39.46
Total	100	100	100
Options Counseling***			
No	27.41	9.63	19.96
Yes	72.59	90.37	80.04
Total	100	100	100

Note: Results are reported as percentages.
$*p \leq .10$, $***p \leq .01$

4.3 Process Study Discussion and Implications

This process study examined site-level organizational, community, service, and partnership characteristics of ADRCs to gain an understanding of differences and similarities in ADRC operations nationally. The study included two types of ADRC respondents: state-level ADRCs and local ADRC sites that serve specific geographic areas (e.g., counties) within a state.
Forty-eight state-level ADRC sites and 472 local ADRC sites participated in this process study by providing responses to a web-based survey fielded from April 1, 2013, through August 16, 2013. Descriptive and bivariate subgroup analyses were used to interpret the data.

This section of the report summarizes key findings and discusses implications within the following areas:

- Motivation to become an ADRC
- Diversion as outcome
- Funding
- Community and consumer information
- Key services provided
- Partnerships
- Comparison by core integration dimensions of ADRC operations: service provision, site integration, and Medicaid integration

4.3.1 Motivation to Become an ADRC

The purpose of an ADRC is to serve as an integrated point of entry (so that there is "no wrong door" nor a single point of entry) to long-term services and supports. ADRCs are designed to meet the needs of consumers and caregivers for information, services, and supports. According to a 2006 ADRC Technical Assistance Exchange report, the integration of LTSS by the ADRCs "create[s] community-wide service systems that reduce consumer confusion and build consumer trust and respect by enhancing individual choice and informed decision-making. This strategy can also help to break down barriers to community-based living by giving consumers information about the complete spectrum of long-term care options."[13]

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[13] The Lewin Group (2006). The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative: Interim Outcomes Report. Retrieved from http://www.adrc-tae.acl.gov/documents/InterimReport.pdf.

Given the purpose of an ADRC, it is not surprising that over 90 percent of state ADRC respondents identified “better integrate the delivery of LTSS for aging and disability populations” and “develop or strengthen partnerships with community providers” as rationales for applying for ADRC grant funding; from the local-site ADRC perspective, these were also the two most frequently cited reasons for becoming an ADRC. Increasing LTSS marketing and awareness, improving data/IT infrastructure, and expanding services to different populations were also cited as motivations for becoming an ADRC by a majority of state ADRC respondents, but markedly less so for local ADRC sites. Expanding to additional geographic locations was identified as a goal by only 37 percent of state ADRCs and less than 1 percent of local sites.

When asked to identify criteria used in selecting which local entities would be tapped to receive grant funding and become a local ADRC, over 68 percent of state-level respondents selected AAAs that were already in existence and 35 percent selected other organizations currently serving older adults, while fewer respondents identified other criteria, such as entities that were already serving disabled groups or organizations that were already considered “integrated” in providing access to LTSS.

Taken together, these findings suggest that primary drivers for seeking ADRC grant funding and establishing ADRC sites were more strongly related to strengthening the LTSS network within the state through the aging network, rather than increasing the reach of existing organizations.

4.3.2 Diversion as an Outcome

Preventing or delaying Medicaid spend-down and admission into nursing homes and other institutional care settings remains an important goal of AoA and ACL programs and activities. Improving access to LTSS options throughout the community and within individuals’ preferred care setting continues to be an express objective of the ADRC program. This mission is strongly reflected in the process study findings, as 91 percent of local-level ADRCs indicated that diversion from nursing homes or other institutional residential care facilities was an outcome their agency sought to achieve. Closer examination of subgroups of local ADRCs shows that centralized ADRCs were significantly less likely to identify diversion as an outcome sought (82%) compared to decentralized (96%) or mixed (96%) ADRCs; significantly fewer small ADRCs identified diversion as an outcome (86%) compared to large (97%) and medium (95%) ADRCs.

As centralized ADRCs are often hallmarked by one organization performing all ADRC functions and services, with less reliance on partners for assistance beyond referrals, there may be an opportunity to effectively target centralized ADRCs to reaffirm the importance of diversion as an outcome and provide support on how to achieve this goal. The same may also apply to smaller ADRCs, which may have fewer resources (or fewer perceived resources) to allocate to diversion.

It is important to note that, while these results are statistically significant, substantially, the vast majority of all types of ADRCs still indicate a commitment to diversion.

4.3.3 Impacts of ADRC Grant Funds and Sources of Funding

Impact of ADRC Grant Funding on Services. As discussed above, better integration of LTSS delivery was cited as a motivation for becoming an ADRC. Findings from this process study suggest that this goal is being achieved, as 95 percent of local-level ADRC respondents reported that their organization saw an improvement in their ability to provide integrated, comprehensive access to LTSS since receiving the ADRC grant. With regard to impact on services at the state level, state ADRC respondents rated strong progress in improving information, referral, and awareness of LTSS programs and good progress in improving options counseling and person-centered transition support since the receipt of ADRC development grant dollars. More neutral ratings of progress were noted, however, in improving streamlined eligibility determination. The lower rating of progress in streamlined eligibility determination may be related to the more external nature of that particular service, as cooperation with other state agencies is necessary, while the other service areas are more endogenous to the ADRC organization.

Impact of ADRC Grant Funding on Operational Outcomes. When asked to identify ways in which the ADRC grant program has had an impact, increasing the number of partnerships and increasing staff skills were the two most commonly identified outcomes reported by both state and local ADRC respondents. Approximately one-half of state ADRCs identified increases in the number of consumers served, populations served, and range of services offered, while 31–42 percent of local ADRCs identified these impacts. Only 19 percent of state-level and 13 percent of local ADRC respondents felt that the grant helped to recruit or attract more experienced staff. It is important to note that for this survey item, states were asked to identify the most significant impact, whereas local ADRCs were able to choose all that applied.

Impact on Resources. Seventy-five percent or more of state-level respondents reported increased coordination between aging and disability agencies, improved staff training opportunities, improved awareness and marketing, and increased service efficiency since the receipt of an ADRC grant; a slightly lower percentage (at least 64%) of local-level respondents also identified these positive impacts of the ADRC grant program on resources. Leveraging other funding was identified as an impact on resources by 60 percent of state ADRCs and 37 percent of local-level ADRCs, while contributing to the development of a statewide database of LTSS services or consumers was identified as an impact by 54 percent of state-level and 36 percent of local-level respondents.

With regard to this last issue, development of a statewide LTSS database, results indicated that *rural*, *government-run* (compared to independent ADRCs), and *large* local ADRCs (those serving 2500+ clients) were statistically significantly more likely to have reported database development as a function of receiving ADRC grant funds. This is an interesting finding to explore in more depth to determine if such databases for these groups were already in place, whether these ADRCs received specific funds other than the ADRC grant money earmarked to develop such databases, or whether databases have been a low-priority area for these types of ADRCs. Maintaining an up-to-date and accurate database of LTSS services is an important facet of service delivery for ADRCs.

Impact on LTSS and HCBS in the Community. Over 70 percent of local-level ADRC agency respondents reported positive impacts on LTSS in their communities since becoming an ADRC, attributable to increased numbers of LTSS providers and improved quality of LTSS services provided. However, after a closer review of the results, these positive impacts differed between institutional services and HCBS. Services most often associated with community-based living and requested most often by consumers, transportation and housing, were reported to be most often inadequately available. This was in contrast to nursing home bed availability, which was reported to have increased since the inception of the ADRCs. These findings are mixed; inadequacy of services essential to remaining in the community, such as transportation and housing, remains a problem for areas served by ADRCs. Yet an increase in the number of nursing home beds may indicate success in transitioning people out of such institutional environments and into community-based settings.

Impact on Consumers Served. Over 60 percent of local-level ADRC respondents reported that, since the beginning of the ADRC grant funding, the number of consumers 60 and older, under 60, and with physical disabilities increased; 52 percent reported that the number of persons with mental disabilities increased. These results are promising in demonstrating that persons with disabilities are becoming more integrated into ADRC services, but more effort is needed to ensure ADRCs are breaking down the traditional silos and truly providing access to LTSS for persons of *all* ages, and *all* disability types.

When asked to indicate operational factors that most positively impacted their ability to provide integrated, comprehensive access to LTSS, 78 percent of local-level ADRC respondents selected partnership development/expansion; 45 percent chose having an explicit focus on person-centered, self-directed services; 24 percent chose staffing changes; and 18 percent indicated shared data as a factor with positive impacts. This finding highlights the importance of partnerships in the ability of ADRCs to achieve their mission, beyond factors more related to changes in daily operations and mission.

Examining this result more closely shows that urban, decentralized, and large local-level ADRCs were significantly more likely to report partnerships as a positive impact (81% or higher). In many ways this finding is expected, as more partnerships may be available in urban areas compared to rural areas, and larger, decentralized models may have more resources to develop and expand these partnerships. It is important to note, however, that between 70 and 75 percent of rural, centralized or mixed, and small and medium-sized local-level ADRCs also reported partnership creation/expansion as an impact, so there may be other unmeasured organizational characteristics influencing the positive effects of partnerships on ADRC services.

State-level respondents were also asked to rate the degree of importance that each operational factor had in improving access to LTSS in their states. Ninety-four percent rated partnerships as important or very important; this corresponds to the role of partnerships as perceived by local-level respondents discussed above. However, 79 percent of state-level respondents rated staffing as important or very important, and 65 percent rated shared data systems as such, while only 24 percent of local-level respondents reported staff changes as a positive impact, and only 18 percent reported shared data as a positive impact. This discrepancy may have implications in resource allocation or prioritization of focus areas as emphasis is placed on staffing and implementing shared data systems. More work is needed to understand why so many fewer local ADRCs found staffing and shared data important, compared to the value of these factors perceived at the state level.

Funding Sources. Sustainability in funding is a critical aspect to ADRCs' success. Findings from this process study show reliance on multiple funding sources, suggesting that, over the past year, local ADRCs expanded their funding networks: The median number of funding sources in 2013 was four, compared to three sources in prior fiscal years. Nearly half of local ADRCs indicated their state unit on aging (SUA) as a funding source, and around one-third of respondents identified local county or "other" sources as funders. Approximately 28 percent identified state general funds as a source of funding, and a quarter reported receiving AoA Title IV ADRC grants.

At the state level, state general revenue was the most commonly selected source of funding (67%), followed closely by AoA Title IV ADRC grants (65%); SUAs were also important to this group, as nearly 48 percent identified SUAs as funding sources. Money Follows the Person demonstration funds were identified by 38 percent of state-level respondents as well, but only 8 percent named Medicare Improvements for Patients and Providers Act as a source. "Other" sources such as OAA Title III-B and local grants were identified by 27 percent.

The greater reliance on federal funds reported by state ADRCs compared to local-level respondents was expected; however, examination of funding sources identified for fiscal year 2013 and those identified for prior fiscal years shows a consistent decrease in the percentage of respondents in both groups in identification of federal sources of funding and increases in the percentages of respondents identifying state and local funding sources. This suggests that state and local ADRCs alike may be becoming less reliant on federal monies to continue operating and providing services. From the federal perspective, this may be a promising finding, as the intent of establishing ADRCs across the country included achieving financial sustainability. However, in the context of constricting state resources, ADRC sites may be feeling negative implications of this possible shift in funding. Regardless, these findings highlight the importance of the federal-state-local partnerships that the ADRC initiative has encouraged.

4.3.4 Community Characteristics and Consumer Information

The national process study measured community service capacity characteristics for both state and local ADRCs, including needs assessments, availability of LTSS, and barriers to service, as well as community populations and consumer characteristics including demographics, health insurance status, poverty, and most frequently sought services.

LTSS Needs Assessment. State and local ADRCs were both asked to indicate whether an assessment for LTSS needs had been conducted within the past year or whether such an assessment was planned. Thirty-three percent of local-level respondents and 25 percent of state-level respondents indicated that a statewide LTSS needs assessment had been conducted within the past 12 months, and an additional 7 percent of state ADRCs reported that LTSS needs had been assessed in some, but not all, communities within the state. Nearly 30 percent of local-level and 21 percent of state-level respondents reported that needs assessments had been done within the past three years. These findings are encouraging, as they demonstrate that a majority of respondents have prioritized assessments and planning.

However, nearly 44 percent of state ADRC respondents and 32 percent of local ADRCs indicated that needs assessments had not been completed. Closer examination of subgroups reveals that urban and small ADRCs were less likely to have completed a needs assessment at all. LTSS needs assessments can provide ADRC programs with hard data and information about the community that are useful not only for planning purposes but also in working with legislatures to secure needed funds in prioritized areas; results from this study indicate that many states and communities may need additional support to gather such data and complete assessments, particularly urban and smaller ADRCs that may have fewer resources.

LTSS Availability in the Community. Respondents were asked to indicate availability of services at the state and local levels. With regard to services that were adequately available, nearly 70 percent of local-level and 54 percent of state-level respondents indicated that ombudsman services were adequate; however, the additional services that state ADRCs and local ADRCs reported as adequate differed between the groups. For example, about 60 percent or fewer of local-level respondents indicated adequacy in education services, nutrition programs, and opportunities to develop advance directives, while state-level respondents identified adequacy in assisted living, socialization/recreation programs, and peer support services. This result suggests that there may be conflicting perceptions of service adequacy, which could have potential implications in service planning and resource allocation.

There was more agreement between state- and local-level respondents with regard to services that were deemed inadequate. Both groups indicated inadequacy in mental health services (85% state-level, 80% local-level), safe and affordable housing options (93% state-level, 84% local-level), and transportation services (86% state-level, 88% local-level). Looking more closely at subgroups, we see that rural local ADRCs were significantly more likely to report transportation inadequacy compared to urban ADRCs, and urban ADRCs were significantly more likely to consider mental health services to be inadequate. These results are not surprising, given the more acute need for transportation infrastructure in rural areas and the higher density of population with mental health needs in urban centers.

Barriers to Services. There was again commonality in factors identified to be barriers to service between local and state ADRC respondents. At least 79 percent of respondents from both groups rated transportation, lack of needed LTSS services, lack of health insurance, and high provider staff turnover as barriers to consumers receiving LTSS. Transportation was the most often indicated barrier, chosen by 96 percent of state and 92 percent of local ADRCs, with no significant difference between rural and urban respondents. At the state level, 79 percent of respondents identified providers not accepting Medicaid as a barrier, and 77 percent indicated problems associated with persons in need of services not having a permanent address. Taken together, these findings suggest that solutions to improving the service environment for individuals in need of LTSS must be multi-faceted and must focus not only on infrastructure (such as increasing transportation options), but also on working with Medicaid and other health insurance systems and on bringing providers on board to acknowledge the importance of their operations (including staff turnover) for service delivery.

Community Populations. When asked to characterize racial and ethnic community composition, on average, respondents indicated that their communities included a majority Caucasian/White population, with Black/African Americans constituting the next-highest group, followed by much smaller segments of Asian, American Indian or Alaska Native, and Native Hawaiian or other Pacific Islanders. On average, respondents reported 91 percent non-Hispanic and 9 percent Hispanic communities. Respondents were provided the option to identify other significant racial/ethnic subpopulations in their areas. Some of the responses provided included cultural groups such as Hmong, Amish, and Middle Eastern, as well as LGBT groups.

Respondents indicated that an average of 17 percent of their local community members lived in poverty; an additional 31 percent reported that they were unsure of the percentage but believed that a significant proportion of their communities experienced poverty. Similarly, respondents estimated that, on average, 15 percent of the local population was uninsured, and 50 percent believed lack of insurance coverage was a significant issue although the exact prevalence of uninsured persons was unknown. No differences were found between ADRC subgroups in these areas. These data show the importance of local ADRCs understanding the context within which they operate and ensuring that outreach, materials, and the like are designed to consider diverse groups.

Consumer Characteristics. In addition to the local communities within which ADRCs operate, discussed in the section above, the process study also inquired about the backgrounds of clients served by the ADRC, including age and disability status. Data show that the majority of persons served were either adults aged 60 years or older or caregivers for persons 60+; this was true for persons with all different types of disabilities, with the exception of those with developmental disabilities—more younger persons were served within this group. The most frequently reported disability group served by local ADRCs was persons with physical disability.

The study also captured which services were most frequently requested by consumers at the local ADRCs. Transportation was the most commonly reported service (identified by 80% of local ADRCs) across all subgroups, followed closely by requests for Medicaid and Medicare eligibility determination (79% and 74%, respectively). About 70 percent of respondents identified affordable housing as a frequently requested service; subgroup analyses show that decentralized and urban local ADRCs were more likely than centralized or mixed ADRCs and rural ADRCs to report this particular service. Interestingly, transportation and housing were identified by respondents as the most inadequately available services. As these are also frequently requested, the study findings point to the critical role that transportation and housing play in the LTSS continuum and the importance of ensuring adequate supply at the state and federal levels.

4.3.5 Key Services Provided

Recognizing that the ADRC initiative attempts to increase awareness of and access to LTSS through three key service areas, the study also assessed the provision of options counseling, care transitions, and Medicaid eligibility determination, as well as how these services were provided at the site level.

Options Counseling. Over three-quarters of local ADRC respondents reported that they provided options counseling services, and decentralized ADRCs were significantly more likely than centralized or mixed-model ADRCs to do so. This interesting finding may reflect greater commitment, increased resources, or more efficiently shared resources from multiple core partner organizations in decentralized ADRCs. Further investigation is needed to determine why some local ADRCs did not provide options counseling and what characteristics of centralized or mixed-model ADRCs influence the ability to do so.

Across all groups, respondents reported providing options counseling to significantly older clients than to those under age 60. This may reflect different needs of each age group, but it potentially also signals a need to more closely examine triggers for options counseling and ensure younger consumers are receiving appropriate counseling.

Care Transitions. Care transition services refer to intensive efforts to reach out to and support individuals who are being discharged from acute care settings back into the community. The goal is to ensure that patients understand and adhere to discharge and self-care instructions, follow up appropriately with care providers, and recognize when immediate attention is needed. The process study survey asked local-level respondents whether or not they provide care transition services. Only 37 percent of respondents said yes, and subgroup analyses showed that urban, independent (versus government), and decentralized ADRCs were more likely to provide care transition services. This finding is notable, as ACL promotes the role of ADRCs in care transitions, and indicates the need for further efforts to encourage the provision of these critical services.

Medicaid Eligibility. Assisting consumers with Medicaid eligibility determination through the ADRC is also supported by ACL. Approximately 76 percent of local ADRC respondents indicated that they administered a screening to make a preliminary determination of Medicaid eligibility and need for publicly funded LTSS. Of these, over a quarter reported the ability to make presumptive eligibility determinations to expedite service receipt while applications are being processed. This is an interesting, innovative approach that may directly benefit persons in need of LTSS while at the same time delaying institutionalization, if services can be provided more expeditiously to prevent the need for institutional care. More research is needed to fully understand the effects of presumptive determination.

With regard to who received eligibility determination, the most commonly reported groups included persons age 65 and older and those with physical disability. Among people who received assistance with eligibility determination, the most common forms of assistance were advising consumers where applications could be obtained and assisting clients in completing applications. Fewer local ADRCs reported checking on the status of applications on behalf of clients or assisting clients with the collection of required documentation. These latter two types of assistance may be areas to improve, as they reflect oftentimes complicated aspects of applying for Medicaid and other public assistance.

How Services Were Provided. Approximately 44 percent of local ADRCs identified as independent, non-profit entities, while 37 percent identified as part of a local government. On average, respondents reported four core operating organizations. Nearly 80 percent of respondents identified the AAA as a core operating organization, while 46 percent identified the SUA as such. Smaller percentages named disability organizations as core to their operations, reflecting the traditional key role that the aging network has played in the development of the ADRC initiative.

Implementing fee-for-service structures is a relatively underused business practice in aging and disability service organizations. Analyses of the process study data reflect this low usage, but also show that some organizations are using this type of business model; between 9 and 18 percent of respondents reported payment through fee-for-service for assessment, options counseling, transition support, screening, application assistance, and other types of services. Payment sources for fee-for-service provision varied, with some respondents indicating payment through Medicaid waivers, other state funds, Medicare, private health plans, or other sources. This innovative approach may be useful to consider in the context of shrinking resources and growing LTSS needs.

As an intention of the ADRC initiative is to streamline the process by which individuals find and access LTSS, assessing consumer needs comprehensively and efficiently is an important aspect of ADRC functions. This study attempted to capture the degree to which ADRCs were using common assessment tools. Twenty-three percent of local ADRCs reported having a common assessment tool shared across all partners, while an additional 25 percent indicated that the tool was common across at least some partners but not all. About 43 percent, however, reported that each partner organization used its own assessment tool. Urban, independent, and centralized ADRCs were more likely to report common assessment tools than other subgroups. This finding suggests that more work is needed to encourage the use of shared tools in order to increase the efficiency and comprehensiveness of client assessment.

4.3.6 Partnerships

As discussed earlier in this section, partnerships are fundamental aspects of ADRC programs. The number and quality of partnerships and the extent of data sharing among partners were measured as part of this study. The average number of partners reported by local ADRCs was 16, and the average number of partnerships rated as highly functional was six, indicating that there may be some partnerships that are more valuable than others.

At the state level, state agencies including mental health agencies, the Medicaid agency, and centers for independent living were the most frequently identified partners. However, at the local level, local organizations including AAAs, Alzheimer’s associations, and hospitals were the most frequently identified. Finally, with respect to data sharing, results were mixed. At the local level, 22 percent reported sharing data with operational partners, and an additional 28 percent indicated plans to develop data-sharing capacities. About 39 percent reported that no plans currently existed to share data with operational partners. On the service partner side (organizations with whom the ADRC partners as service providers), 24 percent reported that they currently share data, and 24 percent reported plans to do so; 45 percent had no plans to share data with service partners. These findings underscore the importance of state and local partnerships in the ADRC model but highlight the variability across partnerships.

More detailed analysis was done to examine how partnerships and partnership quality differed with respect to the type of organizations named as ‘core operating partners’. Three important results were found. First, a higher percentage of strong core operating partnerships were reported by ADRCs having an aging organization (e.g., SUA, AAA) as a core partner, compared to those that identified a CIL as a core partner. Second, a majority of ADRCs across all core partner types identified partnerships with local VAs, SUAs, state and county Medicaid agencies, AAAs, United Way, Alzheimer’s Associations, and CILs; the least-often identified partner organizations included state and county housing offices, and county departments on aging. Third, county and state housing offices were also the organizations most commonly rated as moderate or low functioning. Few strong partnerships were also reported with state mental health agencies, state developmental disability agencies, and vocational/rehabilitation service organizations. These results suggest that more technical assistance may be needed to improve partnerships with disability organizations.

4.3.7 Comparison by Core Integration Dimensions

Using data from the process study, we developed three core measures to assess the range of services provided by the ADRCs and their level of integration across the following three dimensions of ADRC operations:

- Level of core service provision
- Extent of site integration
- Status of Medicaid integration

Core Service Provision. The degree of core service provision was assessed by determining whether sites provided I&R, options counseling, eligibility determination, and care transition services. Approximately 34 percent were categorized as “high core service provision” sites, providing all four of the aforementioned services. Approximately 45 percent were categorized as “medium core service provision” sites, offering I&R, options counseling, and eligibility determination but not care transition services. The remaining 21 percent of sites were classified as “low core service provision” sites because they did not provide both options counseling and eligibility determination.

Bivariate analyses showed significant differences related to ADRC characteristics. Urban, independent, and decentralized ADRC sites were significantly more likely to be categorized into the high core service provision group, compared to rural, government, and centralized or mixed-model ADRC sites. No effect of ADRC size was observed. In addition, some subgroup differences were seen with a number of key process study variables of interest. ADRCs categorized as having *high* core service provision were more likely to:

- Indicate that lack of health insurance was *not* a barrier to accessing LTSS
- Provide care transition services and options counseling
- Specify nursing home diversion as a sought-after outcome
- Indicate that grants enabled expansion of populations served
- Indicate that partnerships positively impacted their ability to provide LTSS

However, high core service provision ADRCs were *less likely* to indicate that shared data and person-centered services positively impacted their ability to provide LTSS. Medium-level core service provision ADRCs were more likely to indicate that grants enabled them to expand service populations and to provide care transition services.

This assessment of core services provided by ADRCs highlights variability among sites that may directly impact consumers' experiences and their ability to understand and access the full range of needed LTSS; consumers in areas served by low service provision ADRCs may be at a decided disadvantage in this regard. Further, consumers using ADRCs without care transition services may experience longer tenures in institutional care, more difficulty transitioning from acute to community-based settings, and potential increased risk of re-hospitalization. As about two-thirds of respondents were classified as medium or low core service provision sites, a majority of current and potential ADRC users are at risk of negative consequences associated with a lack of key service provision.

Site Integration. The measure of the level of site integration was developed to capture the comprehensiveness of the services and supports offered by a local ADRC and the operational processes and degree of partnerships within and across agencies that facilitated these services. Respondents were categorized into three categories (low, medium, or high) according to the extent of their site integration. Just over 9 percent of sites were found to have a high level of integration, while 78 percent were considered medium level and 13 percent low level.

No significant differences in the level of site integration were found among ADRC site characteristic subgroups. However, some differences were observed in the relationship of site integration and a number of key process study variables. Low-level site integration ADRCs were:

- Less likely to specify nursing home diversion as a sought-after outcome
- More likely to report that staffing changes and person-centered services *did not* impact their ability to provide LTSS
- More likely to report that shared data *did* impact their ability to provide LTSS

High-level site integration ADRCs were:

- More likely to report that federal grants enabled expansion of the populations served, "very much" increased the number of consumers served, and increased the number of partnerships
- More likely to provide care transition services and options counseling

Although only a small percentage of sites can be considered highly integrated in terms of the populations they serve, the services they provide, and the nature of their partnerships, the finding that an additional 78 percent are considered to have a medium-level of integration is positive. This suggests that most ADRCs are making progress in offering comprehensive services to broad population groups. However, continued support to encourage and strengthen integration is needed to ensure improvement for a large majority of respondents.

Medicaid Integration. Local ADRCs receiving funding during FY 2013 from any of six Medicaid-related sources (e.g., CMS Systems Change Grants, PACE, Money Follows the Person Demonstration) were considered to be Medicaid integrated. Interestingly, 60 percent of respondents did <u>not</u> receive such funding and were not considered to be Medicaid integrated. This seemingly high percentage may reflect a lack of resources to apply for such funding or a low prioritization for securing external funds for Medicaid among local or state entities. This finding also points to potential disadvantages for older and disabled persons in communities with non-Medicaid integrated ADRCs; these consumers are unable to take advantage of innovative programs that have been associated with positive outcomes and increased ability to remain in the community.

Subgroup analyses showed no differences in Medicaid integration by geographic region but did indicate that independent and decentralized ADRCs were more likely to be Medicaid integrated; mixed-model ADRCs were the least likely. With respect to process study variables of interest, Medicaid integrated sites were:

- More likely to report that person-centered services positively impacted their ability to provide LTSS
- More likely to report that federal grants enabled expansion of populations served
- More likely to identify nursing home diversion as a goal
- More likely to provide care transition services and options counseling
- Less likely to report that data sharing had a positive impact on ability to provide LTSS

This last finding is of note, as the hypothesized relationship between data sharing and ability to provide services is a positive one. Here, it may be that Medicaid integrated sites have already implemented more streamlined practices or MIS that trump the benefit of data sharing as measured by this study. Instead, person-centered services and additional federal grants were cited as positively impacting service provision, suggesting that more direct service-oriented support to Medicaid integrated sites may be more valuable than support around data needs and infrastructure.

CHAPTER 5. OUTCOME STUDY FINDINGS AND IMPLICATIONS

This chapter provides an overview of the purpose of the outcome study and presents the study's findings and implications. Section 5.1 describes the key research questions, and Section 5.2 discusses the outcome study findings by domain. Section 5.3 summarizes the findings and explores the implications of the study.

5.1 Outcome Study Purpose, Research Questions, and Research Domains

5.1.1 Purpose

The primary focus of the outcome study was to capture the experiences of clients seeking information about or access to LTSS and the challenges they face in receiving this assistance. The outcome study assessed:

- How well ADRCs helped older adults and persons with disabilities access needed LTSS;
- The factors that led clients to seek information on LTSS from ADRCs;
- The type and processes of direct and referral services that ADRC provided;
- The challenges that clients faced in accessing LTSS through ADRC; and
- Client satisfaction with ADRCs.

5.1.2 Research Questions

The following research questions were explored in the outcome study:

- How responsive and effective are ADRC representatives in addressing the needs of clients, overall and by subgroups of interest?
- How useful is the information provided by the ADRCs?
- What types of assistance do clients receive from the ADRCs (e.g., information and referral, options counseling, and eligibility determination)?
- What are the factors/needs that lead clients to seek the assistance of ADRCs?
- How seriously are respondents considering a move to a long-term care setting such as a nursing home when they contact ADRCs?
- What are the challenges faced by clients in seeking information about LTSS?
- What organizational, geographic, and client-level characteristics are most closely associated with positive consumer experiences?

- How satisfied are clients with the assistance received at ADRCs?

5.1.3 Research Domains

Our analyses of the key research questions listed above are grouped into the following domains:

- Profile of participants;
- Responsiveness and effectiveness of ADRCs;
- Assistance with services;
- Access to services; and
- Participant satisfaction.

We also explore the differences in participant experiences by the three core measures described earlier in the report:

- Level of core service provision;
- Extent of site integration; and
- Status of Medicaid integration.

5.2 Outcome Study Findings

In this section, we first draw a profile of participating ADRCs and clients. In Section 5.2.1, we describe the coverage area of participating ADRCs, including the breadth of the coverage area, geographic location, and size of the participating sites. We describe the results of analyses of types of clients and their representatives who participated in the survey, and report the demographic characteristics of clients who were the subject of the survey, including gender, race, ethnicity, education, and household income. We also present findings on clients' health (including self-reported health status and previous hospital admissions), health insurance coverage, living situations, marital status, and long-term care (LTC) facility status (i.e., ever resided in a LTC facility).

Section 5.2.2 presents the findings on agency responsiveness and the ability of agency representatives. We describe agency responsiveness by examining the mode of initial ADRC contact by respondents, wait time to receive assistance, number of call attempts to the ADRC, and frequency with which respondents were required to describe their requests. We examine the ability of ADRC representatives in communicating with survey respondents and representatives' knowledge about LTSS. Lastly, we report regression findings that assess the influence of client, ADRC, and community characteristics on the responsiveness and effectiveness of ADRCs.

In Section 5.2.3, we cover the results of analyses on the services that respondents received from the ADRCs. We first examine the reasons why survey respondents contacted the ADRCs, including the top five most common reasons. We describe whether the respondent received direct access to services from the ADRC or was directed to another agency. We also examine the result of their contact and their experience with the referral process. Then, we report respondents' experiences receiving assistance with Medicaid eligibility determination and other types of insurance. This section also describes respondents' assistance with care transition services and examines their assistance with diversion from LTSS facilities. Lastly, we present regression findings to identify client, ADRC, and community characteristics associated with respondents reporting the five most common reasons for contacting the ADRC.

Section 5.2.4 presents the processes and challenges faced by survey respondents in seeking information about LTSS from ADRCs as well as accessing LTSS from other agencies. We begin this section by describing how respondents found out about the ADRCs that they contacted for assistance, and whether the respondent contacted other agencies before contacting the ADRC. We examine whether the ADRCs followed up with consumers on referrals and the usefulness of information provided. Next, we describe respondents' challenges in receiving services from the ADRCs, including length of time to receive service and reasons for not receiving the service at the ADRC, and respondents' challenges in resolving issues. We also examine LTSS referrals by service type and the results of referrals, and lastly, we present regression analyses that explore the client, ADRC, and community characteristics associated with respondent challenges.

In Section 5.2.5, we explore the level of satisfaction that survey respondents had with the various forms of assistance they received from ADRCs. We present respondents' satisfaction with one-on-one options counseling, and report satisfaction with care transition services. Next, we examine satisfaction with the quality of services that respondents' received at the ADRCs. We also describe the overall usefulness of ADRC services by examining whether respondents believed that the services or information received improved respondent awareness of LTSS needs, increased certainty of LTSS options, and was useful in selecting LTSS. Lastly, we present the value of ADRCs to respondents by reporting if respondents would tell a friend or relative to contact the ADRC and the likelihood of the respondent contacting the ADRC in the future.

Section 5.2.6 presents a comparison of key outcomes by the three core measures—level of core service provision, extent of site integration, and status of Medicaid integration.

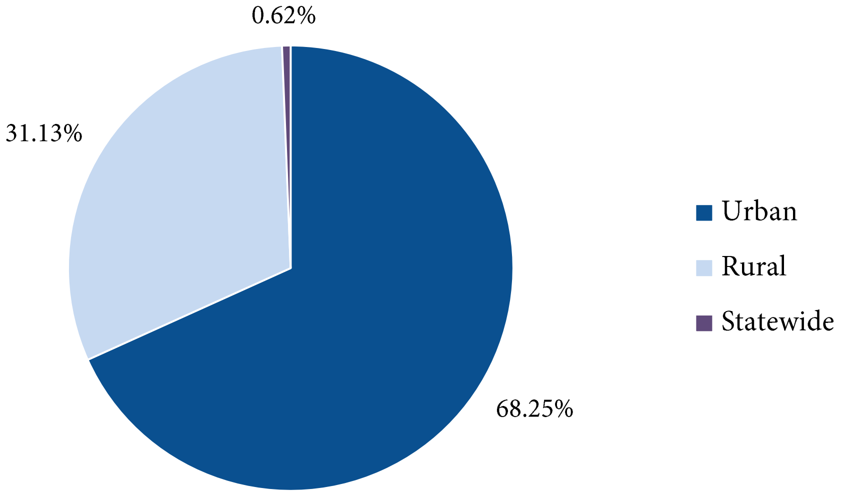
5.2.1 Profile of Participating ADRCs, Clients, and Respondents

Participating ADRC Characteristics

In this section, we present the profile of participating ADRCs in terms of their geographic location (rural/urban/state-wide) and size (number of consumers, FTEs, and partners). Note that the percentages provided are weighted by the sampling weights assigned to each ADRC. Unweighted percentages and a comparison with the distribution of all ADRCs participating in the process and outcome study surveys may be found in Appendix KK, Exhibits 1 and 2.

ADRC Coverage Areas. As described in Section 3.3, Outcome Study Methodology, participants for the outcome study were recruited from two types of ADRCs in terms of breadth of coverage areas: ADRCs whose coverage area is the entire state (i.e., statewide ADRCs, n = 2) and ADRCs whose coverage area is limited to a few counties (local ADRCs, n = 19). The local ADRCs were further classified into rural and urban. As shown in Exhibit 5.1, two-thirds of participating ADRCs served areas that were primarily urban. Nearly one-third of ADRCs had coverage areas that were primarily rural, and less than one percent were statewide.

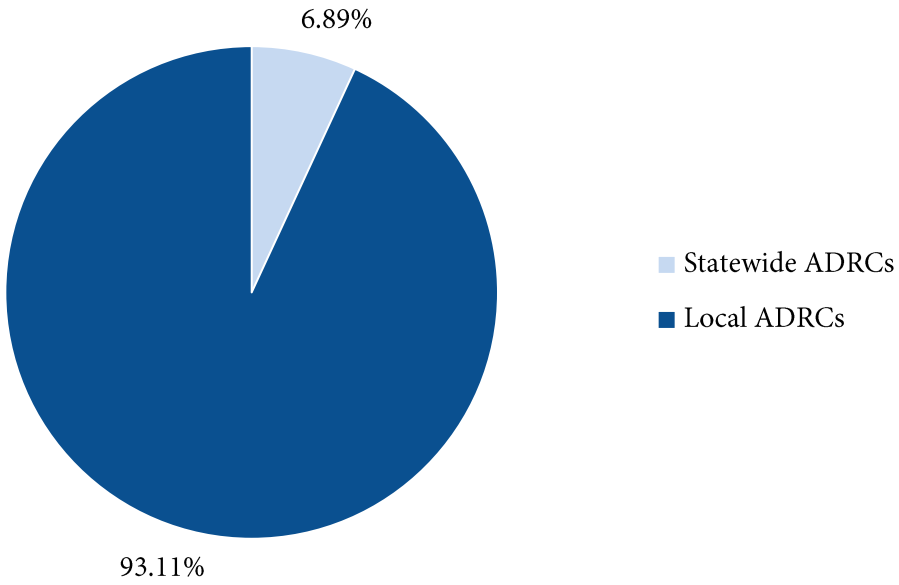
Exhibit 5.1: Geographic Location of ADRC Service Areas



Note: Percentages are weighted.

Exhibit 5.2 shows the share of survey respondents by local and statewide ADRCs. Survey respondents overwhelmingly represented local ADRCs.

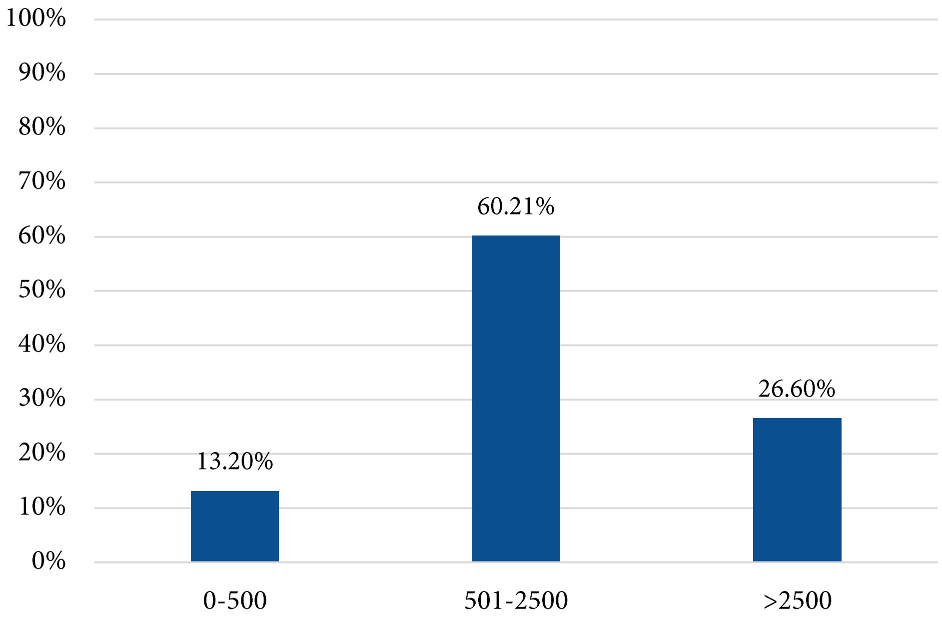
Exhibit 5.2: Respondents from Local and Statewide ADRCs



Note: Percentages are weighted.

Size of ADRCs. As shown in Exhibit 5.3, in the 6-month period from October 2012 through March 2013, 60 percent of participating ADRCs served between 501 and 2,500 consumers, defined as medium sized according to the process study data. Twenty-six percent of ADRCs were large, serving more than 2,500 consumers in that period, and 13 percent were small, serving 500 consumers or less. The mean number of consumers served by these ADRCs was 1,069.

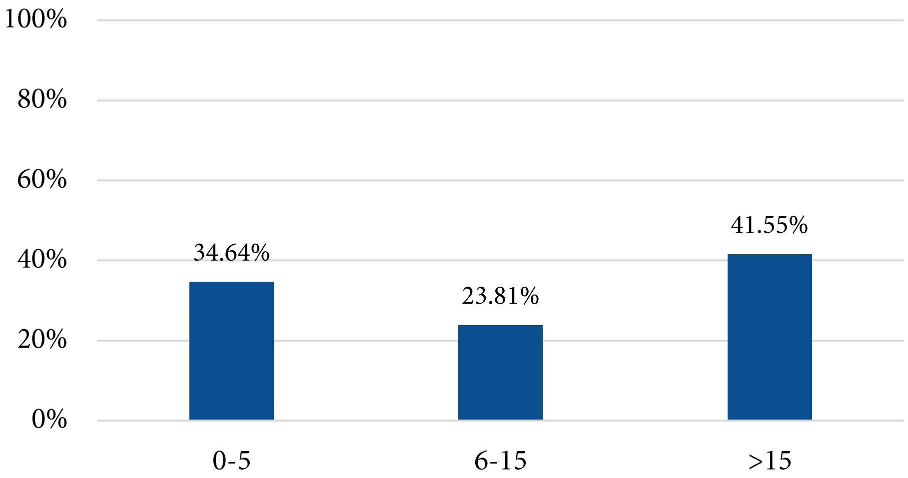
Exhibit 5.3: Number of Consumers Served by ADRC in 6–Month Period



Note: Percentages are weighted.

Exhibit 5.4 presents the number of FTE staff working at the participating ADRCs. It is noteworthy that a considerable number of ADRCs (42%) had more than 15 FTEs. The mean number of FTEs of participating ADRCs was 22.3.

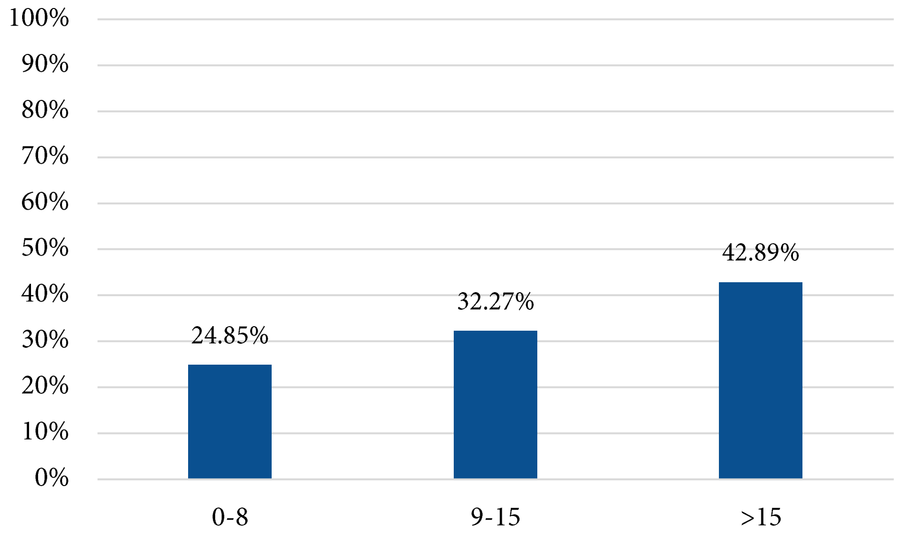
Exhibit 5.4: Number of FTEs at ADRC



Note: Percentages are weighted.

As shown in Exhibit 5.5, participating ADRCs varied in terms of the number of agencies with which they partnered. Nearly half of ADRCs (43%) had more than 15 partners. The mean number of partners among this group was 11.5.

Exhibit 5.5: Number of ADRC Partners



Note: Percentages are weighted.

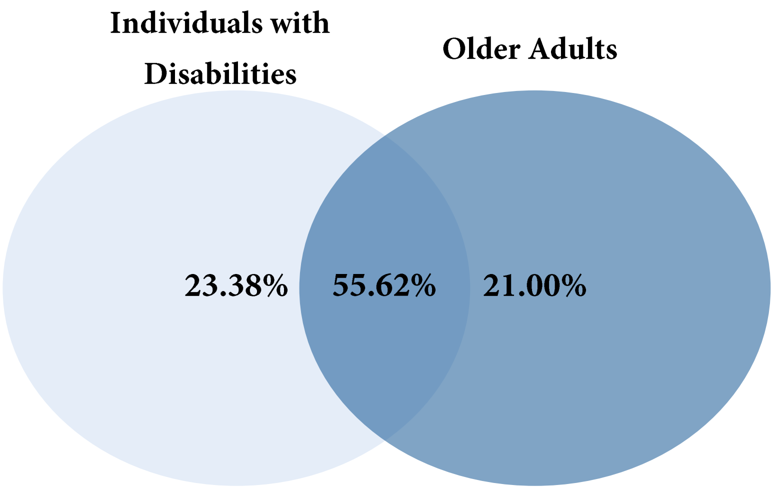
Participating Client and Respondent Characteristics

Types of Clients. Only respondents who contacted ADRCs about the LTSS needs of the following two categories of clients were eligible to participate in the survey:

- Older adults (60 years of age and older);
- Adults with disability (18 years of age and older).

As shown in Exhibit 5.6, the sample of older adults and adults with disabilities were nearly equal with 77 percent of the sample being older adults and 79 percent being individuals with a disability.

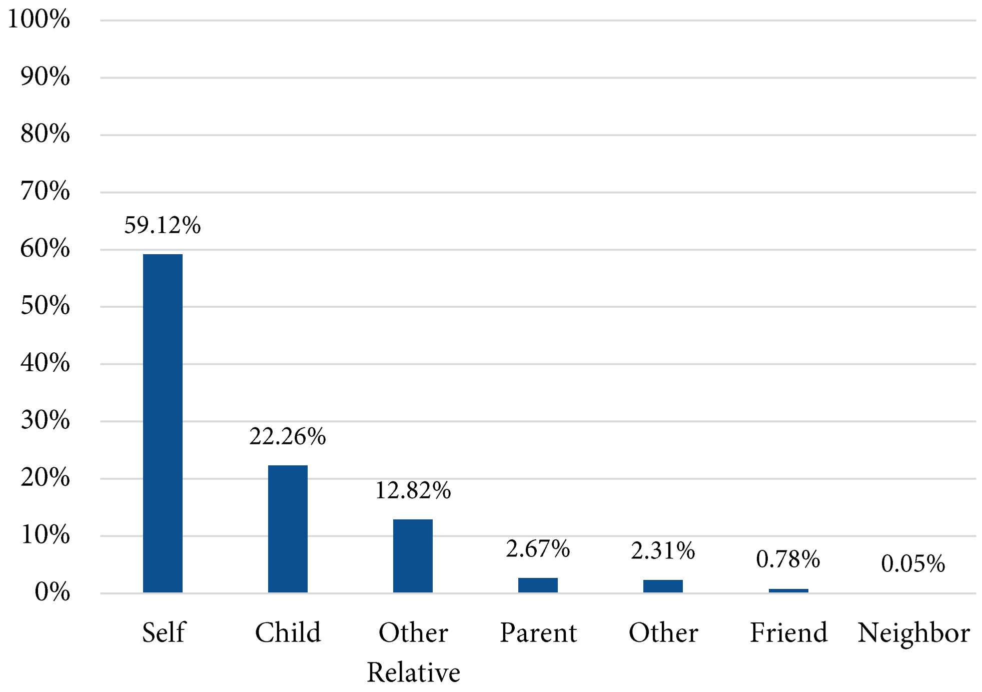
Exhibit 5.6: Client Age and Disability Status



Note: Percentages are weighted.

Types of Respondents. Exhibit 5.7 displays the types of survey respondents. As previously noted, not all survey respondents were clients who needed services. Some had contacted the ADRC to seek LTSS information and services for their family, friends, patients, or clients. A majority of participants (59%) contacted the ADRC on their own behalf.

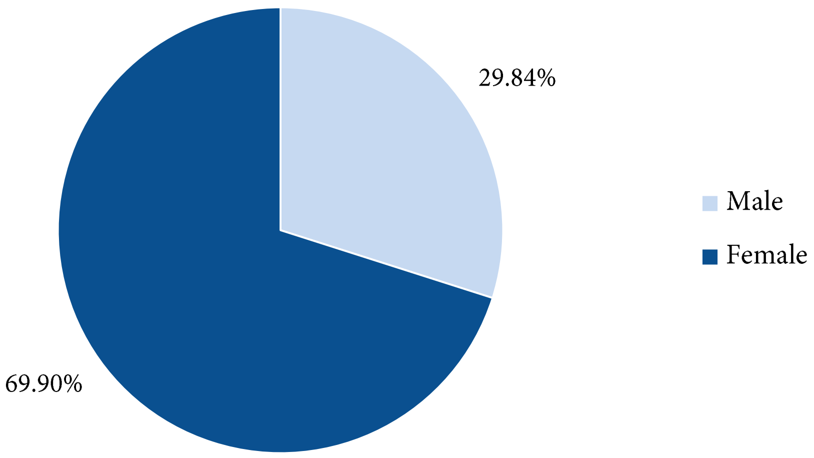
Exhibit 5.7: Survey Respondent Type



Notes: The respondent type indicates the relationship of the respondent to the person on whose behalf the contact was made. Therefore, the rows for child and parent have been switched when compared to Appendix T, Question PP2, which reports the relationship status of the person on whose behalf the contact was made from the perspective of the respondents. While the exhibit in the appendix reports the survey options as they appear in the questionnaire, this recoding was done based on how other questions in the survey were phrased.
Percentages are weighted.

Demographic Characteristics of Clients. Exhibit 5.8 shows the gender distribution of clients who needed LTSS services from ADRCs as reported by survey respondents. As indicated, more than two-thirds of ADRC clients (70%) were female.

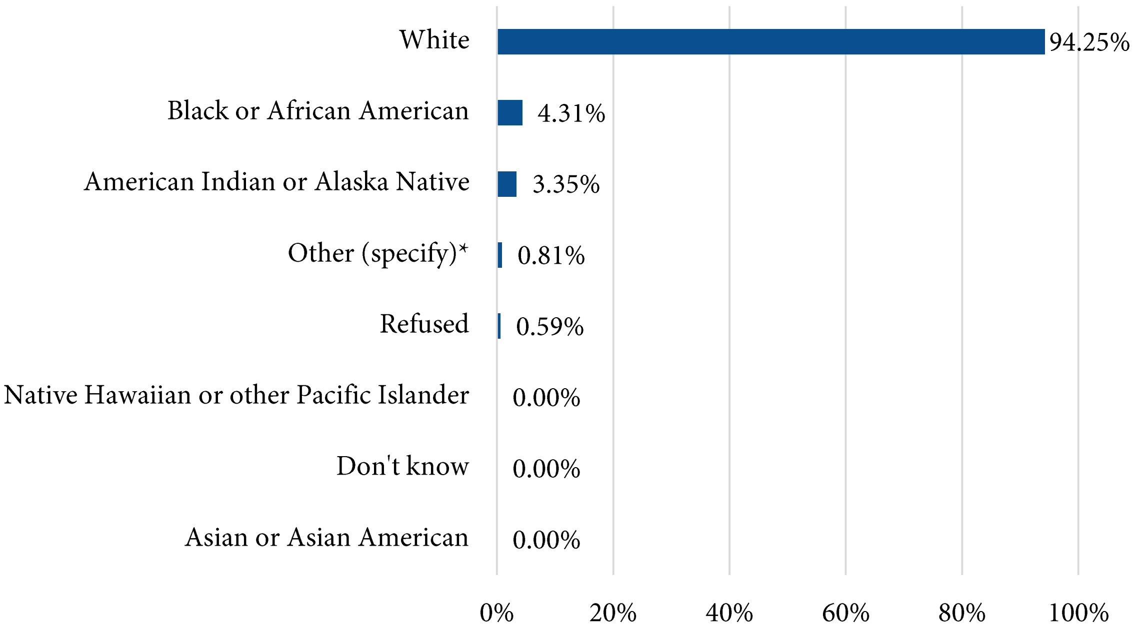
Exhibit 5.8: Gender of ADRC Clients



Note: Percentages are weighted. Percentages do not equal 100 since 0.27 percent of respondents refused to answer.

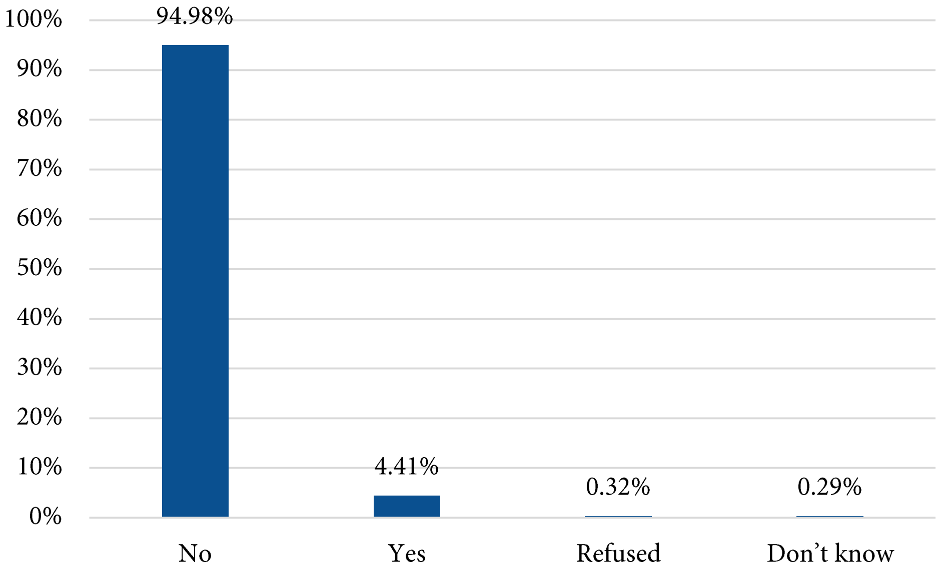
Client demographic characteristic are presented in Exhibits 5.9 and 5.10. Most of the ADRC clients were White (approximately 95%) (Exhibit 5.9), and 4 percent were Black or African American. Approximately 4 percent were Hispanic, Latino, or of Spanish origin (Exhibit 5.10).

Exhibit 5.9: Racial Composition of ADRC Clients



Note: Percentages are weighted.
*Free text responses accompanying this question are available in Appendix U.

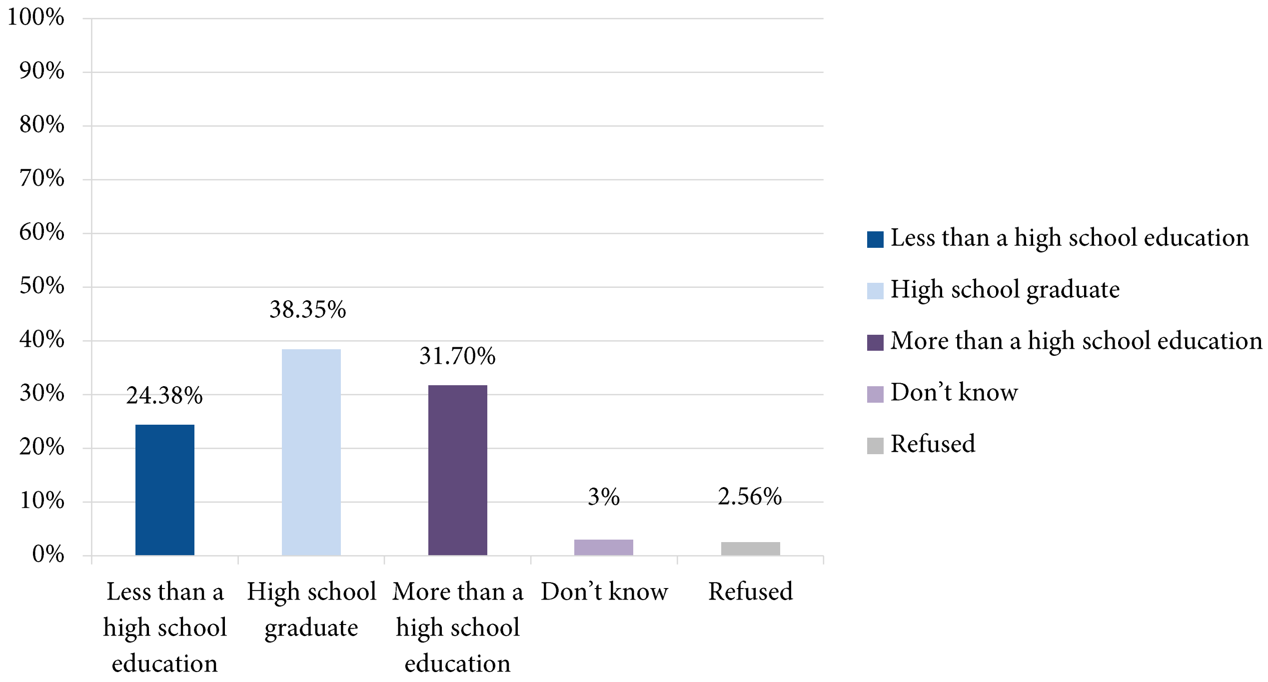
Exhibit 5.10: Ethnicity of ADRC Clients (Hispanic, Latino, or of Spanish Origin)



Note: Percentages are weighted.

More than one-third of ADRC clients (38%) reported being high school graduates, while a quarter (24%) had less than a high school education (Exhibit 5.11). The majority of ADRC clients reported a total household income of less than $40,000 (83%) (Exhibit 5.12).

Exhibit 5.11: Educational Attainment of ADRC Clients



Note: Percentages are weighted.

Exhibit 5.12: Total Household Income of ADRC Clients

Total Household Income	Frequency	Percentage
Less than or equal to $40,000	454	82.91
More than $40,000	49	9.16
Don't know	29	4.90
Refused	20	4.85
Total	552	100

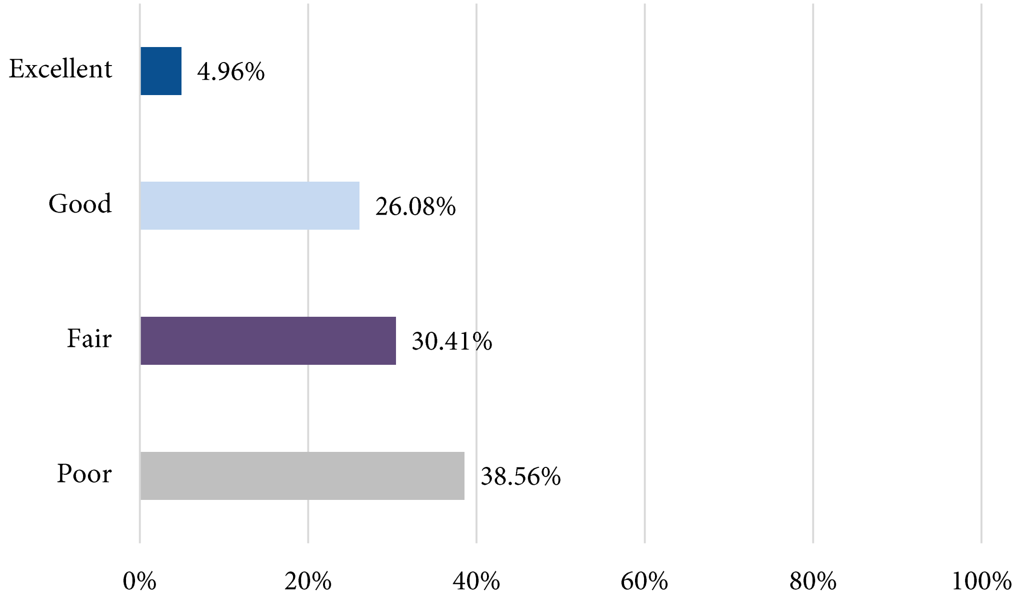
Notes: Frequencies are unweighted; percentages are weighted.

Health Status of Participating Clients. The survey captured the health status of ADRC clients using two measures:

- Current health status self-rated as excellent, good, fair, or poor
- Whether admitted to a hospital in the previous 6 months.

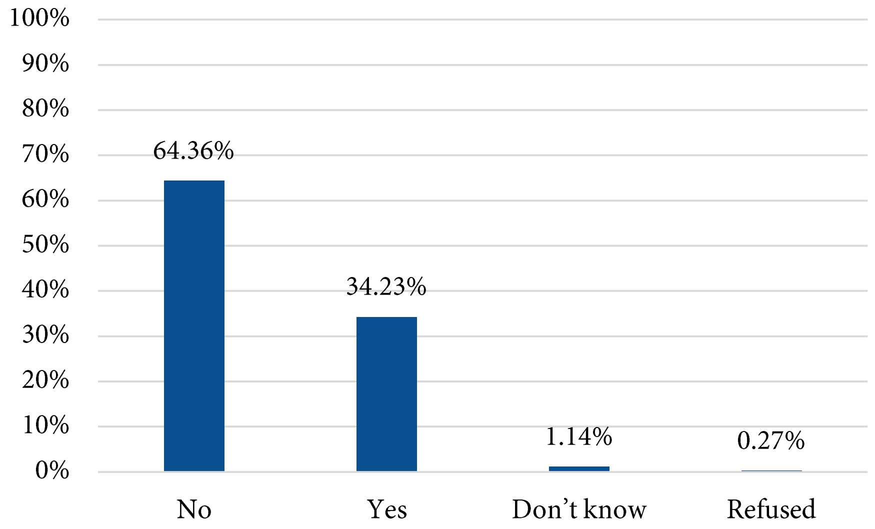
As depicted in Exhibit 5.13, the health status of ADRC clients, as reported by the survey respondents, varied considerably. Only 5 percent of respondents self-rated their health as “excellent,” while nearly 38 percent reported it was “poor”; moreover, 34 percent of clients had been admitted to a hospital in the 6 months prior to the survey administration (Exhibit 5.14).

Exhibit 5.13: Health Status of ADRC Clients



Note: Percentages are weighted.

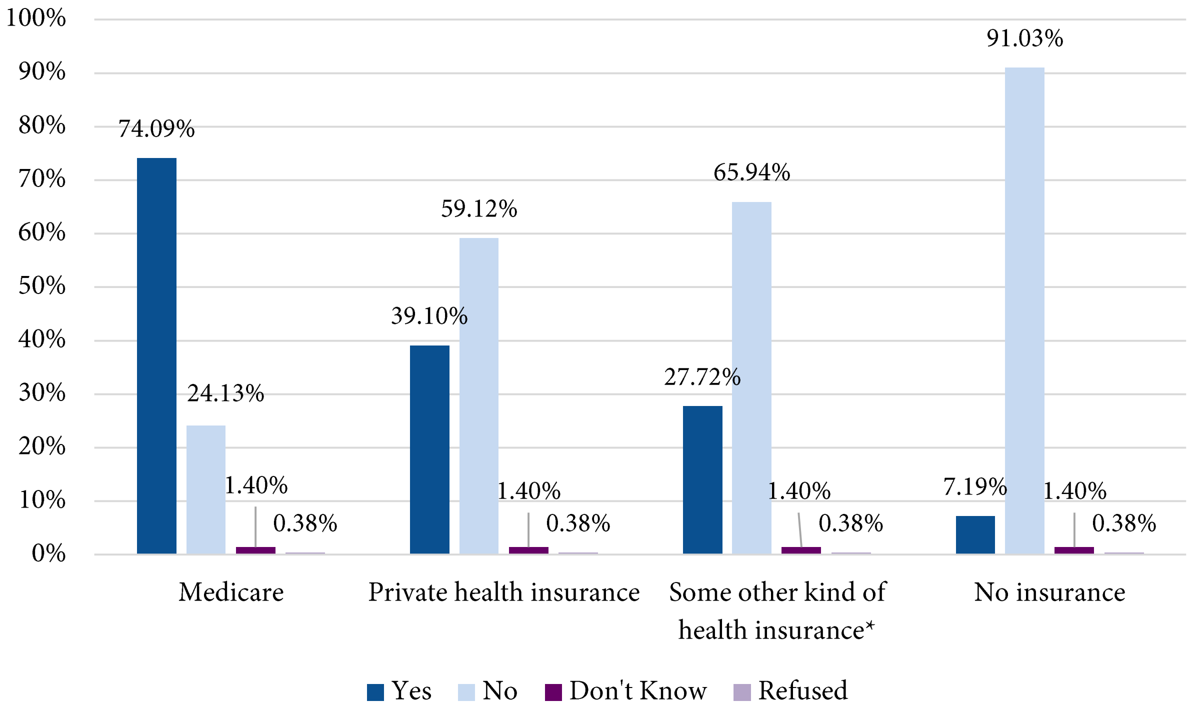
Exhibit 5.14: Hospital Admission of ADRC Clients in the Previous 6 Months



Note: Percentages are weighted.

Client Health Insurance Type. Almost three-quarters of ADRC clients were covered by Medicare (74%); approximately 7 percent had no health insurance at all (Exhibit 5.15). Although the survey did not explicitly ask respondents to report Medicaid status, this information may have been provided in an open-ended response if the respondent reported another type of health insurance. Although it is likely an underestimate, about 15 percent of clients reported being enrolled in Medicaid. Further, 32 percent of ADRC clients who were 65 years old or older did not report having Medicare coverage (Exhibit 5.16).

Exhibit 5.15: Health Insurance Type of ADRC Clients



Notes: Percentages do not add up to 100 because respondents could choose multiple options. Percentages are weighted.
*Free text responses accompanying this question may be found in Appendix U.

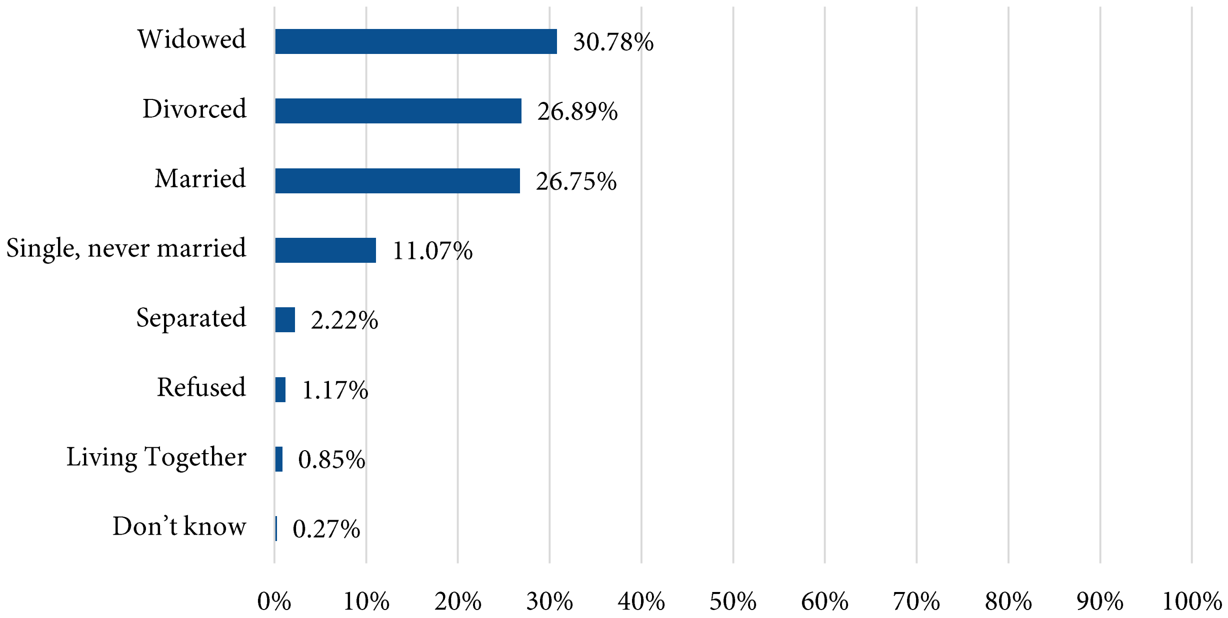
Exhibit 5.16: Client Age by Medicare Enrollment

Age	Do Not Have Medicare	Have Medicare	Total
Younger than 65	68.08	25.22	36.32
65 or older	31.92	74.78	63.68
Total	100	100	100

Note: Percentages are weighted.

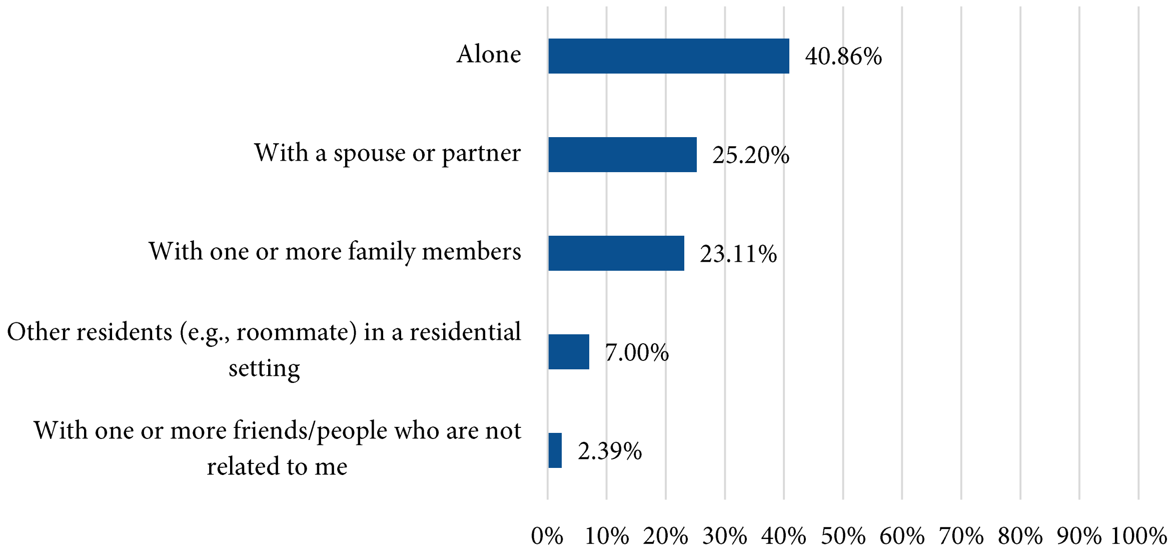
Marital and Residence Status of Participating Clients. As shown in Exhibit 5.17, 27 percent of ADRC clients were married at the time of the survey. One-third each were widowed or divorced/separated. Almost half (48%) of respondents lived with a spouse or other family member at the time of the survey administration, and 41 percent lived alone (Exhibit 5.18). Eighty percent of ADRC clients lived in their own house or apartment, and just less than 1 percent lived in non-medical custodial housing (Exhibit 5.19). About 4 percent of ADRC clients lived in an assisted living setting and 8 percent lived in a nursing home at some point (Exhibit 5.20). Finally, Exhibit 5.21 illustrates that clients who ever lived in an assisted living setting had a mean length of stay of 24 months as compared to 9 months for those who ever lived in a nursing home.

Exhibit 5.17: Marital Status of ADRC Clients



Notes: Only those clients who were not reported as "passed away" when asked to rate their current health were asked this question. Percentages are weighted.

Exhibit 5.18: Living Status of ADRC Clients



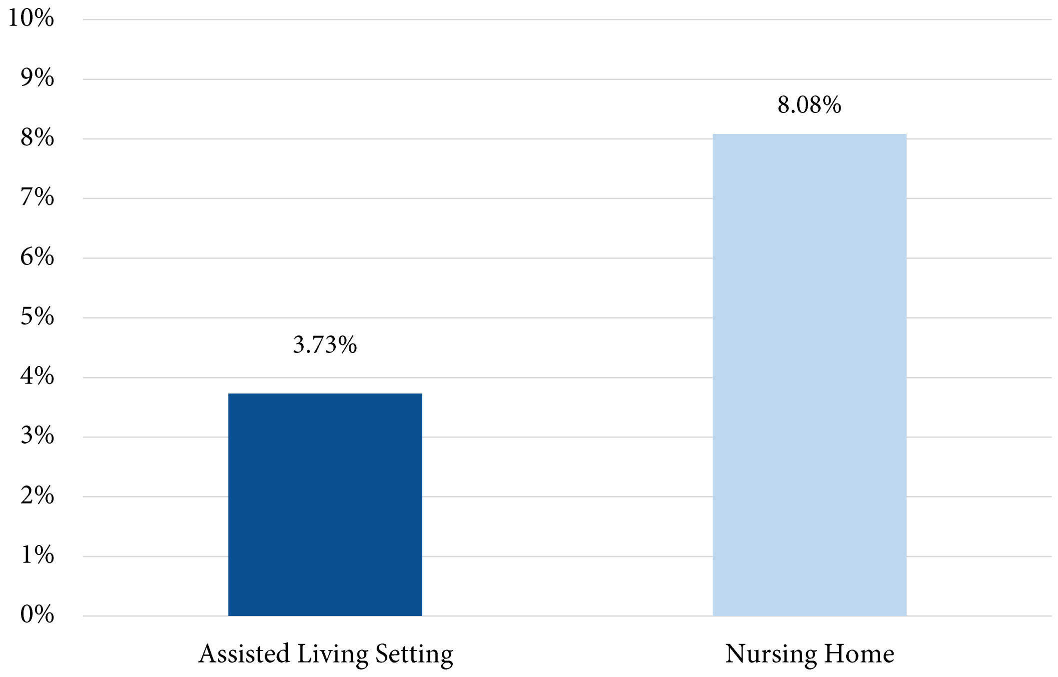
Notes: Only those clients who were not reported as "passed away" when asked to rate their current health were asked this question. Percentages are weighted.

Exhibit 5.19: Residence Type of ADRC Clients

Residence Type	Frequency	Percentage
My own house or apartment (e.g., free-standing, row house, town house, apartment, etc.)	437	79.82
In some other setting, specify*	51	8.66
In an assisted living setting	31	4.07
In a nursing home	10	5.26
Non-medical custodial housing (e.g., group home, congregate house, half-way house, safe-house, recovery house, board and care house, other residential non-medical adult care facility)	7	0.91
Refused	4	0.91
In a continuing care retirement setting	4	0.34
Don’t know	1	0.02
Total	545	100

Notes: Only those clients who were not reported as “passed away” when asked to rate their current health were asked this question. Percentages are weighted; frequencies are unweighted.
*Free text responses accompanying this question are available in Appendix U.

Exhibit 5.20: ADRC Clients Who Ever Lived in a Long-Term Care Setting



Notes: This question was asked of all those who did not respond "In an Assisted Living Setting" when asked to describe their current housing situation. Percentages are weighted.

Exhibit 5.21: Length of Time in Assisted Living Setting or Nursing Home

	Mean*	Median	Mode	Range	
				Min	Max
Assisted Living Setting	23.63	9	24	1	144
Nursing Home	9.32	2	1	1	120

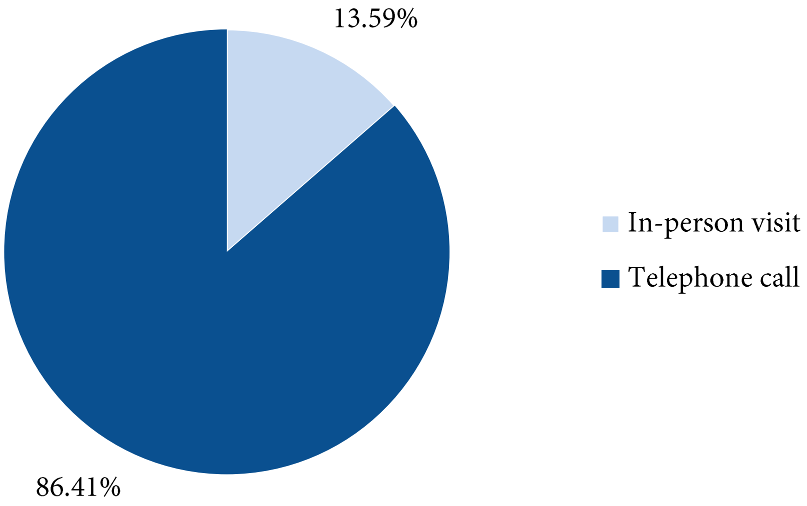
*Length of time is given in months.

5.2.2 Agency Responsiveness and Effectiveness

Agency Responsiveness

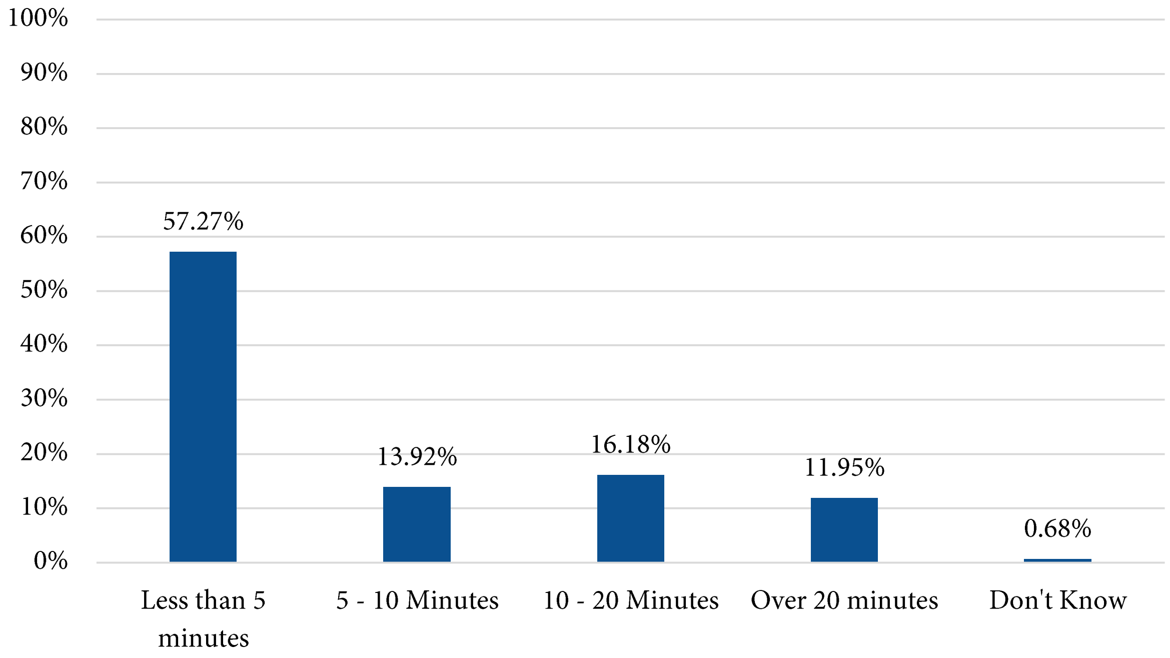
Agency responsiveness was measured by assessing the ease with which respondents could directly talk with an ADRC representative during their initial contact with the agency. As shown in Exhibit 5.22, the majority of survey respondents (86%) contacted the ADRC via telephone during their initial contact; only 14 percent visited the ADRC in person. Among those whose initial contact was through an in-person visit, 57 percent waited less than 5 minutes to speak with someone who could assist them with their request for information or services (Exhibit 5.23), while 12 percent waited more than 20 minutes. For those whose first contact was by telephone, 74 percent spoke with a representative who could assist with their request during their first telephone contact; 18 percent reported that they did not speak with someone who could help with their request (Exhibit 5.24). Of those who did not speak with a representative who could help with their request during their first telephone contact, 38 percent contacted the ADRC one additional time before speaking with a representative, and 11 percent contacted the ADRC four or more times before receiving the requested information or services (Exhibit 5.25). Less than 3 percent did not contact the ADRC again after their initial contact, although they did not receive the assistance they needed during their initial contact. The majority of respondents (70%) reported that they only needed to describe or explain their request once (Exhibit 5.26).

Exhibit 5.22: Mode of Initial Contact



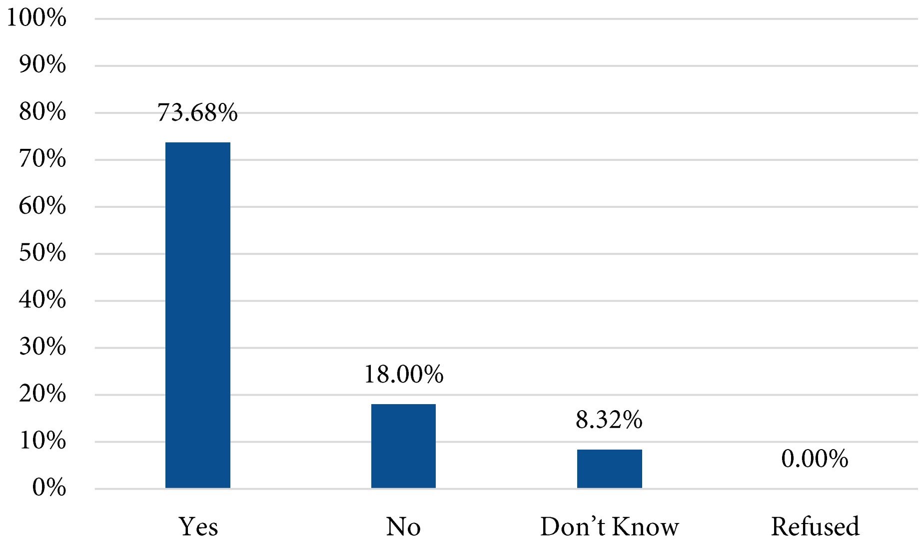
Note: Percentages are weighted.

Exhibit 5.23: Length of Wait to Talk with Someone Who Could Help with Request



Notes: This question was asked of those where the mode of contact was "In-Person Visit." Percentages are weighted.

Exhibit 5.24: Spoke with ADRC Representative Who Could Help with Request During First Telephone Contact



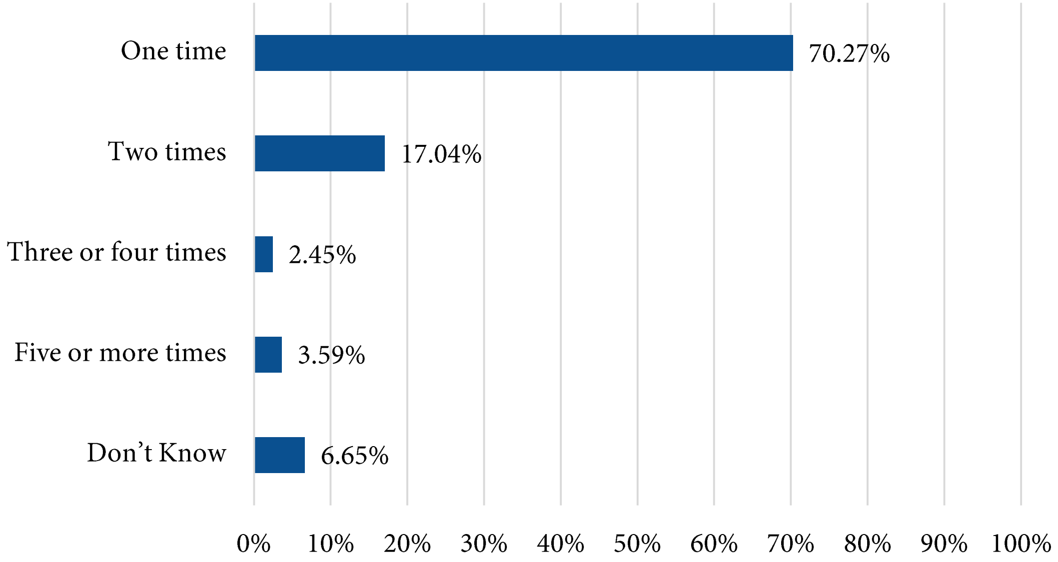
Note: Percentages are weighted.

Exhibit 5.25: Additional Contacts Before Speaking with ADRC Representative Who Could Help with Request

Number of Contacts	Percentage
None	2.76
One	38.03
Two	13.51
Three	8.15
Four or more	11.32
Don’t Know	26.24
Total	100

Note: Percentages are weighted.

Exhibit 5.26: Number of Times Respondents Had to Describe Their Request



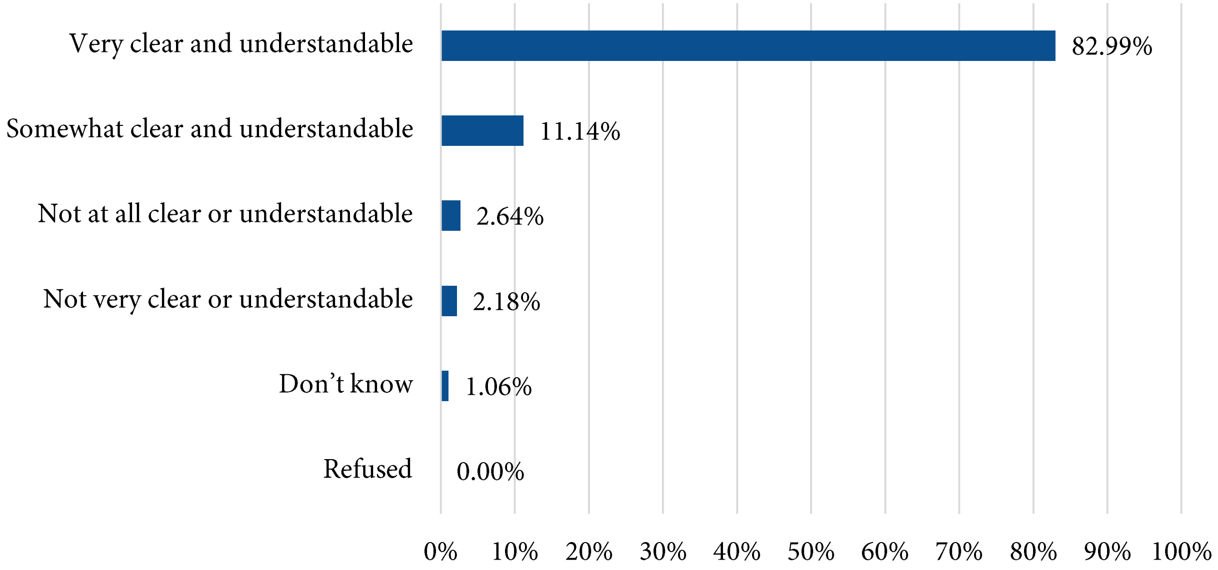
Note: Percentages are weighted.

Effectiveness of Communication. The effectiveness of ADRC representatives’ communication with respondents was assessed using the following survey items:

- Clear and understandable communication
- Listen with close attention
- Probe to correctly assess client needs.

A majority of respondents (83%) indicated that the information they received from the ADRC representative was very clear and understandable (Exhibit 5.27). In contrast, only 3 percent reported that it was not at all clear or understandable. Exhibit 5.28 provides a breakdown of respondents' perceptions of the attentiveness of ADRC representatives. As illustrated, a vast majority of respondents felt that the ADRC representatives "definitely" paid close attention to what they were saying when they contacted the site (84%). Furthermore, a majority of respondents (87%) felt that the ADRC representative asked questions that correctly assessed the needs of the client (Exhibit 5.29).

Exhibit 5.27: Clarity of Information Received from ADRC Representative



Note: Percentages are weighted.

Exhibit 5.28: Attentiveness of ADRC Representative

Paid Close Attention	Percentage
Yes, definitely	83.52
Yes, probably	10.20
No, probably not	1.88
No, definitely not	3.31
Don't know	1.10
Refused	-
Total	100

Note: Percentages are weighted.

Exhibit 5.29: ADRC Representatives' Assessment of Clients' Needs

Asked Questions That Correctly Assessed Needs	Percentage
Yes	87.17
No	8.34
Don't know	4.49
Refused	-
Total	100

Note: Percentages are weighted.

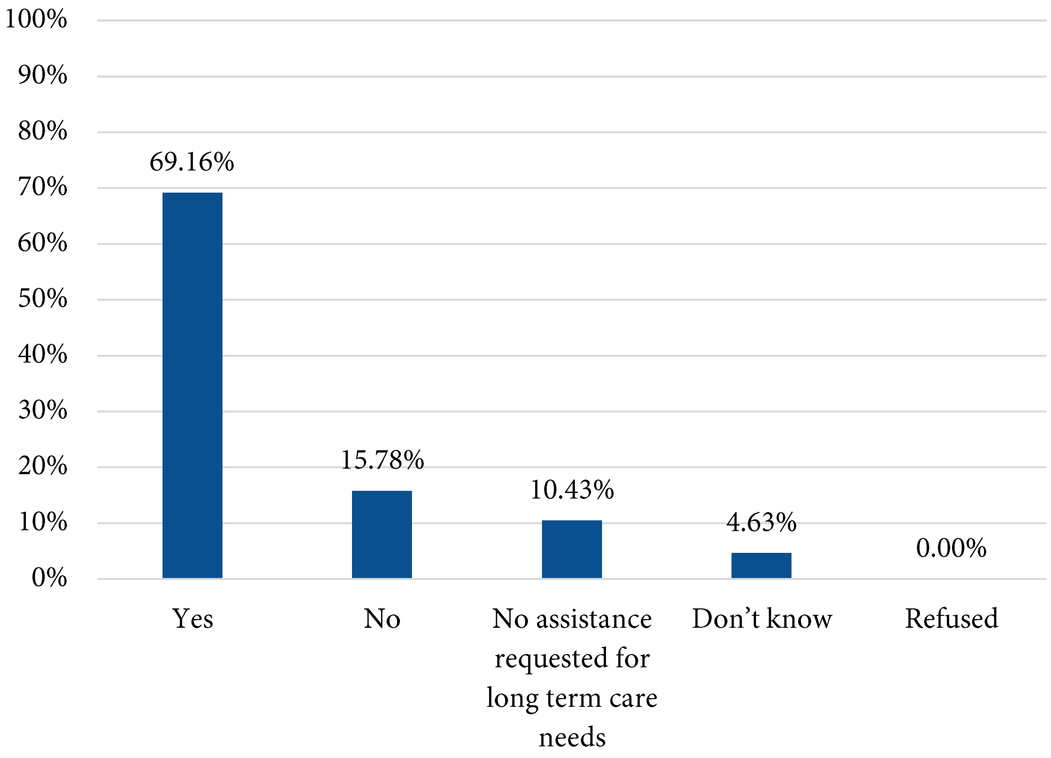
Knowledge about LTSS Services. Most respondents indicated that the ADRC representative was knowledgeable about the reason they contacted the ADRC (Exhibit 5.30). More than three-quarters of respondents (78%) reported that the representative was very knowledgeable. In contrast, only 2 percent reported that the representative was not at all knowledgeable. More than two-thirds (69%) of respondents who requested assistance related to long-term care needs reported that the ADRC representative worked with them to develop a plan outlining next steps in meeting ongoing LTSS needs (Exhibit 5.31); only 16 percent reported that the representative did not work with them.

Exhibit 5.30: ADRC Representatives' Knowledge About Requested Information or Services

Level of Knowledge	Percentage
Very knowledgeable	78.45
Somewhat knowledgeable	14.33
Not very knowledgeable	2.91
Not at all knowledgeable	2.10
Don't know	2.21
Refused	-
Total	100

Note: Percentages are weighted.

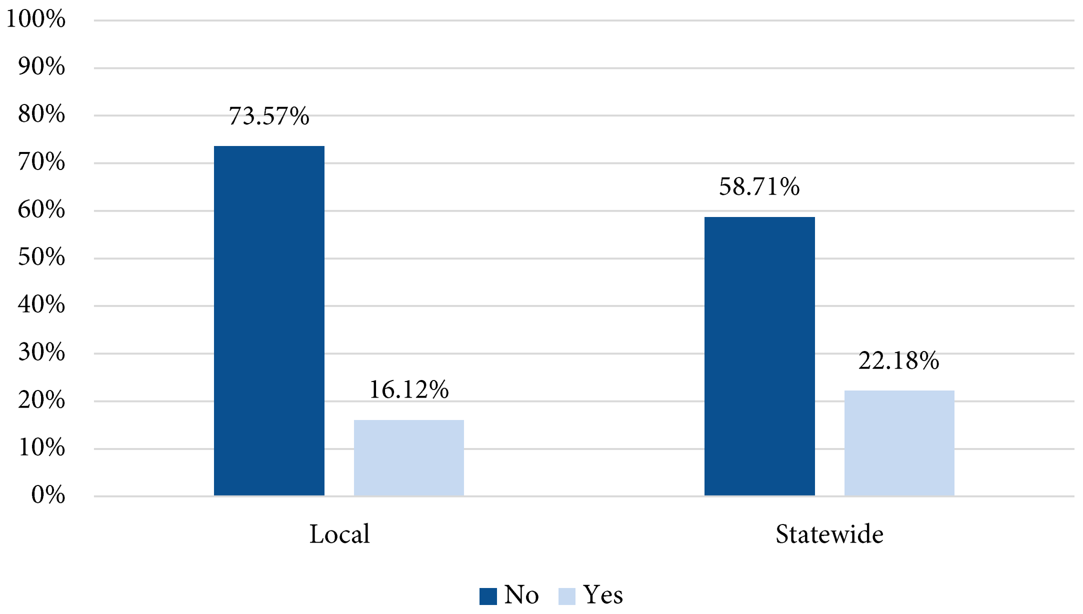
Exhibit 5.31: Assistance from ADRC Representatives with Long-Term Care Plan



Note: Percentages are weighted.

As shown in Exhibit 5.32, subgroup analyses of assistance from ADRC representatives revealed that statewide ADRCs were significantly more likely than local sites to assist respondents with long-term care planning (22% vs. 16%; $p \leq .05$). Detailed results may be found in Appendix FF, Exhibit 1.

Exhibit 5.32: Assistance from ADRC Representatives with Long-Term Care Plan by Agency Type



Note: Percentages are weighted.

As shown in Exhibit 5.33, 71 percent of respondents who received assistance with long-term care planning reported that the plan definitely reflected the client's needs and preferences, while less than 5 percent reported that it definitely did not.

Exhibit 5.33: Accuracy of Long-Term Care Plan

Long-Term Care Plan Accurately Reflects Client's Needs and Preferences	Percentage
Yes, definitely	70.84
Yes, probably	18.74
No, probably not	2.09
No, definitely not	4.82
Don't know	3.51
Refused	-
Total	100

Note: This question was asked of all those who responded "Yes" when asked if the representative of the ADRC worked with the client to develop a plan for obtaining LTSS. Percentages are weighted.

Regression Findings – Responsiveness and Effectiveness of ADRCs

Regression analyses were conducted to investigate the association of client, ADRC, and community characteristics with the responsiveness and effectiveness of ADRCs. The following two outcomes were explored:

- ADRC representative paid close attention to the respondent.
- ADRC representative explained the choices for staying in the community.

In this section, we discuss only those associations with client, ADRC, and community characteristics that are statistically significant at the 95 percent or higher confidence level. Average marginal effects and the p-value of the estimates are reported in parentheses. The complete results of these regression models are provided in Appendix JJ, Exhibit 1.

ADRC Representative Paid Close Attention to the Respondent. The first outcome captures whether the ADRC representative paid close attention to what the respondent said. The survey question offered four ordered options. Small sample sizes for some of the response categories precluded the implementation of ordered choice regression models. Therefore, in order to run a probit regression model with a binary outcome, “Yes, Definitely” and “Yes, Probably” were recoded into a single “Yes” category, and “No, Definitely Not” and “No, Probably Not” into a single “No” category. In addition to the ADRC, community, and client characteristics, the reasons for contact were also included to capture unobserved ADRC and respondent characteristics. Detailed results are shown in Appendix JJ, Exhibit 1, column 1.

Respondents with disabilities and those who called the ADRC on their behalf were less likely to report that the ADRC representative paid close attention to what they said were than older adults who did not report disabilities (-4.9 percentage points; $p \leq .05$). Married clients were also less likely than unmarried clients to report that they received close attention from the ADRC representative (-7.9 percentage points; $p \leq .01$). However, clients with a high school diploma were more likely to find that the representative paid closer attention than did those who did not have a high school diploma (7.0 percentage points; $p \leq .05$).

Respondents contacting rural ADRCs were more likely than those contacting urban ADRCs to report that they received close attention from the agency representative (11.9 percentage points; $p \leq .01$). Statewide ADRCs were associated with a higher likelihood of respondents receiving close attention compared to local ADRCs (11.2 percentage points; $p \leq .01$).

The results of the analysis of the number of home health agencies per 10,000 individuals 60 and above in a community and the number of nursing home beds per 1,000 individuals 60 years and above demonstrated opposite directions. The likelihood of respondents' reporting that they received close attention from ADRC representatives increased with the number of home health agencies within the ADRC service area (17.7 percentage points; $p \leq .01$) whereas the likelihood decreased with the number of nursing home beds in the ADRC service area (-54.1 percentage points; $p \leq .01$).

ADRC Representative Explained the Choices for Staying in the Community. The second outcome that was analyzed was whether the ADRC representative explained to the respondent the choices for staying in the community. This model includes all client, ADRC, and community characteristics, including reasons for contact. Detailed findings are presented in Appendix JJ, Exhibit 1, column 2.

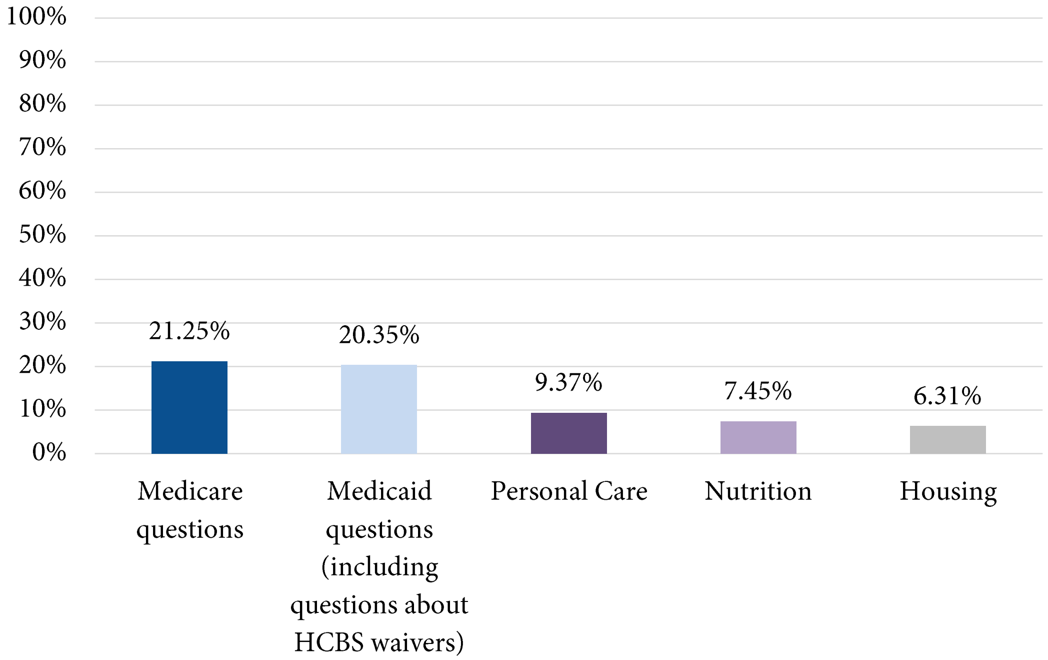
Clients with a disability or respondents who called on their behalf had a higher likelihood of reporting that the ADRC representative explained their choices for staying in the community than did those without a disability (19.5 percentage points; $p \leq .01$). Clients with self-reported poor health status or respondents who called on their behalf were also more likely to report that the ADRC representative explained choices for staying in the community than did those with a better self-reported health status (19.6 percentage points; $p \leq .01$). Finally, we found that respondents contacting statewide ADRCs were associated with a lower likelihood of the ADRC representative explaining their choices to stay in the community than those contacting non-statewide agencies (-31.8 percentage points; $p \leq .01$).

5.2.3 Assistance with Services

Reasons for and Results of Contacting ADRCs

Reasons for Contact. Exhibit 5.34 presents the five most common reasons why respondents contacted ADRCs. Approximately one-fifth of respondents contacted the ADRCs for Medicare-related questions (21%) and about the same proportion contacted for Medicaid-related questions (20%). In Exhibit 5.35, we compare the most common reasons for contact by category of respondent. Among older adults without disability, Medicare was the most frequent reason for contact (36%) whereas for both older adults with disability (25%) and younger adults with disability (26%) the most frequent reason for contact was personal care. While personal care and attendant care services are among the most common reasons for contact by older and younger individuals with disability, it was not one of the five most common reasons for contact for older adults without disability. The reasons for contacting an ADRC differed by respondent type. Clients who contacted ADRCs for themselves most commonly contacted for Medicare information (25%), whereas individuals who contacted on behalf of a client most commonly requested information about personal care services (29%) (Exhibit 5.36).

Exhibit 5.34: Most Common Reasons for Contacting ADRCs



Note: Percentages are weighted.

Exhibit 5.35: Most Common Reasons for Contacting ADRCs by Age and Disability Status

Older Adults without Disability	Freq.	%	Older Adults with Disability	Freq.	%	Younger Adults with Disability	Freq.	%
Medicare	39	36.11	Personal Care	109	24.55	Personal Care	35	26.72
Housing	10	9.26	Medicaid	54	12.16	Medicare	15	11.45
Income Assistance	7	6.48	Medicare	42	9.46	Attendant Care Services	14	10.69
Medicaid	6	5.56	Attendant Care Services	36	8.11	Medicaid	9	6.87
Energy Assistance	4	3.70	Housing	32	7.21	Housing	8	6.11

Notes: Frequencies are unweighted; percentages are weighted. They do not add to 100 because the exhibit shows only the five most common reasons for contact.

Exhibit 5.36: **Most Common Reasons for Contacting ADRCs by Self versus Representatives**

Self	Frequency	Percentage	Representative	Frequency	Percentage
Medicare	72	24.66	Personal Care	75	28.85
Personal Care	37	12.67	Medicaid	39	15.00
Medicaid	21	7.19	Attendant Care Services	26	10.00
Housing	19	6.51	Housing	23	8.85
Transportation	14	4.79	Caregiver/Respite support	13	5.00

Note: Frequencies are unweighted; percentages are weighted. They do not add to 100 because the exhibit shows only the five most common reasons for contact.

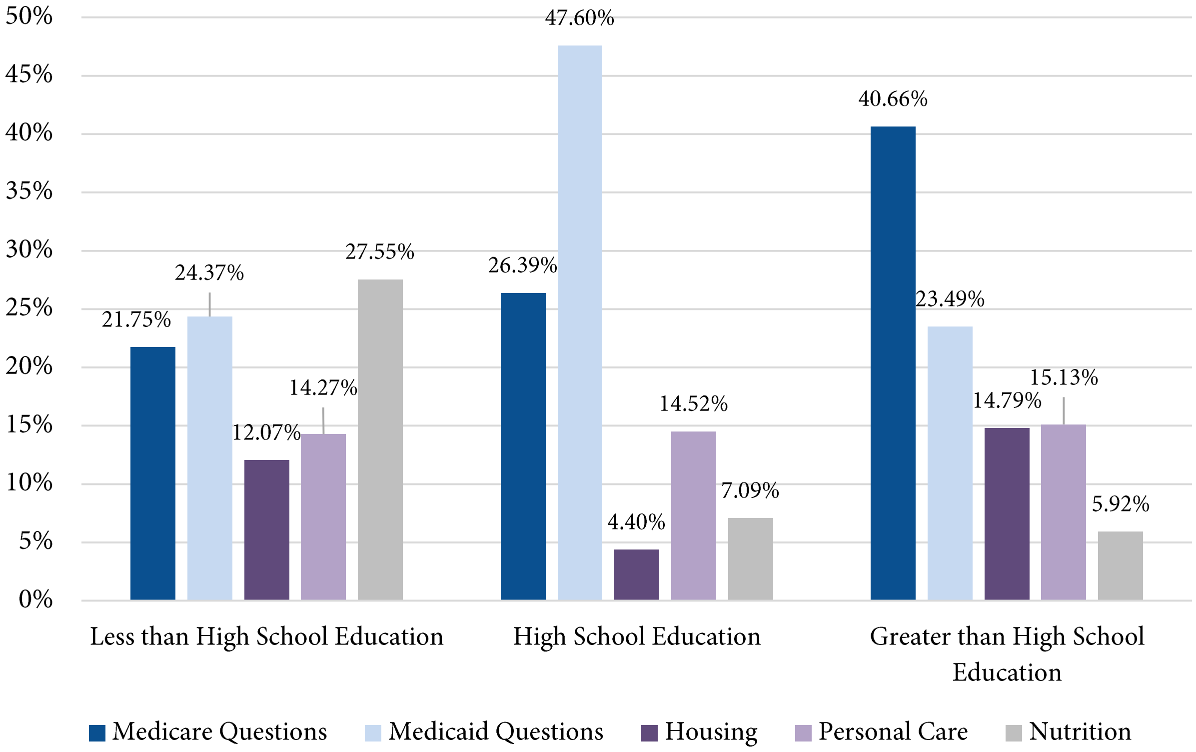
Several analyses were conducted to identify statistically significant differences between subgroups based on reason for contacting the ADRC. Differences in reasons by client education, income, age, disability, and health status were examined, as well as whether the respondent contacted an urban or rural, statewide or local ADRC.

As shown in Exhibit 5.37, there were significant between-group differences based on education. Respondents with greater than a high school education were significantly more likely than clients with a high school diploma or less to contact ADRCs about Medicare and housing ($p \leq .10$). Clients with a high school diploma were more likely than those with more or with less education to contact ADRCs about Medicaid ($p \leq .10$). Clients without a high school diploma were more likely than others to contact ADRCs about nutrition ($p \leq .10$, Exhibit 5.37). See Appendix Z, Exhibit 1, for detailed results. Analyses also indicated that clients with a disability were more likely than clients without a disability to cite one of the five most common reasons for ADRC contact except for Medicare questions ($p \leq .01$, Exhibit 5.38). See Appendix CC, Exhibit 1 for detailed results.

Respondents who self-reported their health as poor were significantly more likely than those who reported fair, good, or excellent health to inquire about Medicaid, personal care services, and nutrition services ($p \leq .05$, Exhibit 5.39). For detailed results, see Appendix BB, Exhibit 1. Statistically significant differences were also found between urban and rural ADRCs. Respondents contacting rural ADRCs were less likely to cite Medicaid questions and housing services as the reason for contact compared to respondents from urban ADRCs ($p \leq .10$, Exhibit 5.40). There were no significant differences between rural and urban ADRCs in terms of the percentage of respondents contacting them for personal care and nutrition services ($p \leq .10$). See Appendix DD,

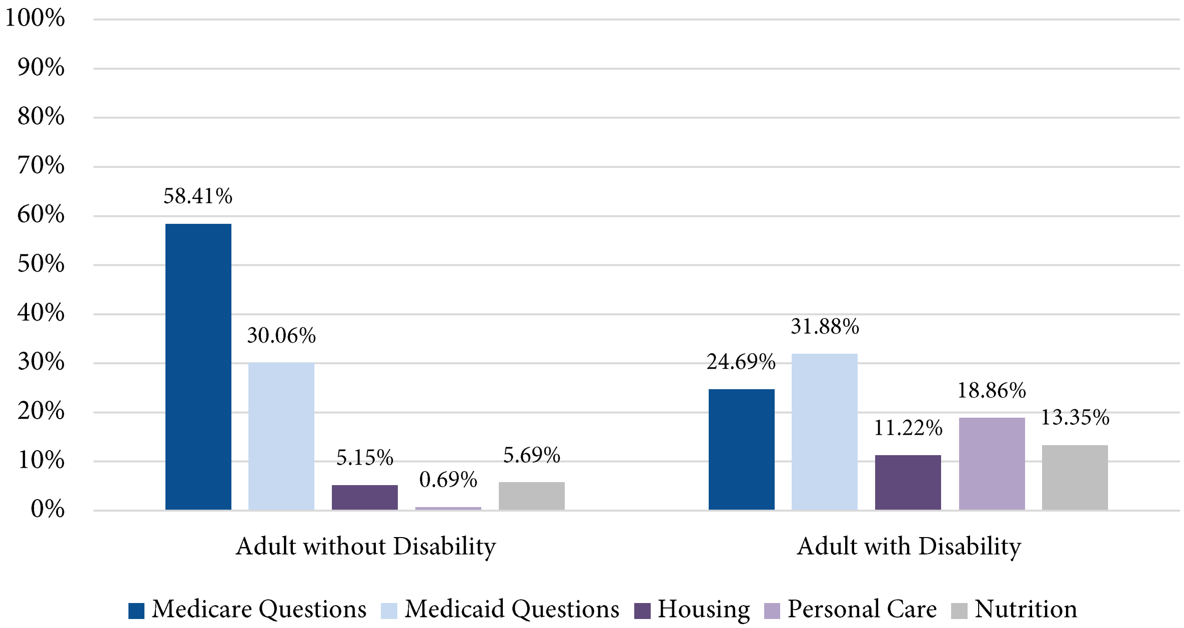
Exhibit 1 for details. Clients who contacted local ADRCs were significantly more likely than clients who contacted statewide ADRCs to inquire about the top five reasons, as seen in Exhibit 5.41 ($p \leq .01$). See Appendix FF, Exhibit 2 for detailed results.

Exhibit 5.37: Most Common Reasons for Contacting ADRCs by Client Education



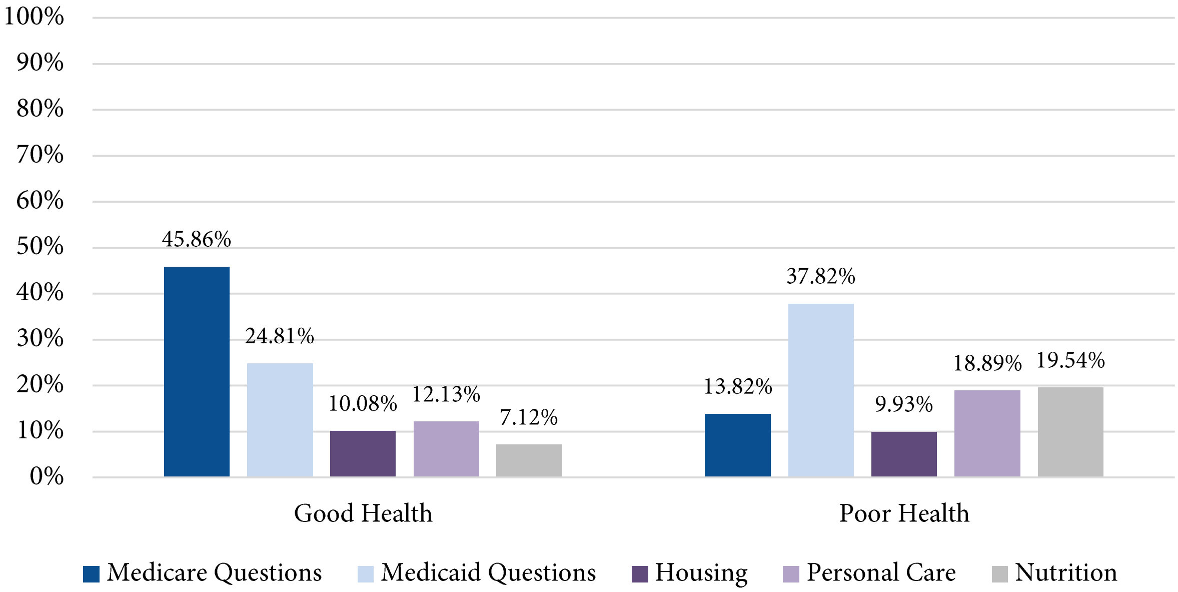
Note: Percentages are weighted.

Exhibit 5.38: Most Common Reasons for Contacting ADRCs by Disability Status



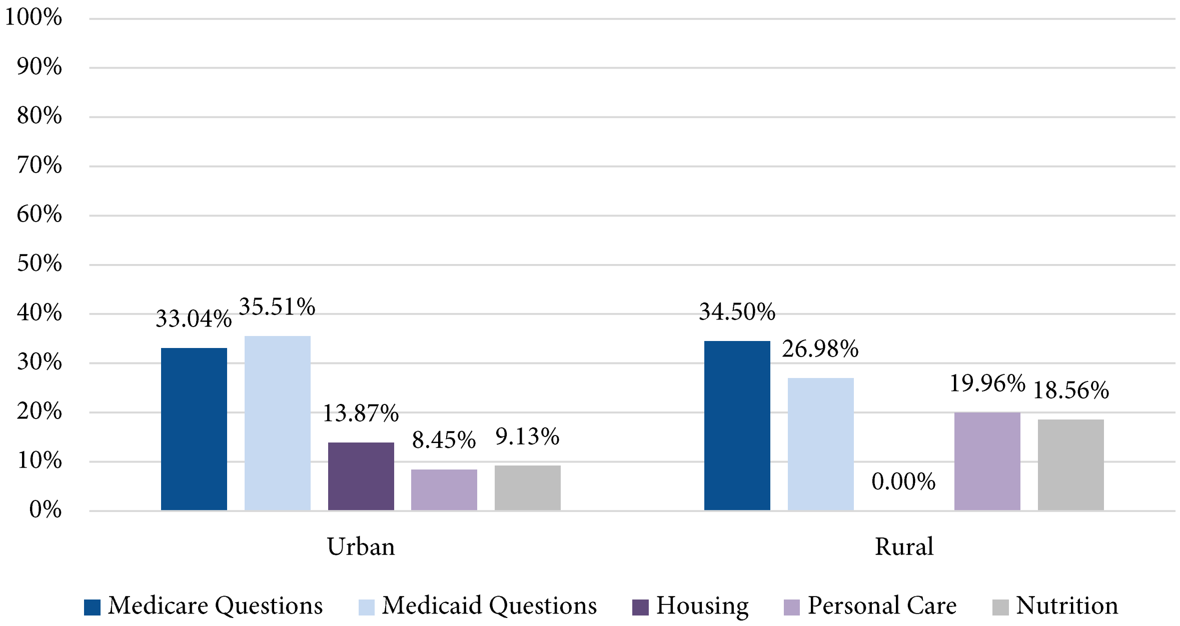
Note: Percentages are weighted.

Exhibit 5.39: Most Common Reasons for Contacting ADRCs by Client Health



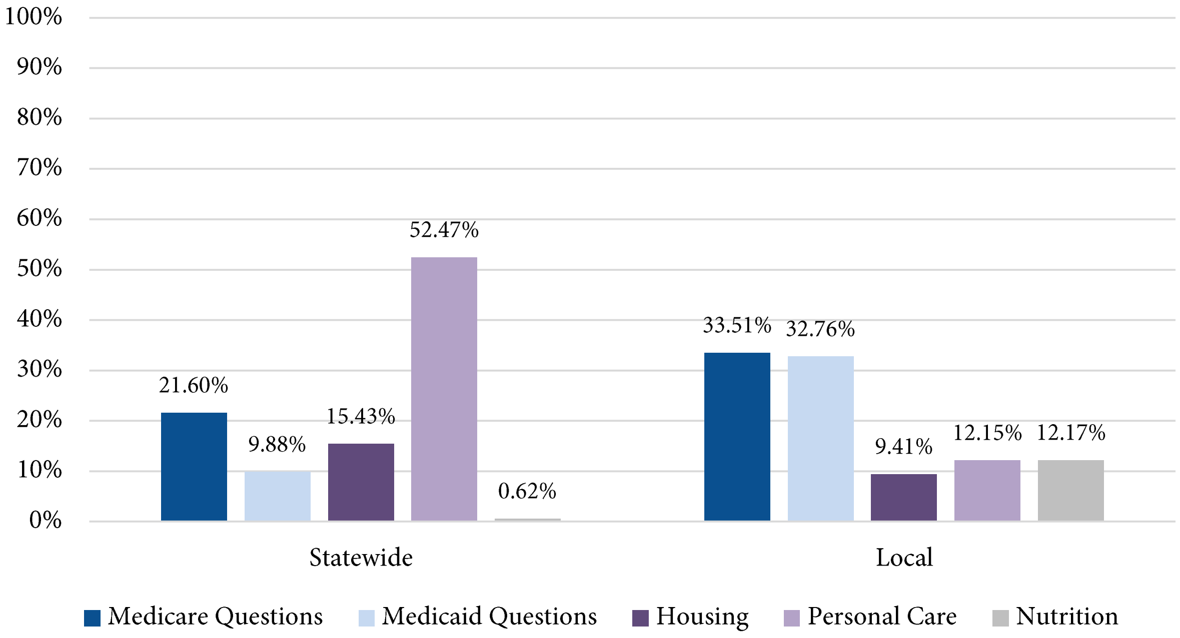
Note: Percentages are weighted.

Exhibit 5.40: Most Common Reasons for Contacting ADRCs by Agency Location



Note: Percentages are weighted.

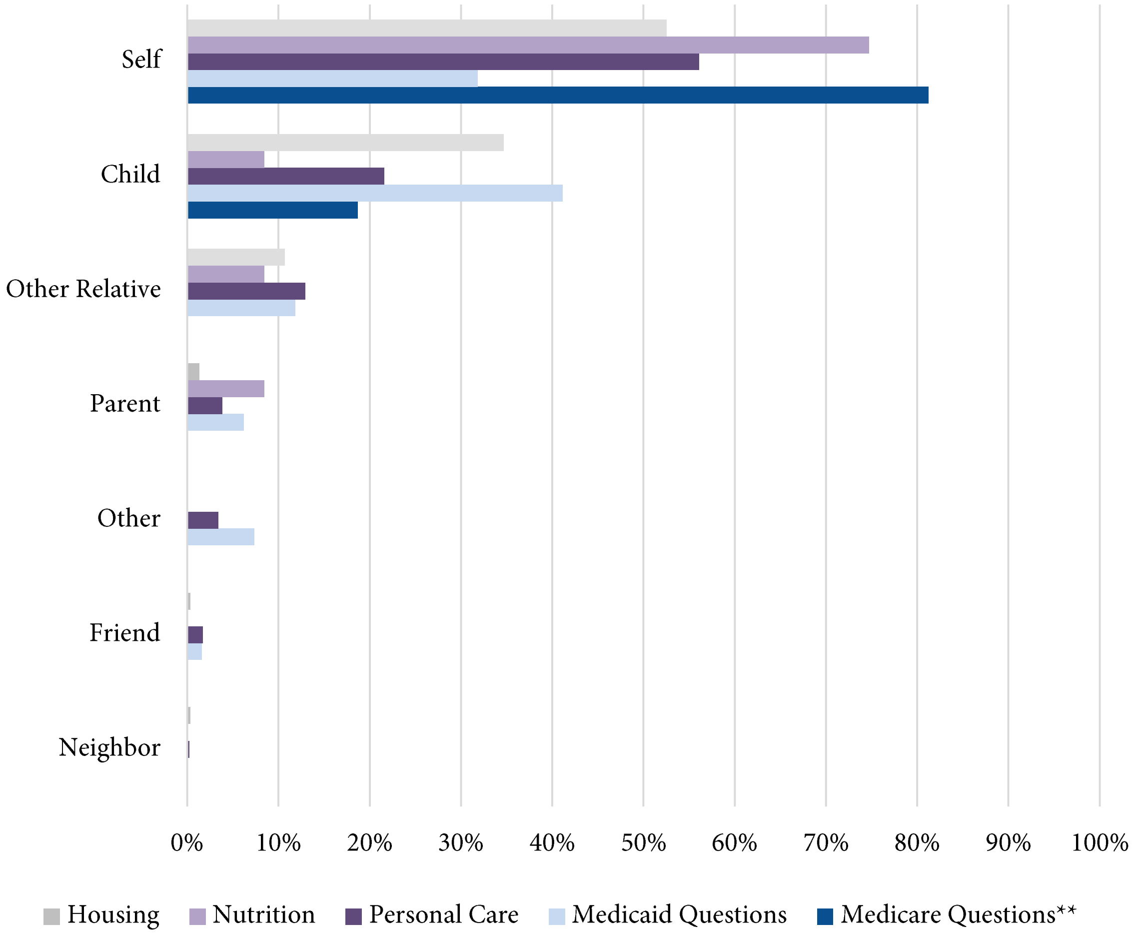
Exhibit 5.41: Most Common Reasons for Contacting ADRCs by Agency Coverage



Note: Percentages are weighted.

Similarly, survey respondents who contacted the agency on their own behalf were significantly more likely than respondents who called on behalf of others to cite one or more of the five most common reasons for contact ($p \leq .10$) (Exhibit 5.42). The only instance where this was not the case was for Medicaid questions, where more respondents calling on behalf of a parent asked about Medicaid compared to those who called on their own behalf.

Exhibit 5.42: Most Common Reasons for Contacting ADRCs by Respondent Type



Notes: The respondent type indicates the relationship of the respondent to the person on whose behalf the contact was made. Therefore, the rows for child and parent have switched when compared to Appendix T, Exhibit PP2, which reports the relationship status of the person on whose behalf the contact was made from the perspective of the respondents. While the exhibit in the appendix reports the survey options as they appear in the questionnaire, this recoding was done based on how other questions in the survey were phrased.
Percentages are weighted.

Regression Findings – Reasons for Contact

Exhibit 5.34 shows that the three most frequently cited reasons why respondents contacted ADRCs were:

- Medicare questions
- Medicaid questions
- Personal care.

Regression analyses were conducted to explore the relationship between client, ADRC, and community characteristics and the most common reasons for contacting ADRCs. Appendix JJ, Exhibit 2 shows the detailed regression results.

Medicare Questions. The estimated average marginal effects from the probit regressions on Medicare questions as a reason for contact are presented in Appendix JJ, Exhibit 2, column 1. Clients who lived alone or respondents who contacted ADRCs on behalf of such individuals were more likely to have questions about Medicare compared to clients who lived with others (10.5 percentage points; $p \leq .01$). In addition, married clients were more likely than unmarried clients to contact the ADRCs regarding Medicare (12.8 percentage points; $p \leq .01$). Individuals contacting statewide ADRCs were more likely than those contacting local ADRCs to have Medicare questions (72.5 percentage points; $p \leq .01$).

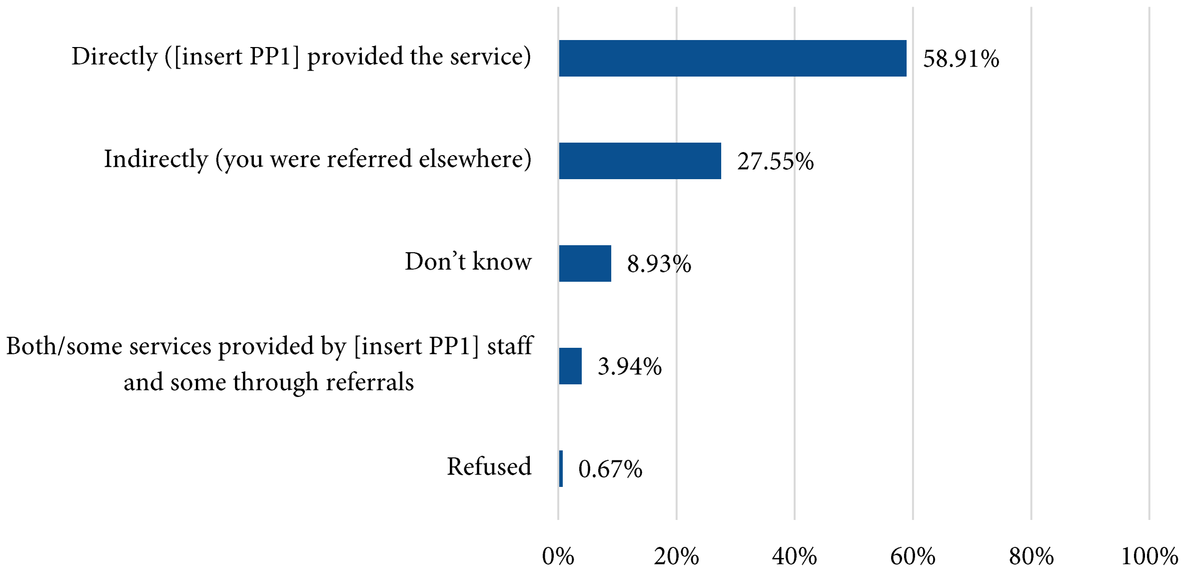
Medicaid Questions. The association of client, ADRC, and community variables with Medicaid questions as the main reason for contacting ADRCs is shown in Appendix JJ, Exhibit 2, column 2. Those who were single, widowed, or divorced were more likely than married clients to contact regarding Medicaid (-14.8 percentage points; $p \leq .05$). Moreover, White non-Hispanic clients were more likely to contact the ADRCs regarding Medicaid than were non-Whites and Hispanic clients (17.6 percentage points; $p \leq .01$). Finally, respondents who contacted statewide ADRCs were significantly more likely to request Medicaid information than respondents who contacted local ADRCs (74.9 percentage points; $p \leq .01$).

Personal Care. The third most common reason for contacting ADRCs was personal care. The average marginal effects from the probit regression analysis with personal care as the reason for contact are presented in Appendix JJ, Exhibit 2, column 2. Statistically significant findings resulted from these analyses. For example, respondents with disabilities were more likely than clients without disabilities to contact ADRCs for personal care reasons (10.3 percentage points; $p \leq .01$). At the ADRC level, respondents were more likely to contact rural ADRCs for personal care reasons than respondents from urban ADRCs (42 percentage points; $p \leq .01$). Furthermore, the larger the number of nursing home beds in the ADRC service area, the greater the likelihood that respondents contacted ADRCs for personal care reasons (3.1 percentage points; $p \leq .05$). However, the more home health agencies in the community, the lower the likelihood of respondents contacting ADRCs for personal care reasons (-1.2 percentage points; $p \leq .05$).

Direct Access to Services

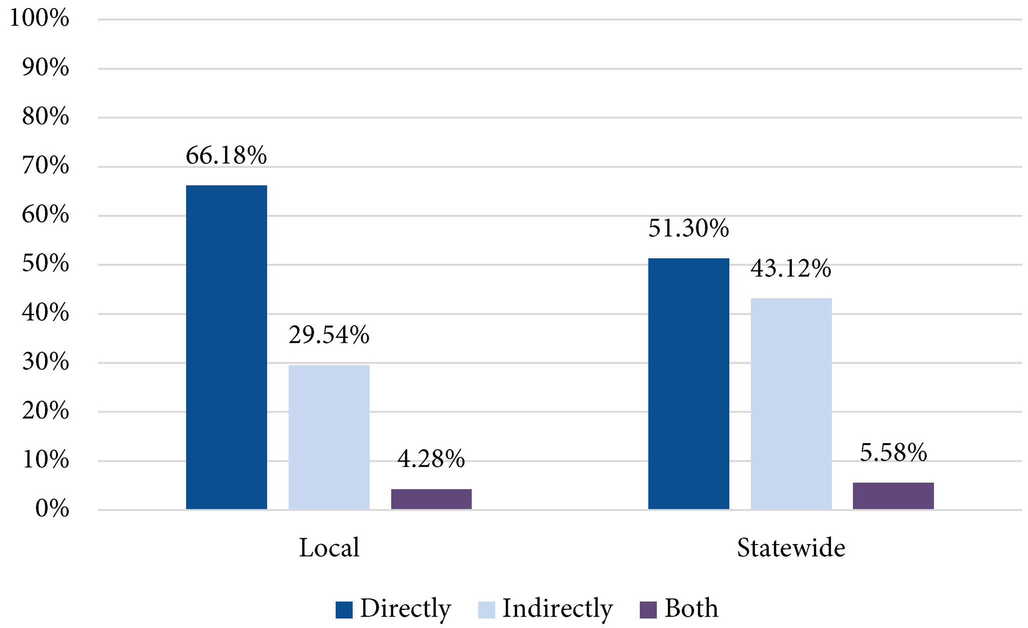
Survey participants were asked whether needed services were received directly from ADRCs or indirectly through referrals to another agency, or both. A majority of respondents (59%) reported that access to the services was received directly from the ADRC (Exhibit 5.43). Nearly 28 percent reported that needed services were received indirectly by a referral to another agency. How respondents received access to services was analyzed to identify statistically significant differences by several ADRC-level subgroups. The only statistically significant difference was between statewide and local ADRCs. Respondents from local ADRCs were more likely than those from statewide ADRCs to report that they received access to needed services directly from the site ($p \leq .05$) (Exhibit 5.44). Detailed results are presented in Appendix FF, Exhibit 3. Finally, of the respondents who reported that access to needed services was received indirectly through another agency, 62 percent reported that the ADRC representative helped them connect with the services they needed. Nearly 36 percent reported that their ADRC representative did not help them connect with needed services (Exhibit 5.45).

Exhibit 5.43: Direct Access to Needed Services



Note: Percentages are weighted.

Exhibit 5.44: Direct Access to Needed Services by Agency Type



Note: Percentages are weighted.

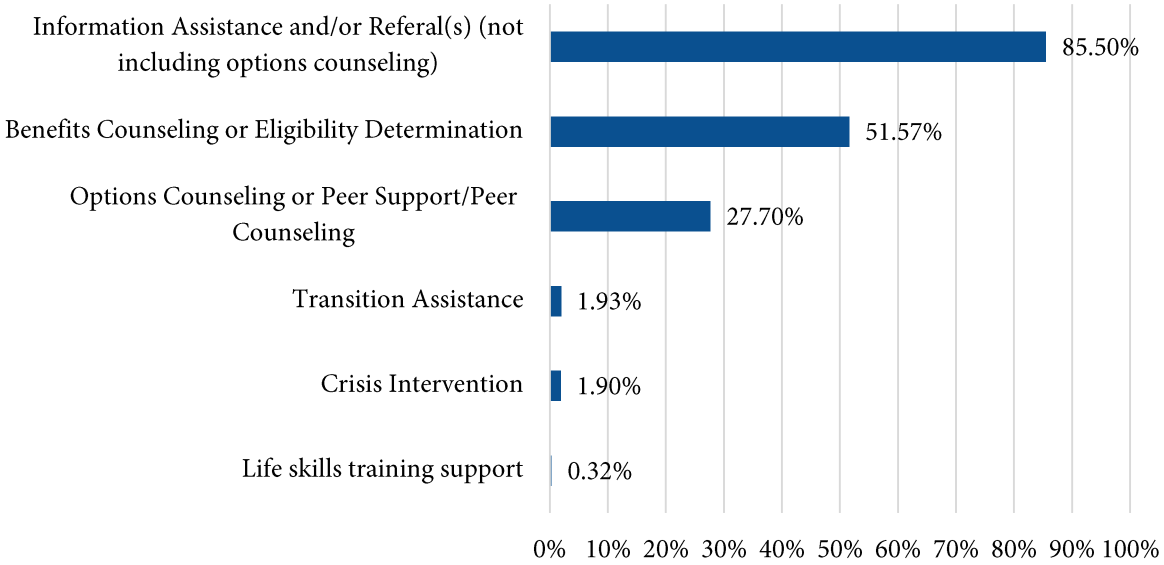
Exhibit 5.45: ADRC Representative Connected Respondent to Needed Services

Helped Connect to Services*	Percentage
Yes	61.91
No	35.65
Don’t know	2.44
Refused	-
Total	100

Note: This question was asked of all respondents who did not respond “Directly” when asked how they received access to services. Percentages are weighted.

Results of Contact. Exhibit 5.46 presents the results of analyses on respondents’ contact with ADRCs. Information assistance and/or referrals were selected most often as the result of the contact (86%). More than half of the respondents (52%) reported that their contact resulted in benefits counseling or eligibility determination, and over one-quarter (28%) reported that their contact resulted in options counseling or peer support/counseling.

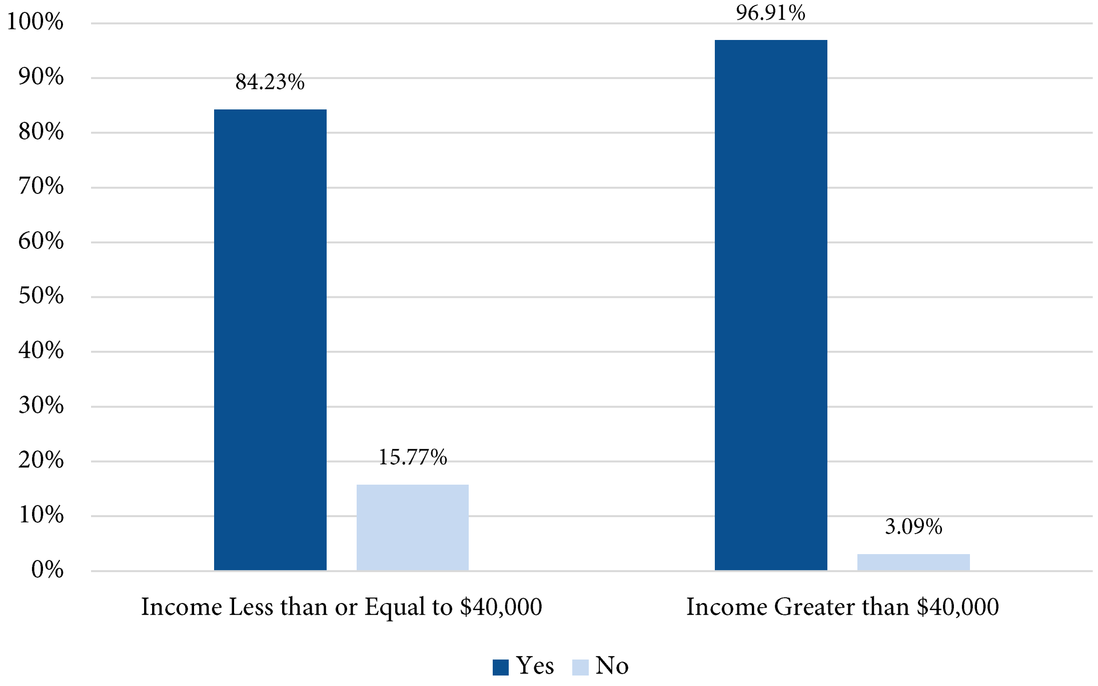
Exhibit 5.46: Results of Contact with ADRCs



Notes: Percentages are weighted. Percentages do not add up to 100 because respondents could choose multiple options.

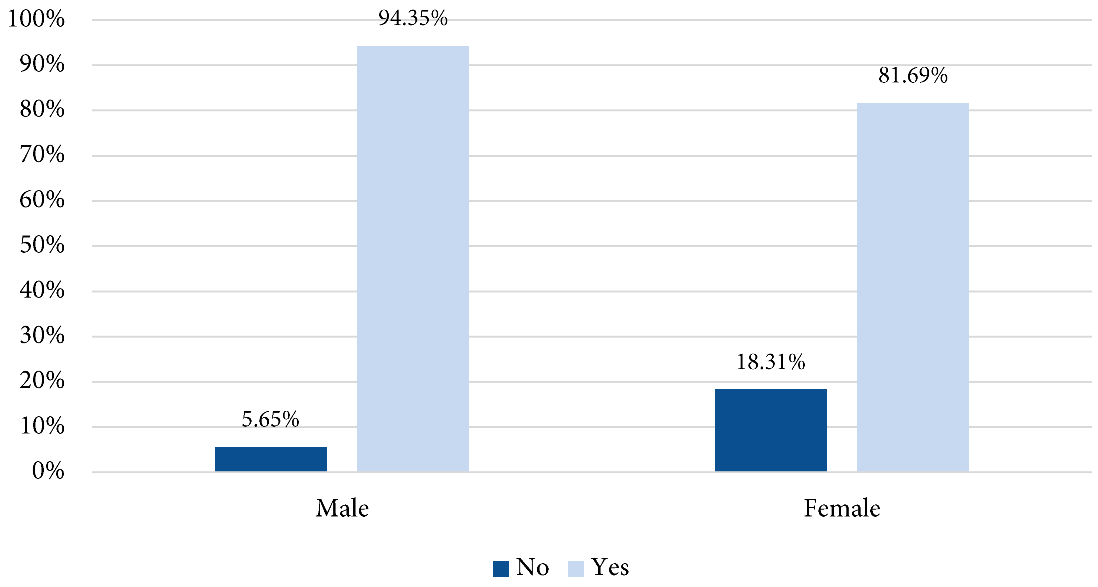
The results of contact with ADRCs were analyzed by client and ADRC characteristics. There were statistically significant between-group differences for income, gender, and local versus statewide ADRC on receiving I&R/I&A. Specifically, respondents with income of $40,000 or less as compared to those with income over $40,000 ($p \leq .01$), those who are female as compared to male ($p \leq .01$), and those who contacted a local ADRC as compared to a statewide ADRC, ($p \leq .01$) were more likely to receive information assistance or referrals as a result of their contact. In addition, there was a trend toward significance for those who contacted an urban ADRC being more likely ($p \leq .10$) to receive information assistance or referrals compared to those who contacted a rural ADRC. The results of these subgroup analyses are shown in Exhibits 5.47–5.50. Detailed results may be found in Appendix AA, Exhibit 1; Appendix X, Exhibit 1; Appendix FF, Exhibit 4; and Appendix DD, Exhibit 2, respectively.

Exhibit 5.47: Information Assistance as Result of Contact by Client Income



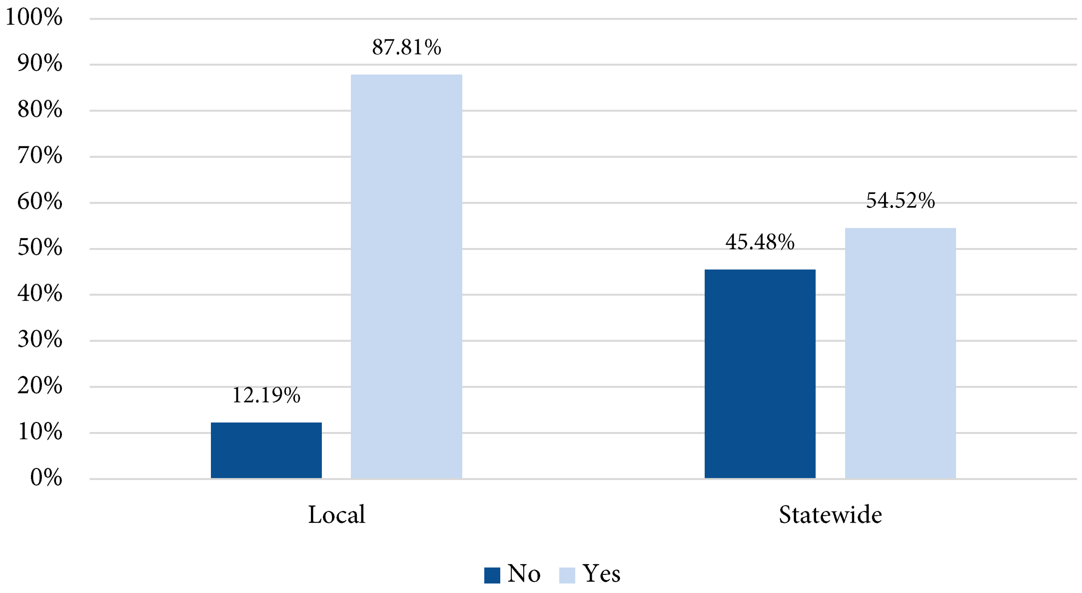
Note: Percentages are weighted.

Exhibit 5.48: Information Assistance as Result of Contact by Client Gender



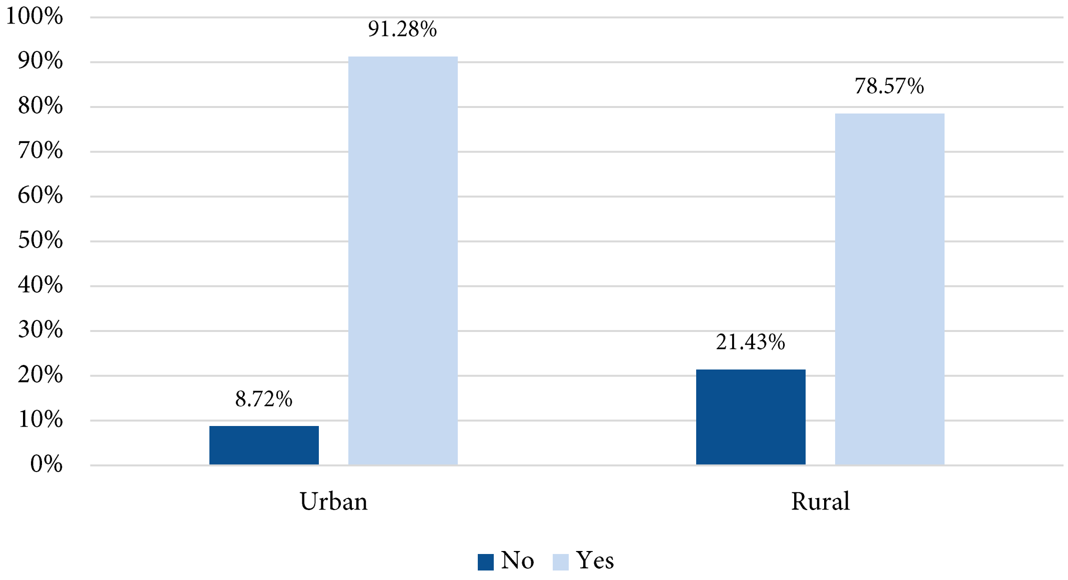
Note: Percentages are weighted.

Exhibit 5.49: Information Assistance as Result of Contact by Agency Coverage



Note: Percentages are weighted.

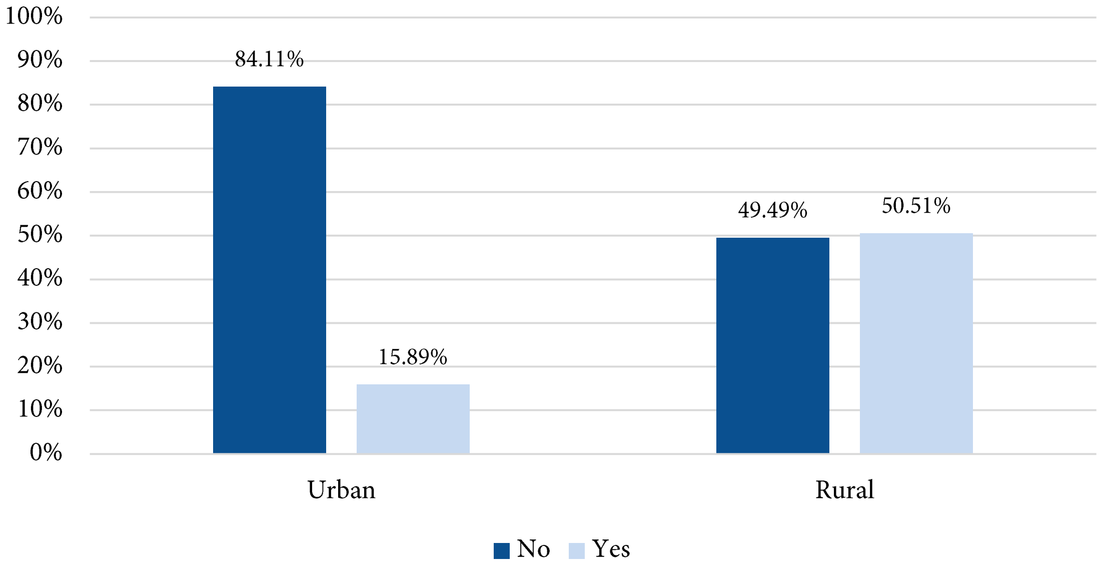
Exhibit 5.50: Information Assistance as Result of Contact by Agency Location



Note: Percentages are weighted.

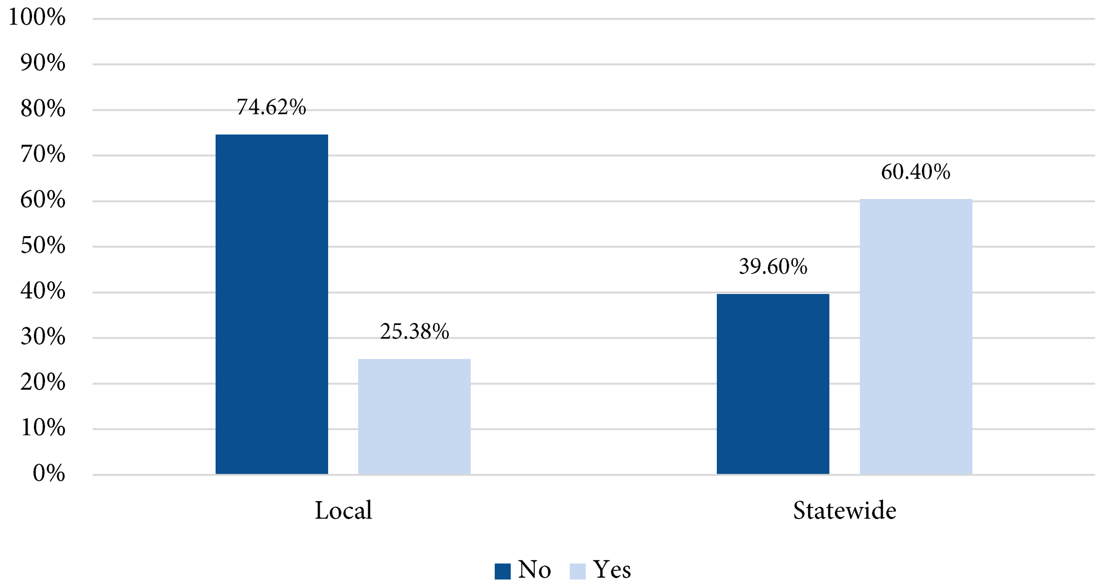
Significant differences were also revealed in the analyses of options counseling/peer support. Respondents who contacted rural ADRCs as compared to urban ADRCs, and those who contacted statewide ADRCs as compared to local ADRCs, were significantly more likely to receive options counseling ($p \leq .01$ and $p \leq .01$, respectively). Detailed results are presented in Appendix DD, Exhibit 3, and Appendix FF, Exhibit 5, respectively. Furthermore, respondents who contacted ADRCs that served 500–2,500 consumers in the previous 6 months (compared to those that served fewer than 500 or more than 2,500 consumers) and respondents who contacted ADRCs with more than 15 FTEs (compared to ADRCs with 0–5 and 5–15 FTEs) were less likely to receive options counseling or peer support/counseling as a result of their contact with ADRCs ($p \leq .01$ and $p \leq .05$, respectively). Detailed results are presented in Appendix GG, Exhibit 1 and Appendix HH, Exhibit 1, respectively. Age differences approached significance: adults aged 60 or older were more likely to receive options counseling or peer support/counseling as a result of their contact with an ADRC than adults under 60 years of age ($p \leq .10$). These results are presented graphically in Exhibits 5.51–5.55. For detailed results, see Appendix Y, Exhibit 1.

Exhibit 5.51: Counseling or Peer Support Options as Result of Contact by Agency Location



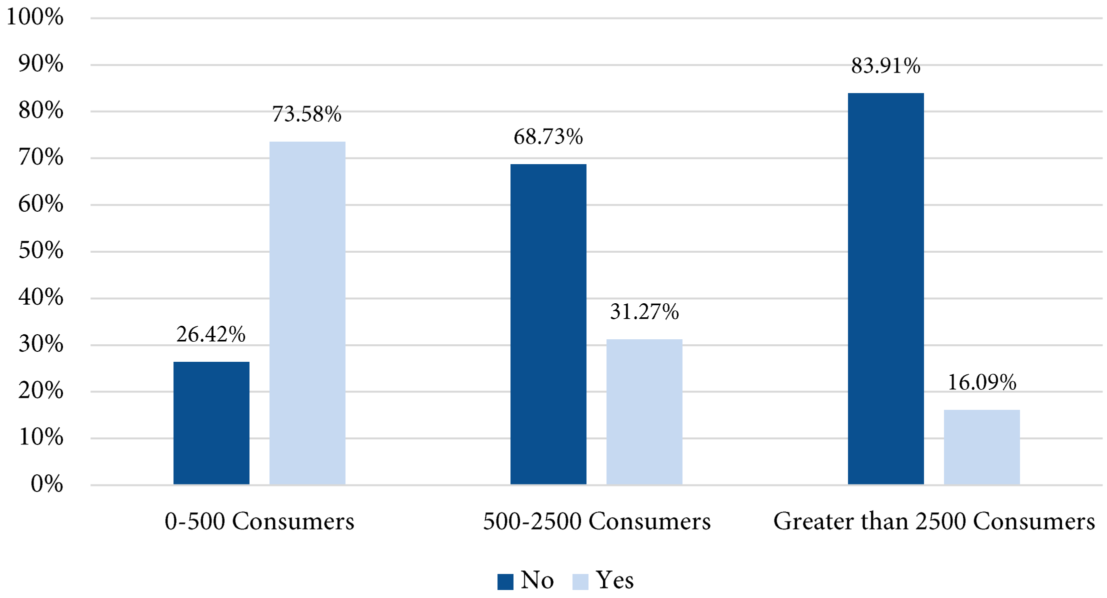
Note: Percentages are weighted.

Exhibit 5.52: Counseling or Peer Support Options as Result of Contact by Agency Coverage



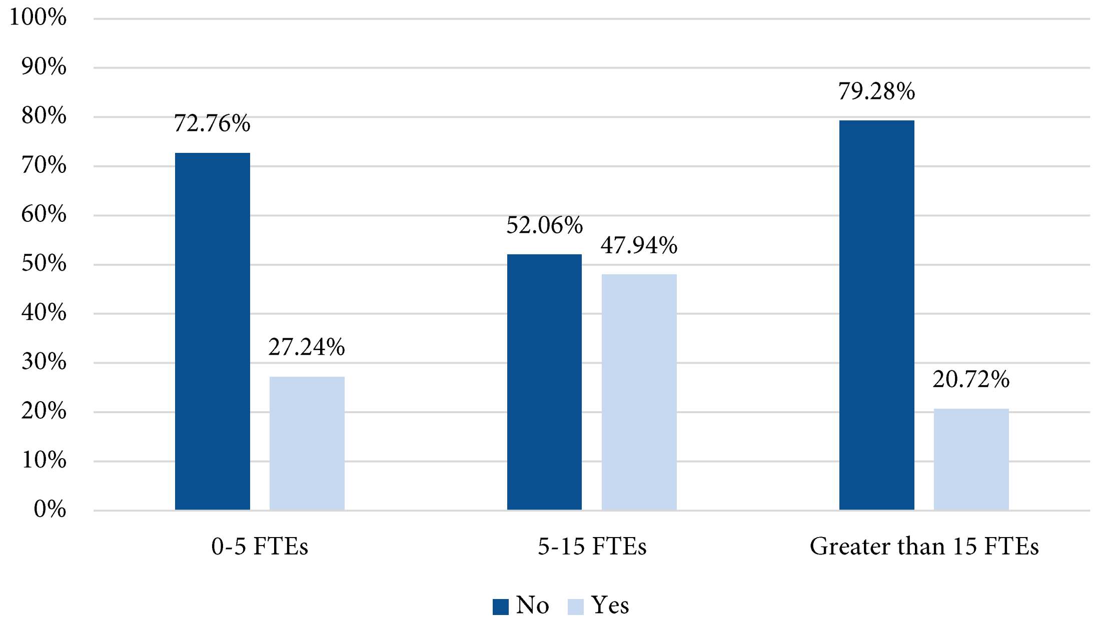
Note: Percentages are weighted.

Exhibit 5.53: Counseling or Peer Support as Result of Contact by Number of Consumers



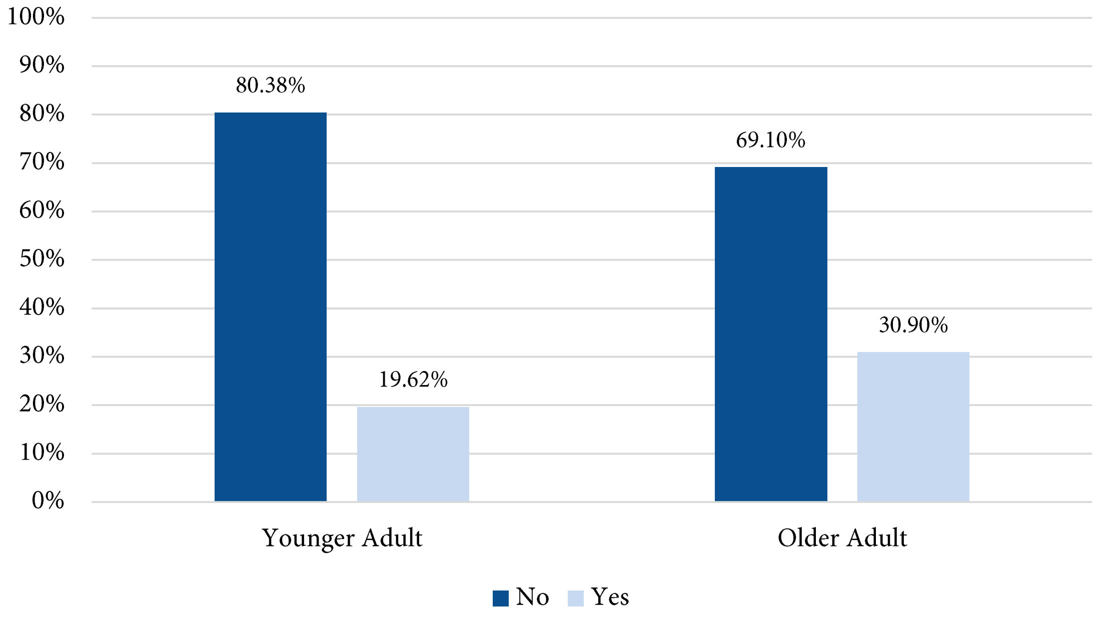
Note: Percentages are weighted.

Exhibit 5.54: Counseling or Peer Support as Result of Contact by Number of FTEs in ADRC



Note: Percentages are weighted.

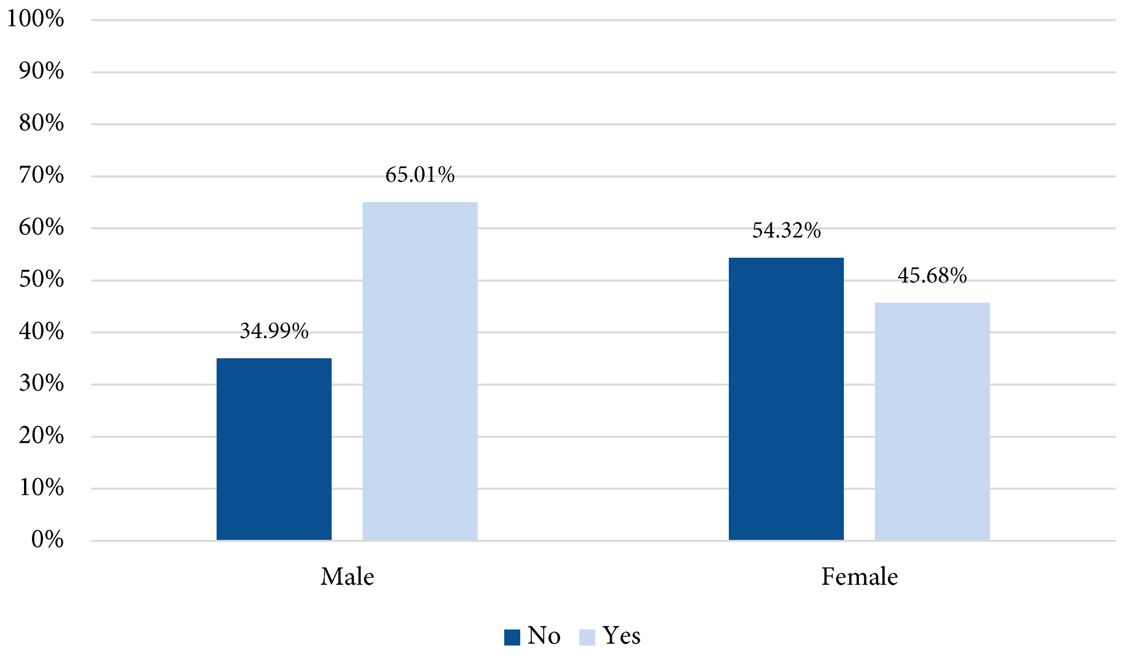
Exhibit 5.55: Counseling or Peer Support Options as Result of Contact by Client Age



Note: Percentages are weighted.

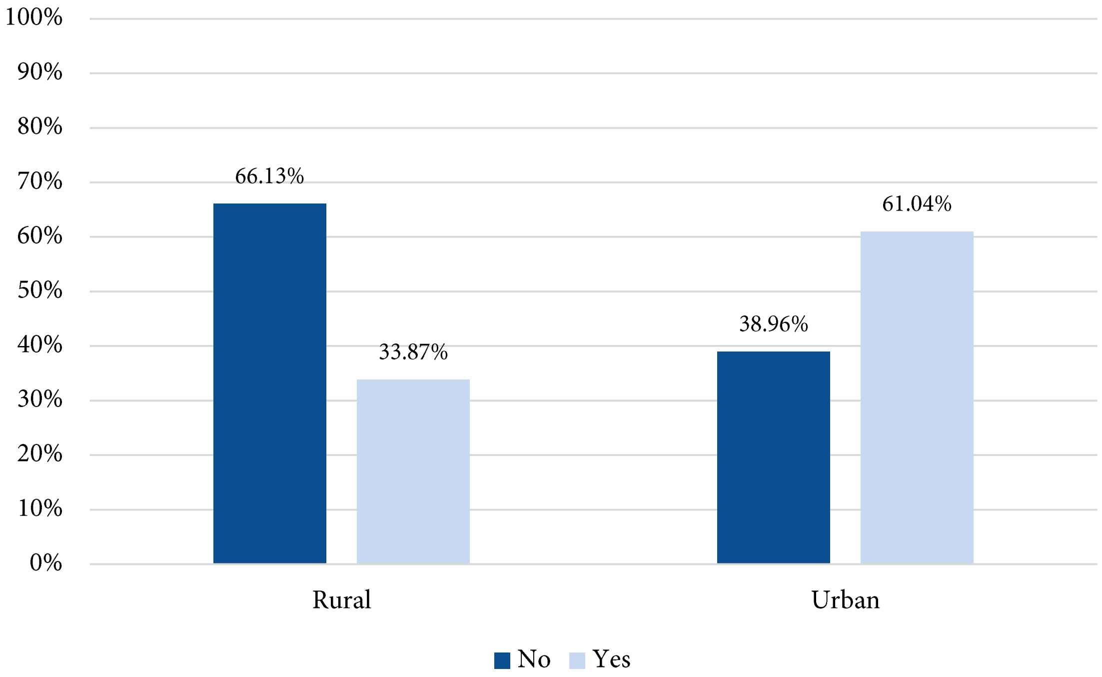
Several client and ADRC characteristics showed statistically significant differences in the likelihood of receiving benefits counseling or eligibility determination. For example, male clients were more likely than their female counterparts to receive benefits counseling or eligibility determination as a result of their contact with ADRCs ($p \leq .05$). For detailed results, see Appendix X, Exhibit 2. Respondents contacting urban (compared to rural) or local (compared to statewide) ADRCs were also more likely to receive benefits counseling or eligibility determination services ($p \leq .01$ and $p \leq .01$, respectively). For detailed results, see Appendix DD, Exhibit 4 and Appendix FF, Exhibit 6, respectively. Respondents contacting medium-sized (compared to small and large) ADRCs, and ADRCs reporting fewer than 5 or more than 15 FTEs (compared to ADRCs with 5–15 FTEs) were more likely to receive benefits counseling or eligibility determination as a result of their contact with the ADRC ($p \leq .01$ and $p \leq .05$, respectively). For details, see Appendix GG, Exhibit 2 and Appendix HH, Exhibit 2, respectively. The results of these cross-tabulations are presented in Exhibits 5.56–5.60.

Exhibit 5.56: Benefits Counseling as Result of Contact by Client Gender



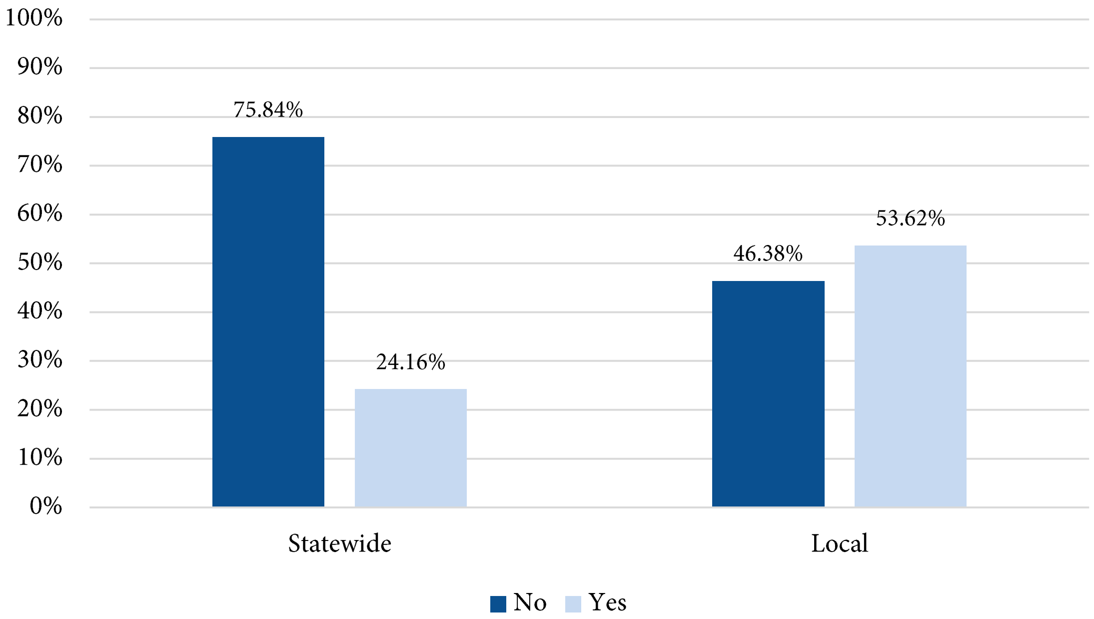
Note: Percentages are weighted.

Exhibit 5.57: Benefits Counseling as Result of Contact by Agency Location



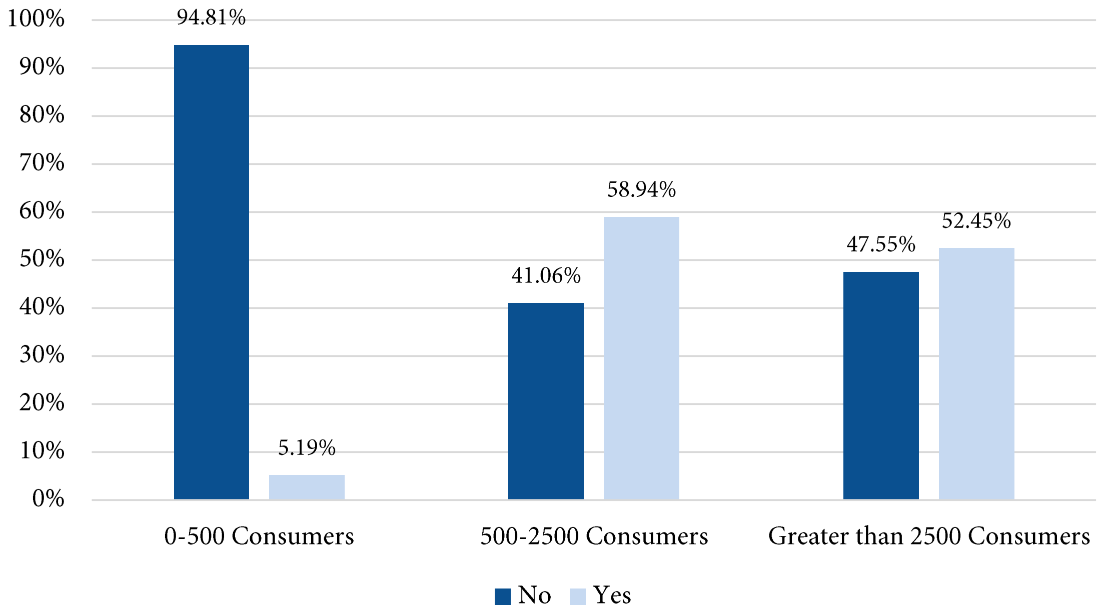
Note: Percentages are weighted.

Exhibit 5.58: Benefits Counseling as Result of Contact by Agency Coverage



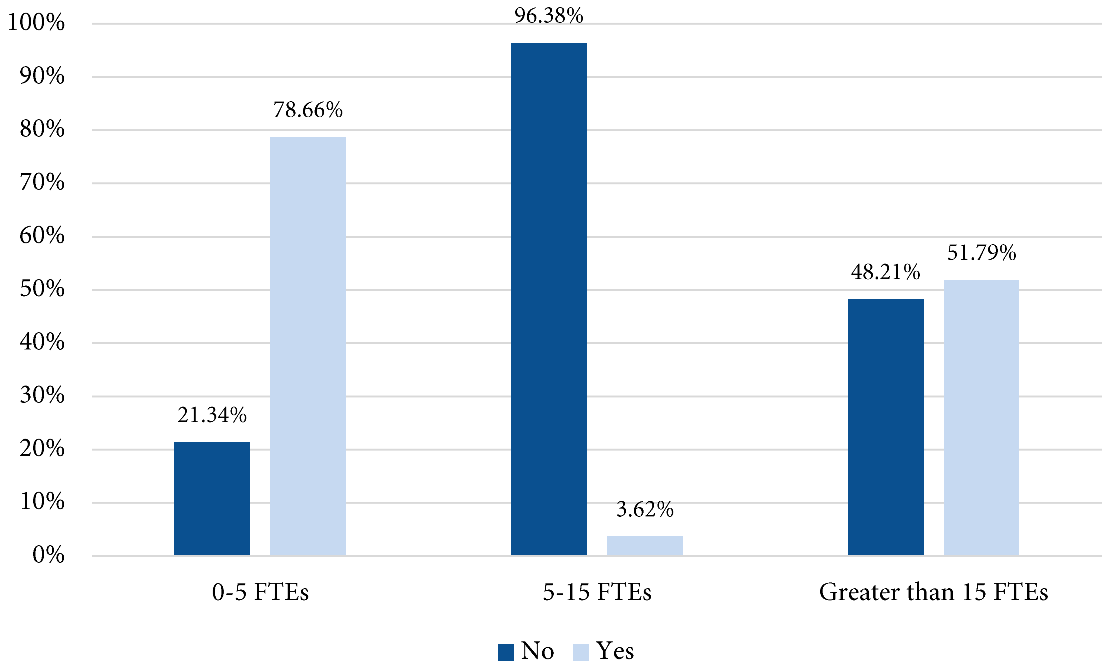
Note: Percentages are weighted.

Exhibit 5.59: Benefits Counseling as Result of Contact by Number of Consumers



Note: Percentages are weighted.

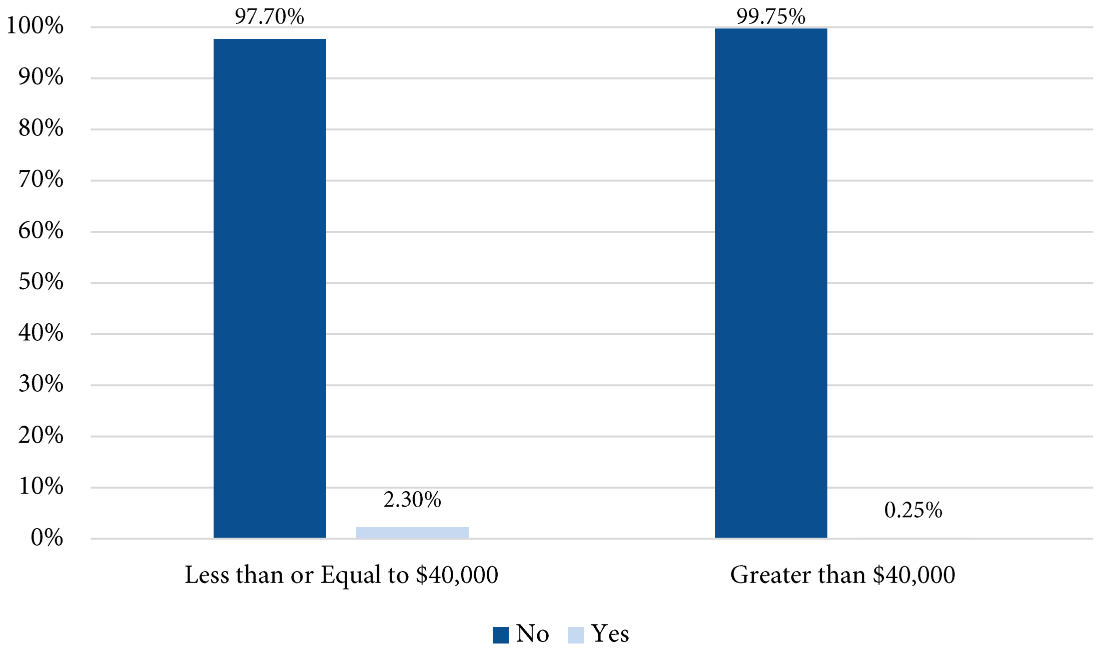
Exhibit 5.60: Benefits Counseling as Result of Contact by Number of FTEs in ADRC



Note: Percentages are weighted.

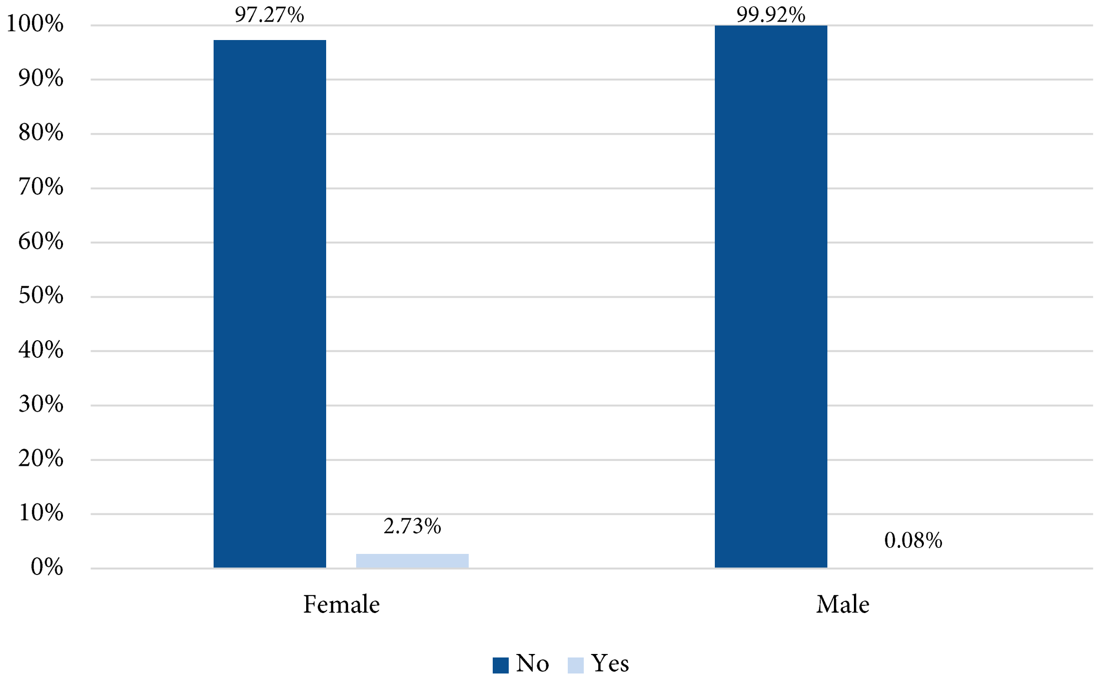
Group differences on care transition assistance were also statistically significant. Clients with an income of $40,000 or less compared to those with an income over $40,000 ($p \leq .05$), those who were female compared to male ($p \leq .01$), and clients with disability compared to those who did not have a disability ($p \leq .01$) were more likely to receive care transition assistance as a result of their contact with the ADRC. However, as shown, only 3 percent of respondents received care transition assistance. For detailed results, see Appendix AA, Exhibit 2; Appendix X, Exhibit 3; and Appendix CC, Exhibit 2, respectively. The results of these analyses are displayed below in Exhibits 5.61 - 5.63.

Exhibit 5.61: Care Transition Assistance as Result of Contact by Client Income



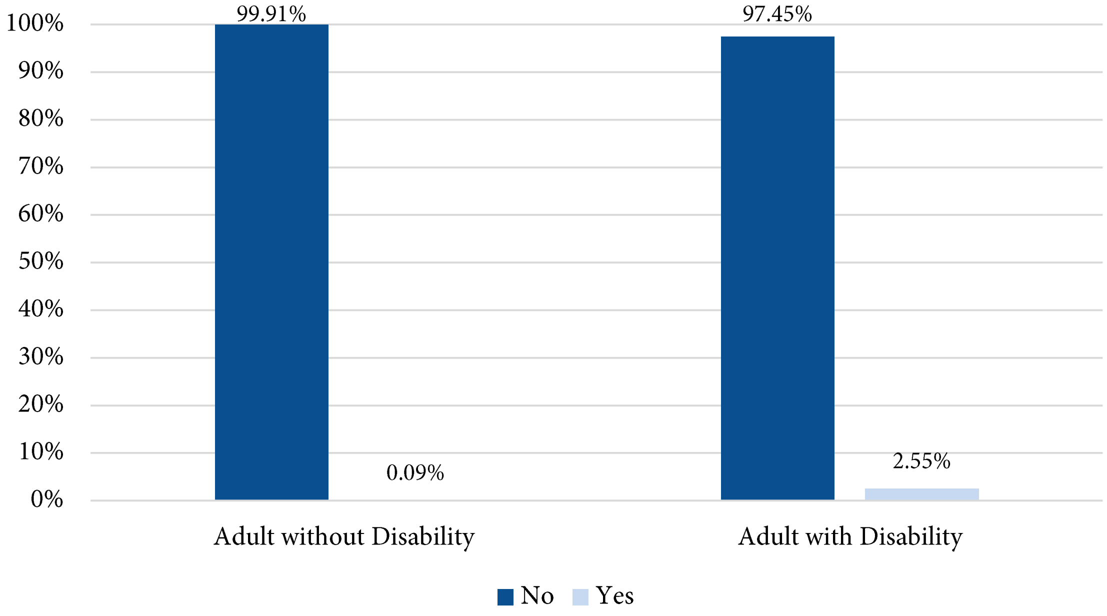
Note: Percentages are weighted.

Exhibit 5.62: Care Transition Assistance as Result of Contact by Client Gender



Note: Percentages are weighted.

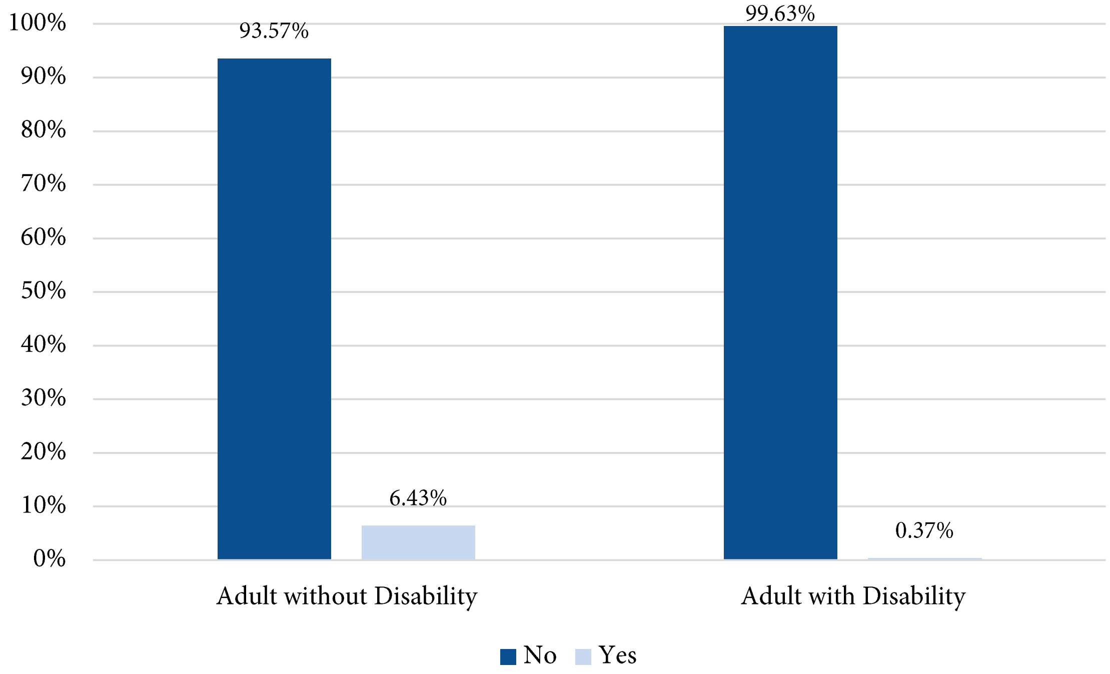
Exhibit 5.63: Care Transition Assistance as Result of Contact by Client Disability



Note: Percentages are weighted.

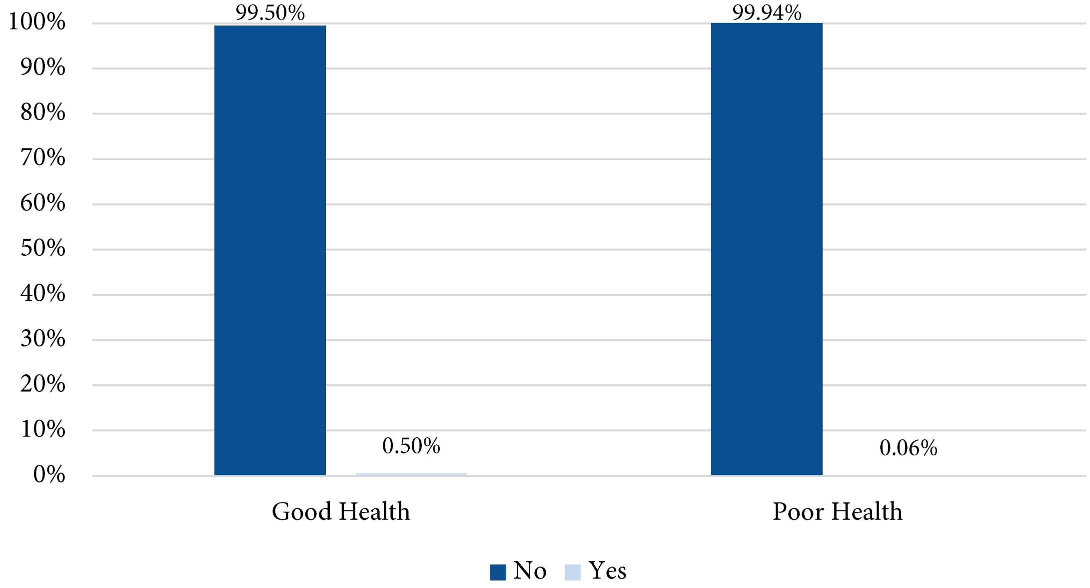
Finally, statistically significant group differences were also found for receipt of crisis counseling. Clients with a disability were less likely to receive crisis counseling than clients who did not have a disability ($p \leq .01$, Exhibit 5.64). Clients who reported poor health were more likely to receive life skills training or support as a result of their contact with the ADRC compared to those who reported better health ($p \leq .10$, Exhibit 5.65). Detailed results are presented in Appendix CC, Exhibit 3, and Appendix BB, Exhibit 2, respectively.

Exhibit 5.64: Crisis Intervention as Result of Contact by Client Disability



Note: Percentages are weighted.

Exhibit 5.65: Crisis Intervention as Result of Contact by Client Health



Note: Percentages are weighted.

We also explored whether the results of contact with the ADRC varied based on the reasons for contact (Exhibit 5.66). I&A/I&R was a result of contact for the large majority of respondents (81%). Respondents whose contact with the ADRC resulted in information assistance and/or referrals were not statistically more likely or less likely to have contacted the ADRC for any of the most common reasons.

Respondents who contacted the ADRC for reasons related to personal care or housing were more likely to receive options counseling or peer support/peer counseling than those who contacted for the other most frequently reported reasons, although this finding only approached statistical significance ($p \leq 0.10$). Those who contacted ADRCs with questions about Medicare (92%) or Medicare (53%), however, were significantly more likely to receive benefit counseling or eligibility determination services ($p \leq .01$).

Exhibit 5.66: Result of Contact, by the Most Common Reasons for Contact

Results of Contact	Medicare Questions	Medicaid Questions	Personal Care	Nutrition	Housing
Information Assistance and/or Referral(s) (not including options counseling)	81.33	79.45	78.50	94.96	97.45
Options Counseling or Peer Support/Peer Counseling	31.51	20.12	58.05	18.93	46.97
Benefits Counseling or Eligibility Determination	92.29	53.05	22.00	18.42	35.92
Transition Assistance	4.83	-	-	3.70	7.04
Crisis Intervention	-	-	-	-	-
Life skills training or support	0.14	-	-	-	-

Notes: Percentages are based on 312 respondents reporting one of the five most common reasons for contact. Percentages are weighted.

Exhibit 5.67 presents the results of cross-tabulating the results of contact with whether the services were received directly or indirectly from ADRCs. Exhibit 5.43, above, showed that 59 percent of survey respondents reported that they received the services directly, while 28 percent received them indirectly. Exhibit 5.67, Part I illustrates that most services that respondents requested were more likely to be provided directly by the ADRCs. The only exception is care transition assistance, where 77 percent of respondents reported they received this service indirectly compared to 18 percent who reported that they received it directly. Almost equal proportions (49% and 43%) of respondents who reported receiving options counseling or peer support/counseling were direct and indirect recipients of services, respectively.

Exhibit 5.67 Part II shows that the most frequent result of contact was I&A/I&R, regardless of the reported path of service receipt, with more than eighty percent of direct and indirect recipients of service(s) reporting that they received the service. The differences between results of contact by direct or indirect receipt of data were statistically significant for options counseling ($p \leq .05$), and life skills training or support ($p \leq .05$).

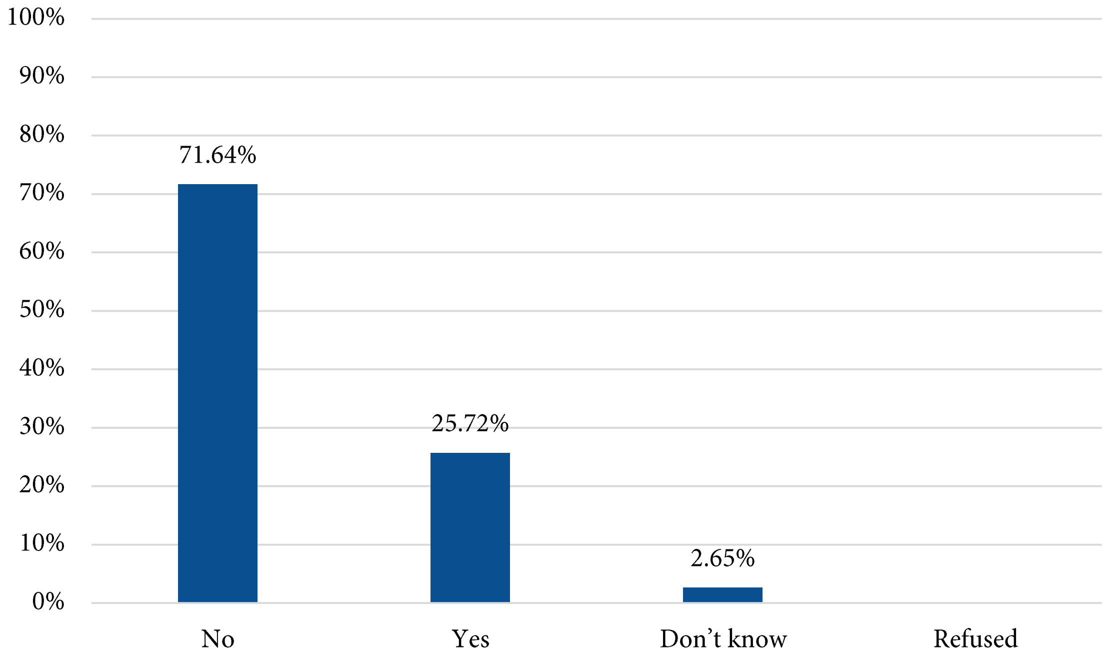
Exhibit 5.67: Result of Contact by Path of Service Receipt

Result of Contact	Path of Receiving Services			
	Directly	**Indirectly**	**Both**	**Total**
Part I — Row Percentages				
Information Assistance and/or Referral(s)	65.88	30.05	4.07	100
Options Counseling or Peer Support/Counseling	49.13	43.42	7.45	100
Benefits Counseling or Eligibility Determination	72.56	23.75	3.69	100
Transition Assistance	17.98	76.97	5.06	100
Crisis Intervention	100	0	0	100
Life Skills Training or Support	0	57.14	42.86	100
Part II – Column Percentages				
Information Assistance and/or Referral(s)	87.05	84.93	80.39	N/A
Options Counseling or Peer Support/ Counseling	19.80	37.26	44.92	N/A
Benefits Counseling or Eligibility Determination	58.51	40.96	44.73	N/A
Transition Assistance	0.42	3.81	1.76	N/A
Crisis Intervention	2.76	0	0	N/A
Life Skills Training or Support	0	0.11	0.59	N/A

Notes: Percentages do not add up to 100 because respondents could choose multiple options. Percentages are weighted.

Referral Process. Of the respondents who were referred to another agency and who reported that the ADRC representative helped them connect with requested services, only one-quarter (26%) reported that the ADRC representative provided a “warm transfer” (i.e., transferred the call to the agency to which they were referred) (Exhibit 5.68). Of the respondents who reported that the ADRC did not transfer their call, nearly 75 percent reported that the ADRC representative gave them contact information, such as a telephone number, address, or web address of the agency or organization that provided the services (Exhibit 5.69). Of those who reported that the ADRC did not provide the contact information, more than 75 percent reported that the ADRC representative did not contact the service provider on the client’s behalf (Exhibit 5.70). Finally, of those who reported that the ADRC representative transferred their call, provided contact information, or arranged contact between the respondent and the referral agency, 31 percent reported that the provider had the correct information about the services the client was seeking (see Exhibit 5.71). Over 48 percent reported that the provider did not have the correct information, and the respondent had to start the process again.

Exhibit 5.68: Transfer of Respondent’s Call to Agency to Which Client Was Referred



Notes: This question was asked of all those who responded “Yes” when asked if the representative of the ADRC helped connect the client to needed services. Percentages are weighted.

Exhibit 5.69: Provision of Contact Information for Agency to Which Client Was Referred

Gave Contact Information	Percentage
Yes	73.25
No	26.75
Don’t know	-
Refused	-
Total	100

Notes: This question was asked of all those who did not respond “Yes” when asked if the representative of the ADRC transferred the call to an agency that provided the needed service. Percentages are weighted.

Exhibit 5.70: ADRC Representative Contacted Agency for Respondent

Arranged Contact Between Respondent and Referred to Agency	Percentage
Yes	22.73
No	76.82
Don’t know	0.45
Refused	-
Total	100

Notes: This question was asked of all those who responded “No” when asked if the representative provided contact information for an agency that provided the client with needed services. Percentages are weighted.

Exhibit 5.71: Provider’s Knowledge of Referred Client’s Needs

Referred to Agency/Provider Had Information About Needed Services	Percentage
Provider had the information	30.84
Provider had the information but it was not correct or it was incomplete and you had to start the process again	6.23
Provider did not have the information – had to start the process again	48.35
Don’t know	14.48
Refused	0.11
Total	100

Notes: This question was asked of all those who responded “Yes” when asked if the ADRC representative transferred the call to an agency that provided the needed service, if the representative provided contact information for an agency that provided the client with needed services, or if the ADRC representative contacted the outside agency on the client’s behalf. Percentages are weighted.

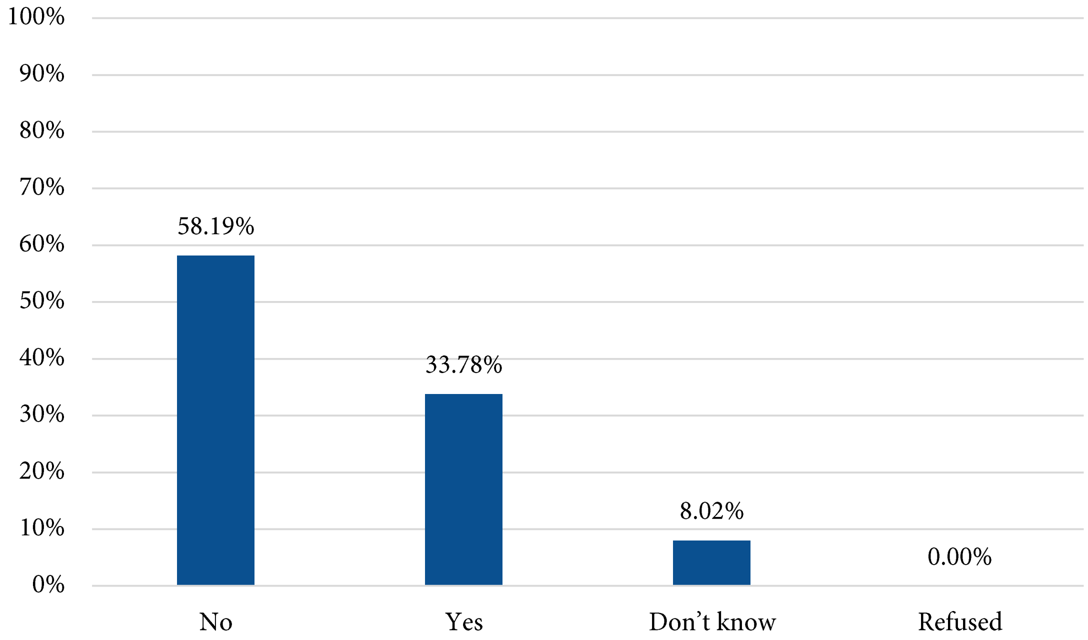
Assistance with Medicaid Eligibility Determination

Assistance with Medicaid Application. Respondents who were not receiving Medicaid benefits at the time of the survey and who spoke to an ADRC representative about Medicaid eligibility were included in the following analyses. As shown in Exhibit 5.72, a majority (58%) of respondents reported that they did not receive specific information on applying for financial assistance for healthcare and residential support services. There were no statistically significant differences related to ADRC size or geographic location in whether respondents received information on applying for Medicaid services.

Of those who reported that they received specific information on federally sponsored financial assistance for healthcare and residential support services, 47 percent reported that they completed an application (Exhibit 5.73). Of respondents who completed an application, 70 percent reported that they received assistance from the ADRC in completing it (Exhibit 5.74). Of the respondents who reported *not* completing an application, 80 percent (n = 85) provided a reason. The most common reason was that respondents believed they or the person on whose behalf they contacted the agency was ineligible. The next most common response was that they were "working on applying."

Some respondents did not complete an application because they did not see a need for Medicaid (n = 13), although six of those respondents thought they or their relative might need it in the future. Nine respondents mentioned that they already had Medicare, and two reported that they had completed an application (despite giving a "no" response). For some respondents (n = 5), they or their relatives were too sick to fill out the application. Other respondents (n = 3) described being "proud" or "independent of the government" as their reasons for not completing an application.

Exhibit 5.72: Respondent Received Information on Applying for Federally Funded Financial Assistance for Healthcare and Residential Support Services



Notes: This question was asked of all those who did not indicate they already receive Medicaid benefits or who said they did not talk about being eligible for Medicaid benefits when told the next questions would focus on Medicaid eligibility. Percentages are weighted.

Exhibit 5.73: Respondent Completed Application for Federally Sponsored Financial Assistance for Healthcare and Residential Support Services

Completed Application	Percentage
Yes	46.74
No	49.28
Don’t know	3.99
Refused	-
Total	100

Notes: This question was asked of all those who did not respond “No” when asked if the client received information on applying for financial assistance for healthcare or residential support from the government. Percentages are weighted.

Exhibit 5.74: Respondent Received Assistance in Completing Application for Federally Sponsored Financial Assistance for Healthcare and Residential Support Services

Received Assistance with Application	Percentage
Yes	70.14
No	27.48
Don’t Know	2.38
Refused	-
Total	100

Notes: This question was asked of all those who responded “Yes” when asked if they completed an application for financial assistance for healthcare or residential services from the government. Percentages are weighted.

Information on Other Types of Insurance. Of those who spoke to an ADRC representative about Medicaid eligibility, 20 percent reported that the ADRC provided information on other insurance options, including private coverage and other types of government insurance (Exhibit 5.75).

Exhibit 5.75: Respondent Was Provided Information About Other Insurance Options

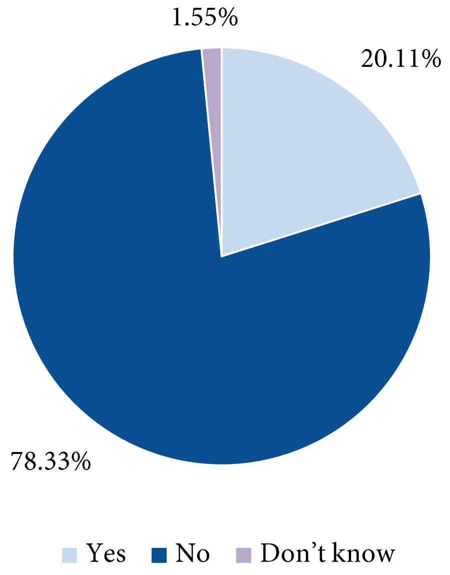
Provided Information About Other Insurance Options	Percentage
Yes	20.41
No	74.23
Don’t know	5.36
Refused	-
Total	100

Notes: This question was asked of all those who did not indicate they already receive Medicaid benefits or who said they did not talk about being eligible for Medicaid benefits when told the next questions would focus on Medicaid eligibility, and who did not answer “Don’t Know” or “Refused” when asked what other programs they applied for. Percentages are weighted.

Assistance with One-on-One Options Counseling

Request and Receipt of One-on-One Options Counseling. As shown in Exhibit 5.76, over three-quarters of the respondents (78%) did not request a conversation with an ADRC representative to discuss LTSS beyond information and referral, such as home delivered meals, personal care, household help, transportation, or similar kinds of services (i.e., options counseling).

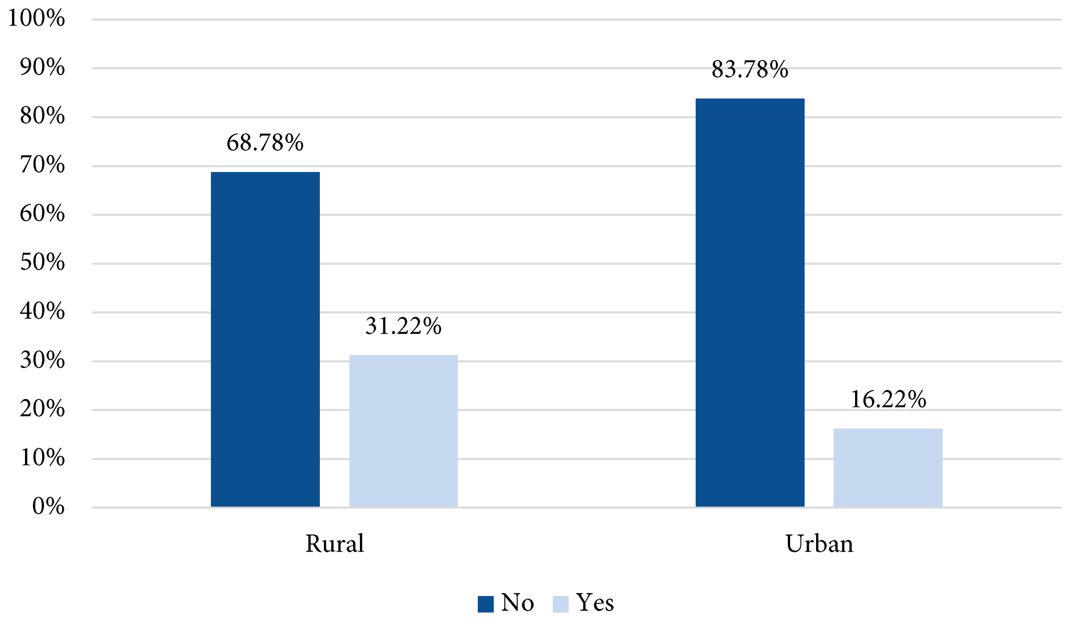
Exhibit 5.76: Respondent Requested Options Counseling



Note: Percentages are weighted. Percentages do not add up to 100 due to rounding.

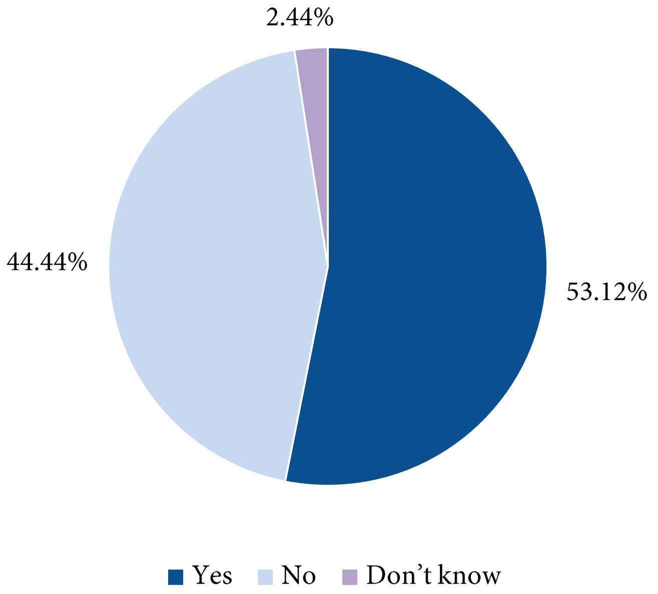
The next set of analyses was conducted to determine whether there are statistically significant differences in requests for options counseling based on geographic location. The results revealed that respondents contacting rural ADRCs were significantly more likely to request options counseling compared to those contacting urban ADRCs (31% and 16%, respectively; $p \leq .05$) (Exhibit 5.77). The complete cross-tabulation results are provided in Appendix DD, Exhibit 5. Of the 21 percent of respondents who requested options counseling, only 53 percent reported receiving the service by having a conversation with an ADRC representative about understanding and selecting LTSS beyond information and referral (Exhibit 5.78).

Exhibit 5.77: Respondent Requested Options Counseling by Agency Location



Note: Percentages are weighted.

Exhibit 5.78: Respondent Received Options Counseling



Notes: This question was asked of all those who responded "Yes" when asked if they requested a conversation about understanding and selecting LTSS. Percentages are weighted.

Process of One-on-One Options Counseling. Of those who received options counseling, 60 percent reported that the ADRC representative visited the client's home to discuss his or her understanding of LTSS (Exhibit 5.79). Over 69 percent of respondents who received options counseling reported that the ADRC representative followed up with them either by phone call or additional in-home visits after the first conversation (see Exhibit 5.80).

Exhibit 5.79: ADRC Representative Provided Options Counseling at Client's Home

Options Counseling at Client's Home	Percentage
Yes	60.43
No	39.35
Don't know	0.22
Refused	-
Total*	100

Notes: This question was asked of all those who responded "Yes" when asked if the client had a conversation with someone about understanding and selecting LTSS. Percentages are weighted.

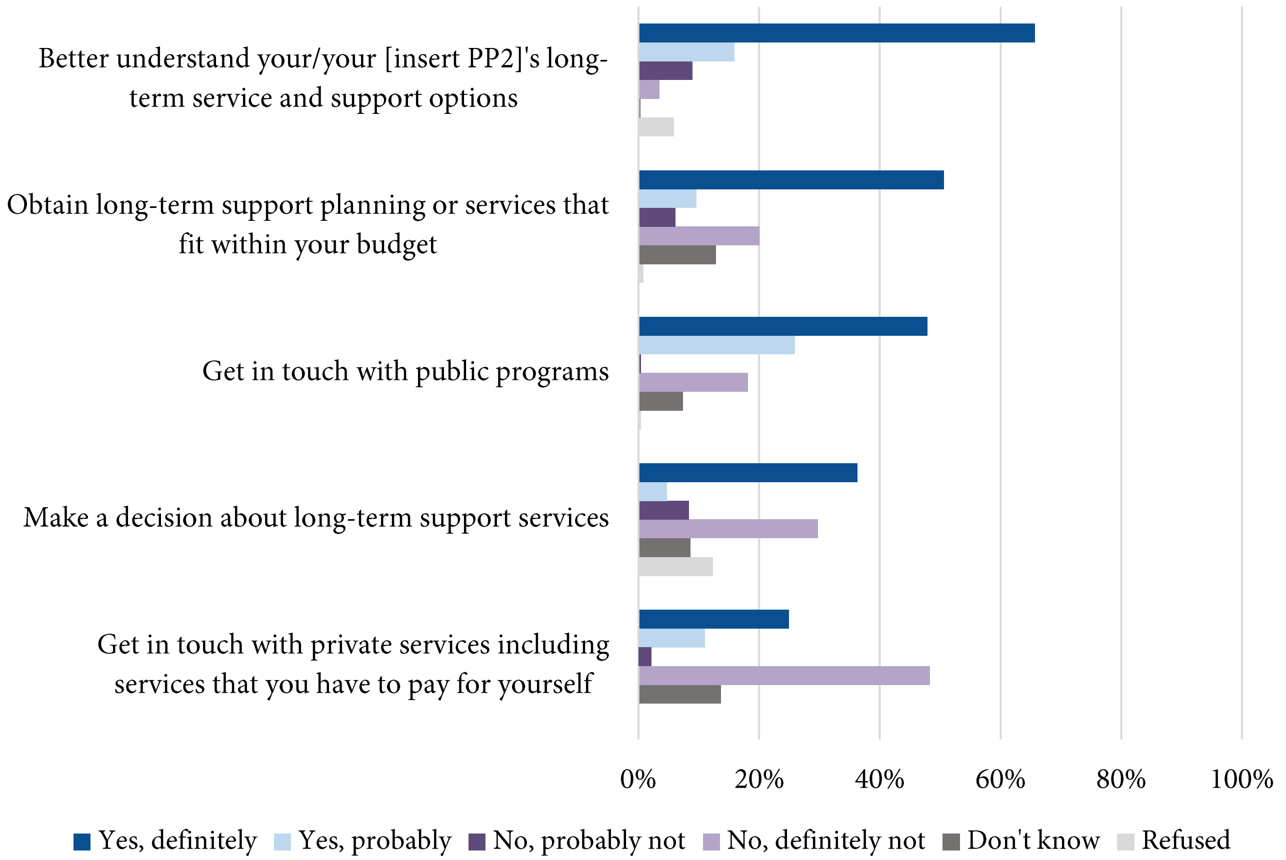
Exhibit 5.80: Respondent Received Follow-up after Initial Options Counseling Session

Received Follow-Up	Percentage
Yes	69.25
No	27.03
Don’t know	3.51
Refused	0.22
Total*	100

Notes: This question was asked of all those who responded “Yes” when asked if the client had a conversation with someone about understanding and selecting LTSS. Percentages are weighted.

Results of One-on-One Options Counseling. As shown in Exhibit 5.81, 81 percent of respondents who received options counseling reported that the conversation with the representative definitely or probably helped them to better understand their LTSS options. Nearly 61 percent reported that it helped them to obtain long-term support planning or services that fit within their budget; 74 percent reported that it helped them to get in touch with public programs; and 41 percent reported that it helped them to make a decision about LTSS.

Exhibit 5.81: Results of Options Counseling

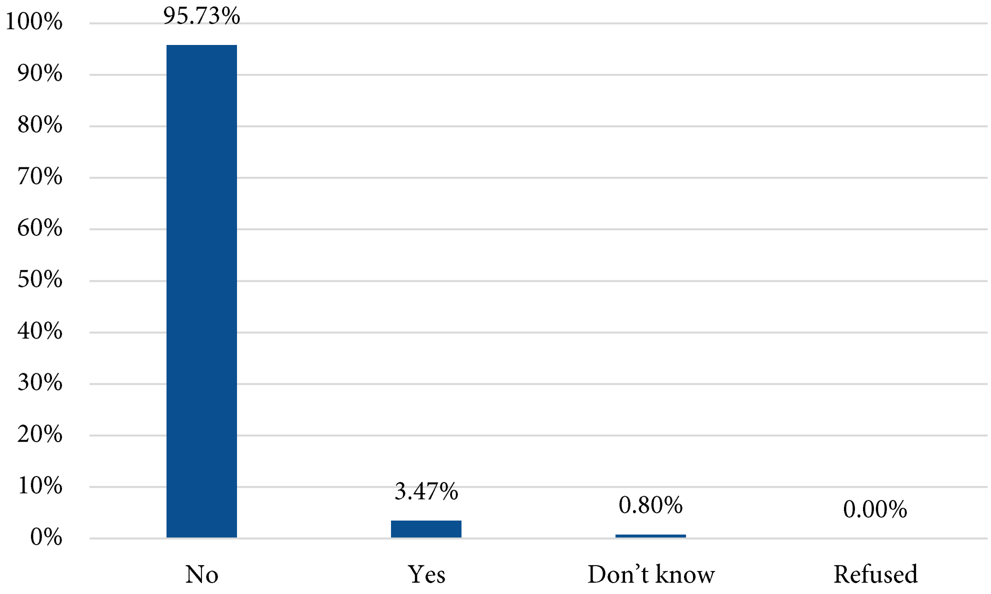


Notes: This question was asked of all those who responded “Yes” when asked if the client had a conversation with someone about understanding and selecting LTSS. Percentages are weighted.

Assistance with Care Transition Services

Results of the analyses on care transition services indicated that only 3 percent of respondents reported that they received services that helped clients to transition from a hospital or other acute care facility into the community (Exhibit 5.82). Of the respondents who received care transition services, 77 percent received a contact before discharge to assess the client’s discharge needs; 88 percent received an explanation of the client’s discharge instructions; and 79 received post-discharge services such as transportation to a doctor, help filling prescriptions, or household help. Over 25 percent received a follow-up phone call or visit within 48 hours of discharge (Exhibit 5.83).

Exhibit 5.82: Client Received Care Transition Services



Note: Percentages are weighted.

Exhibit 5.83: Specific Care Transition Services Received

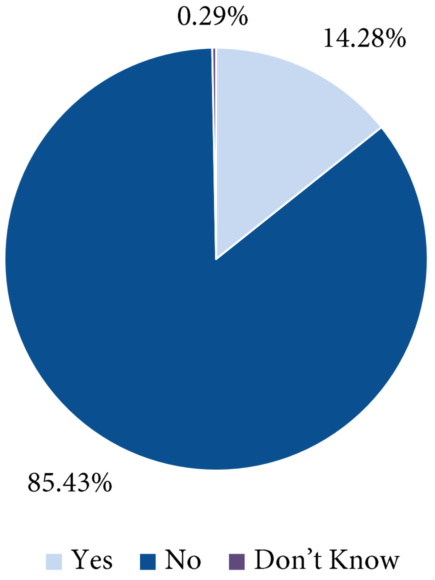
Services Received	Yes	No	Don’t Know	Total
An explanation of your/your [insert PP2]’s discharge instructions	87.64	11.70	0.66	100
Post discharge services such as transportation to the doctor, help filling prescriptions, or household help	78.59	13.69	7.73	100
A contact before discharge to assess your/your [insert PP2]’s discharge needs	77.26	21.41	1.32	100
Follow-up phone call or visit within 48 hours of discharge	29.14	39.29	31.57	100

Notes: This question was asked of all those who responded “Yes” when asked if the client received care transitions services. Percentages are weighted.

Assistance with Diversion

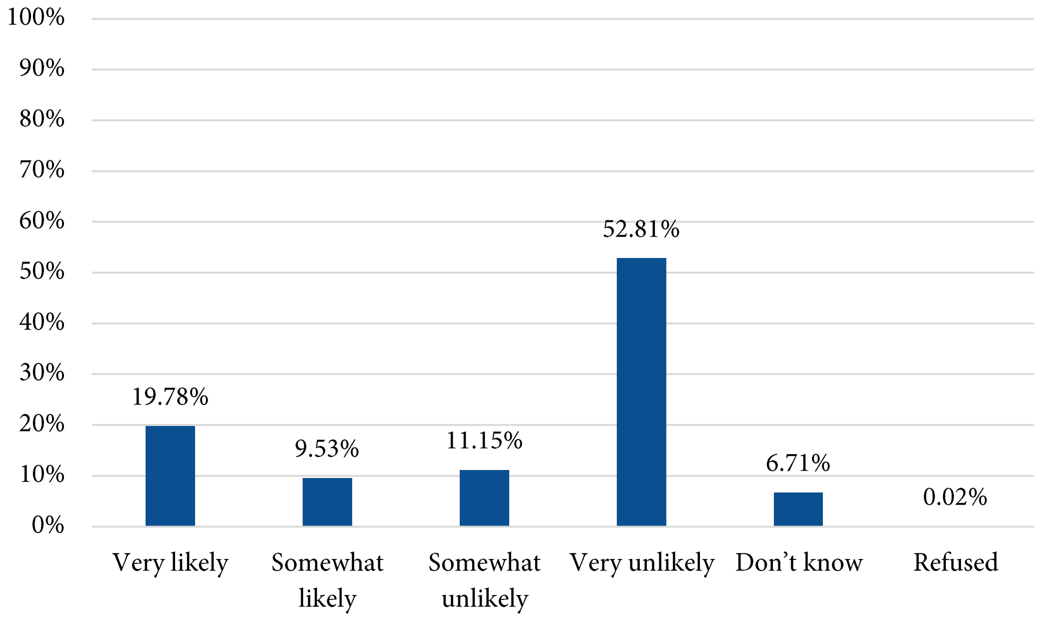
Exhibit 5.84 shows that at the time of contact with the ADRC, most respondents (85%) were not considering a move to a long-term care facility, either for themselves or for the client on whose behalf they called. There were no statistically significant difference in the likelihood of clients considering a move to a long-term care facility based on their education, income, gender, or health status, or on the geographic location of the agency. As Exhibit 5.85 indicates, only 29 percent of respondents believed that they were "very likely" or "somewhat likely" to move into a nursing home within 5 years. ADRC representatives helped 31 percent of respondents understand their choices for remaining in the community (Exhibit 5.86).

Exhibit 5.84: Respondents Considering a Move to a Long-Term Care Facility



Note: Percentages are weighted.

Exhibit 5.85: Likelihood of Respondents Moving into a Nursing Home within 5 Years



Note: Percentages are weighted.

Exhibit 5.86: Representative Helped Respondent Understand Choices for Staying in the Community

Helped Understand Choices	Percentage
Yes	31.15
No	65.09
Don’t know	3.76
Refused	-
Total	100

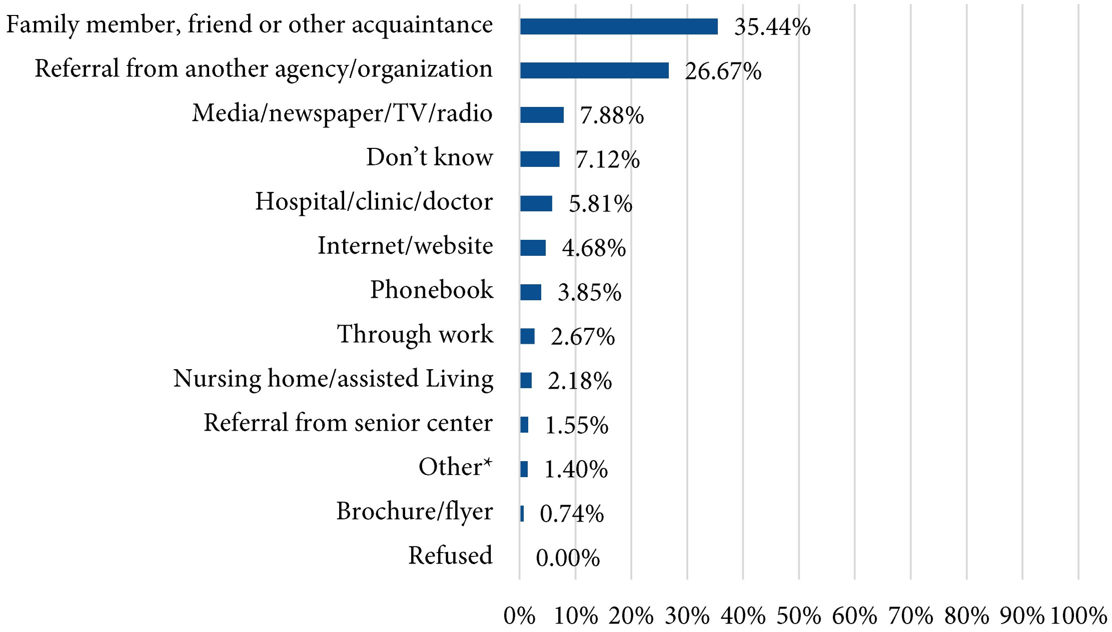
Note: Percentages are weighted.

5.2.4 Access to Services

Contacting ADRCs

Respondents first found out about ADRCs from a wide variety of sources (Exhibit 5.87). Among those, two stood out as the most frequent sources of initial information on ADRCs. The most common response was that respondents initially heard of ADRCs from a family member, friend, or other acquaintance (35%), followed by referral from another agency or organization (27%).

Exhibit 5.87: How Respondents Found Out About ADRCs



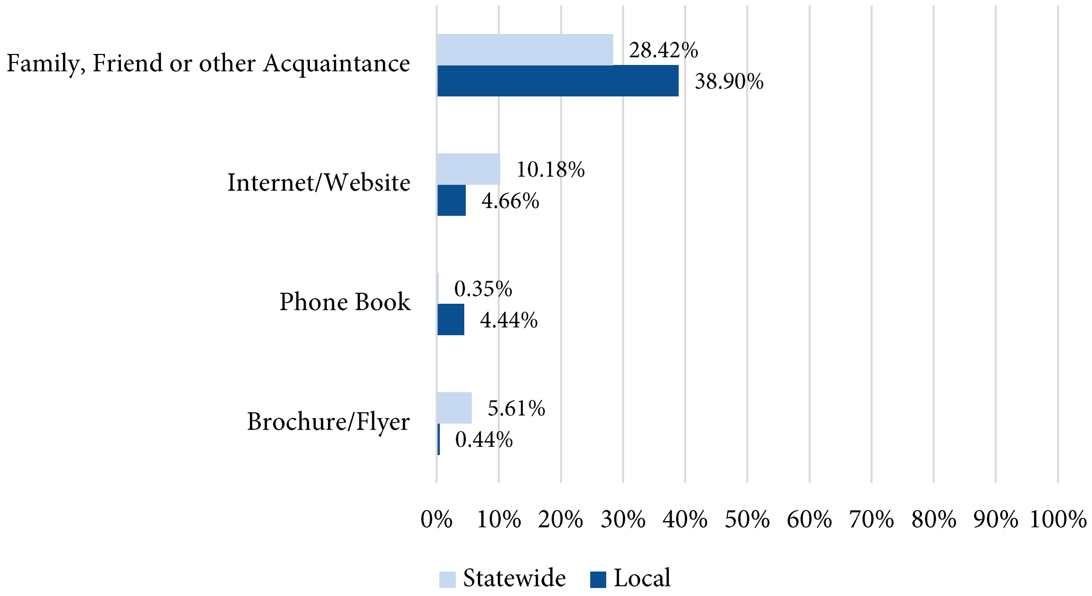
Notes: Percentages are weighted. Free text responses accompanying this question are available in Appendix U.

Subgroup analyses were conducted to determine whether the method respondents used to find out about ADRCs varied according to client income, education, gender, disability status, age, or health at the time of the questionnaire. However, no statistically significant differences in the initial source of information on ADRCs by client characteristics were observed.

Differences by ADRC characteristics were also examined, such as the geographic location of the ADRC and the size of the agency in terms of number of consumers served and FTEs. Only the difference between local and statewide ADRCs was found to be statistically significant. As illustrated in Exhibit 5.88, respondents who contacted a local ADRC were more likely to find out about the ADRC through a family member, friend, or other acquaintance than respondents contacting a statewide ADRC ($p \leq .01$). The corresponding cross-tabulations are presented in Appendix FF, Exhibit 7. About 79 percent of respondents contacted the ADRC before they contacted any other organization (Exhibit 5.89); 18 percent contacted another agency before contacting the ADRC. Exhibit 5.90 shows that only 9 percent of respondents contacted a similar agency after contacting the ADRC.

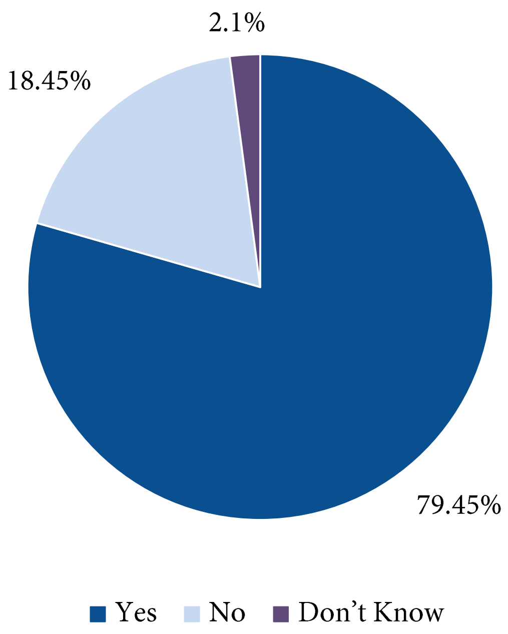
As presented in the supplemental tables in Appendix U, respondents who contacted a similar agency after contacting the ADRC were in touch with a range of organizations, from governmental organizations to volunteer church-based groups. The most common organizations mentioned were the VA and nearby AAAs. Of the 83 respondents who contacted a similar agency after contacting the ADRC, about one-quarter (27%) found that the other agency was able to provide services that the ADRC could not (Exhibit 5.91). Respondents indicated a variety of needs that could not be met by the ADRC such as services related to medical care, including in-home care, evaluation for assisted living, and supplemental payment for medical care. However, 71 percent of respondents indicated that the other agency also was unable to meet their needs.

Exhibit 5.88: How Respondents Found Out About ADRCs by Agency Type



Note: Percentages are weighted.

Exhibit 5.89: Respondent Contacted ADRC Before Contacting Any Other Organization



Note: Percentages are weighted.

Exhibit 5.90: Respondent Contacted Similar Agencies After Contacting the ADRC

Has Respondent Been in Touch With Any Similar Organizations Since Contacting the ADRC?	Percentage
Yes	9.08
No	89.22
Don’t know	1.7
Refused	-
Total	100

Notes: Percentages are weighted. Free text responses accompanying this question are available in Appendix U.

Exhibit 5.91: Other Agency Able to Meet Needs That the ADRC Could Not

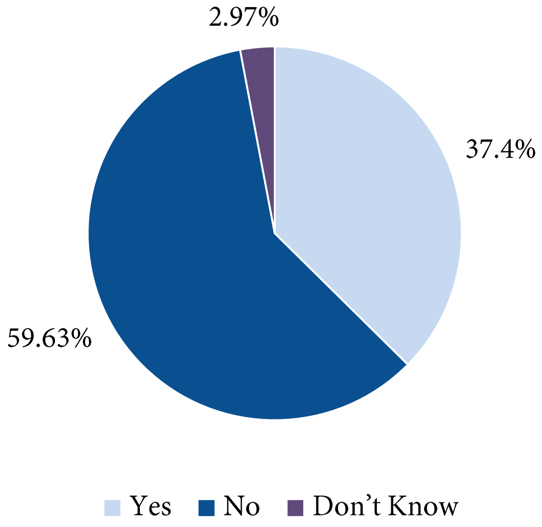
Other Agency Met Needs the ADRC Could Not	Percentage
Yes	26.50
No	70.97
Don't know	2.53
Refused	-
Total**	100

Notes: This question was asked of all those who responded "Yes" when asked if the client had been in touch with other agencies regarding the client's reason for contact after contacting the ADRC. Free text responses accompanying this question are available in Appendix U. Percentages are weighted.

Follow-up by ADRCs

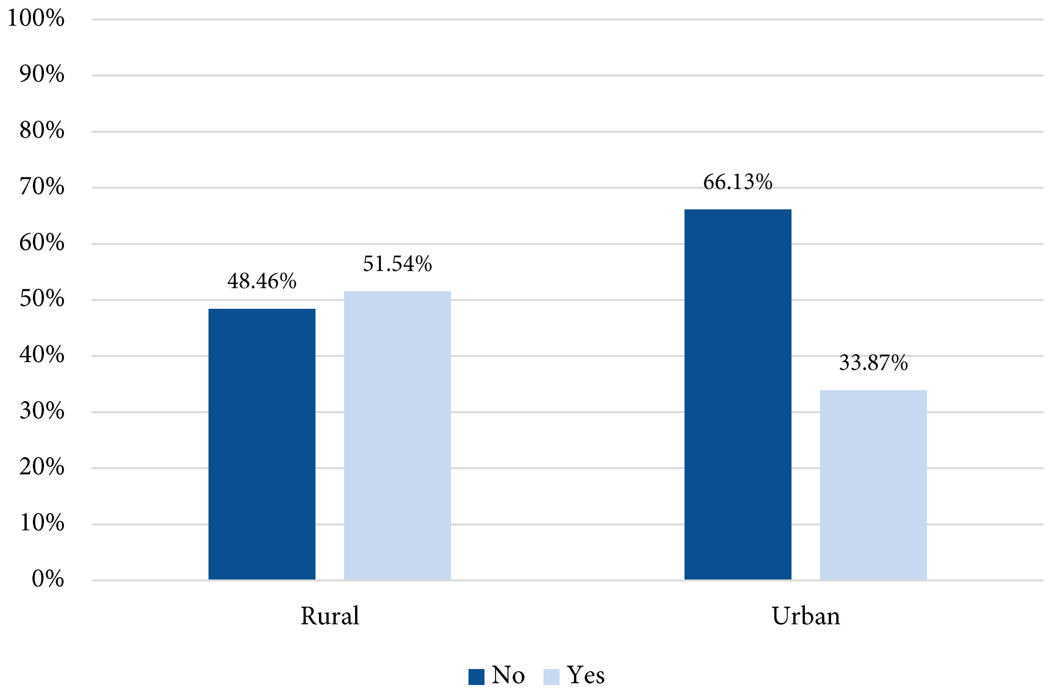
The survey asked respondents whether ADRC staff followed up with them on referrals and the usefulness of the information provided. As of the time of the survey, only 37 percent of respondents indicated that the ADRC had followed up with them regarding either the referral or the usefulness of the information provided (Exhibit 5.92). We then examined whether there were significant differences in ADRC follow-up according to ADRC characteristics. There was a trend toward significance, with rural ADRCs more likely to follow up with respondents than urban ADRCs ($p \leq .10$) (Exhibit 5.93). The corresponding cross-tabulations are presented in Appendix DD, Exhibit 6.

Exhibit 5.92: ADRC Follow-up on Referral and the Usefulness of Information Provided



Note: Percentages are weighted.

Exhibit 5.93: ADRC Follow-up on Referral and the Usefulness of Information Provided by Agency Location

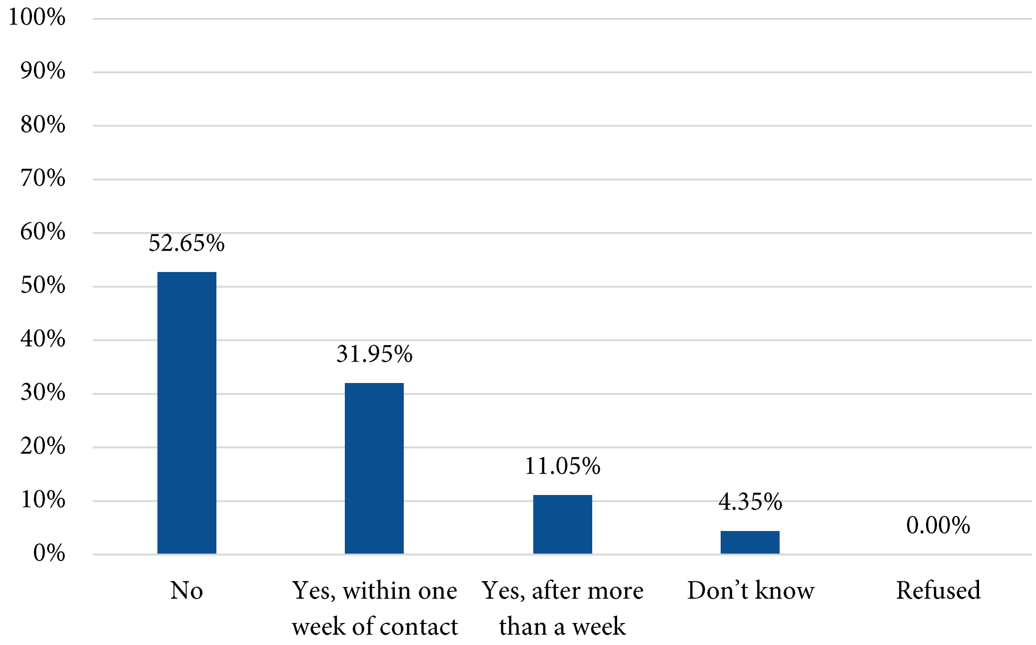


Note: Percentages are weighted.

Challenges in Receiving Services from ADRCs

Length of Time to Service Receipt. The survey included items on the receipt of services and the length of time it took to receive the services. A majority of respondents (53%) indicated that they did not receive the services they requested (Exhibit 5.94). About 32 percent of respondents received services within 1 week of contact, while 11 percent received services after more than a week.

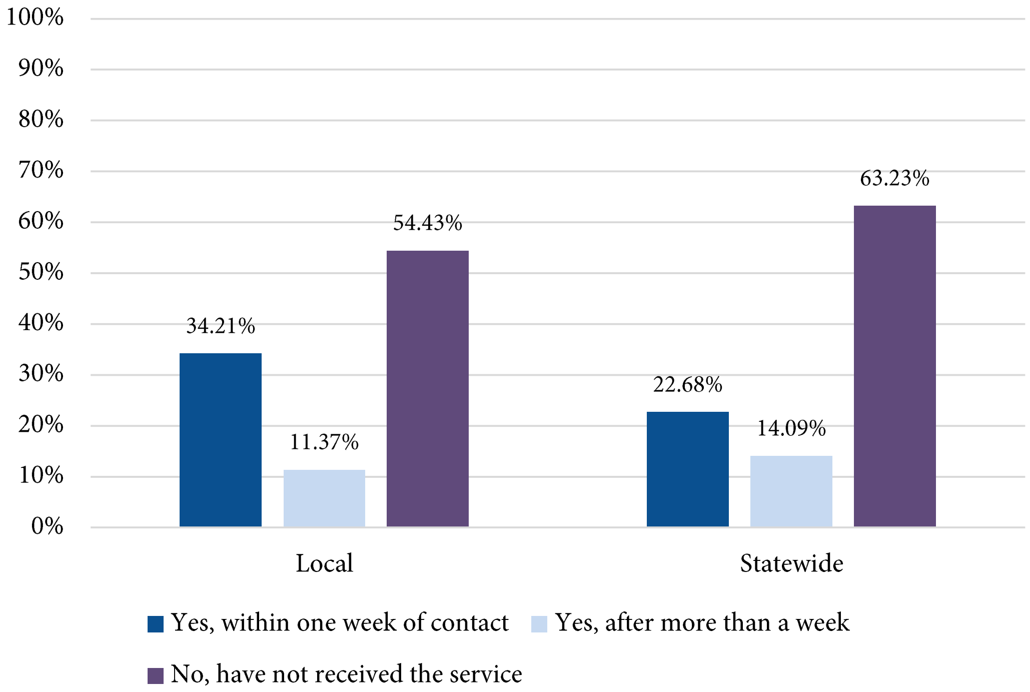
Exhibit 5.94: Length of Time to Receipt of Requested Service



Note: Percentages are weighted.

The question of whether respondents received services was analyzed by subgroups of interest. There were statistically significant differences between respondents who contacted local ADRCs and statewide ADRCs both in reporting that they received the services sought and in the length of time to receive the services. Respondents who contacted a statewide ADRC were more likely to report that they did not receive services than those who contacted a local ADRC ($p \leq .10$) Exhibit 5.95). Respondents who contacted a local ADRC reported that they received services within 1 week of contact more frequently than those who contacted a statewide ADRC, but this finding only approached statistical significance ($p \leq .10$). The corresponding cross-tabulations are presented in Appendix FF, Exhibit 8.

Exhibit 5.95: Length of Time to Receipt of Requested Service by Agency Type



Note: Percentages are weighted.

Reasons for Non-Receipt of Services. When respondents were asked the reason why they did not receive the services they requested, they provided a range of responses. The two most common reasons, as shown in Exhibit 5.96, were that the services were not available and that the respondent was currently on a waitlist (15% each). Some respondents provided reasons that were not listed as a choice on the survey: the most common one was lack of follow-up by the service provider.

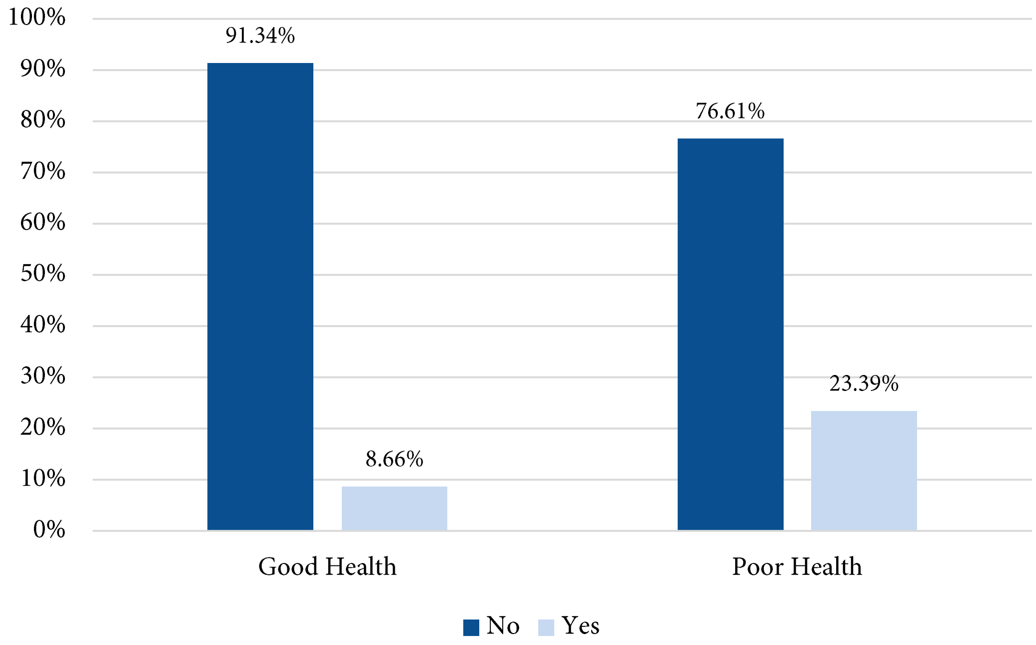
Exhibit 5.96: Reason Respondent Believes Services Have Not Been Received

Reason	Percentage
You/your [insert PP2] is on a waitlist	14.87
The services were not available	14.81
You/your [insert PP2] did not follow-up on the information and/or referral.	11.17
Difficulties filling out paperwork	10.88
Some other reason, Unclassified	10.11
Service provider did not follow-up with me/have not heard back from service provider	9.92
The information/help received from [insert PP1] was not useful	9.91
You/your [insert PP2] no longer need the services	9.08
Don’t know	9.08
Not eligible	6.01
Not being the right age for these services	5.00
You/your [insert PP2] could not get to the services (e.g., hours of operation, transportation barriers)	5.25
Too expensive/not affordable	5.05
Still in the planning/beginning stages	4.55
Have not applied for services	2.40
Waiting for evaluation/meeting	2.26
Refused	-

Notes: This question was asked of all those who responded “No” when asked if the client ever received the requested services. Percentages do not add up to 100 because respondents could choose multiple options. Percentages are weighted.

Significant differences based on subgroups of interest were found for several of the reasons that respondents provided for not receiving services. For example, respondents who made the contact for clients who were in poor health were more likely than respondents who made contact for clients who were not in poor health to indicate that the services were not available ($p \leq .10$) (Exhibit 5.97). For detailed results, see Appendix BB, Exhibit 3.

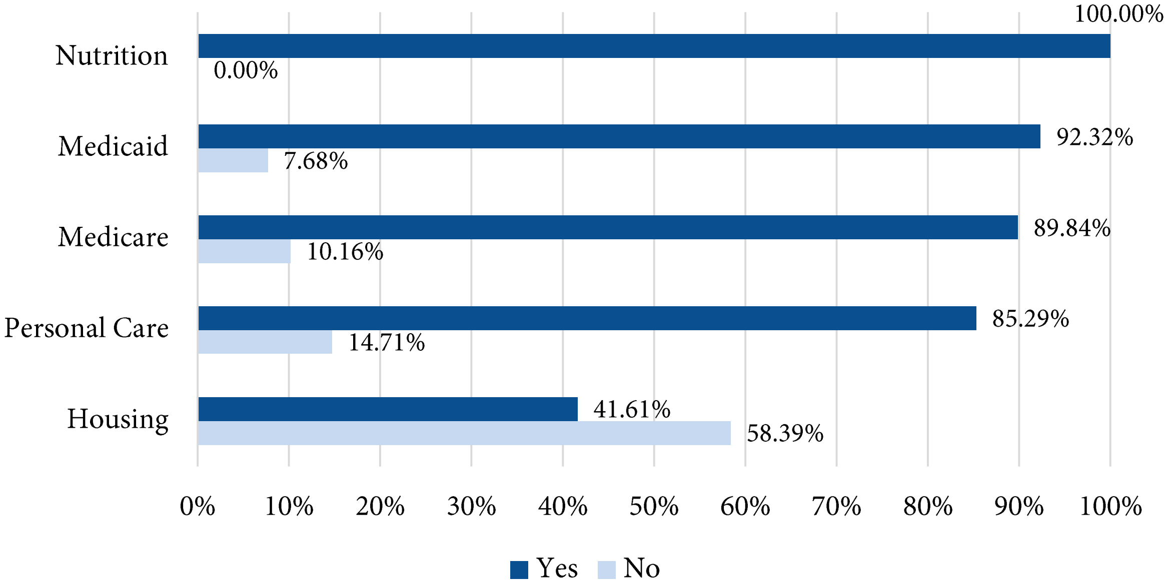
Exhibit 5.97: Availability of Services by Client Health



Note: Percentages are weighted.

We also explored whether there were statistically significant differences in service availability by reason for contact. Respondents who contacted the ADRC for housing-related assistance were more likely to indicate that the ADRC did not have the necessary services available than those who contacted the ADRC for the other four most common reasons for contact ($p \leq .05$) (Exhibit 5.98). Housing was the only reason for which a majority of respondents indicated that the services were unavailable. See Appendix EE, Exhibit 1 for detailed results.

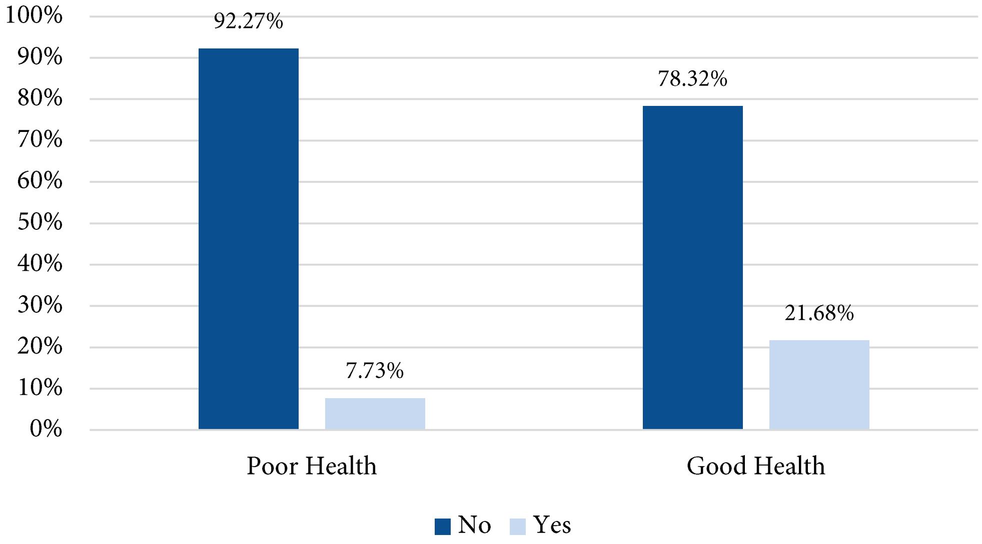
Exhibit 5.98: Availability of Services by Reason for Contact



Note: Percentages are weighted.

In addition, we identified a trend toward statistical differences in waitlist status. Clients who were in poor health were less likely to be on a waitlist than those in better health ($p \leq .10$) (Exhibit 5.99). For detailed results, see Appendix BB, Exhibit 4.

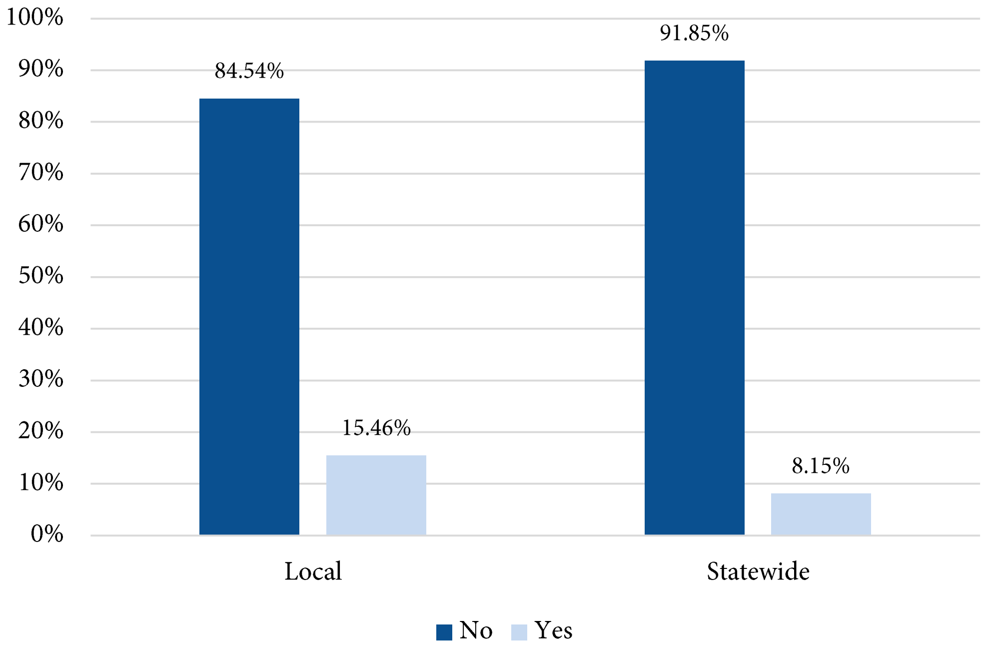
Exhibit 5.99: Services Not Received Because Client Was on a Waitlist by Client Health



Note: Percentages are weighted.

As illustrated in Exhibit 5.100, respondents who contacted a statewide ADRC also were slightly less likely to report being on a waitlist ($p \leq .10$), although this finding only approached statistical significance. See Appendix FF, Exhibit 9, for detailed results.

Exhibit 5.100: Services Not Received Because Client Was on a Waitlist by Agency Coverage

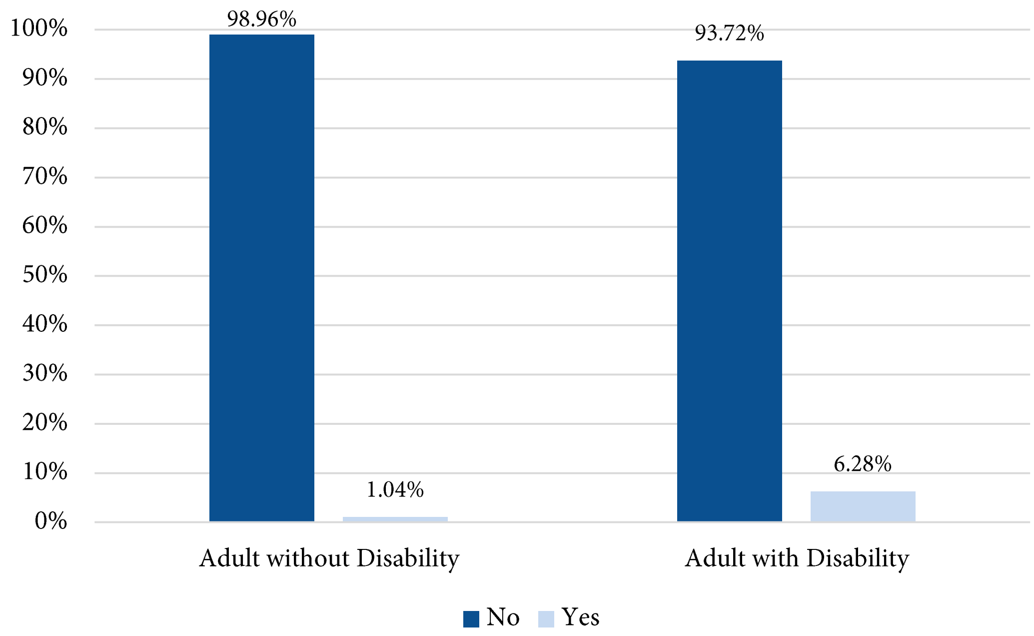


Note: Percentages are weighted.

Subgroup analyses between clients with and without a disability revealed significant differences in the degree to which clients felt their access to services served as a barrier to the receipt of services. Clients with a disability were more likely than clients without a disability to report that they could not get to services ($p \leq .05$) (Exhibit 5.101). Clients with a disability were also significantly more likely to indicate that the information/help they received from the ADRC was not useful ($p \leq .01$) (Exhibit 5.102). See Appendix CC, Exhibits 4 and 5, respectively, for detailed results. In contrast, clients in poor health were less likely than those who were not in poor health to indicate that the information they received was not useful ($p \leq .10$) (Exhibit 5.103). See Appendix BB, Exhibit 5, for detailed results. Finally, respondents contacting rural ADRCs were less likely to consider the information/help they received as not useful as compared to those contacting urban ADRCs ($p \leq .01$) (Exhibit 5.104). Appendix DD, Exhibit 7, presents detailed results.

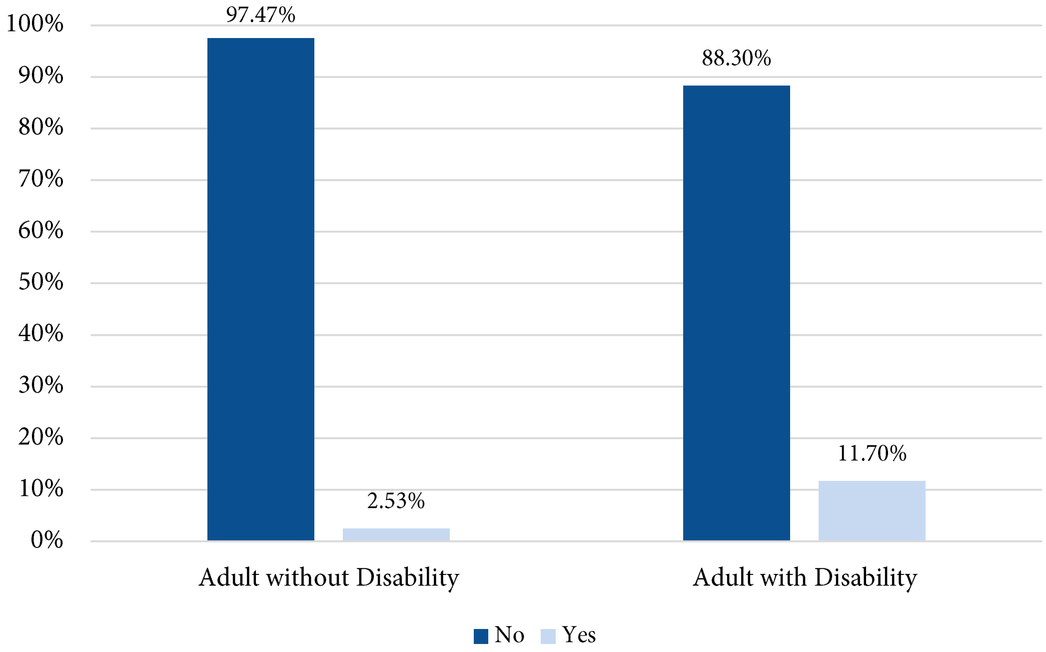
Another reason for non-receipt of services was difficulty in filling out paperwork. Clients with a disability were much more likely than those without a disability to report this as a reason for non-receipt of services ($p \leq .01$) (Exhibit 5.105). The corresponding cross-tabulations are presented in Appendix CC, Exhibit 6.

Exhibit 5.101: Could Not Get to Services by Client Disability



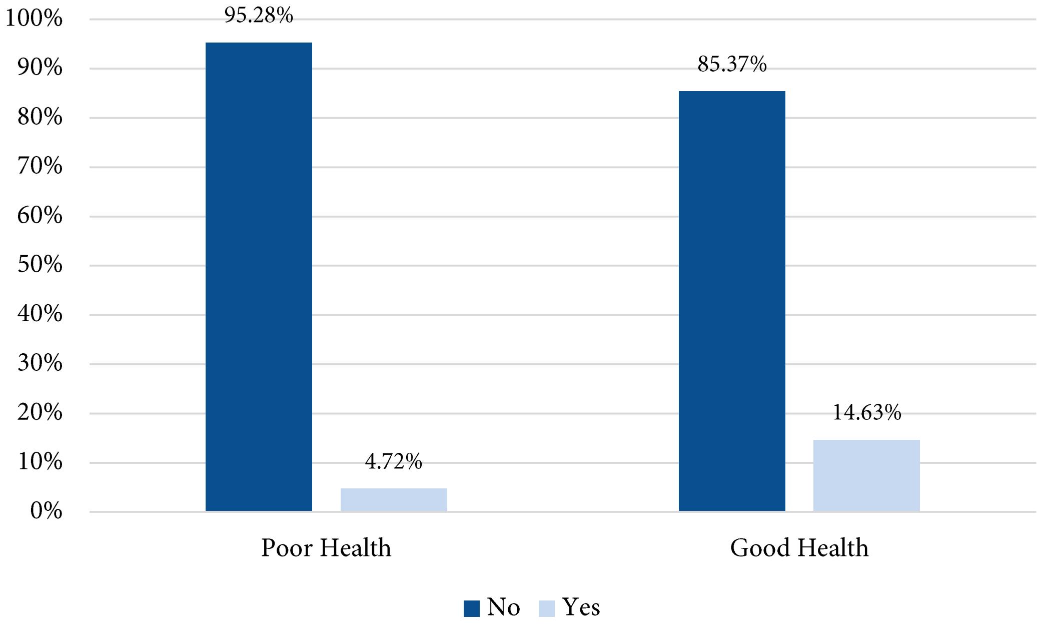
Note: Percentages are weighted.

Exhibit 5.102: Information Was Not Useful by Client Disability



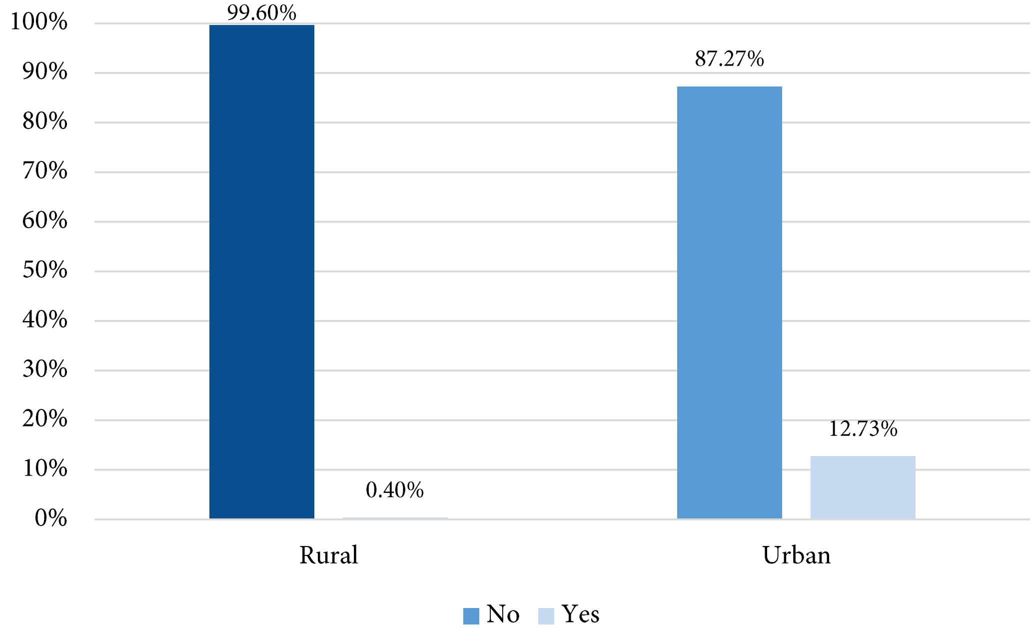
Note: Percentages are weighted.

Exhibit 5.103: Information Was Not Useful by Client Health



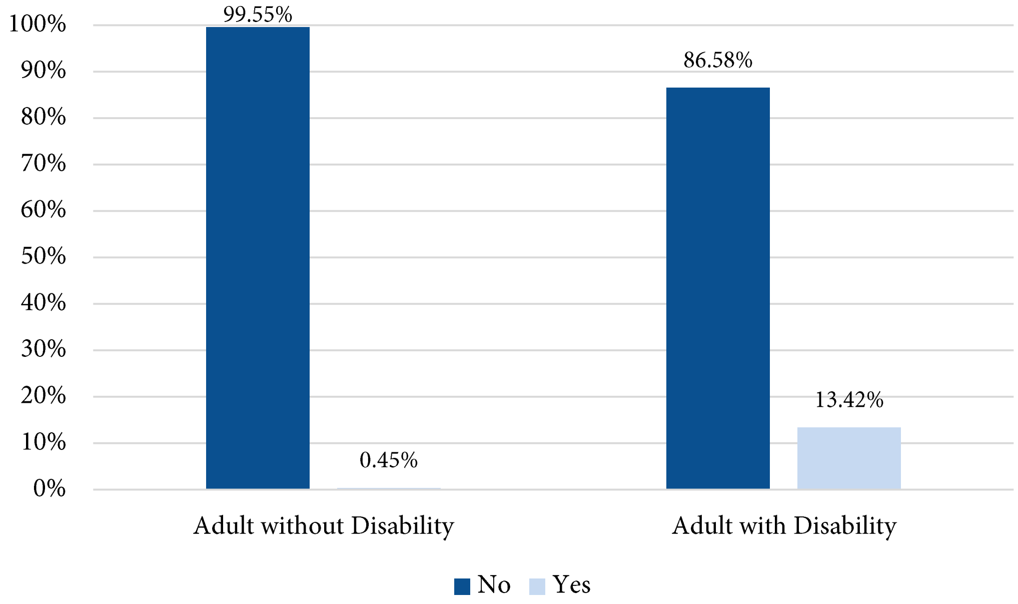
Note: Percentages are weighted.

Exhibit 5.104: Information Was Not Useful by Agency Location



Note: Percentages are weighted.

Exhibit 5.105: Services Not Received Because of Difficulty Filling Out Paperwork by Client Disability

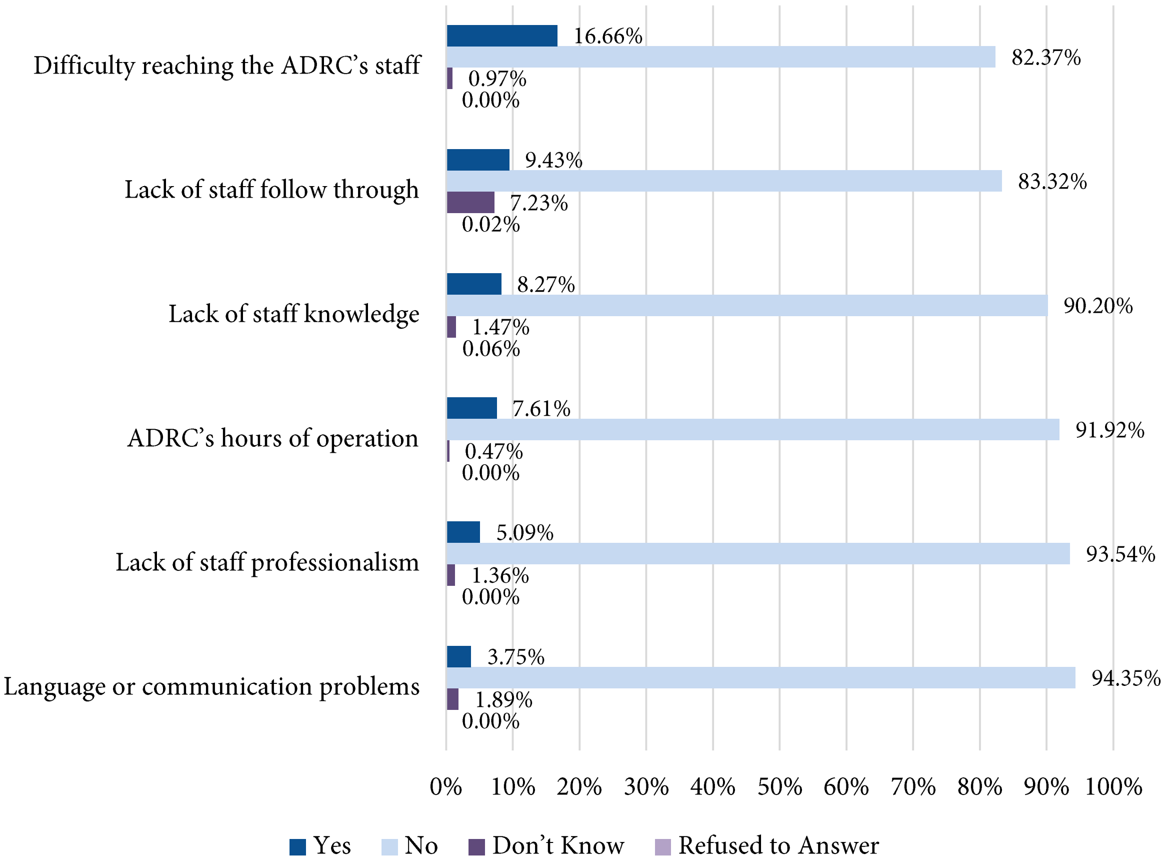


Note: Percentages are weighted.

Challenges in Resolving Issues

Less than one-fifth of respondents reported challenges in dealing with ADRCs that limited their ability to resolve issues (Exhibit 5.106). The most common challenge was difficulty reaching ADRC staff, with 17 percent of respondents reporting this problem. The second most common challenge was a lack of staff follow-through (9%).

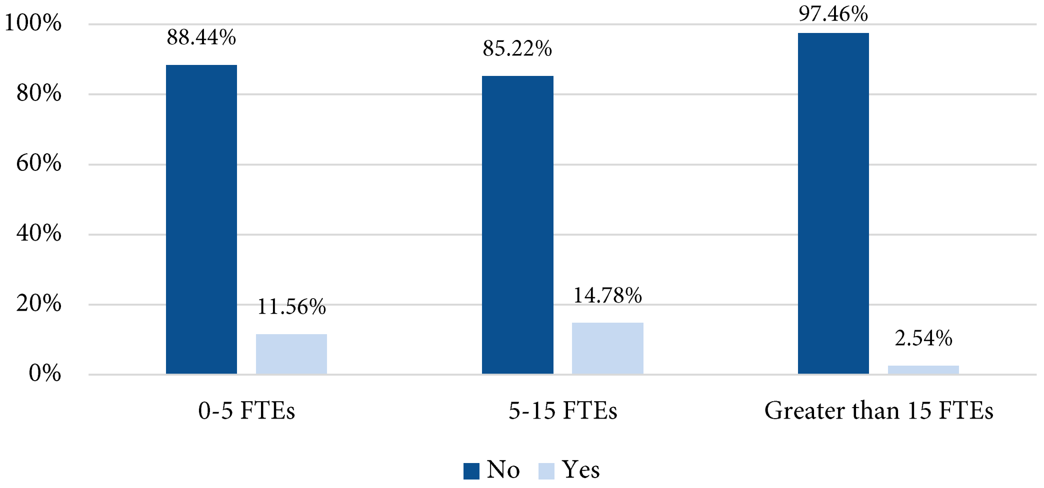
Exhibit 5.106: Challenges that Inhibited Issue Resolution



Note: Percentages are weighted.

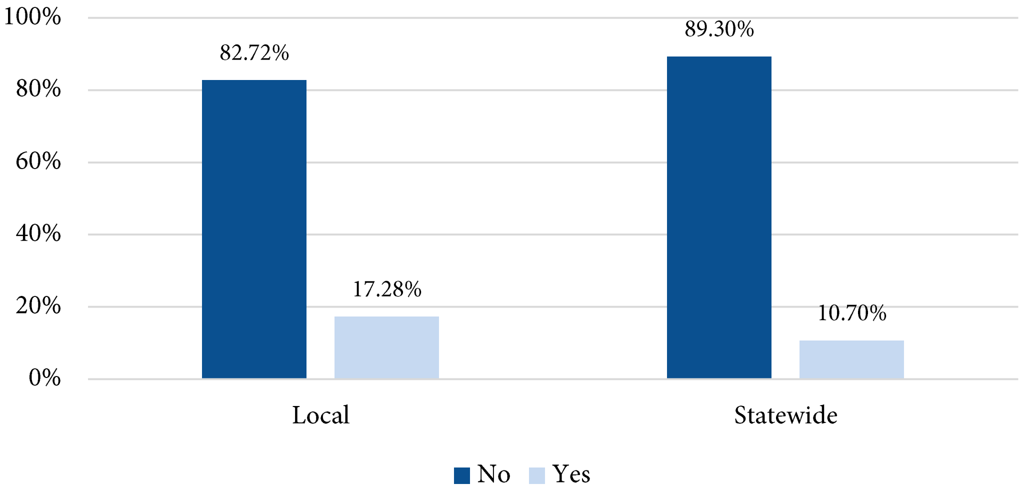
We conducted subgroup analysis to assess if the challenges that survey respondents faced varied by ADRC characteristics. Findings indicated that there were statistically significant differences among subgroups on two of the challenges: ADRCs' hours of operation and difficulty reaching ADRC staff. As shown in Exhibit 5.107, respondents contacting ADRCs with more than 15 FTEs were less likely to report hours of operation as a challenge than respondents contacting ADRCs with fewer FTEs ($p \leq .05$). Exhibit 5.108, below, shows that respondents contacting local ADRCs were more likely to indicate that they had difficulty reaching staff as compared to those contacting statewide ADRCs ($p \leq .10$). The corresponding cross-tabulations are presented in Appendix HH, Exhibit 3 and Appendix FF, Exhibit 10, respectively.

Exhibit 5.107: Reduction in Ability to Resolve Issue Because of Hours of Operation by Number of FTEs in ADRC



Note: Percentages are weighted.

Exhibit 5.108: Reduction in Ability to Resolve Issue Because of Difficulty Reaching ADRC Staff by Agency Type



Note: Percentages are weighted.

Regression Findings – Challenges in Resolving Issues

Regression analyses were used to explore the client, ADRC, and community characteristics associated with respondents facing the following challenges in working with ADRCs to resolve their issues: difficulty reaching ADRC staff and lack of staff follow–through.

We could not conduct regression analyses on other challenges such as hours of operation, language or communication problems, lack of staff professionalism, and lack of staff knowledge, because there were very few observations with a value of “1” (i.e., “Yes, a challenge”).

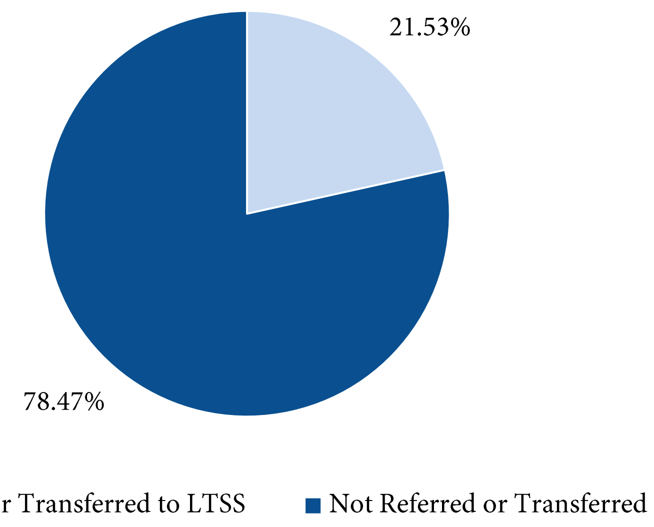
Difficulty Reaching ADRC staff. The outcome of interest for these analyses is whether respondents faced difficulties in reaching the ADRC staff. The complete results are presented in Appendix JJ, Exhibit 3, column 1. Only ADRC characteristics were found to have a significant association. Respondents from rural ADRCs were less likely to report difficulties in reaching staff compared to their urban counterparts (-14.2 percentage points; $p \leq .05$). Similarly, respondents contacting statewide ADRCs were less likely to report difficulty in reaching staff compared to respondents contacting local ADRCs (-23.1 percentage points; $p \leq .01$).

Lack of Staff Follow-through. The findings from the analysis of the likelihood of respondents reporting lack of staff follow-through as a challenge in achieving issue resolution may be found in Appendix JJ, Exhibit 3, column 2. None of the covariates were shown to have a statistically significant association with this outcome of interest.

LTSS Referrals by ADRCs

LTSS Referrals. Data were obtained to explore the types of LTSS to which respondents were referred or transferred. As shown in Exhibit 5.109, 22 percent of clients were transferred or referred to LTSS.

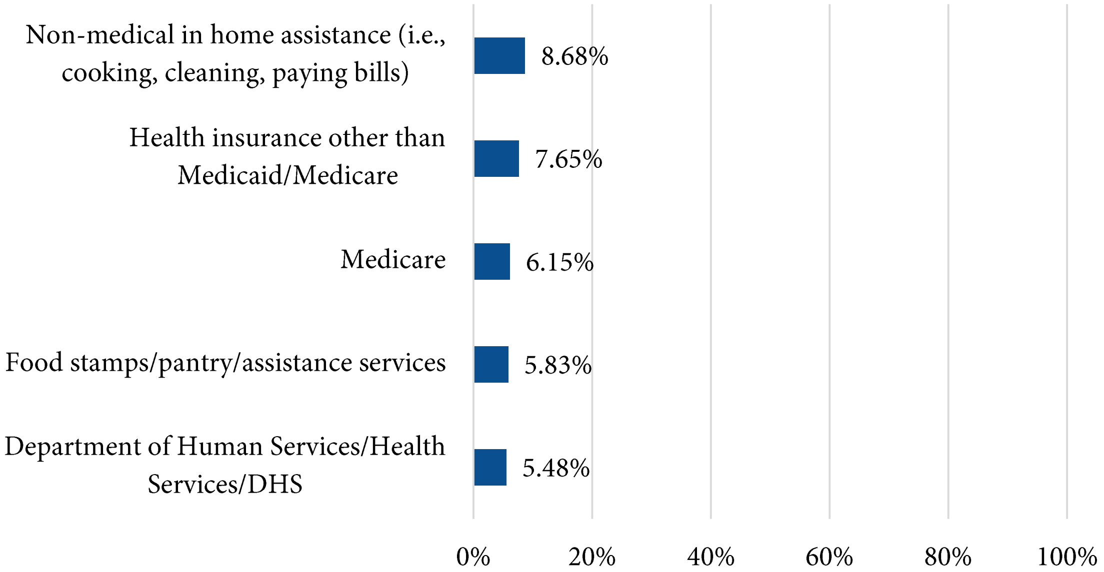
Exhibit 5.109: ADRC Clients Transferred or Referred to LTSS



Note: Percentages are weighted.

Respondents were referred to a variety of LTSS, and no one service was predominant. Exhibit 5.110 presents the five most common LTSS services, out of a total of 26, reported by survey respondents. The complete results may be found in Appendix U, Question E.7.

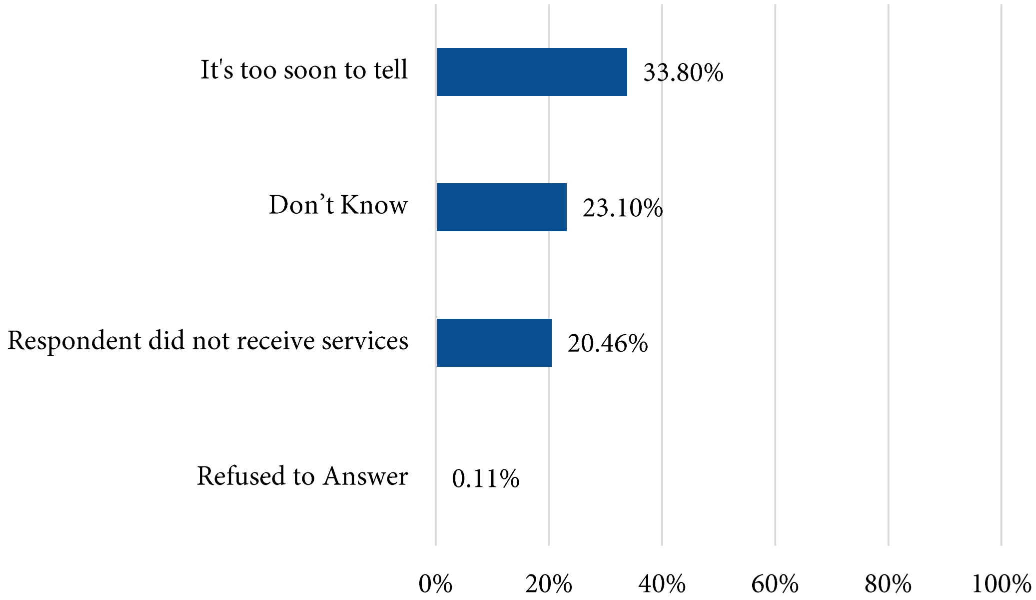
Exhibit 5.110: LTSS to Which Respondents Were Transferred or Referred



Notes: **T**his question was asked of all those who responded "Yes" when asked if the representative of the ADRC transferred the call to an agency that provided the needed service, if the representative provided contact information for an agency that provided the client with needed services, or if the ADRC representative contacted the outside agency on the client's behalf. Percentages are weighted.

Results of Referrals. Of the 126 respondents who were referred to LTSS, 43 percent received the services for which they were referred. As shown in Exhibit 5.111, only 20 percent of respondents indicated they did not receive services, while 34 percent said it was too soon to tell whether services were received.

Exhibit 5.111: Result of Referrals to LTSS



Notes**:** This question was asked of all those who responded "Yes" when asked if the representative of the ADRC transferred the call to an agency that provided the needed service, if the representative provided contact information for an agency that provided the client with needed services, or if the ADRC representative contacted the outside agency on the client's behalf. Percentages are weighted.

Of the 20 percent of respondents who indicated they did not receive the LTSS to which they were transferred or referred, more than one-third stated that the available services were not what they wanted or needed (Exhibit 5.112).

Exhibit 5.112: Respondents' Reasons for Non-Receipt of Referred LTSS

Respondent's Reason for Non-Receipt of LTSS	Percentage
The services were not what [insert PP2] wanted/needed	37.39
Don't know	36.87
Other, _______________	8.70
The service or program is not available at times needed	6.78
The service/program is not accepting applications/there is a waitlist	6.09
Have not yet contacted, but plan to	2.09
[insert PP2] is not eligible	1.57
It is too expensive	0.52
There is no transportation	-
I tried to contact the service or program that was referred, but was busy/unavailable	-
Line was busy	-
Wait time was too long	-
Have no plans to contact the service or program Please specify ________________________	-
Refused	-
Total	100

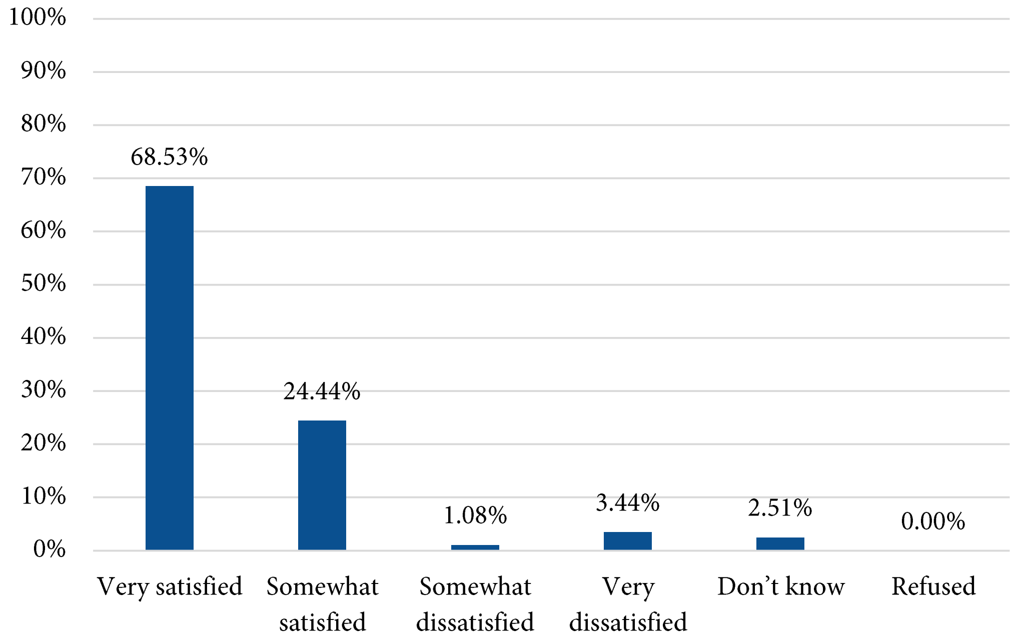
Notes: This question was asked of all those who indicated the client did not receive services when asked what the result of the referral was. Percentages are weighted. Free text responses are available in Appendix U.

5.2.5 Participant Satisfaction

Satisfaction with One-on-One Options Counseling

Almost 93 percent of respondents who received options counseling indicated that they were either "very satisfied" or "somewhat satisfied" with the one-on-one options counseling they received. As illustrated in Exhibit 5.113, only 5 percent of respondents indicated they were "somewhat dissatisfied" or "very dissatisfied."

Exhibit 5.113: Satisfaction with One-on-One Options Counseling

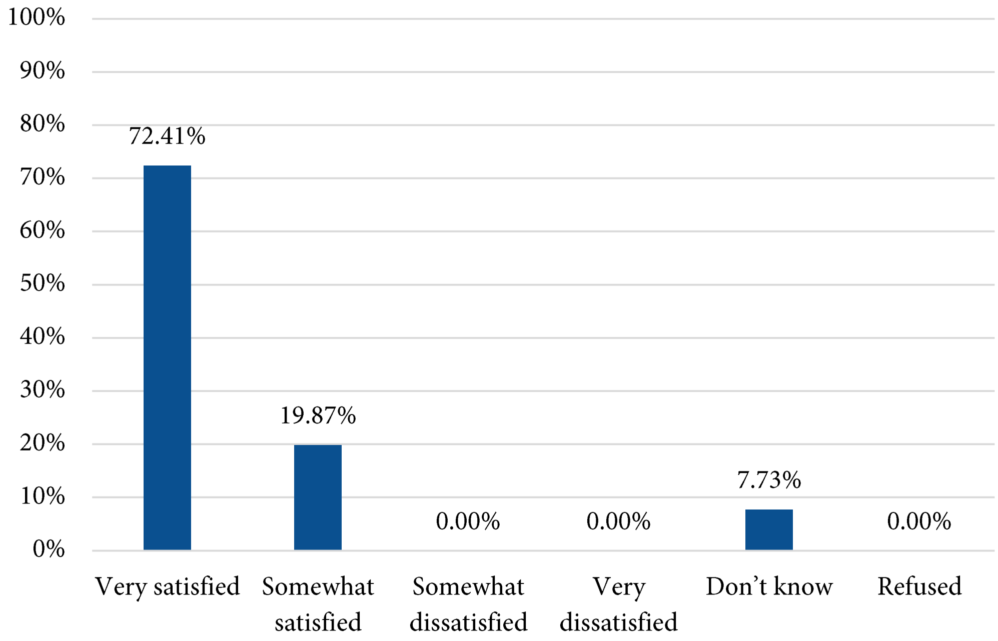


Notes: This question was asked of all those who responded "Yes" when asked if the client had a conversation with someone about understanding and selecting LTSS. Percentages are weighted.

Satisfaction with Care Transition Services

Of the 3 percent of respondents who indicated that their clients received care transition services directly from the ADRC, 92 percent were either "very satisfied" or "somewhat satisfied" with the services received. None of the respondents reported dissatisfaction (Exhibit 5.114).

Exhibit 5.114: Satisfaction with Care Transition Services



Notes: This question was asked of all those who responded "Yes" when asked if they received care transition services. Percentages are weighted.

Satisfaction with the Quality of All Services

We examined respondent satisfaction with the quality of services provided by ADRCs on multiple dimensions:

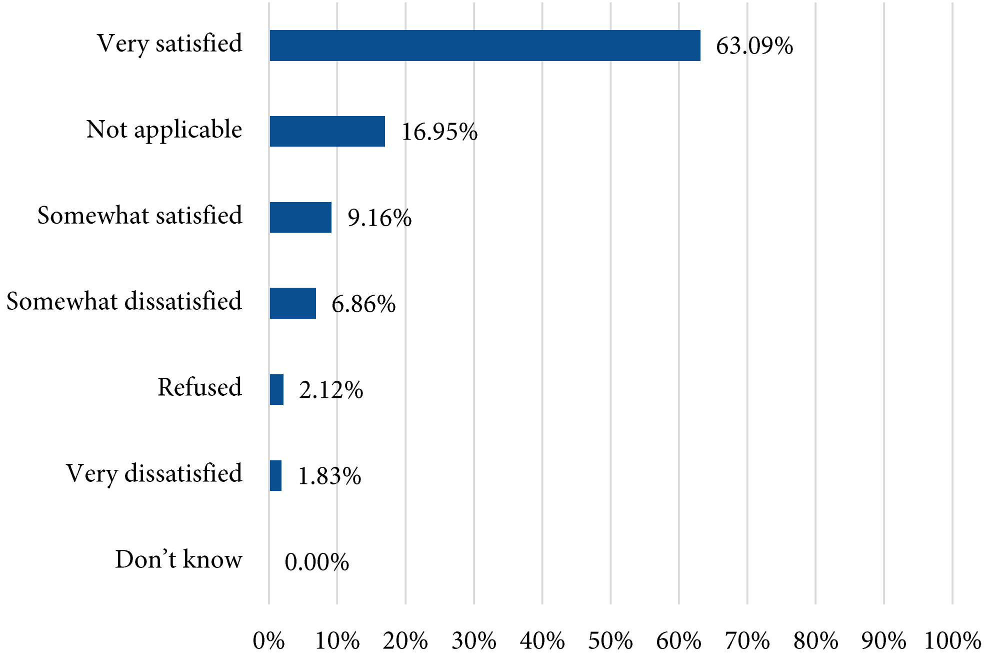
- Direct service receipt
- Completeness of information
- Degree to which services met specific needs
- Accuracy of information
- Support related to decision-making
- Professionalism of staff
- Ease of working with ADRCs to resolve issues
- Services received at agencies to which referred.

Direct Service Receipt. Of the 63 percent of respondents who received all or some of the services directly, 63 percent indicated that they were "very satisfied" with the services they received

(Exhibit 5.115). Of the respondents who reported being "very dissatisfied," the most common reason was that they did not receive the services they sought.

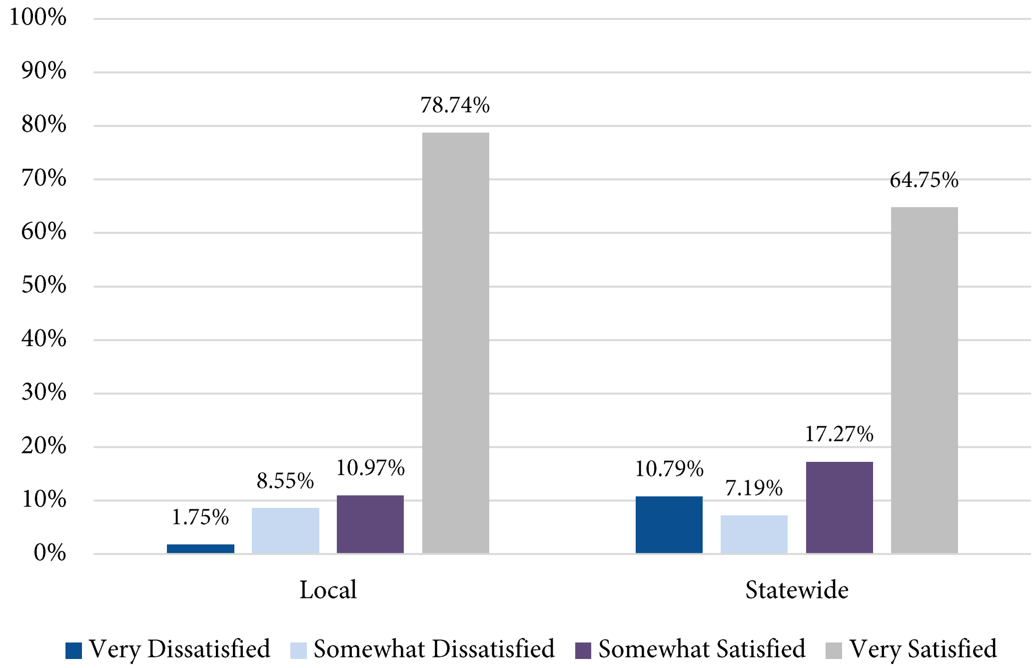
Respondents' level of satisfaction with the direct services they received was examined for potential statistically significant variations by agency location and size as well as by client characteristics. The findings showed that respondents who contacted local ADRCs were significantly more likely to be satisfied with the services received compared to respondents who contacted statewide ADRCs ($p \leq .01$) (Exhibit 5.116). Clients with an annual income greater than $40,000 were significantly less satisfied with the services they received directly when compared to clients with an income of $40,000 or less per year ($p \leq .10$) (Exhibit 5.117). The corresponding cross-tabulations are presented in Appendix FF, Exhibit 11 and Appendix AA, Exhibit 3, respectively.

Exhibit 5.115: Satisfaction with Services Received Directly from the ADRC



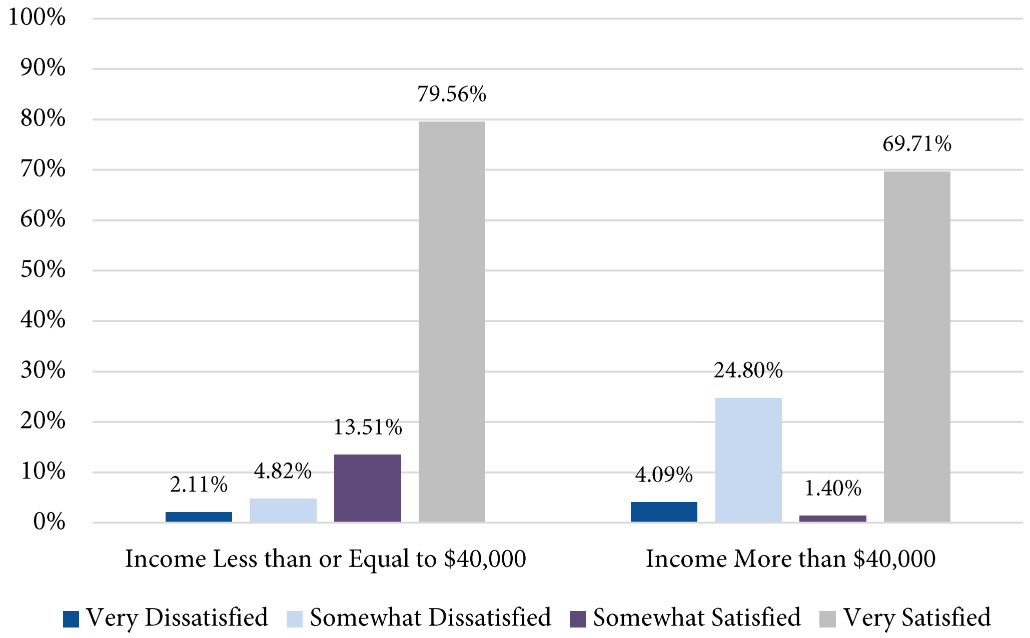
Note: Percentages are weighted.

Exhibit 5.116: Satisfaction with Direct Services by Agency Type



Note: Percentages are weighted.

Exhibit 5.117: Satisfaction with Direct Services by Client Income



Note: Percentages are weighted.

Completeness of Information. We examined respondent satisfaction with the completeness of information that they received from the ADRC (Exhibit 5.118). Respondents were generally satisfied, with 83 percent indicating they were either “very satisfied” or “somewhat satisfied.” Of the respondents who indicated being “very dissatisfied,” the most common reasons were that the respondent never received follow-up after the initial contact, and the information received was not helpful or was not the information sought.

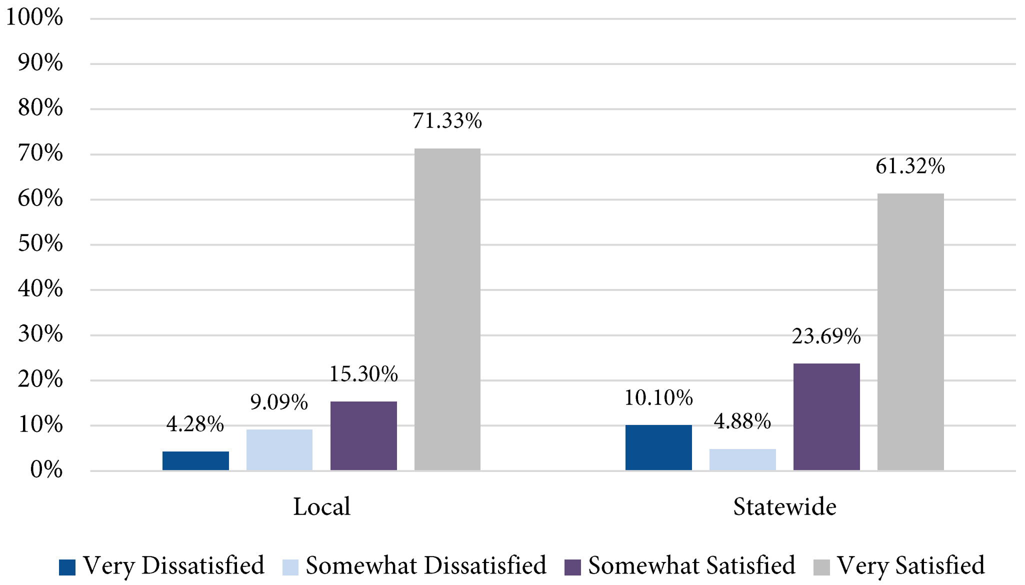
Exhibit 5.118: Satisfaction with the Completeness of Information

Satisfaction	Percentage
Very satisfied	67.37
Somewhat satisfied	15.14
Somewhat dissatisfied	8.39
Very dissatisfied	4.47
Not applicable	4.44
Don’t know	0.20
Refused	-
Total	100

Note: Percentages are weighted.

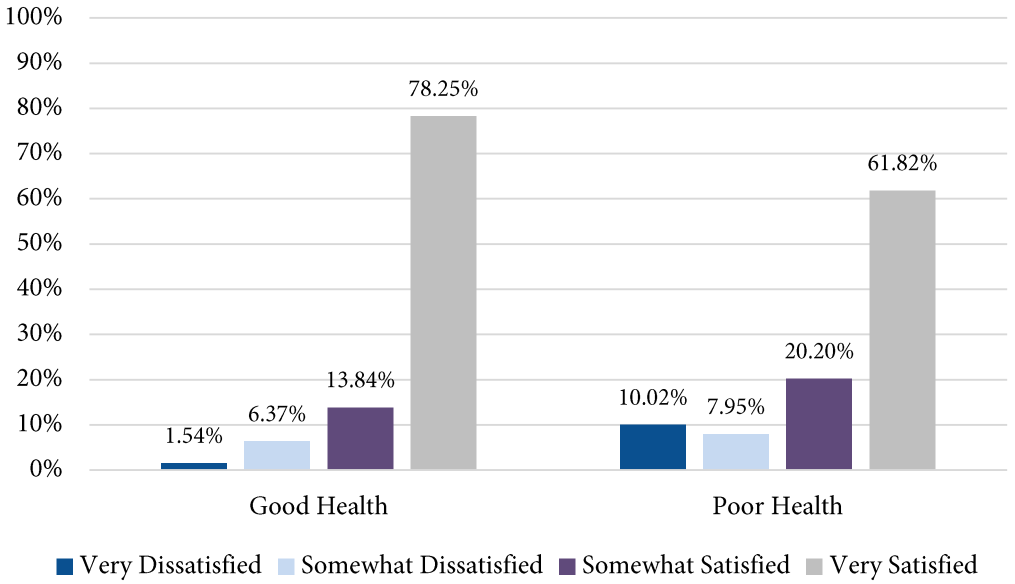
According to the subgroup analyses, respondents who contacted a local ADRC were significantly more likely to express higher levels of satisfaction compared to those who contacted a statewide ADRC about the completeness of information received ($p \leq .01$) (Exhibit 5.119). Further, respondents calling on behalf of clients in poor health were significantly less likely to report being satisfied with the completeness of information they received compared to those calling on behalf of clients in good health ($p \leq .05$) (Exhibit 5.120). The corresponding cross-tabulations are presented in Appendix FF, Exhibit 12, and Appendix BB, Exhibit 9, respectively.

Exhibit 5.119: Satisfaction with Completeness of Information by Agency Coverage



Note: Percentages are weighted.

Exhibit 5.120: Satisfaction with Completeness of Information by Client Health



Note: Percentages are weighted.

Degree to which Services Met Needs. Respondents were asked how satisfied they were with the degree to which the services received met their needs. Almost 80 percent of respondents reported being either "very satisfied" or "somewhat satisfied" with the degree to which the services received met their specific needs (Exhibit 5.121). Of the respondents who indicated that they were "very dissatisfied" (10%), the most common reason was that the service did not meet their needs.

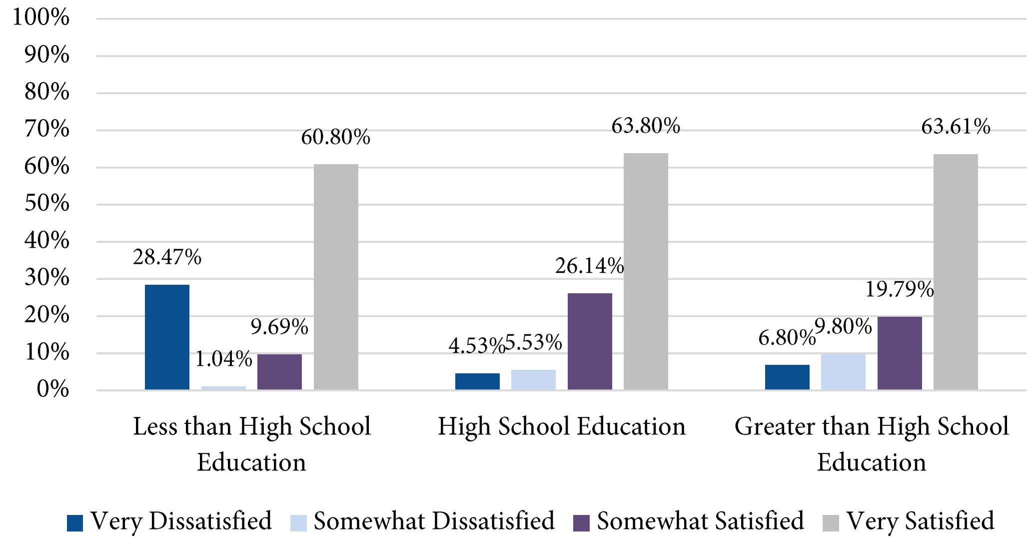
Exhibit 5.121: Satisfaction with the Degree to Which Services Met Specific Needs

Satisfaction	Percentage
Very satisfied	61.53
Somewhat satisfied	18.11
Somewhat dissatisfied	5.50
Very dissatisfied	10.46
Not applicable	4.40
Don't know	-
Refused	-
Total	100

Note: Percentages are weighted.

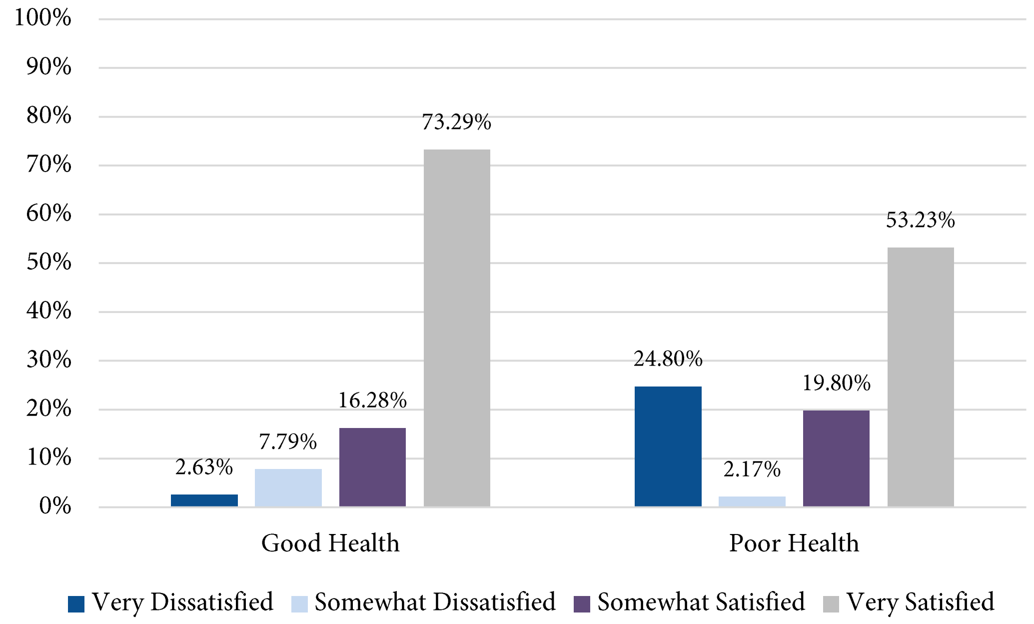
Respondent satisfaction appeared to vary by clients' education level. Respondents with a high school education or higher were significantly more likely to be satisfied with the degree to which services provided met client needs as compared to those with less than a high school education ($p \leq .01$). Clients with poor health reported lower levels of satisfaction than did those without poor health ($p \leq .01$). The corresponding cross-tabulations are presented in Appendix Z, Exhibit 2 and Appendix BB, Exhibit 10, respectively, and graphical depictions are found below in Exhibits 5.122 and 5.123.

Exhibit 5.122: Satisfaction with the Degree to Which Services Met Needs by Client Education



Note: Percentages are weighted.

Exhibit: 5.123 Satisfaction with the Degree to Which Services Met Needs by Client Health



Note: Percentages are weighted.

Accuracy of Information. Exhibit 5.124 shows the levels of satisfaction with the accuracy of the information that ADRCs provided. Over 91 percent of respondents indicated being “very satisfied” or “somewhat satisfied” with the accuracy of the information provided, and only 5 percent reported feeling “very dissatisfied.” Of the respondents who indicated being “very dissatisfied,” the most common reasons were that they were not helped by the agency, they were awaiting follow-up, or they did not get any information or sufficient information.

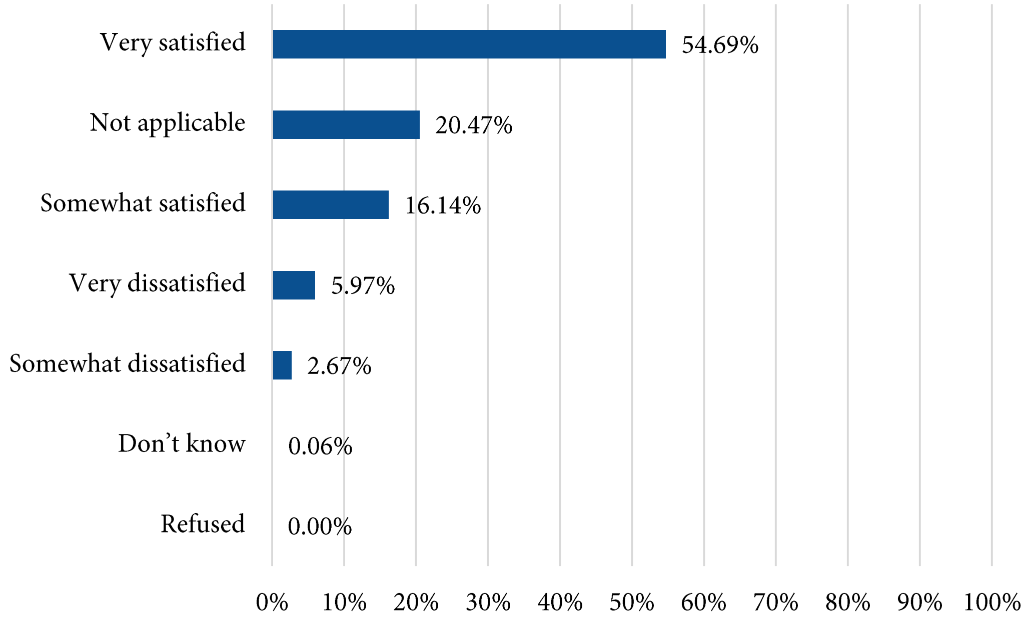
Exhibit 5.124: Satisfaction with the Accuracy of Information Provided

Satisfaction	Percentage
Very satisfied	70.42
Somewhat satisfied	20.63
Somewhat dissatisfied	1.83
Very dissatisfied	4.80
Not applicable	2.32
Don’t know	-
Refused	-
Total	100

Note: Percentages are weighted.

Support Related to Decision-Making. Respondents were generally satisfied with the support they received related to decision-making. As shown in Exhibit 5.125, 71 percent were either “very satisfied” or “somewhat satisfied” with the support they received. Similar to the previous questions, waiting for follow-up was commonly mentioned as a reason why respondents were dissatisfied with the support received. The most common response was that the respondent did not receive any support (18 respondents) or did not receive services (11 respondents).

Exhibit 5.125: Satisfaction with the Support Received Related to Decision-Making

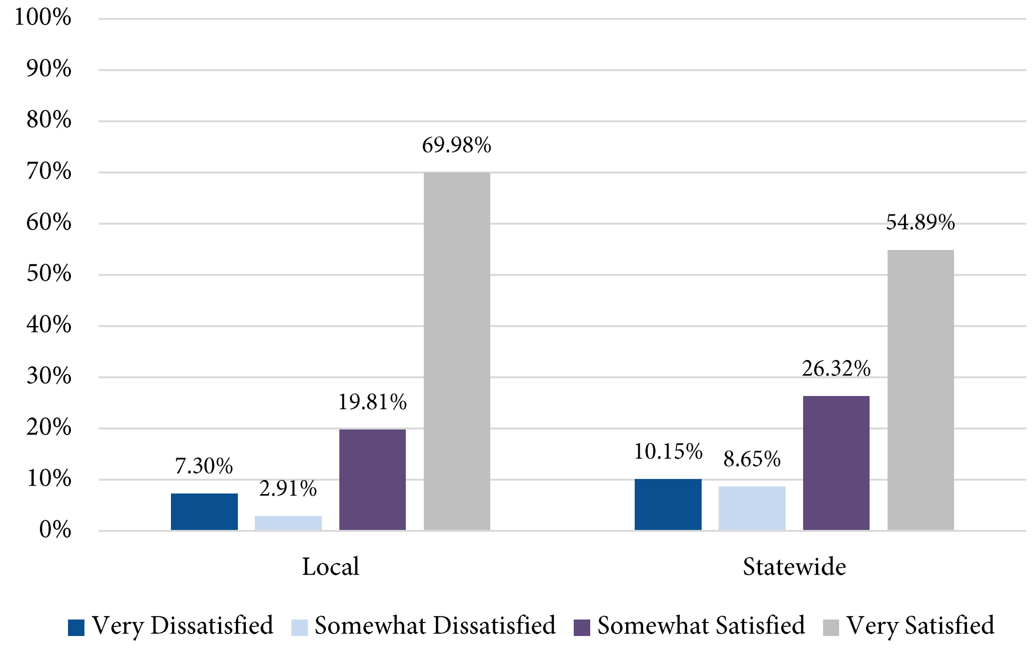


Note: Percentages are weighted.

Subgroup analyses revealed that respondents from local ADRCs were significantly more likely to report feeling satisfied with the support they received for decision-making than respondents from statewide ADRCs ($p \leq .01$, Exhibit 5.126). See Appendix FF, Exhibit 13 for detailed results. More educated clients were significantly more likely to be satisfied with the decision-making support received than those with less than a high school education ($p \leq .10$, Exhibit 5.127). Detailed results are presented in Appendix Z, Exhibit 3.

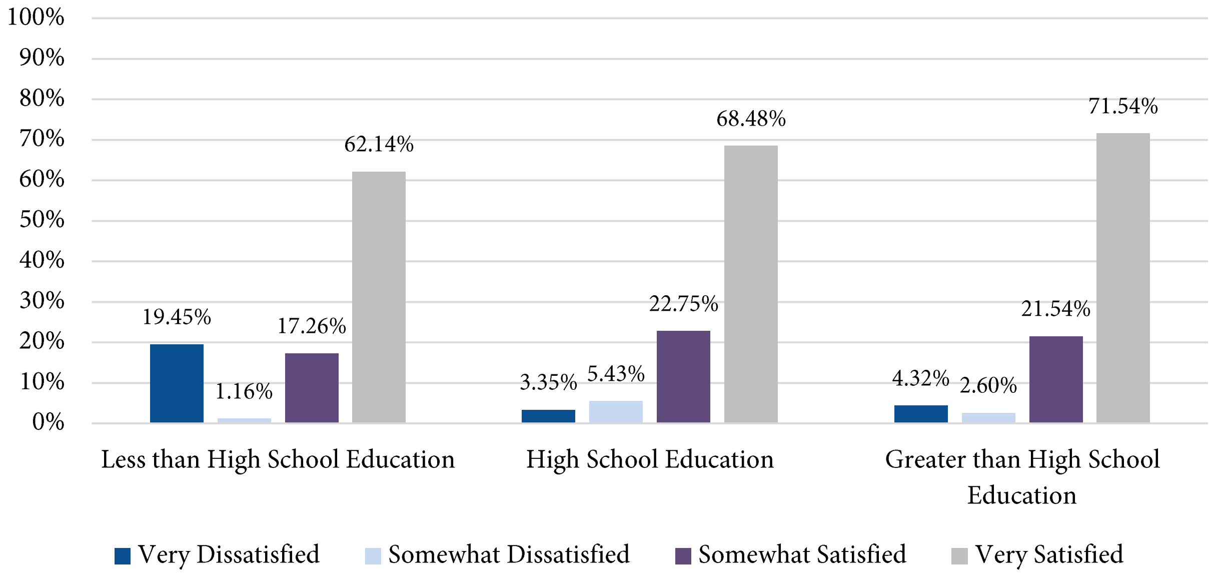
Clients with a disability were less satisfied with the support they received related to decision-making than clients without a disability ($p \leq .05$, Exhibit 5.128). Clients who rated their health as poor were also significantly less likely to report being satisfied ($p \leq .01$, Exhibit 5.129). The corresponding cross-tabulations are presented in Appendix CC, Exhibit 9, and Appendix BB, Exhibit 9, respectively.

Exhibit 5.126: Satisfaction with Support Received for Decision-Making by Agency Type



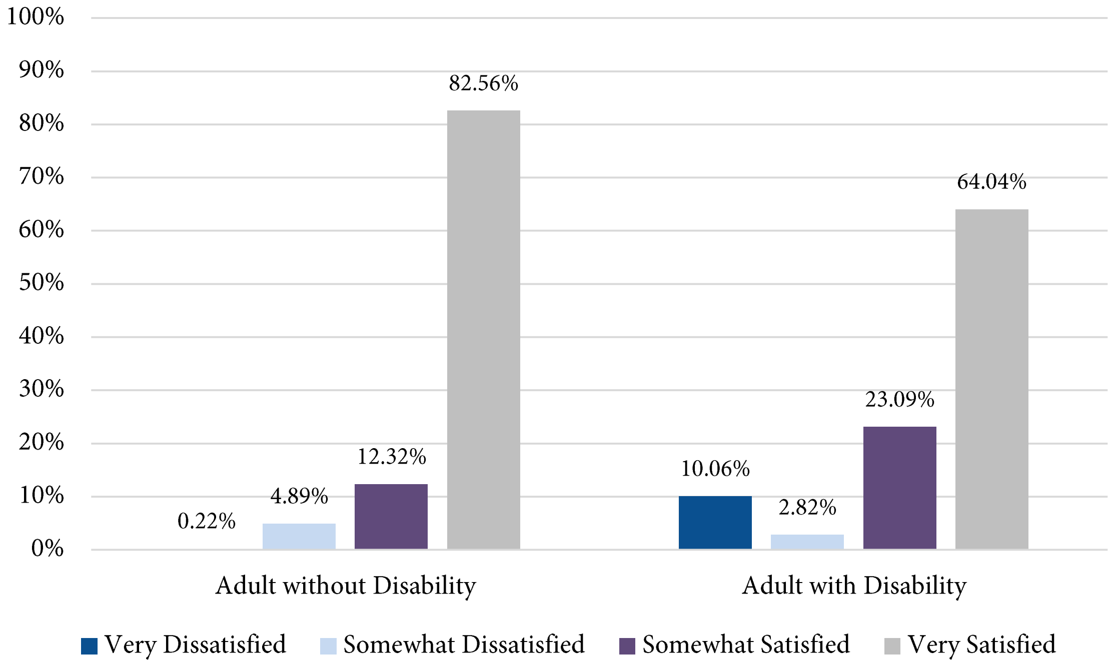
Note: Percentages are weighted.

Exhibit 5.127: Satisfaction with Support Received for Decision-Making by Client Education



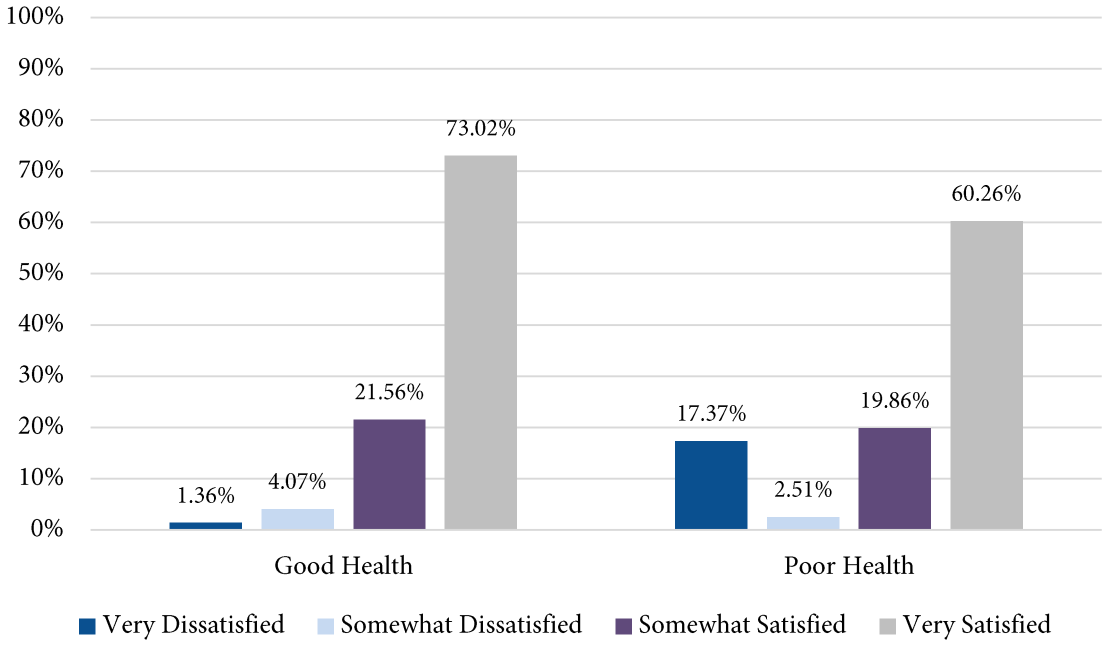
Note: Percentages are weighted.

Exhibit 5.128: Satisfaction with Support Received for Decision-Making by Client Disability



Note: Percentages are weighted.

Exhibit 5.129: Satisfaction with Support Received for Decision-Making by Client Health



Note: Percentages are weighted.

Professionalism of Staff. Respondents rated the professionalism of ADRC staff highly, with 93 percent of respondents expressing satisfaction. As shown in Exhibit 5.130, only 4 percent of respondents reported being either "somewhat dissatisfied" or "very dissatisfied" with the professionalism of the ADRC or its staff. Most of the reasons respondents gave for their dissatisfaction with staff were related to staff attitude: not helpful; not knowledgeable; rude or blunt. Lack of follow-up was also mentioned as a reason for dissatisfaction.

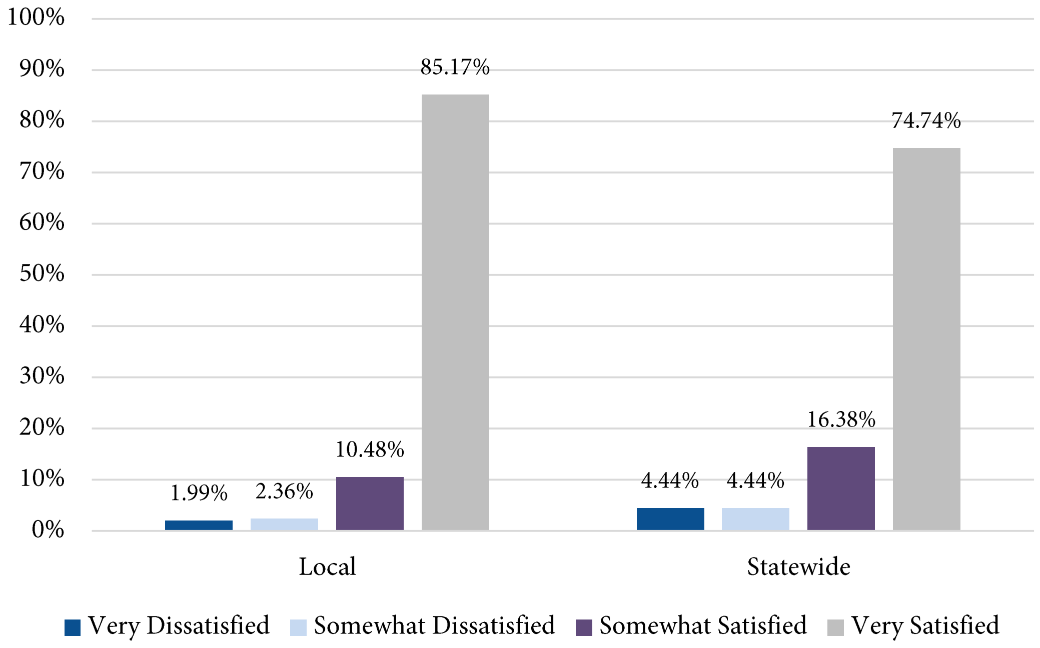
Exhibit 5.130: Satisfaction with the Professionalism of ADRC Staff

Satisfaction	Percentage
Very satisfied	82.42
Somewhat satisfied	10.62
Somewhat dissatisfied	2.44
Very dissatisfied	2.11
Not applicable	2.41
Don't know	-
Refused	-
Total	100

Note: Percentages are weighted.

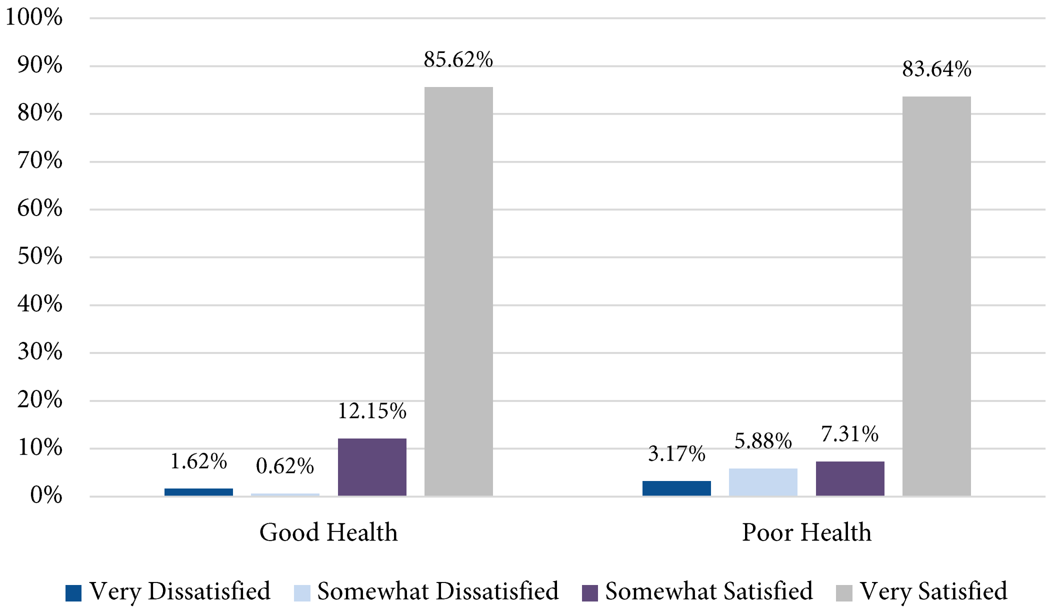
Respondents who contacted local ADRCs reported higher levels of satisfaction with staff professionalism than respondents who contacted statewide ADRCs ($p \leq .05$). Similarly, respondents with good health compared to those with poor health reported higher levels of satisfaction with staff professionalism ($p \leq .05$). The corresponding cross-tabulation are presented in Appendix FF, Exhibit 14 and Appendix BB, Exhibit 12, respectively, and Exhibits 5.131 and 5.132 depict this information graphically.

Exhibit 5.131: Satisfaction with Professionalism of the ADRC Staff by Agency Coverage



Note: Percentages are weighted.

Exhibit 5.132: Satisfaction with the Professionalism of ADRC Staff by Client Health



Note: Percentages are weighted.

Ease of Working with ADRCs to Resolve Issues. We also explored the level of satisfaction that respondents had with the ease of working with ADRCs to resolve their issues and found that respondents were generally satisfied with the ease of working with the ADRC. As highlighted in Exhibit 5.133, 84 percent of respondents indicated they were "very satisfied" or "somewhat satisfied." The most commonly mentioned reason for dissatisfaction when working to resolve issues was lack of follow up followed by a lack of helpfulness from staff.

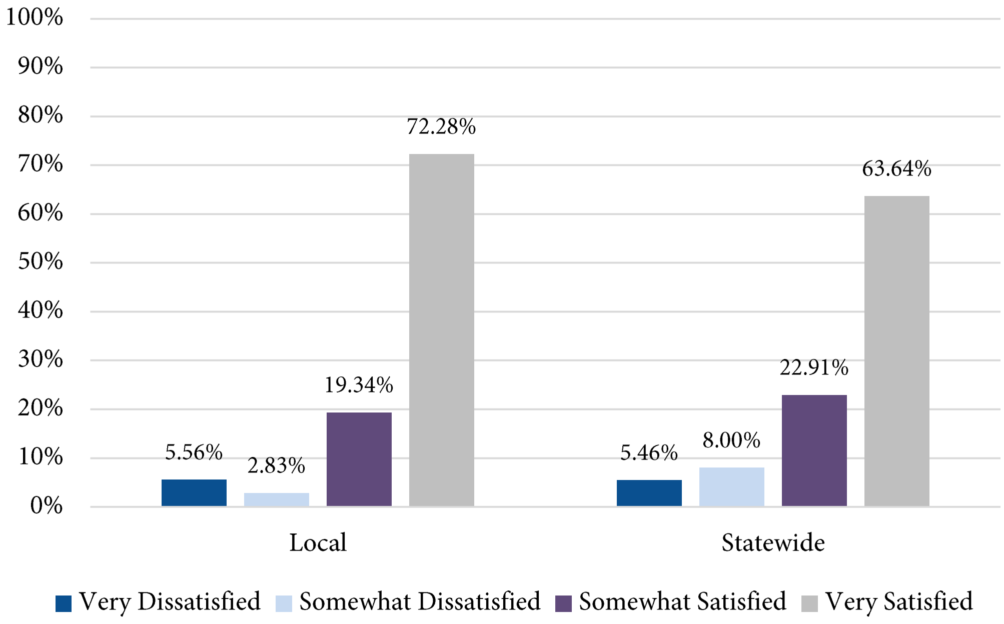
Exhibit 5.133: Satisfaction with the Ease of Working with the ADRC to Resolve Issues

Satisfaction	Percentage
Very satisfied	68.10
Somewhat satisfied	18.59
Somewhat dissatisfied	3.01
Very dissatisfied	5.27
Not applicable	5.03
Don't know	-
Refused	-
Total	100

Note: Percentages are weighted.

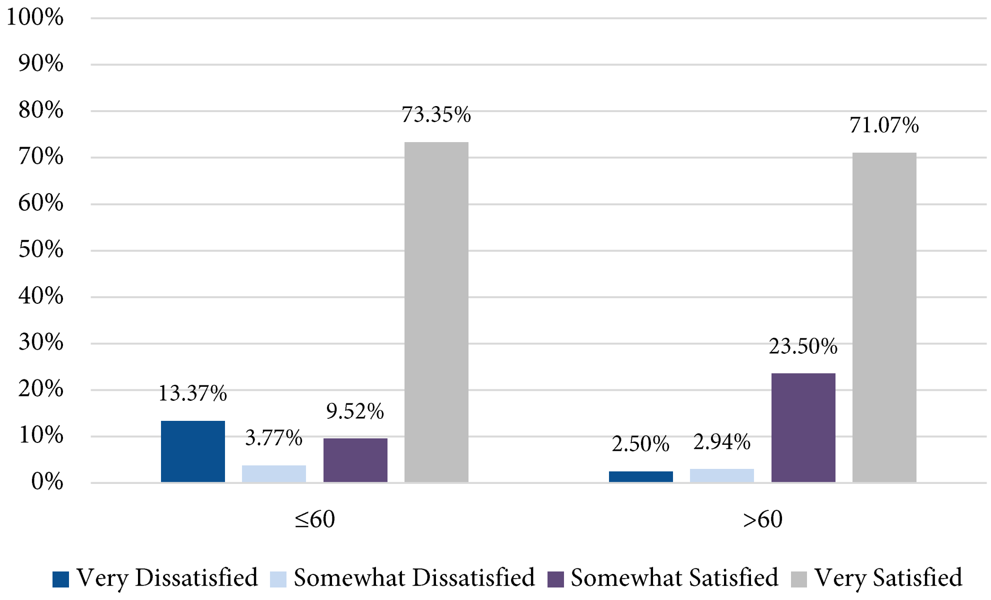
Respondents from local ADRCs were more likely to report feeling "very satisfied" when compared to respondents from statewide ADRCs who were slightly more likely to indicate being either "somewhat satisfied" or "somewhat dissatisfied" with the ease of working with the ADRC ($p \leq .05$) (Exhibit 5.134). Older clients were more likely to report being "somewhat satisfied" with the ease of working with the ADRC, while younger clients with a disability were more likely to report being "very dissatisfied" ($p \leq .01$, Exhibit 5.125). Further, respondents who rated their health as poor health, compared to those who rated their health as good, were more likely to report that they were "very dissatisfied" with ease of resolving issues ($p \leq .05$, Exhibit 5.126). The corresponding cross-tabulations are presented in Appendix FF, Exhibit 15; Appendix Y, Exhibit 2; and Appendix BB, Exhibit 13, respectively.

Exhibit 5.134: Satisfaction with Ease of Resolving Issues by Agency Type



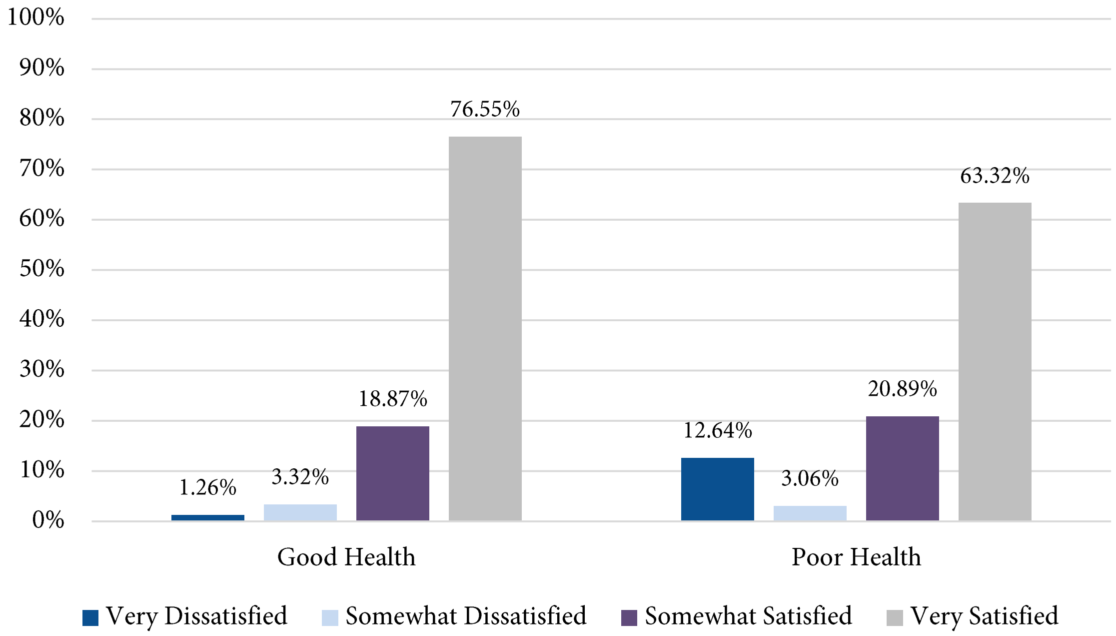
Note: Percentages are weighted.

Exhibit 5.135: Satisfaction with Ease of Resolving Issues by Client Age



Note: Percentages are weighted.

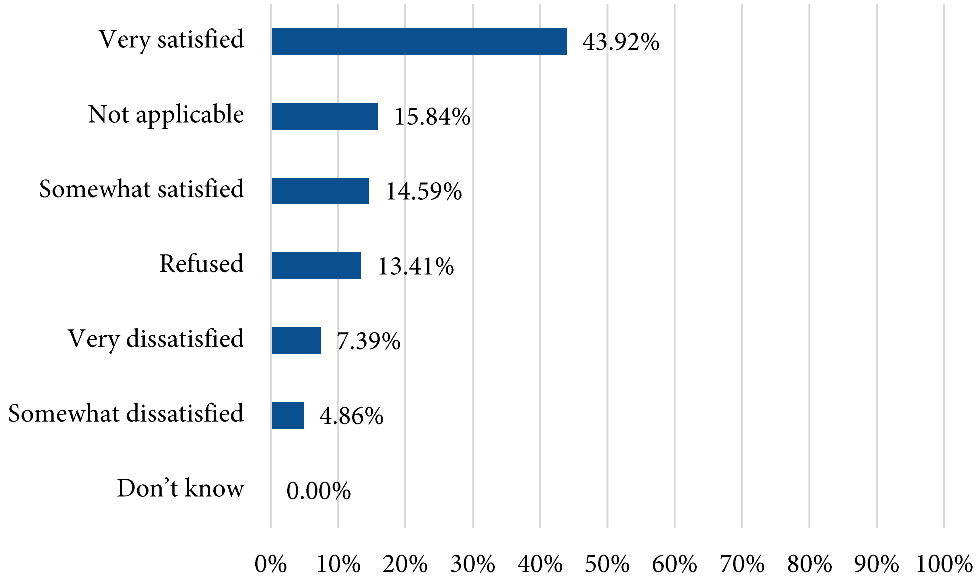
Exhibit 5.136: Satisfaction with Ease of Resolving Issues by Client Health



Note: Percentages are weighted.

Services Received at Referral Agencies. As displayed in Exhibit 5.137, only 59 percent of respondents who reported receiving services indirectly, or both directly and indirectly, indicated that they were satisfied with the quality of services they received from the agencies to which they were referred. Notably, 13 percent of respondents refused to answer the question. The most common reasons for dissatisfaction were not receiving help from the contacted agency and not receiving the requested service. Some respondents also reported they had not yet contacted a referral agency or that when they did contact the agency, the staff seemed uninterested in working with them.

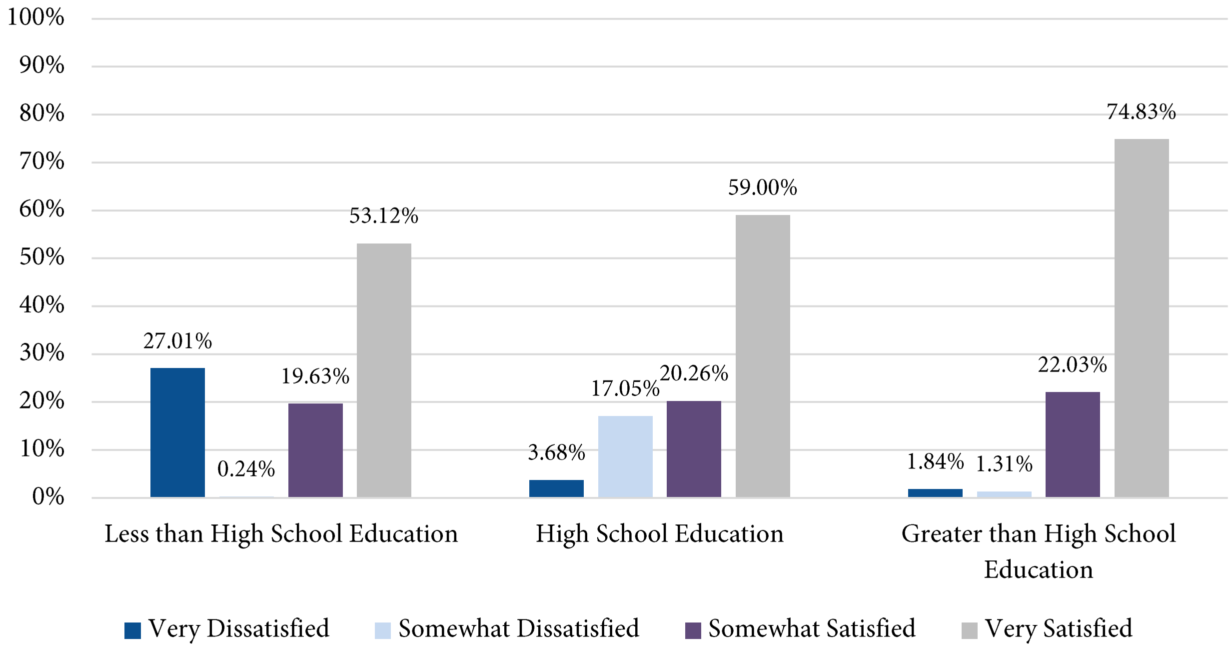
Exhibit 5.137: Satisfaction with the Services of Agencies to Which Respondent was Referred



Note: Percentages are weighted.

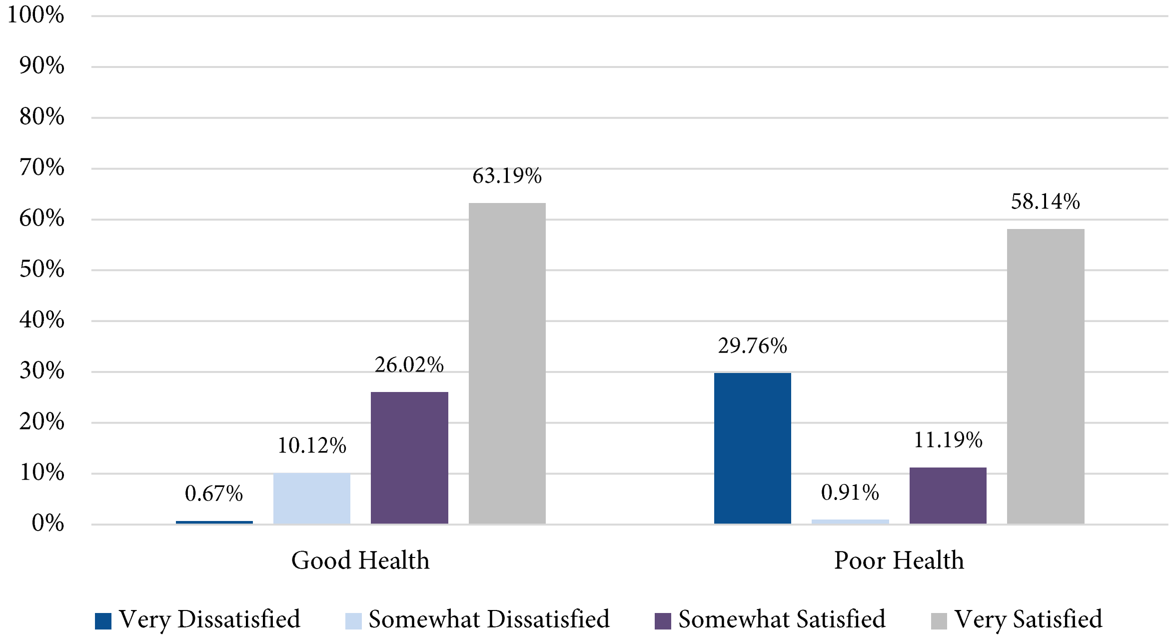
Respondent satisfaction varied across client education levels. Clients with more than a high school education expressed significantly higher levels of satisfaction compared to those with a high school education or less ($p \leq .05$, Exhibit 5.138). Clients who rated their health as poor were significantly less likely to be satisfied with the services they received at the referral agencies compared to clients who did not report poor health ($p \leq .01$, Exhibit 5.139). Detailed results are presented in Appendix Z, Exhibit 4 and Appendix BB, Exhibit 14.

Exhibit 5.138: Satisfaction with Quality of Services by Client Education



Note: Percentages are weighted.

Exhibit 5.139: Satisfaction with Quality of Services by Client Health



Note: Percentages are weighted.

We explored the variation in respondent satisfaction by the five most common reasons for contacting ADRCs on all the dimensions discussed above. We found no statistically significant association between the reasons for contact and the degree of satisfaction with the services received.

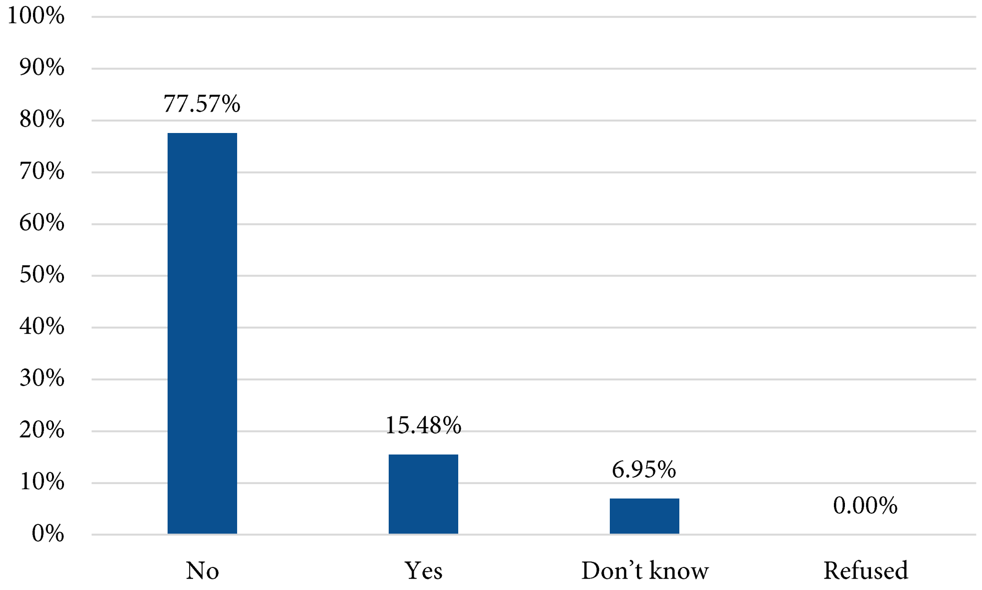
Usefulness of Services

To assess the overall usefulness of ADRC services, respondents were asked to report on:

- Improved awareness of LTSS needs
- Increased certainty of LTSS options
- Usefulness of information in selecting LTSS.

Exhibit 5.140 shows that only 16 percent of respondents reported that after contacting the ADRC, they identified an LTSS need of which they were previously unaware.

Exhibit 5.140: Improved Awareness of LTSS Needs After Contact with ADRC



Note: Percentages are weighted.

Respondents felt increased certainty about their long-term care options as a result of contact with ADRCs. About 58 percent of respondents reported feeling more certain about their long-term care options, while 14 percent of respondents felt more confused. As shown in Exhibit 5.141, 26 percent remained at about the same level of certainty.

Exhibit 5.141: Certainty about Long-Term Care Options as a Result of Contact with ADRC

Certainty About Long-Term Care Options	Percentage
Much more certain about your/you [insert PP2]'s long-term care options	37.14
A little more certain	20.59
About the same	25.80
A little more confused	9.32
Much more confused	4.56
Don't know	2.53
Refused	0.06
Total	100

Note: Percentages are weighted.

Respondents were asked to rank the level of usefulness of the information provided by ADRCs as they were selecting long-term care options. Sixty-nine 69 percent of respondents reported that the information they received was either "very useful" or "somewhat useful"; only 20 percent reported that the information was not useful (Exhibit 5.142). There` were no statistically significant differences in reports of level of usefulness by ADRC or client characteristics.

Exhibit 5.142: Usefulness of Information for Selecting Long-Term Care Options

Usefulness	Percentage
Very useful	45.43
Somewhat useful	23.26
Not too useful	5.46
Not useful at all	14.18
Don't know	10.64
Refused	1.03
Total	100

Note: Percentages are weighted.

Value of ADRCs to Respondents

The survey indirectly assessed the value that ADRCs held for respondents by asking the respondents whether they would recommend contacting an ADRC to a friend or relative in need and how likely they themselves were to contact ADRCs in the future, if needed.

Exhibit 5.143 shows an overwhelming majority of respondents (94%) indicated that they would tell a friend or relative who needed help to contact the ADRC.

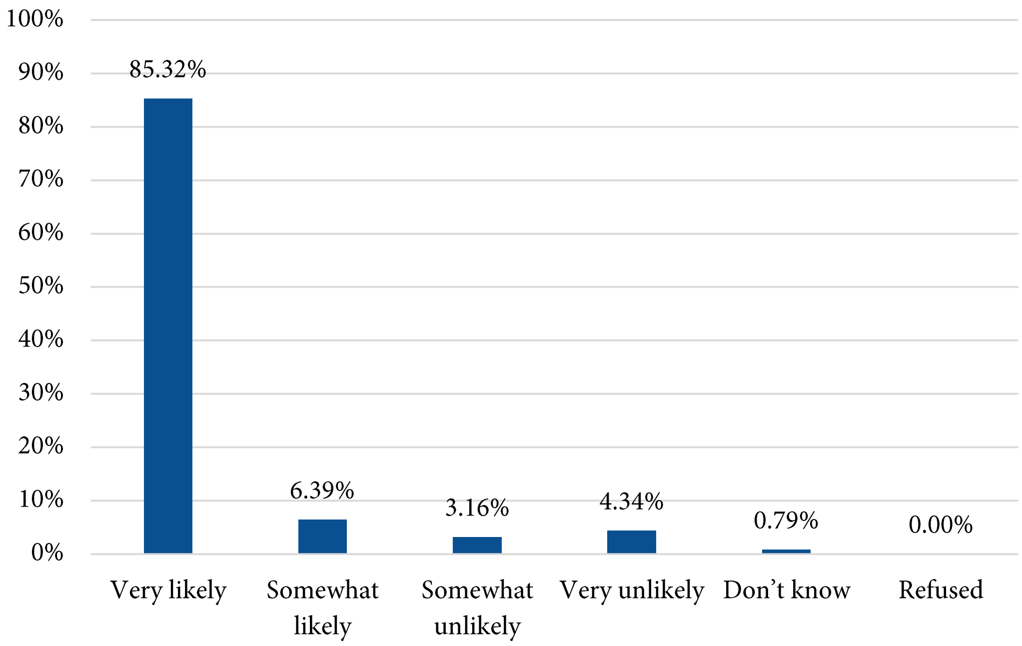
Exhibit 5.143: Respondents who would Tell a Friend/Relative who Needed Help to Contact ADRC

Recommend ADRC	Percentage
Yes	94.05
No	5.24
Don’t know	0.71
Refused	-
Total	100

Note: Percentages are weighted.

When asked if they would contact the ADRC again if needed, 92 percent of respondents indicated that they were “very likely” or “somewhat likely” to contact. Only eight percent of respondents indicated they were either “somewhat unlikely” or “very unlikely” to contact the ADRC again, as shown in Exhibit 5.144.

Exhibit 5.144: Likelihood of Respondent Contacting the ADRC Again If Needed



Note: Percentages are weighted.

Regression Findings – Satisfaction with the Quality of Services

We explored the satisfaction expressed by survey respondents on the following four dimensions of ADRC services:

- Comprehensiveness of information
- Personalization of services
- Accuracy of information
- Support in decision-making.

The survey had seven questions that measured satisfaction with different aspects of the ADRC service. However, three had very few observations with a value of 0 (i.e., “Not satisfied”), and therefore these outcomes were not included in the analysis.

In all the satisfaction-related regression models, we included client characteristics together with the reasons for contact. In addition, we included respondent type (i.e., self vs. other) as a covariate in these models to explore whether satisfaction with ADRCs varied by whether the contact was made by the clients themselves or by others on their behalf.

Since satisfaction was a reflection of respondents’ experience interacting with ADRCs, agency characteristics also were included. ADRC type (a statewide ADRC versus a local ADRC) was used to explore whether respondent satisfaction varied based on contacting a statewide network as compared to a local office. In addition, an indicator for whether the ADRC operated in a rural or urban coverage area was included. Community characteristics were included in the models as proxies for unobserved client and ADRC characteristics that may influence respondent satisfaction.

Comprehensiveness of Information. The likelihood of respondents’ satisfaction with the comprehensiveness of information received from ADRCs is presented in Appendix JJ, Exhibit 4, column 1. Clients who live alone were less likely to be satisfied with the comprehensiveness of information received from ADRCs (-14.1 percentage points; $p \leq .05$). Also respondents contacting ADRCs for Medicare-related reasons were less likely to be satisfied (-10.5 percentage points; $p \leq .05$). Respondents contacting rural ADRCs were more likely to be satisfied than respondents contacting urban ADRCs (12.25 percentage points; $p \leq .05$). Finally, respondents contacting ADRCs serving areas with a higher number of home health agencies were also more likely to be satisfied with the comprehensiveness of information (0.8 percentage points; $p \leq .05$).

Personalization of Services. Here we analyzed respondent satisfaction with the personalization of services (see Appendix JJ, Exhibit 4, column 2). Respondents who contacted ADRCs themselves were less likely to be satisfied than those who contacted on behalf of someone else (-12.4 percentage points; $p \leq .01$). Also, clients with a high school degree or respondents calling on behalf of clients with a high school degree were more likely to be satisfied with the personalization of services compared to clients with less than a high school degree or respondents calling on their behalf (15.0 percentage points; $p \leq .01$). Respondents contacting ADRCs for Medicare-related reasons were more likely to be satisfied with the personalization of the information received from ADRCs than those contacting ADRCs for other reasons (7.0 percentage points; $p \leq .05$). In addition, respondents contacting rural ADRCs were more likely to be satisfied with the personalization of services received from their ADRCs compared to respondents contacting urban ADRCs (17.1 percentage points; $p \leq .05$). The likelihood of respondents expressing satisfaction with the personalization of services increased with the number of home health agencies in the ADRC service area (1.8 percentage points; $p \leq .01$).

Accuracy of Information. The regression results for respondent satisfaction with the accuracy of information received from ADRCs are shown in Appendix JJ, Exhibit 4, column 3. Among the client characteristics, clients with a high school degree or respondents contacting ADRCs on their own behalf were more likely to be satisfied with the accuracy of information than those with less than a high school degree (9.3 percentage points; $p \leq .05$). None of the other client characteristics were statistically significant. Among ADRC characteristics, respondents contacting statewide ADRCs were more likely to be satisfied with the accuracy of information compared to those who contacted local ADRCs (12.2 percentage points; $p \leq .01$). In addition, the larger the number of home health agencies in ADRC service areas, the higher the satisfaction of respondents with the accuracy of information received (1.5 percentage points; $p \leq .05$). However, respondent satisfaction was negatively associated with the number of nursing home beds in the ADRC coverage areas (-5.8 percentage points; $p \leq .01$).

Support in Decision-Making. The regression results for satisfaction with the decision-making support that respondents received are shown in Appendix JJ, Exhibit 4, column 5. This is the only instance where gender was statistically significant. Male clients and respondents contacting ADRCs on their behalf were more likely to be satisfied with the support received from ADRCs compared to female clients and their respondents (5.9 percentage points; $p \leq .05$). However, clients who were married were less likely to be satisfied with the decision-making support received (-10.0 percentage points; $p \leq .05$). Also, clients who rated their health as poor were less likely to be satisfied with the support they received from the ADRCs (-10.07 percentage points; $p \leq .01$) as were clients living alone (-12.1 percentage points; $p \leq .05$).

Satisfaction with decision-making support also varied with the reasons for contact. Respondents who contacted the ADRC regarding Medicaid (9.3 percentage points; $p \leq .05$) or personal care services (5.0 percentage points; $p \leq .05$) were more likely to be satisfied with the support received compared to those who contacted for other reasons. Among ADRC characteristics, respondents contacting statewide ADRCs were more likely to be satisfied with the support in decision-making compared to those who contacted local ADRCs (16.4 percentage points; $p \leq .01$). Also, the number of home health agencies in the ADRC service areas was positively associated with respondents' being satisfied with the decision-making support received (3.5 percentage points; $p \leq .01$). In contrast, the number of nursing home beds in the ADRC services areas was negatively associated with satisfaction with decision-making support (-15.9 percentage points; $p \leq .01$).

Usefulness of Information. Respondents were asked to choose one of four ordered categories to indicate the degree of usefulness of the information that ADRCs provided to assist in selecting LTSS. To assess the factors associated with this item, we converted the ordered response variable into a binary variable. "Very Useful" and "Somewhat Useful" were recoded into a single category of "Useful," and "Not too Useful" and "Not at all Useful" into a single category of "Not Useful."

The average marginal effects from the probit regression analysis are provided in Appendix JJ, Exhibit 5. Client, ADRC, and community characteristics are all included in this regression because they are likely to influence whether respondents found the information useful. In addition, we included the reasons for contacting the ADRC, because the usefulness of information may vary by the reason for contact.

The likelihood of finding the information useful slightly decreased with clients' age (-0.7 percentage points; $p \leq .05$). None of the other client characteristics were statistically significant. Among ADRC characteristics, respondents who contacted a statewide ADRC were significantly less likely to find the information provided by ADRCs useful when compared to respondents who contacted local ADRCs (-69.7 percentage points; $p \leq .01$). No other ADRC characteristic showed a statistically significant association with this outcome. At the community level, ADRCs serving communities with a higher number of home health agencies were associated with higher respondent satisfaction with the usefulness of the information received (1.4 percentage points; $p \leq .01$).

5.2.6 Comparison by Core Integration Dimensions

In this section, we explore whether there are statistically significant differences on key outcome study variables across the three core measures for ADRCs participating in the outcome study: level of core service provision, extent of site integration, and Medicaid integration.

Core Service Provision. Exhibit 5.145 indicates that respondents who contacted ADRCs that had a medium or high level of core service provision were much more likely to have had counseling or peer support as the result of contact when compared to those who contacted ADRCs that had a low level of core provision ($p \leq .10$).

Exhibit 5.145: Counseling or Peer Support by Level of Core Service Provision

Counseling or Peer Support	Low Level	Medium Level	High Level	Total
No	91.31	79.78	64.80	72.78
Yes	8.69	20.22	35.20	27.22
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .10$.

In addition, respondents from ADRCs with a medium level of core service provision were significantly more likely than respondents from ADRCs with low or high levels of core service provision to report benefits counseling as the result of contact with the ADRC ($p \leq .05$, Exhibit 5.146).

Exhibit 5.146: Benefits Counseling by Level of Core Service Provision

Benefits Counseling	Low Level	Medium Level	High Level	Total
No	83.61	38.18	53.60	48.20
Yes	16.39	61.82	46.40	51.80
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Respondents from ADRCs with a low level of core service provision were more likely to contact the ADRC for nutrition-related services than respondents from ADRCs with medium or high levels of core service provision (Exhibit 5.147). Respondents from ADRCs with medium and high levels of core service provision were most likely to contact the ADRC regarding Medicare and Medicaid assistance requests, respectively. These differences were statistically significant ($p \leq .01$).

Exhibit 5.147: Most Frequent Reasons for Contact by Level of Core Service Provision

Most Frequent Reasons to Contact	Low Level	Medium Level	High Level	Total
Medicare Questions	6.52	46.97	27.22	34.27
Medicaid Questions	2.17	23.37	33.71	28.56
Housing	0.00	19.31	4.27	10.03
Personal Care	2.17	2.48	24.38	15.01
Nutrition	89.13	7.88	10.42	12.13
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Respondents from ADRCs with a high or medium level of core service provision were significantly more likely to hear about the agency from family, friends, or other acquaintances as compared to respondents from ADRCs with a low level of core service provision (Exhibit 5.148). Respondents from ADRCs with a low level of core service provision were more likely to have been referred by another agency. These differences were statistically significant ($p \leq .05$).

Exhibit 5.148: Where Respondent First Heard About Agency by Level of Core Service Provision

How Respondent First Heard About Agency	Low Level	Medium Level	High Level	Total
Family, Friend or other Acquaintance	18.94	38.63	41.95	39.38
Hospital/Clinic/Doctor	0.00	3.23	8.28	5.57
Nursing Home/Assisted Living	0.00	4.36	0.84	2.41
Phone Book	15.53	3.25	4.31	4.34
Brochure/Flyer	1.14	0.00	1.58	0.84
Referral from Senior Center	2.27	0.38	2.47	1.50
Referral from another Agency/Organization	59.85	26.53	25.30	27.44
Work	2.27	0.41	5.06	2.80
Internet/Website	0.00	4.90	6.09	5.27
Media/Newspaper/TV/Radio	0.00	18.15	1.10	8.87
Other	0.00	0.15	3.05	1.56
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Respondents from ADRCs with low levels of core service provision were significantly more likely to indicate that the ADRC's hours led to a reduction in the ability to resolve the respondent's issue as compared to respondents from ADRCs with medium and high levels of core service provision ($p \leq .01$, Exhibit 5.149).

Exhibit 5.149: Reduction in Ability to Resolve Issues as Result of Hours of Operation by Level of Core Service Provision

Reduction in Ability to Resolve Issue	Low Level	Medium Level	High Level	Total
No	53.93	92.63	95.17	92.01
Yes	46.07	7.37	4.83	7.99
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

There was a statistically significant difference between respondents who reported about ADRCs with core service provision levels that were categorized as high or medium versus low (Exhibit 5.150). Respondents from ADRCs with a high or medium level of core service provision were more likely to report being "very satisfied" with the professionalism of the staff compared to respondents from ADRCs with a low level of core service provision ($p \leq .01$).

Exhibit 5.150: Satisfaction with Professionalism of the Staff by Level of Core Service Provision

Level of Satisfaction	Low Level	Medium Level	High Level	Total
Very Dissatisfied	0.98	0.67	3.76	2.26
Somewhat Dissatisfied	0.00	1.34	2.50	1.86
Somewhat Satisfied	40.33	4.24	14.09	11.05
Very Satisfied	58.96	93.76	79.65	84.83
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

In results showing statistical significance or a trend toward significance, as seen in Exhibit 5.151, respondents were more likely to indicate being "very satisfied" with the ease of resolving the issue faced if the ADRC had a high or medium level of core service provision compared to having a low level of core service provision ($p \leq .05$).

Exhibit 5.151: Satisfaction with Ease of Resolving Issues by Level of Core Service Provision

Level of Satisfaction	Low Level	Medium Level	High Level	Total
Very Dissatisfied	0.00	3.79	6.73	5.03
Somewhat Dissatisfied	0.00	0.29	6.16	3.15
Somewhat Satisfied	60.49	20.03	16.02	20.15
Very Satisfied	39.51	75.89	71.09	71.67
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Site Integration. We explored whether the result of respondents' contact with ADRCs varied by the extent of site integration of the ADRCs and found that respondents who contacted an ADRC with a low or high level of site integration were significantly more likely to indicate that the result of contact was information assistance when compared to those who contacted an ADRC with a medium level of site integration ($p \leq .05$, Exhibit 5.152). Respondents from ADRCs with a low level of site integration were much more likely to have had their contact result in life skills training or support than respondents from ADRCs with medium or high levels of site integration ($p \leq .01$, Exhibit 5.153).

Exhibit 5.152: Information Assistance by Extent of Site Integration

Information Assistance	Low Level	Medium Level	High Level	Total
No	0.00	18.77	5.75	14.90
Yes	100.00	81.23	94.25	85.10
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Exhibit 5.153: Life Skills Training or Support by Extent of Site Integration

Life Skills Training or Support	Low Level	Medium Level	High Level	Total
No	50.00	99.97	100.00	99.70
Yes	50.00	0.03	0.00	0.30
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Exhibit 5.154 shows that no respondents from ADRCs with a low level of site integration contacted the ADRC for any of the five most frequently given reasons for contacting the agency. Respondents who contacted an ADRC with a medium level of site integration did so primarily for Medicare questions, while respondents who contacted an ADRC with a high level of site integration did so primarily for Medicaid questions. These differences were statistically significant ($p \leq .01$).

Exhibit 5.154: Most Frequent Reasons to Contact the ADRC by Extent of Site Integration

Most Frequent Reasons to Contact	Low Level	Medium Level	High Level	Total
Medicare Questions	0.00	45.27	10.91	34.27
Medicaid Questions	0.00	26.40	33.15	28.56
Housing	0.00	12.83	4.09	10.03
Personal Care	0.00	6.37	33.35	15.01
Nutrition	0.00	9.12	18.50	12.13
Total	0.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Respondents from ADRCs with high or medium levels of site integration were more likely to indicate that a lack of staff professionalism served as a barrier to resolving their issue ($p \leq .10$). Interestingly, none of the respondents from ADRCs with a low level of site integration cited lack of staff professionalism as a barrier to resolving issues (Exhibit 5.155).

Exhibit 5.155: Reduction in Ability to Resolve Issues Due to Lack of Staff Professionalism by Extent of Site Integration

Reduction in Ability to Resolve Issue	Low Level	Medium Level	High Level	Total
No	100.00	96.64	89.48	94.60
Yes	0.00	3.36	10.52	5.40
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .10$.

Exhibit 5.156 shows that respondents of ADRCs that had a medium or high level of site integration were statistically more likely to report lack of staff follow-through as leading to a reduced ability to resolve issues ($p \leq .05$).

Exhibit 5.156: Reduction in Ability to Resolve Issues due to Lack of Staff Follow-through by Extent of Site Integration

Reduction in Ability to Resolve Issue	Low Level	Medium Level	High Level	Total
No	100.00	92.81	81.39	89.60
Yes	0.00	7.19	18.61	10.40
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Respondents from ADRCs with a medium level of site integration were significantly more likely to report being satisfied with the ease of resolving issues than those from ADRCs with a low or high level of site integration ($p \leq .01$, Exhibit 5.157).

Exhibit 5.157: Satisfaction with Ease of Resolving Issues by Extent of Site Integration

Level of Satisfaction	Low Level	Medium Level	High Level	Total
Very Dissatisfied	0.00	3.04	10.39	5.03
Somewhat Dissatisfied	0.00	0.96	8.97	3.15
Somewhat Satisfied	50.00	19.93	20.09	20.15
Very Satisfied	50.00	76.08	60.55	71.67
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Finally, respondents were significantly more likely to report being satisfied with the professionalism of the staff if they were reporting on an ADRC with a low level of site integration compared to an ADRC with a medium or high level of site integration ($p \leq .05$, Exhibit 5.158).

Exhibit 5.158: Satisfaction with Professionalism of the Staff by Extent of Site Integration

Agency Followed Up	Low Level	Medium Level	High Level	Total
Very Dissatisfied	0.00	1.04	5.19	2.26
Somewhat Dissatisfied	0.00	1.30	3.24	1.86
Somewhat Satisfied	0.000	8.27	17.90	11.05
Very Satisfied	100.00	89.39	73.67	84.83
Total	100.00	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Medicaid Integration. Regressions were used to determine the presence of associations between outcome variables and whether the ADRC was classified as Medicaid integrated. Exhibit 5.159 shows that respondents who contacted ADRCs that were Medicaid integrated were more likely than respondents who contacted those that were not Medicaid integrated to report that information assistance was the result of their contact ($p \leq .05$).

Exhibit 5.159: Receipt of Information Assistance by Status of Medicaid Integration

Information Assistance	Not Medicaid Integrated	Medicaid Integrated	Total
No	25.18	11.54	14.47
Yes	74.82	88.46	85.53
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Respondents from ADRCs that were not Medicaid integrated were significantly more likely to have counseling or peer support as a result of contact than respondents from ADRCs that were Medicaid integrated ($p \leq .01$, Exhibit 5.160).

Exhibit 5.160: Receipt of Counseling or Peer Support by Status of Medicaid Integration

Counseling or Peer Support	Not Medicaid Integrated	Medicaid Integrated	Total
No	52.06	77.73	72.78
Yes	47.94	22.27	27.79
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

There were statistically significant differences between Medicaid integrated and non-Medicaid-integrated ADRCs on reasons for contacting the ADRC. Respondents from ADRCs that were Medicaid integrated were more likely to contact the ADRC for personal care, housing, or nutrition issues, while respondents from ADRCs that were not Medicaid integrated were more likely to contact the ADRC for questions regarding Medicaid or Medicare ($p \leq .01$, Exhibit 5.161).

Exhibit 5.161: Most Frequent Reasons to Contact ADRC by Status of Medicaid Integration

Most Frequent Reasons to contact	Not Medicaid Integrated	Medicaid Integrated	Total
Medicare Questions	44.59	28.70	32.61
Medicaid Questions	49.71	25.63	31.55
Housing	4.01	11.67	9.78
Personal Care	1.55	18.75	14.52
Nutrition	0.15	15.26	11.54
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Respondents of Medicaid-integrated ADRCs were slightly more likely to indicate that difficulty in reaching ADRC staff led to a reduction in the ability to resolve their issues ($p \leq .10$, Exhibit 5.162). Moreover, respondents who contacted Medicaid-integrated ADRCs were significantly more likely to indicate that communication problems ($p \leq .01$), and a lack of follow-through by ADRC staff ($p \leq .01$) led to a reduction in the ability to resolve the respondent's issue.

Exhibit 5.162: Reduction in Ability to Resolve Issues by Status of Medicaid Integration

Reduction in Ability to Resolve Issue Due To:	Not Medicaid Integrated	Medicaid Integrated	Total
Difficulty Reaching Staff*			
No	91.93	80.68	83.12
Yes	8.07	19.32	16.88
Total	100.00	100.00	100.00
Communication Problems***			
No	99.57	95.21	96.16
Yes	0.43	4.79	3.84
Total	100.00	100.00	100.00
Lack of Staff Professionalism***			
No	99.89	93.41	94.82
Yes	0.11	6.59	5.18
Total	100.00	100.00	100.00
Lack of Staff Follow-Through***			
No	96.93	87.84	89.80
Yes	3.08	12.16	10.20
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages.
*p ≤ .10, ***p ≤ .01

Finally, respondents were statistically slightly more likely to indicate that they did not receive services because of being on a waitlist if they had contacted an ADRC that was not Medicaid integrated than if they had contacted a Medicaid-integrated ADRC (*p* ≤ .10, Exhibit 5.163).

Exhibit 5.163: Clients Did Not Receive Service Because They Were on a Waitlist by Medicaid Integration

Did Not Receive Services Because of Waitlist	Not Medicaid Integrated	Medicaid Integrated	Total
No	69.94	88.20	85.11
Yes	30.06	11.80	14.89
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at *p* ≤ .10.

With regard to differences in ability to get to needed services, there was a trend toward statistical significance. Respondents from Medicaid-integrated ADRCs were less likely to be unable to get to services ($p \leq .10$, Exhibit 5.164).

Exhibit 5.164: Clients Could Not Get to Services by Medicaid Integration

Could Not Get To Services	Not Medicaid Integrated	Medicaid Integrated	Total
No	84.24	96.88	94.74
Yes	15.76	3.12	5.26
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .10$.

Statistically significant differences were also found for the usefulness of the information and whether the clients still needed the services. Respondents of Medicaid-integrated ADRCs were significantly more likely than sites that were not Medicaid integrated to report that the information provided by the ADRC was not useful ($p \leq .01$, Exhibit 5.165). They were also more likely to indicate that they did not receive services from ADRCs because the services were no longer needed ($p \leq .01$, Exhibit 5.166). Further, respondents were more likely to indicate that services were not received due to difficulty in filling out paperwork ($p \leq .05$, Exhibit 5.167) or non-eligible age ($p \leq .05$, Exhibit 5.168) if the ADRC contacted was not Medicaid integrated.

Exhibit 5.165: Information Was Not Useful by Medicaid Integration

Information Was Not Useful	Not Medicaid Integrated	Medicaid Integrated	Total
No	98.19	88.43	90.08
Yes	1.81	11.57	9.92
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Exhibit 5.166: Clients No Longer in Need of Services by Medicaid Integration

No Longer in Need of Services	Not Medicaid Integrated	Medicaid Integrated	Total
No	98.19	89.43	90.91
Yes	1.81	10.57	9.09
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

Exhibit 5.167: Clients Did Not Receive Services Because of Difficulty Filling Out Paperwork by Medicaid Integration

Difficulty Filling Out Paperwork	Not Medicaid Integrated	Medicaid Integrated	Total
No	74.07	92.16	89.10
Yes	25.93	7.84	10.90
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Exhibit 5.168: Clients Did Not Receive Services Because of Age by Medicaid Integration

Not the Right Age for Services	Not Medicaid Integrated	Medicaid Integrated	Total
No	83.98	96.98	94.79
Yes	16.02	3.02	5.22
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .05$.

Respondents were significantly more likely to indicate that the ADRC followed up regarding the usefulness of its information if the ADRC contacted was not Medicaid integrated ($p \leq .01$, Exhibit 5.170).

Exhibit 5.169: Agency Follow-up about Usefulness of Information by Medicaid Integration

Agency Followed Up	Not Medicaid Integrated	Medicaid Integrated	Total
No	41.66	67.07	61.56
Yes	58.34	32.93	38.44
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .01$.

We also examined the relationship between respondents' satisfaction with ADRC contact and Medicaid integration and found several statistically significant results. For example, as presented in Exhibit 5.170, respondents receiving services from ADRCs that were not Medicaid integrated were more likely to report being "somewhat satisfied" or "very satisfied" with the services received ($p \leq .01$) as well as the degree to which the services met their needs ($p \leq .05$) compared to Medicaid-integrated ADRCs. Similarly, compared to those reporting on Medicaid-integrated

ADRCs, respondents reporting on ADRCs that were not Medicaid integrated were more likely to state being “very satisfied” with the support received for decision-making ($p \leq .05$) and with the ease of resolving issues they faced ($p \leq .10$).

Exhibit 5.170: Satisfaction with Services Received by Medicaid Integration

Level of Satisfaction	Not Medicaid Integrated	Medicaid Integrated	Total
Satisfaction with Services Received* **			
Very Dissatisfied	0.58	2.72	2.27
Somewhat Dissatisfied	0.58	10.63	8.52
Somewhat Satisfied	3.31	13.53	11.39
Very Satisfied	95.53	73.12	77.82
Total	100.00	100.00	100.00
Satisfaction with Degree to which Services Met Needs **			
Very Dissatisfied	5.05	12.62	10.98
Somewhat Dissatisfied	1.75	6.89	5.77
Somewhat Satisfied	11.78	21.00	19.01
Very Satisfied	81.42	59.49	64.24
Total	100.00	100.00	100.00
Satisfaction with Support Received for Decision-Making by Medicaid Integration **			
Very Dissatisfied	4.23	8.62	7.55
Somewhat Dissatisfied	1.31	4.04	3.37
Somewhat Satisfied	8.11	24.37	20.39
Very Satisfied	86.36	62.98	68.70
Total	100.00	100.00	100.00
Satisfaction with Ease of Resolving the Issue by Medicaid Integration*			
Very Dissatisfied	3.64	6.11	5.57
Somewhat Dissatisfied	1.63	3.61	3.18
Somewhat Satisfied	8.20	22.84	19.65
Very Satisfied	86.53	67.44	71.60
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages.
$^*p \leq .10$, $^{**}p \leq .05$, $^{***}p \leq .01$

The final analyses related to Medicaid integration explored differences in whether respondents would recommend the ADRC that they contacted to others. There was a trend toward statistical significance, with respondents being slightly more likely to recommend the ADRC that they contacted if the agency was not Medicaid integrated than it if was Medicaid integrated ($p \leq .10$, Exhibit 5.171).

Exhibit 5.171: Recommend the ADRC to Others in Need by Medicaid Integration

Respondent Would Tell Friends or Relatives to Contact Agency	Not Medicaid Integrated	Medicaid Integrated	Total
No	2.30	6.12	5.30
Yes	97.70	93.88	94.71
Total	100.00	100.00	100.00

Note: Results are reported as weighted percentages. Results are statistically significant at $p \leq .10$.

5.3 Outcome Study Discussion and Implications

This section of the report discusses the main research domains examined by this outcome study. The primary focus of the outcome study was to capture the experiences of respondents who sought information about or access to LTSS, and the challenges they faced in receiving this assistance. The telephone-based survey assessed ADRC users' experiences accessing needed LTSS, factors that led them to seek assistance, information about the services that ADRCs provided to them, challenges they faced, and their overall satisfaction with the ADRC. The final sample consisted of 20 ADRC sites that agreed to participate in the study; from these sites, 552 ADRC respondents completed the survey.

First, a profile of participating ADRCs and consumer respondents is presented. Then, descriptive and regression results are provided for the following domains:

- Responsiveness and effectiveness of ADRCs
- Assistance with services
- Access to services
- Participant satisfaction.

5.3.1 Profile of Participating ADRCs and Consumers

Participating ADRC Sites. The majority of the 20 ADRC sites participating in the study were local ADRCs (90%) in urban settings (68%), and were medium-sized (60.2%), serving 500–2,500 consumers; about one-quarter (27%) were larger sites serving more than 2,500 clients. In general, these characteristics are similar to the distributions in the national sample of ADRCs that participated in the process study. Nearly 43 percent of participating ADRCs identified more than 15 partnerships; 32 percent reported having between 9 and 15 partners; and the remaining 25 percent reported 8 or fewer partners.

Survey Respondents from ADRC Sites. The sample of survey respondents consisted of 552 ADRC users. Over half of this group came from statewide ADRC sites, indicating an important skew in the data because only 2 out of the 20 participating sites were statewide. However, all but 6 percent of respondents came from medium-sized or large sites; and of the consumers from local ADRC sites, more were from sites located in urban areas than in rural areas. These characteristics more closely align with the size and geographic regions represented by the participating ADRC sites.

Demographically, survey respondents were most often White (94.%), female (70%), and older adults with or without disability (73%). The majority had a high school diploma or less (63%), and reported a yearly income of $40,000 or less (82.9%). Over 40 percent of the sample reported living alone, and nearly 80 percent of the sample reported living in the community. Approximately 69 percent self-rated their health as fair or poor , and more than a third had been hospitalized within the past 6 months. A small but meaningful percentage had lived in a nursing home (8%) or assisted living setting (4%) at least once. This demographic profile identifies many ADRC users with backgrounds often associated with negative health outcomes, such as low income, limited education, poorer health, and recent hospitalizations. Supporting these clients by helping them to understand the full range of available LTSS, thus prolonging their tenure in the community, is a key goal of the ADRC program. However, as this profile shows, some ADRC users are healthier and younger with more education and a higher income. This suggests that many ADRC sites are successfully realizing their mission of providing services not only to older, more at-risk populations, but to all persons living in a variety of settings.

5.3.2 Agency Responsiveness and Effectiveness

Initial Contact with ADRC. Overall ADRC efficiency was measured by assessing the ease with which respondents could directly talk with an ADRC representative during their initial contact, including mode of initial contact, wait time, and the number of call attempts needed to speak to an ADRC representative. The overwhelming majority of respondents first contacted the ADRC via telephone (86%) compared to visiting in person. The results suggest that some ADRC sites are efficient in responding to respondents during initial contact, with 57 percent of respondents reporting a wait-time under 5 minutes; however, about 14 percent waited between 5 and 10 minutes, while an additional 28 percent waited more than 10 minutes, and at times, more than 20 minutes. This can be a significant barrier for clients calling from work, those who are caring for children or other family members, or those who simply do not have the time to wait.

Over 73 percent of respondents reported speaking with a representative who was able to help them, and about 70 percent had to describe their request only once. However, 25 percent of respondents had to explain their request two or more times. Of the 18 percent who spoke with an ADRC representative who was not able to help them, nearly 71 percent had to make at least one additional contact to the ADRC before reaching that representative (nearly 20% of this group reached out three or more times). These data may reflect clients who have more difficulty explaining their needs or understanding information provided over the phone or in-person, but the outcome also highlights the need for continued improvement on the part of ADRC sites to make the initial contact and intake process as easy as possible for consumers of all abilities.

Respondents were asked to identify the primary reasons for contacting the ADRC. The five most common reasons were information about Medicare (21%), Medicaid (20%), personal care programs (9%), nutrition programs (7%), and housing options (6%). Differences between subgroups were identified in regression analyses. Respondents calling from one of the two statewide ADRC sites had a greater likelihood of inquiring about Medicare or Medicaid, and persons from local ADRCs in rural areas had a greater likelihood of inquiring about personal care programs. Clear explanations for these findings could not be determined. Additional analyses that control for client income and the availability of services would help to tease out the underlying drivers of these findings.

Effectiveness of ADRC Representatives. Results from this survey suggest that ADRC representatives are effective in communicating with clients. Most respondents reported positive interactions with ADRC staff. About 87 percent indicated that representatives correctly assessed their LTSS needs, and nearly 93 percent rated the representative as very or somewhat knowledgeable about the information or services inquired about. In addition, 94 percent of respondents indicated that the information they received was “very” or “somewhat” clear and understandable, and about the same percentage felt that the representative paid close attention. However, two notable findings emerged in the regression analyses. First, persons with disabilities and their proxies were less likely to report that the representative paid close attention. This finding may be related to the complex needs of this group, which are difficult to understand and solve, but it also suggests that ensuring attentiveness to persons with disabilities is a potential area of quality improvement for ADRCs. Second, a large effect was observed for those living in areas with more nursing home beds; this group had a significantly lower likelihood of feeling that the representative paid close attention (-54.1 percentage points; $p \leq .01$). While the connection between nursing home bed supply and representative attentiveness is not immediately clear, ADRCs located in such areas may be operating in an environment with an increased demand and limited supply of HCBS, which may detract from representatives' ability to identify and convey information about available services.

With regard to whether LTSS planning was provided by ADRC representatives, in general, the findings are positive. Among those who requested it, 69 percent of respondents indicated that they received assistance with long-term planning (significantly more respondents from local ADRCs received planning assistance compared to those using statewide ADRCs). Of this group, about 90 percent felt that the plan reflected their specific LTSS needs and preferences. Examining specifically whether respondents were given an explanation of choices for remaining in the community, regression analyses showed that persons with disabilities and those who self-rated their health as poor were more likely to have received such an explanation; however, respondents from statewide ADRC sites were less likely to have community options explained. In many respects these results are positive, indicating that persons with potentially higher risk of institutionalization are appropriately targeted and made aware of community-based options.

Results of Contacting ADRC. Survey participants were asked a number of questions to determine the nature of services received as a result of contacting the ADRC. About 59 percent of respondents accessed needed services directly from the ADRC, while 28 percent were referred elsewhere. Respondents from local ADRCs were more likely than statewide ADRC users to have accessed services directly. Not surprisingly, the most common services provided directly by the ADRC were I&R, options counseling, and eligibility determination—core services encouraged throughout the Federal ADRC program. The exception to this was care transition services, which were more commonly reported to be delivered indirectly, through a referral to an external organization. This is notable, because increasing the ability of ADRCs to either directly deliver care transition services or partner with other organizations to provide those services has been promoted through grant programs at the Federal level.

Of those respondents who were referred elsewhere to receive services, 62 percent reported that an ADRC representative helped them connect to services through the referred providers, suggesting that even when referrals are made, many ADRCs continue to assist clients as they engage with the external providers. However, only 26 percent of this group reported receiving a "warm transfer," whereby an ADRC representative remained on the line to assist in transferring the caller to the provider organization. Of the 71 percent who did not receive warm transfers, 73 percent reported being given contact information for the referred organization, and 22.7 percent indicated that the ADRC helped arrange contact in some other way.

Warm transfers help ensure that complete and accurate information, including the client's needs, preferences, and eligibility, is relayed to the provider; the low proportion of warm transfers flags a potential area for quality improvement, since some respondents in this sample were left to contact providers and arrange services on their own. The practice of not providing a warm transfer or not continuing to be involved as callers are referred elsewhere may result in clients not following through with the referral, needing to provide key information again, going through additional assessments, becoming confused about their options, or experiencing delays in the receipt of services. The survey explored such negative consequences, and found that of respondents referred to outside agencies, 48 percent reported that the provider did not have any information and the process had to be started over again; an additional 6 percent indicated that providers had some information, but it was not correct. This finding points to another aspect of service provision that might be considered for future ADRC quality improvement initiatives.

Assistance with Medicaid Eligibility. The survey examined the Medicaid eligibility determination experiences of ADRC users who were not current beneficiaries, but who spoke to a representative about the Medicaid program. A majority of this group (58%) reported *not* receiving specific information on applying for federally sponsored healthcare financial assistance and residential support services, while just over one-third did receive such information. About 74 percent of this group also did *not* receive information about other insurance options. This finding points to a potential service gap experienced by a majority of ADRC users interested in Medicaid and other public programs, because applying for this program is often considered a time-consuming and complicated task, which may be a barrier to receiving services as quickly as possible.

Of those respondents who did receive information on applying, nearly half (47%) reported that they completed an application; most of those who completed the application reported receiving assistance from the ADRC (70%). Respondents who did not complete an application (49%) cited several reasons: they believed they or their family members to be ineligible for Medicaid, or that they were currently in the process of gathering information, making a decision to apply, or hadn't yet received an application. Taken together, these reasons indicate a continued need for education on eligibility as well as hands-on assistance in completing applications to ensure enrollment as quickly as possible.

Assistance with One-on-One Options Counseling. Options counseling refers to an interactive process through which appropriate and desired LTSS needs are determined and planned according to an individual's particular circumstances. Often considered a "value-added" benefit that sets ADRCs apart from other organizations, one-on-one options counseling may encourage proactive planning for current and future needs in a comprehensive manner. The outcome study measured aspects of options counseling services and the results of receiving such counseling. While a large majority of survey participants did not request options counseling (78%), about one-fifth did.

Of those who requested options counseling, 53 percent reported that they received the service, while, surprisingly, 44 percent indicated that they did not receive it. It may be worthwhile to more closely examine the reasons for this discrepancy by matching respondents who did not receive requested options counseling to their home ADRC sites to determine the reasons why the service was not provided.

Of those that requested and received options counseling, 60 percent received such counseling in their own homes, and nearly 70 percent received a follow-up call after completion of the options counseling. As a result of receiving the counseling, 81 percent of respondents felt that they better understood their LTSS options, 74 percent intended to get in touch with public programs, and 61 percent reported that they obtained LTSS planning or services that fit within their budget. These data suggest that options counseling was fairly successful in delivering clear, tailored options that included public programs. However, only 41 percent of respondents reported that they were able to make a decision about LTSS, and only 36 percent intended to get in touch with private-pay services. These data point to a need to bolster the decision-making aspects of options counseling, as well as private-pay components, which may include helping lower-income clients more thoroughly understand how to budget non-publicly funded services.

Care Transition Service. The vast majority of respondents reported that they did not receive care transition services (96%). This finding is important because although the process study and subgroup analyses revealed the characteristics of sites more likely to offer care transition services (e.g., local vs. statewide, decentralized, and Medicaid-integrated sites), the provision of such services is still quite low in this sample. Given the growing interest in care transitions and the key role such services play in individuals' ability to remain in the community, it may be of interest to explore why care transition services are frequently not provided even though they may be offered.

Of the 3 percent of respondents who indicated that they did receive care transitions services, most received some combination of the following: a needs assessment prior to discharge from the acute care setting, an explanation of discharge instructions, and post-discharge services such as transportation, help filling prescriptions, or household help. However, less than one-third of this group received a follow-up phone call or in-person visit within 48 hours of discharge. Since "having eyes on" newly discharged clients is often considered an essential aspect of care transition management, such a low number of respondents receiving follow-up points to another area where improvement is needed.

Diversion from Nursing Homes. At the time of contact with the ADRC, most respondents (85%) were not considering a move to a long-term care facility, either for themselves or for the person on whose behalf they called. Further, only 29 percent of respondents believed that they were "very likely" or "somewhat likely" to move to a nursing home within 5 years.

The study explored whether ADRC representatives helped respondents understand their options for staying in the community and thereby avoid or delay a move to a nursing home or another long-term care facility. Only 31 percent of respondents indicated that ADRC representatives helped them in this regard. When considered together with the finding that most ADRC users in this sample were not thinking about entering a nursing home, it would seem to follow that ADRC representatives did not have reason to provide this assistance. However, in the process study, approximately 91 percent of local ADRCs indicated that diversion from nursing homes or other institutional residential care facilities is an outcome their agency seeks to achieve. There is a mismatch, then, in that less than one-third of respondents received services in line with this goal.

5.3.3 Access to Services

This section summarizes the results related to the processes and challenges faced by respondents in seeking information about LTSS from ADRCs and accessing LTSS from other agencies. This information is useful in identifying areas for improvement in ADRCs' performance and for facilitating access to LTSS.

ADRC Contact and Follow-up. Over 35 percent of respondents initially heard about the ADRC from a family member, friend, or other acquaintance; 27 percent were referred to the ADRC from another agency or organization. The remaining respondents said they learned about the ADRC through media, hospitals, or doctors; by browsing the Internet or telephone book, or through their workplaces. These data highlight the importance and impact of word-of-mouth in outreach efforts.

Just over 79 percent of respondents contacted the ADRC before they contacted any other organization, while 18 percent contacted another agency first. However, relatively few (9%) respondents were in touch with a similar agency *after* contacting the ADRC, and of those who did, about 71 percent felt that the other organization was unable to meet their needs.

After contact with the ADRC was initiated, only 37 percent of respondents indicated that the ADRC made a follow-up call regarding either the referrals that were made or the usefulness of the information received. Interestingly, rural ADRCs were more likely to have made follow-up calls compared to urban sites. More work should be done to examine the utility and benefit of follow-up contact related to referrals and information quality, to determine if specific protocols for follow-up should be put in place.

Challenges in Receiving Services from ADRCs. Respondents were asked whether they received the services they needed and desired and, if so, the length of time it took to begin receiving the service. Approximately 32 percent received services within 1 week's time, while 11 percent waited more than 1 week to receive services.

However, a majority of respondents (53%) reported that they did not receive services that they had requested. These survey participants were asked to provide the reasons that they did not receive the requested services. Responses included placement on a waitlist, lack of available services, and difficult paperwork. Respondents with lower self-rated health were more likely to identify lack of available services, waitlists, and information that was not useful compared to respondents with higher self-rated health. Persons with disabilities were more likely to identify inconvenient hours, transportation issues, and difficulty filling out paperwork as challenges. Identifying surmountable challenges to these two subgroups of clients, who may be at higher risk for hospitalizations or institutional placement, is an important finding of this research. Focusing efforts to reduce these barriers, to the extent possible, may help these individuals more easily access the services they need to help them remain healthier and in the community.

Challenges in Resolving Issues. When asked about challenges experienced while working with ADRCs, less than one-fifth of respondents reported experiencing challenges that limited their ability to resolve issues. However, among those that did report challenges, the most common issue was difficulty reaching ADRC staff (17%), followed by lack of staff follow-through, lack of staff knowledge, and hours of operation. Regression analyses showed that respondents from rural ADRCs and those contacting statewide sites were *less likely* to report challenges in reaching ADRC staff. An examination of policies and procedures surrounding operational aspects such as methods of contacting staff members, follow-up protocols, and more convenient hours of operation may reveal solutions to reduce these challenges; however, relatively few respondents reported having experienced these challenges.

LTSS Referrals by ADRCs. Types and results of referrals made by ADRCs were also explored in the study. A small number of respondents (126) reported being referred to a variety of LTSS; no single service category stood out. The five most common referred services, as reported by respondents, were the following:

- Non-medical in-home assistance (9%)
- Health insurance other than Medicaid or Medicare (8%)
- Medicare (6%)
- Food stamps/pantry/assistance services (6%)
- Departments of Health/Human Services (5%).

Of this group, only 43 percent received the services for which they were referred, while 20 percent did not. Those who did not receive the services cited reasons such as the service was not wanted or needed, or the service was not available at needed times (some respondents were consequently placed on waitlists).

5.3.4 Participant Satisfaction

A major goal of the study was to understand respondent satisfaction with a number of ADRC services and the overall quality of information and support provided. This section summarizes and discusses results related to these aspects of satisfaction and suggests potential areas for improvement.

Satisfaction with Services. Among those who received key services from ADRC sites, there was relatively high satisfaction reported by respondents. About 93 percent of respondents reported being "very" or "somewhat" satisfied with one-on-one options counseling, and 92 percent were satisfied with the care transition services received.

However, when considering overall direct services received, a slightly smaller proportion of respondents indicated satisfaction (63% were "very satisfied," 9% were "somewhat satisfied"). Subgroup analyses showed that respondents from local ADRCs were more likely to be, whereas those who reported lower incomes were more likely to be satisfied with overall direct services received. The most common reason cited for dissatisfaction was respondents' belief that they did not receive the services they sought from the ADRC.

Completeness of Information. Respondents were generally satisfied with the completeness of information received (83%). However, regression analyses show that respondents who lived alone and those who contacted the ADRC for Medicare-related questions were less likely to report satisfaction. It may be that respondents living alone lacked support in helping them use the information they received, resulting in a misperception by the ADRC that they had provided complete, adequate information. This may indicate an opportunity for the ADRC to more closely support those without a co-resident. A lesser likelihood of satisfaction regarding Medicare-related questions may reflect the complexity inherent in the program, or misunderstanding of what Medicare does and does not cover; again, ADRCs may have an opportunity to improve services to those calling about Medicare inquiries by bolstering the amount of information that staff have and their ability to comprehensively and efficiently convey it in a way that is easy to understand.

Degree to Which Services Met Needs. Approximately 80 percent of respondents reported being "very" or "somewhat" satisfied with the degree to which services that were offered met their specific needs. Factors identified in regression analyses as associated with higher satisfaction include having more education, accessing rural ADRC sites, and calling about Medicare-related questions. Respondents contacting the ADRC on their own behalf (versus as a proxy for someone else), however, were less likely to be satisfied with the degree to which services met their needs. This may not indicate actual dissatisfaction, but, rather, may suggest that proxies are differently assessing how well services meet the needs of their care recipients. Regardless, there may be opportunities to support users who contact the ADRC on their own behalf to ensure that they have enough information, support, and service levels to meet their LTSS needs and preferences.

Accuracy of Information. Over 91 percent of respondents indicated being “very” or “somewhat” satisfied with the accuracy of the information they received. Bivariate analyses showed that respondents contacting local ADRCs reported higher satisfaction. However, when controlling for other factors, regression analyses showed higher likelihoods of satisfaction from those respondents having a high school degree and contacting a statewide ADRC. Interestingly, regressions also demonstrated that persons calling from areas with higher availability of nursing home beds were significantly more likely to report dissatisfaction, albeit with a relatively low effect size.

Decision-Making Support. About 71 percent of respondents were either “very satisfied” or “somewhat satisfied” with the support they received for decision-making. Regressions showed that factors associated with higher satisfaction likelihood included respondents from statewide ADRC sites, and respondents with Medicaid-related inquiries. A number of factors associated with lower likelihoods of satisfaction were also identified: married respondents, respondents who self-rate their health as poor, respondents who live alone, and respondents from areas with a higher number of nursing home beds available. In many respects, these findings are logical; persons living alone, those in poor health, and those living in regions where HCBS may be constrained might require more support in making decisions than others. However, the finding that married respondents had lower likelihood of satisfaction with decision-making support was unexpected and is difficult to explain.

Staff Professionalism. Respondents rated the professionalism of ADRC staff highly, with 93 percent of respondents expressing satisfaction. Subgroup analyses revealed that respondents who contacted local ADRCs and who had better self-reported health reported higher levels of satisfaction with staff professionalism, compared to those who contacted statewide ADRCs and those with poorer self-rated health. No other subgroup effects were observed, suggesting that, overall, ADRC sites have hired and appropriately trained staff.

Ease of Working with ADRCs to Resolve Issues. Respondents were generally satisfied with the ease of working with the ADRCs; more than 86 percent of respondents indicated they were “very satisfied” or “somewhat satisfied.” Older respondents were more likely to report being “somewhat” satisfied, while younger participants were more likely to report being “very dissatisfied." Since all younger adults in the sample have a disability, this finding supports our earlier assumption that problems experienced by adults with disabilities are more complicated or difficult to resolve, resulting in less satisfaction with ADRC services. No other significant subgroup effects were found.

Satisfaction with Services Received at Agencies to Which Respondents Were Referred. Only 59 percent of respondents who reported receiving services indirectly, or both directly and indirectly, indicated that they were satisfied with the services they received from the agencies to which they were referred. The results of the subgroup analyses show that those with more education reported higher satisfaction, while respondents who rate their health as poor were less likely to be satisfied. Those reporting dissatisfaction identified reasons such as not receiving services, or their perception that the agency seemed to be uninterested in working with them. These results underscore the reality that clients are referred to external agencies that may or may not be partner organizations to the ADRC, which alters the degree of control of how and when services are provided. The results also highlight the importance and value of ADRC staff remaining involved as clients set up services with referred providers, and of following up to ensure clients' needs are being met.

5.3.5 Usefulness of Services

To assess the overall usefulness of ADRC services, the outcome study survey asked respondents to report on awareness of LTSS needs, certainty of LTSS options, and usefulness of information in selecting LTSS. Only 15.5 percent of respondents indicated improved awareness of LTSS needs, suggesting either that most respondents who contact ADRCs already have a comprehensive understanding of their needs, or that ADRC staff are not sufficiently assessing additional, previously unknown needs during contact.

Respondents were asked to rank the level of usefulness of the information provided by ADRCs as they were selecting LTSS options. About 69 percent reported that the information they received was either "very useful" or "somewhat useful." Only 20 percent indicated that the information was not useful. Regression analyses showed a large effect on perceived usefulness of services among respondents who contacted statewide ADRCs (vs. local ADRCs): this group was much less likely to rate the information as useful.

5.3.6 Value of ADRCs to Respondents

Finally, the study assessed the value that ADRCs held for respondents by asking respondents whether they would recommend contacting an ADRC to a friend or relative in need and how likely they themselves were to contact ADRCs in the future, if needed. An overwhelming majority (94%)

indicated that they would recommend the ADRC to others, and 92 percent said that they were "very likely" or "somewhat likely" to contact the ADRC again if needed. Only 8 percent indicated they were either "somewhat unlikely" or "very unlikely" to do so. This suggests that despite dissatisfaction with specific aspects of ADRC services, respondents had an overall positive experience and sense of value, and felt that others would experience the same value.

5.3.7 Comparison by Core Integration Dimensions

Bivariate exploratory analyses were conducted on key variables for each of the three core measures developed for this project: level of core service provision, extent of site integration, and status of Medicaid integration.

Core Service Provision. The results of the bivariate analyses showed some evidence of effects associated with the level of core services provided by the ADRC, with regard to specific issues in assistance with services, access to services, and participant satisfaction. As discussed in earlier sections, high-level core service providers were those that provide information and referral, options counseling, eligibility determination, and care transition services; medium-level core service provision sites offer all of the above but *not* care transition services; and low-level sites do not offer options counseling or eligibility determination.

First, an association between level of core service provision and reason for ADRC contact was observed; respondents from low-level core service provision ADRCs were significantly more likely to cite nutrition services as a reason for contact (89%), those from medium-level sites were more likely to cite Medicare questions (47%), and those from high-level sites were more likely to inquire about Medicaid questions (34%). Differences in reason for contact were not expected to vary between levels of core service provision, but the results may point to such sites operating in environments where nutrition services are more needed or more available, or where other agencies are known to provide information on Medicare and Medicaid. In addition, respondents from low-level core service provision sites were also significantly less likely to have received benefits counseling as a result of contacting the ADRC, with a lower likelihood of receiving counseling or peer support that approached significance. These results are in line with sites that, by definition, do not provide either options counseling or Medicaid eligibility determination.

Next, two significant differences were seen between ADRC core service provision levels and accessing ADRC services. First, respondents from low-level core service provision sites were significantly more likely to have first heard about the ADRC via referral from another agency or organization (nearly 60%), compared to respondents from medium-level (27%) and high-level (25%) core service provision sites. On the other hand, a significantly higher percentage of respondents from medium-level (39%) and high-level (42%) core service provision sites learned about the ADRC via friends, family, or other acquaintances compared to those from low-level sites (19%). It may be that medium- and high-level sites have more resources for outreach and marketing, thus increasing general awareness and higher usage of their ADRCs than low-level sites, which is translated by work-of-mouth to others in need. It may also be the case, however, that low-level sites have stronger referral networks to compensate for a lack of resources that prevents them from offering options counseling or eligibility determination services. Second, significantly more respondents from low-core service provision sites reported hours of operation to be a barrier in resolving their issues (46% versus only 7% for medium-level and 5% for high-level sites). ADRCs that offer fewer services may have more limited hours of operation. No other significant differences were observed.

Finally, two measures of participant satisfaction were shown to vary by core service level. As a whole, most respondents reported satisfaction with the professionalism of ADRC staff. However, a higher percentage of those from high-level core service provision sites reported being either very or somewhat dissatisfied with staff professionalism (6%) than respondents from low-level (1%) and medium-level (2%) core service sites. A similar result was observed for satisfaction with ease of resolving issues; about 13 percent of respondents from high-core service level sites reported dissatisfaction, compared to about 4 percent of medium-level and 0 percent of low-level sites. Perhaps this is related to a greater opportunity to experience dissatisfaction in sites that provide more services; respondents from high-level sites received more services from potentially more staff members, thereby increasing the chance to observe a lack of professionalism. Alternately, it may be that staff from high-level sites are busier or stretched more thinly. Still, the vast majority of respondents from all core service provision levels reported satisfaction with these two outcomes, and no other outcomes demonstrated significant between-group differences.

Overall, the results from these analyses show some differences between outcomes from respondents of low-level core service provision ADRCs compared to high- and medium-level sites. These differences suggest that low-level sites may depend more heavily on referrals and provide a narrower scope of services, while high-level sites may have operational practices that are associated with a slightly higher degree of dissatisfaction. However, most of the significant differences observed are marginal or have relatively low practical significance, indicating that level of core service provision is not a major determinant of participant experience.

Site Integration. Extent of site integration was captured by determining the comprehensiveness of services and supports offered by an ADRC, and the operational processes and degrees of partnerships that facilitate these services. This included assessing populations served, specific services offered, extent of integration and sharing of data, and the breadth of partnerships and stakeholder involvement. Bivariate analyses revealed a number of differences between respondents from low-, medium-, and high-level site integration ADRCs in the domains of assistance with services, access to services, and participant satisfaction.

Only three aspects of assistance with services were found to significantly differ by level of site integration. A lower percentage of respondents from medium-level sites reported receiving information and referral services as a result of contacting the agency, while a much larger proportion of respondents from low-level sites reported receiving life skills training. Further, no respondents from low-level sites indicated any of the five most common reasons for contact (Medicare, Medicaid, housing, personal care, and nutrition), whereas about one-third of respondents from high-level sites mentioned Medicaid questions and the same proportion reported personal care inquiries. The relationship between the extent of site integration and access to services is not clear; these results show unexpected differences related both to respondent motivation in seeking out an ADRC and the services received as a result.

Regarding access to services, only two significant differences in site integration were observed. First, more respondents from high-level site integration ADRCs identified a lack of staff follow-through as a challenge in getting their issues resolved. Two additional results approached but did not meet statistical significance: respondents from low-level sites were more likely to identify hours of operation as a challenge, while a greater percentage of respondents from high-level sites reported lack of staff professionalism as a challenge. Second, a higher percentage of respondents from high-level sites indicated that the organization did *not* follow up about referrals/information provided (76%) compared to those from medium-level sites (57%) and low-level sites (50%). Taken together, these results contradict what was anticipated: ADRCs with more comprehensive services and broad partnership networks were expected to be able to provide consistent follow-up. That respondents from this group were less likely to report receiving follow-up and more likely to indicate lack of follow-up as a barrier to addressing their unique issues suggests that follow-up policies and procedures may need to be examined and strengthened.

Two aspects of participant satisfaction demonstrated significant differences related to site integration. First, a greater percentage of respondents from high-level sites reported dissatisfaction with staff professionalism (8%, vs. 2% of medium-level sites and 0% of low-level sites). Similarly, a higher percentage of this group also reported dissatisfaction with the ease of resolving issues (19%) compared to medium-level (4%) and low-level (0%) sites. Because high-level sites were classified based on the depth and breadth of partnerships, number of consumers served, and services offered, these results may reflect that staff have less time to spend with each client, or have an increased workload compared to less integrated sites. Fine-tuning these aspects of customer service may be particularly important to more integrated ADRCs. However, it is important to note that a majority of respondents across all groups reported satisfaction with staff professionalism and the ease of resolving issues.

Evidence from the outcome study suggests that some aspects of service provision—offering follow-up and ensuring client satisfaction—are related to the extent of integration an ADRC strives to achieve. Yet most outcomes of interest to this project did not vary between site integration subgroups. Teasing apart the aspects of site integration that account for the largest variance in the few differences that were observed may shed more light on potential strategies to improve services and satisfaction.

Medicaid Integration. A dichotomous variable was computed to categorize ADRC sites on Medicaid integration, based on whether they had received funding from any of six Medicaid-related sources during FY 2013: CMS Real Choice Systems Change Grants, CMS Person-Centered Hospital Discharge Planning Grants, Money Follows the Person Demonstration, Program of All-inclusive Care for the Elderly (PACE), Medicaid for Direct Services, and Medicaid for Federal Financial Participation. Significant differences were detected through bivariate analyses that examined Medicaid integration and assistance with services, access to services, and participant satisfaction.

First, a slightly higher percentage of respondents from Medicaid-integrated ADRCs reported receipt of information and referral services (89%) versus those from sites that were not Medicaid integrated sites (75%). In contrast, a larger proportion of respondents from sites that were not Medicaid integrated (48%) reported receiving counseling or peer support (compared to just 22% of those from Medicaid-integrated ADRCs). No significant differences were found with regard to receipt of eligibility determination, which was unexpected. Interestingly, with regard to reasons for contacting an ADRC, a higher percentage of respondents from sites that were not Medicaid integrated cited Medicaid questions (50%) compared to just over one-quarter of respondents from Medicaid-integrated sites, underscoring the importance of all ADRCs having accurate and easily understood information about the Medicaid program to convey to clients, regardless of whether they engage with Medicaid-related funding sources.

Significant differences by Medicaid integration were observed for three outcomes related to access to services. A larger proportion of respondents from Medicaid-integrated sites identified communication problems (5%), lack of staff professionalism (7%), and lack of staff follow-through (12%) as barriers to resolving their issues. These findings suggest that ADRCs with a focus on Medicaid programming have staff who may be less attuned to client preferences; however, the percentages of respondents who identified these issues in the first place are quite small.

Respondents were asked whether they received requested services, and those who indicated that they had not received requested services were asked the reasons for this. Differences between respondents from Medicaid-integrated and non-Medicaid-integrated ADRCs were observed.

Compared to respondents from sites that were not Medicaid integrated, 12 percent of respondents from Medicaid-integrated sites said that the “information was not useful,” compared to 2 percent from non-Medicaid-integrated sites; and 11 percent indicated they were no longer in need of the service, compared to 2 percent from non-Medicaid-integrated sites. However, larger percentages of respondents from sites that were not Medicaid integrated reported not receiving services due to difficulty filling out paperwork (26% vs. 8% from Medicaid-integrated sites), or not being the right age for the services (16% vs. 3% from Medicaid-integrated sites). Yet when asked if staff followed up about the usefulness of information or referrals, a larger percentage of respondents from sites that were not Medicaid integrated said yes (58% vs. 33% from Medicaid-integrated sites). These results demonstrate the value of Medicaid-integrated sites in assisting with paperwork that may be confusing to clients, and appropriately assessing age-based eligibility for programs. The findings also highlight a potential need to improve the quality of information given and institute more standardized follow-up procedures. Again, it should be noted that the majority of respondents from both groups did not report these problems.

Finally, subgroup differences were observed in three measures of participant satisfaction. A larger percentage of respondents from Medicaid-integrated sites indicated dissatisfaction with the services received, the degree to which services met their needs, and the support received for decision-making. On all of these measures, 12–20 percent of respondents from Medicaid-integrated sites expressed dissatisfaction, compared to just 7% percent or less from sites that were not Medicaid integrated. These data may reflect a greater complexity in the services and information delivered by integrated ADRCs, or the more complicated needs of clients who are likely to be linked to the Medicaid program. Although a majority of all respondents indicated satisfaction on these measures, these findings point to a need to examine the quality of information and services, as well as the manner in which they are delivered, in organizations that are engaged in Medicaid-related activities.

Overall, these findings suggest that Medicaid integration is associated slightly negatively with the services clients receive and with the quality of interactions between clients and staff with regard to communication, clarity, and meeting client needs. Given the relative importance of integrating ADRC services with Medicaid and public program eligibility determination, improving these aspects of participant experiences—and ensuring that declines do not occur as more ADRCs move toward integration—may be a priority area for the near term.

CHAPTER 6. CONCLUSIONS FROM THE PROCESS AND OUTCOME STUDIES

The first national process and outcome study of ADRCs was designed to understand how ADRCs are facilitating access to LTSS as needed and desired by older persons, individuals with disabilities, and their caregivers and to understand clients' experiences when contacting an ADRC for assistance in obtaining LTSS.

Process study data were collected from 48 state-level and 472 local-level ADRC sites via a web-based survey fielded in conjunction with required ADRC program reporting through the SART. Survey items considered motivation and objectives in becoming an ADRC, funding, community and consumer information, organizational information, and partnerships. The outcome study gathered data through a telephone-based PES, completed by 552 clients from a sample of 20 ADRCs. The PES captured the characteristics of participants and assessed the responsiveness and effectiveness of ADRCs, assistance with services, access to services, and participant satisfaction.

6.1 Progress in Achieving the Goals and Vision of the ADRC Program

The ADRC program was designed around a vision of providing integrated access to LTSS to persons of all ages, disabilities, and incomes. To assess the ADRCs' progress in achieving this vision, relevant domains were identified and evaluated in the process and outcome studies. This chapter highlights a number of meaningful findings from the process and outcome studies and situates the results in the context of the status of the ADRC program at the time of the study. Limitations of the research and considerations for the future evolution of ADRCs are also discussed.

6.1.1 Providing Access to LTSS through Key Services

Overall, many positive findings in both studies demonstrate that ADRCs are making strides to meet their mission as evidenced by the services they provide, the improvements they have instituted since receiving ADRC funding, and their increasingly diversified sources of funding. For example, over three-quarters of ADRC respondents indicated that they provide one-on-one options counseling and conduct initial screenings for Medicaid eligibility—two services deemed key to the original vision of the ADRC program. About 25 percent of sites that provide eligibility determination also reported the ability to make presumptive eligibility determination to expedite service receipt while applications are processed. This may help consumers get needed services more quickly and thus lengthen their tenure in the community by delaying institutionalization.

However, a vast majority of PES respondents reported that they did not receive care transition services, and only 37% of ADRCs reported offering care transition services. This finding is important: Despite specific funding efforts to encourage care transition services, provision was quite low. Of the 3 percent of respondents who indicated that they did receive care transitions services, most received some combination of:

- A needs assessment prior to discharge from the acute care setting
- An explanation of discharge instructions
- Post-discharge services such as transportation, help filling prescriptions, or household help

While these low numbers may be, in part, a result of the eligibility requirement for study participation that excluded health care professionals and professional caregivers, who are typically the people who initiate care transition services, this is an area for more research. Further, less than one-third of this group received a follow-up phone call or an in-person visit within 48 hours of discharge. As “having eyes on” newly discharged clients is often considered an essential aspect of care transition management, the low number of respondents receiving follow-up contact points to another area where improvement is needed. Going forward, given the growing interest in care transition and the key role such services play in individuals’ abilities to remain in the community, it may be of interest to explore this apparent disconnect.

More than half of PES respondents said that they had not received the services they had requested by the time of the survey, which was approximately three to four weeks after contact with the ADRC. However, it is important to note that most of the services requested by clients—transportation, housing, and the like—are not provided directly by the ADRC. The ADRC serves to provide integrated *access*, including referral to appropriate services. This finding may reflect a lack of availability of needed services in the community, or it may suggest that a longer duration of time may be needed to determine whether the services were indeed eventually received. Notwithstanding, this is an area for further review in order to determine what technical assistance or future funding initiatives might be developed to understand the etiology of the problem and to ensure that ADRC consumers are receiving needed and wanted LTSS to the extent possible.

Delaying or preventing individuals from having to spend-down to meet Medicaid eligibility requirements or to rely on more expensive LTSS options by helping them learn about low-cost options and make better use of their own resources has been a focus of ADRC grants since their inception in 2003. Results of the process study show that 91 percent of ADRC sites indicated that diversion from nursing homes or other institutional residential facilities was an outcome their agency sought to achieve. However, only 31 percent of PES respondents reported that ADRC representatives helped them understand their options for staying in the community and, thereby, avoid or delay a move into a nursing home or another long-term care facility. It may be that clients did not request assistance with diversion services, but further work is needed to determine if a mismatch exists between citing diversion as a goal and providing information and assessments accordingly.

6.1.2 Effects of Funding on Achieving Mission and Goals

Sites were generally positive about the effects of ADRC funding on their program goals. Nearly all local ADRC representatives reported improvement in the ADRC's ability to provide integrated, comprehensive access to LTSS since the inception of the ADRC program. Information, referral, and awareness of LTSS programs; options counseling; and person-centered transition support were cited as services provided since the receipt of ADRC grant dollars. Furthermore, most state ADRCs reported that ADRC program funding enabled them to increase the number of partnerships and improve the skills of staff members, while local-level sites reported that funding increased their level of coordination with aging and disability network organizations and improved staff training opportunities. Some evidence, however, suggests that large and medium-sized ADRCs that served more clients realized larger benefits of funding. More work is needed to understand why differences exist and to develop strategies to reduce this disparity in the future.

6.2 Partnerships

State and local partnerships have been recognized as a central component of the ADRC program since its inception. The importance of partnerships has been reflected in the evolution of the ADRC program at the federal level as well, as formal agreements with AoA/ACL, CMS, and VHA over the past decade have encouraged changes to the ADRC model, emphasizing inclusion of populations served by each agency.

The process and outcome studies were designed to understand the structure and quality of partnerships at the state and local levels and to elucidate specific aspects of partnerships such as data sharing and assessing client needs. Importantly, local ADRC sites indicated that partnership development and expansion fostered through receiving grant funding had the most positive impact on providing access to LTSS, suggesting that sites share in the recognition that partnerships are vital to realizing their mission.

With respect to organizational structure, ADRC respondents identified an average of four core operating organizations and 16 organizational partners. The most frequently identified partnerships were between ADRCs and state units on aging, centers for independent living, area agencies on aging, state Medicaid agencies, and local Veterans Administration (VA) offices, demonstrating the importance of aging, disability, and other organizations in providing integrated and streamlined access to LTSS. In general, a majority of respondents indicated that these partnerships were highly functional. A notable exception, however, was found in partnerships with the local VA. While nearly half of local ADRC sites reported having formal partnerships with their local VA, few of them considered this partnership as highly functional. This was seen at the state level as well, as less than one-quarter of state-level respondents reported a highly functional relationship. Given the partnership building between the VHA and the federal ADRC program, understanding reasons for this discrepancy and determining strategies for improving partnership relations may be vital to ensuring success of these recent initiatives.

The ACL might also promote collaboration and coordination between the ADRCs and their partners by encouraging the sharing of client resources and information. For instance, less than half of ADRC respondents indicated that a consumer assessment tool was used and shared across partners, and fewer said that data were shared between the organization and service provider partners. The current vision of ADRCs to serve as a "No Wrong Door" site for accessing LTSS is dependent on coordination with a full range of aging, disability, and other organizations to provide integrated and seamless services to individuals. It is clear that support and resources are needed to help the ADRCs foster partnerships and encourage the sharing of consumer information and data.

6.3 ADRC Client Satisfaction

Overall, ADRC clients were quite positive about their interactions with the ADRC. For example, a large majority of respondents indicated that ADRC representatives correctly assessed their LTSS needs, and nearly all reported that representatives were knowledgeable, paid close attention, and provided information that was clear and understandable. A majority of respondents were satisfied with completeness of information received, the degree to which services offered met their specific needs, the accuracy of the information they received, and staff professionalism. Finally, most indicated that they would recommend the ADRC to friends or family in need and that they were likely to contact the ADRC again.

Interestingly, however, satisfaction was not uniform across all groups. For example, respondents contacting urban ADRCs and ADRCs with less than 15 full-time equivalent staff reported difficulty reaching the ADRC staff. Also, differences for persons with disabilities and those who rated their health as poor were found. Individuals with disabilities were less likely to perceive that ADRC staff paid close attention to what they said, to receive information that was helpful, and to perceive that accessible services were unavailable. Further, they were more likely to express that they had difficulty completing paperwork. On the positive side, this group was more likely to report that that ADRC staff talked to them about their options for staying in the community. Similarly, individuals with poor health were more likely to say that ADRC staff talked with them about options for staying in the community and were less likely to report that the services they requested were not available.

These subgroup results are mixed in nature. On one hand, it is a positive finding that persons with disabilities and poor health were more likely to report that ADRC staff discussed community options, as these groups may be at increased risk for institutionalization. Providing appropriate and adequate home- and community-based options to persons at risk may help to keep them in the community longer and delay institutionalization. However, the findings also point to the fact that quality improvement initiatives should be considered to encourage ADRC staff to be more attentive to the needs of these at-risk populations. Importantly, service availability is likely to be dependent not on what the ADRC can provide, but on what is adequately available in the community; while ADRCs may not have direct control over solutions to this problem, it is still in the interest of ADRCs at the local, state, and federal level to advocate for increased LTSS to help persons with disabilities and poorer health remain in the community as long as possible.

6.4 LTSS Supply and Availability

This study examined aspects of the community and LTSS service environment within which ADRCs operate. When asked to identify LTSS considered adequately available, ADRCs respondents most commonly reported ombudsman services, opportunities to develop advance directives, nursing homes, education services, and nutrition programs. Those most frequently deemed inadequate included transportation, housing options, income assistance, mental health services, and energy assistance. Interestingly, transportation, Medicaid and Medicare eligibility determination, and affordable housing were among the most frequently requested services, as reported by local ADRCs. These results pinpoint areas in which LTSS are needed in communities and underscore the limitations faced by ADRCs in providing streamlined access to needed services in environments where they may be inadequately available.

6.5 Consumer Characteristics

The overarching vision of the ADRC program is to provide access to LTSS for persons of all ages, all disability groups, and all income levels. In the process study, local ADRCs reported service areas comprising a majority of consumers who were adults age 60 and older, who were White and non-Hispanic, and who had no health insurance coverage. Further, ADRCs reported serving more persons with physical disabilities and their caregivers than any other disability type, across all ages. This underscores the importance of improving the ability of ADRCs to reach and appropriately serve ethnic, cultural, age, and disability-diverse communities; the finding suggests that there may be a disparity in access to or understanding of the value of ADRC services.

6.6 Limitations

A number of limitations in the research design should be noted, including a non-representative sample of ADRC sites as well as ADRC consumers and the lack of a comparison group that would enable us to make statements regarding between-group differences in the execution of the ADRCs' goals and vision for seamless access to LTSS.

The primary limitation of the analyses conducted with the process study responses concerns the issue of item non-response. While item non-response is not a serious problem for many questions, such as those that required ADRCs to select responses from a range of options, it is an issue of concern for questions that sought a numerical response. For example, non-response ranged from 45 to 95 percent on questions asking local ADRCs to provide the number of disabled consumers by type. Similarly, on questions where local ADRC representatives were asked to report funding amounts by type, non-response ranged from 51 percent to 97 percent. We did not consider imputation of missing values as an appropriate method to address item non-response. This is an issue that should be further examined for possible technical assistance if the issue is found to be a result of a lack of reliable data or of data collection or storage methods.

Although the outcome study was intended to be a nationally representative, comparative study of ADRC and AAA consumer experiences, we were unable to recruit a representative sample of ADRCs across the AAA regions, states, and rural/urban coverage areas as planned. We addressed this limitation by using sample weights that adjusted for selection probability and non-response. However, even with these adjustments, these data should be taken as suggestive rather than definitive.

The number of eligible clients that the recruited ADRCs and AAAs referred for participation in the PES was much less than anticipated. In spite of intensive respondent recruitment efforts by our team, we ended up with a final sample of 552 PES respondents from ADRCs and 72 PES respondents from AAAs. In addition, because of the low response rate, all eligible clients were invited to participate in the study, resulting in a non-randomly selected, skewed population of ADRC clients primarily from two large, statewide ADRCs. This small sample size limited the types of data analysis we could conduct and the number of covariates we could include in our regression models. Furthermore, the number of AAA respondents who participated in the PES was so few that we were unable to implement our original plan of using them as a comparison group to conduct a quasi-experimental impact study of ADRCs on client experiences. Therefore, this study is limited to an account of a limited group of ADRC client experiences and does not demonstrate the value of ADRCs compared to AAAs.

6.7 Conclusions and Considerations for the Future

Broadly, evidence from this work suggests that ADRCs have made progress towards the goals and vision of the ADRC program, but challenges in connecting persons to LTSS are still present. Further, improvements are needed in some key areas such as expanding geographic service areas, increasing diversity in ADRC clientele, and strengthening key partnerships. Results from the outcome study confirm these challenges but also show that, despite the challenges, respondents are largely satisfied with their experiences in accessing ADRCs.

A number of specific areas that may be appropriate to improve through targeted technical assistance or through future funding initiatives include:

- Expanding service areas and/or outreach to ensure inclusion of diverse populations
- Improving the quality of partnerships with local VAs
- Providing adequate and appropriate person-centered approaches to meet the needs of clients with disabilities and poor health
- Increasing the delivery of diversion and care transition services
- Supporting the collection of high quality data about consumers and their interactions with the ADRCs

In conclusion, findings from the national ADRC process and outcome studies suggest that local and state ADRC programs are, at their foundation, true systems change initiatives, as there is evidence that ADRCs are increasing partnerships, standardizing and sharing information and assessment tools across stakeholders, and providing highly satisfactory access even in the environment of inadequate LTSS. PES respondents indicated that they felt listened to and that their care plans reflected their needs and desires; a majority of ADRCs reported providing core aspects of integrated access to LTSS, including options counseling and Medicaid eligibility determination. However, there is still room for progress in many areas, including increasing care transition service provision, improving aspects of participant satisfaction for specific groups of people, expanding the reach of ADRCs to underserved populations, and solidifying partnerships with key stakeholders such as local VAs.