2009 HOUSE HUMAN SERVICES

HB 1476

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1476

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 26, 2009

Recorder Job Number: 7702

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz called the hearing to order on HB 1476.

Tami Wahl from Governor Hoeven's office of Health and Human Services: Introduced Linda Wright.

Linda Wright, Director of Aging Services Division: Testified in support. **See Testimony #1.**

Rep. Conrad: Presently our county social services function in this way would you agree?

Linda Wright: The county social service office does a good job, but they work real with the small percentage of the population that needs information and eligibility about long term care services. We can see the social services being a part of the ADRC.

Rep. Conrad: County social service said the summer was there busy time because people would come home and visit their elderly parents and all of sudden realized things weren't as they thought they were. Would this then save the county that kind of crisis roll?

Linda Wright: Definitely this would help serve adult family members, older people and people with disabilities.

Rep. Frantsvog: Where would you set these shops up?

Linda Wright: Five different kinds of location office. Talked to counterpart in Montana and he said one of his most successful locations for ADRC was at a shopping mall and set it up

across from a pharmacy. You'd have people from social services, human service center, public health and all of those entities coordinated so that they would be a part of that ADRC.

Rep. Potter: How many ADRC's are you thinking of? One per county?

Linda Wright: It would begin with a pilot site that would involve an urban center and serve the rural areas around the urban center. Eventually, we hope to have sites statewide.

Rep. Potter: Are you thinking county wide or several counties together?

Linda Wright: This would be put out on a competitive process. I'm aware of many people who are interested in this, including some counties in the southwestern part of the state.

Marlowe Kro, Associate State Director for Community Outreach for AARP: Testified in support. **See Testimony #2.**

Rep. Merle Boucher from District 9 sponsored and testified in support of bill: See Testimony #3.

Bruce Murry, lawyer with ND Protection and Advocacy Project: Testified in support. **See Testimony #4.**

Jane Strommen, Executive Director of Community of Care in Fargo: See Testimony #5.

Rep. Frantsvog: In your testimony you talked about providing services to rural Cass County residents. How do you get the word out to those residents of your existence?

Jane Strommen: We have learned over the years, marketing to people in rural areas is different from a metro area. Word of mouth is the best advertising. Church bulletin inserts and local newspaper are some of our best ways.

Rep. Potter: How local is local?

Jane Strommen: People in small cities are uncomfortable driving in Fargo. Each county is different population wise and that has to be determined in a pilot project.

Rep. Potter: I think you are. When we think of the quadrant of the state doesn't seem local in my mind. Would you go with quadrants?

Jane Strommen: Each region is different. Having too few is not be the best situation for people to access and get the information they need.

Rep. Conrad: How many do you serve and how much will your budget serve?

Jane Strommen: Our budget $150,000 a year. Last year we served over 500 people. We are flexible in our program and we may help same person many times.

Rep. Holman: Qualifications of person doing the screening?

Jane Strommen: Person in our program is a licensed social worker and I've worked also with a person who has a degree in human services administration and worked in the field of case management for 25 years.

A.J. Klein: Testified in support. Father suffered stroke and did research in care of him. Spent many hours consulting with agencies and having family meetings. Process is overwhelming and stressful. If we could have had one person to contact it would be helpful.

James Moenich, Executive Director of ND Disabilities Advocacy Consortium: See Testimony # 6.

Amy Armstrong, Project Coordinator for ND Medicaid Infrastructure Grant: See Testimony #7.

Chairman Weisz: Linda, I need to ask you a question. Concerning the fiscal note on bill, it appears you don't plan to expand beyond the pilot project and curious why?

Linda Wright: We hope to be able to expand beyond the pilot project. A lot of the start-up costs will already be in the first two years. There are plans to go on beyond the pilot project after this next biennium.

NO OPPOSITION.

Chairman Weisz closed the hearing.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1476

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 4, 2009

Recorder Job Number: 8604 15 min. 6 sec.

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Take up 1476 the pilot project.

Rep. Conrad: This is something we've talked about for many years. We are in a position in the state where we have income and feel this is a tremendous investment.

Rep. Porter: Pilot project would barely touch anywhere in the state in contrast with what we are doing at the aging and disabilities grant at 1.2 million. I think that there's enough leeway if the dept. wants to do something in addition inside of the 1.2 million that they could certainly do more. Referred to pilot project as having no end to what proposal would cost. Much already being done through human service centers.

Rep. Porter: recommended a DO NOT PASS.

Rep. Uglem: Second.

Rep. Conrad: (Inaudible) outcome of the aging. That's pretty specific, that Alzheimer's and dementia (inaudible) I don't know (inaudible). How do we explain to constituents that we backed off (inaudible).

Rep. Kilichowski: Talked about how large the population is over the age of 65 (mentioned 85 also). Feels this is something that should be looked at.

Rep. Potter: It's important not only to elderly, but also to their families. This is a single point of entry that focuses on the Alzheimer's and dementia problem. People won't have to go to several places to get helpful information.

Much discussion among Representatives about their personal experience with hospital's social worker staff. Most felt they were very helpful.

Rep. Holman: We are sent to a general practitioner who sends us to a specialist when we need one. Isn't this the same concept?

Rep. Frantsvog: Shouldn't we expect the Dept. of Human Services should be able to put something together so they can answer your question and mine? Don't think we need a study or an appropriation to set this up.

Chairman Weisz: If people don't know to call social services how would they know to call a special pilot project.

Rep. Kilichowski: People can look up on the internet and get all kinds of information and figure out who to contact.

(Chatter, everyone talking at once.)

Roll Call Vote for DO NOT PASS on HB 1476. 8 yes, 5 no, 0 absent.

Motion for a DO NOT PASS.

Bill Carrier: Rep. Porter

FISCAL NOTE

Requested by Legislative Council
01/20/2009

Bill/Resolution No.: HB 1476

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2007-2009 Biennium		2009-2011 Biennium		2011-2013 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$600,000		$624,000	
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2007-2009 Biennium			2009-2011 Biennium			2011-2013 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. Bill and fiscal impact summary: *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill directs the Department to plan and implement an Aging and Disability Resource Center (ADRC) for the State.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 identifies the need for the state to implement the ADRC.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

It is estimated to cost $600,000 (general fund) to establish a pilot project to implement this bill. It is expected that this pilot would be competatively bid under current state procurement rules.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The executive budget for the Department of Human Services (HB 1012) includes the necessary funding for the law change.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	01/23/2009

Date: 2-4-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1476

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☒ Do Not Pass ☐ Amended

Motion Made By Rep. Porter Seconded By Rep. Uglem

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	√		REP. TOM CONKLIN		√
VICE-CHAIR VONNIE PIETSCH	√		REP. KARI L CONRAD		√
REP. CHUCK DAMSCHEN	√		REP. RICHARD HOLMAN		√
REP. ROBERT FRANTSVOG	√		REP. ROBERT KILICHOWSKI		√
REP. CURT HOFSTAD	√		REP. LOUISE POTTER		√
REP. MICHAEL R. NATHE	√				
REP. TODD PORTER	√				
REP. GERRY UGLEM	√				

Total (Yes) 8 No 5

Absent 0

Bill Carrier Rep. Porter

If the vote is on an amendment, briefly indicate intent:

DO NOT PASS

REPORT OF STANDING COMMITTEE

HB 1476: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (8 YEAS, 5 NAYS, 0 ABSENT AND NOT VOTING). HB 1476 was placed on the Eleventh order on the calendar.

2009 TESTIMONY

HB 1476

#1

Testimony
House Bill 1476 – Aging and Disability Resource Center
House Human Services Committee
Representative Weisz, Chairman
January 26, 2009

Chairman Weisz and members of the House Human Services Committee,

I am Linda Wright, Director of the Aging Services Division, Department of Human Services. I am testifying in favor of House Bill 1476.

The need for easier access for consumers to information, service eligibility and service options has been documented in many studies that have been conducted in our state. Please refer to Attachment A, which was published in 1987 as a result of the "Drayton Study", recommending that a single point of entry be established. Twenty-two years later, this is still a need in North Dakota. The current terminology for single point of entry or no wrong door is an Aging and Disability Resource Center (ADRC). Aging and Disability Resource Centers have been established in 45 states. A description of ADRCs and a map of current states that have established ADRCs is in Attachment B.

The Governor and the Department of Human Services consider the establishment of an ADRC as a priority, and therefore, have included $600,000 in the Aging Services Division budget for the 2009-2011 biennium.

House Bill 1476 amends N.D.C.C. 50-06-29 which currently restricts the Department to using federal funds to establish an ADRC. The Department did submit one unsolicited grant application to the Administration on Aging and one application to the Centers for Medicare

and Medicaid Services. Due to lack of funding and competition from urban states, the applications were not successful.

The functions or components of an ADRC are outlined in Attachments C and D. The purpose of an ADRC is not to create another layer of bureaucracy, but instead to coordinate existing services and providers to eliminate duplication and create greater efficiency and effectiveness, and to provide consumers easier access to services.

Several current federal initiatives require coordination with ADRCs. One example is the Money Follows the Person grant which the Department is currently implementing in North Dakota. Another example is a recent grant announcement that would provide additional funding to State Health Insurance Assistance Programs (SHIPs). If the Insurance Commissioner's office applies for this grant, it requires coordination with an ADRC, however, it does not provide funding for an ADRC.

Attachments E and F are examples of how an ADRC, or single point of entry, works. In contrast, consumers in the state of North Dakota face a confusing system of multiple entry points to information, services and eligibility sometimes resulting in more restrictive, and more expensive care. As an example, Mr. Jones has been hospitalized due to a stroke and the physician tells Mrs. Jones that her husband will be released in two days and could go home if he had supportive services in place. Otherwise, Mr. Jones will need to enter institutional care. Mrs. Jones doesn't know where to begin. After visiting with the hospital discharge planner, Mrs. Jones contacts six different agencies and completes six different application forms to arrange for services for her husband, which has been a frustrating and exhausting process. If an ADRC were

established, Mrs. Jones could make one contact with the ADRC which would provide her with information, eligibility determination for several different services and assistance arranging for all of the services needed by Mr. Jones.

Attachment G outlines the successes of the first ADRCs established in 2003 and 2004. Attachment H contains information about the fiscal impact of ADRCs on long term care costs. At this time, it appears that established ADRCs have slowed the rate of growth of the costs of institutional care. This has been accomplished through assisting consumers to remain at home and in their own communities through the provision of home and community based services.

In summary, we recommend approval of House Bill 1476, the funding for which is already in the Department of Human Services budget.

I would be happy to answer any questions you may have.

A

Summary of Information

North Dakota Long Term Care: Issues and Recommendations, 1987
By: Interagency Task Force on Long Term Care
Targeted Population: Elderly and people with disabilities

The ND Interagency Task Force on Long Term Care, which includes the Governor's Office, Department of Human Services, and Department of Health, conducted a study in Drayton, ND in 1986. This study established the need to look at the structural, functional, financial and social concerns regarding the long term care delivery system in ND and how it affects the needs of the aging population in our state. The report is not directly about the Drayton Study, but about the issues that the nation and ND is facing in regards to long term care.

The following recommendations were given by the ND Interagency Task Force on Long Term Care:

- State policy be implemented to include: a) a balanced continuum of long term care services b) the functional limitations and needs of the elderly will serve as the principal criterion for the use of long term care services or the development of additional long term care services, c) the financial and organizational structure of the long term care delivery system will be designed to assist older adults in obtaining appropriate long term care services, d) access to appropriate long term care services for older adults will be improved through provided a central point of entry. e) institutional services will be considered "alternative" services with in the continuum of long term cares services f) families, as the principle caregivers to older adults, will be supported, g) ND's certificate of need law will continue as a function of the State Health Council and the Council will make necessary changes in it's review process that will further the development of a balanced continuum of long term cares services in ND.
- Single point of entry to the system of long term care be recognized and used, and that a system of case management be established and used.
- Federal and state dollars for long term care services be pooled in state government and dispersed on the basis of the functional needs of clients.
- The Department of Health and DHS continue the ongoing consolidation of the inspection of care function with the certification survey for ICF/MRs.
- Based upon the demonstrated efficiencies expected to be achieved under the ICF/MR consolidation pilot project, the task force recommends that the Department of Health and DHS consolidated the inspection of care, certification and licensure functions for all long term care facilities.
- Consolidation of inspection of care with the certifications survey process should accompany the consolidation of authority for imposing graduated economic sanctions on those facilities that fail to meet the quality compliance standards.
- The State Health Council, with the assistance of the Department of Health and DHS, should recommend to ND's Congressional delegation a series of changes in federal nursing requirements that would permit the state to reduce the burden of regulation for long term care facilities.
- Passage of legislation to improve access to HCBS by a) requiring all HCBS that are financed by the state be available in each county, b) apply economic assistance on a sliding fee scale, c) extend eligibility standards through assessments of functional impairment rather than the likelihood of institutionalization, d) a system of case management within the communities and pre-admission assessment of all applicants for nursing home care.
- Enact a bill that 1) Directs the DHS to develop a case-mix reimbursement system for nursing homes which will a) provide that the rates determined will be adequate to support the basic services, b) assures that payment system will provided incentives for service to "heavy care patients", c) require the payment system incorporate positive economic incentives for the efficient operation of nursing homes. 2) Provides that the rate of payment for the basic services required participation in the Medicaid program will apply to all residents equally.
- The Health Department, the DHS, the Governor's Office and the Office of Management and Budget recommend an appropriated level of state funding of the health planning/certificate of need programs for the 1987-1989 biennium.

Aging and Disability Resource Centers

A Joint Program of the Administration on Aging & Centers for Medicare & Medicaid Services

Working to Build the Future of Long-Term Care

Empowering adults as they age with reliable information and access to the care they need

Enabling individuals who are at high risk of nursing home placement to remain at home

Building disease prevention into community living through the use of low-cost, evidence-based programs

BACKGROUND

The Aging and Disability Resource Center Program (ADRC), a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), is designed to streamline access to long-term care.

The ADRC initiative supports state efforts to develop "one-stop shop" programs at the community level that will help people make informed decisions about their service and support options and serve as the entry point to the long-term support system. States are using ADRC funds to better coordinate and/or redesign their existing systems of information, assistance and access and are doing so by forming strong state and local partnerships.

ADRC programs provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients, and individuals planning for their future long-term care needs. ADRC programs also serve as the entry point to publicly administered long-term supports including those funded under Medicaid, the Older Americans Act and state revenue programs.

In particular, ADRCs streamline access to long-term care services for individuals with disabilities, older adults, and their family caregivers, particularly those at highest risk of nursing home placement and spenddown to Medicaid.

AoA & CMS VISION FOR RESOURCE CENTERS

The goal of the ADRC Program is to empower individuals to make informed choices and to streamline access to long-term support. Long-term support refers to a wide range of in-home, community-based, and institutional services and programs designed to help individuals with disabilities.

The vision is to provide individuals across the United States access to ADRCs, which are highly visible and trusted places where people can turn for information on the full range of long-term support options. To help and support these efforts, in 2006, the Older Americans Act was reauthorized with the inclusion of language supporting the development of ADRC efforts in every state.

In many communities, long-term support services are administered by multiple agencies and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services is difficult. A single, coordinated system of information and access for all persons seeking long-term support minimizes confusion, enhances individual choice and supports informed decision-making. It also improves the ability of state and local governments to manage resources and to monitor program quality through centralized data collection and evaluation.

ADRC GRANTEES

AoA and CMS launched the ADRC initiative in the fall of 2003. From 2003 to 2005 43 states were awarded grants to develop pilot programs. Additional funding was awarded in 2006 and 2007 to expand existing states efforts. In 2008, an additional two new states were funded bringing the total number of funded ADRC states to 45.

While grantees are only required to pilot their ADRC in at least one community, they are all striving to replicate the program

AoA Administration on Aging

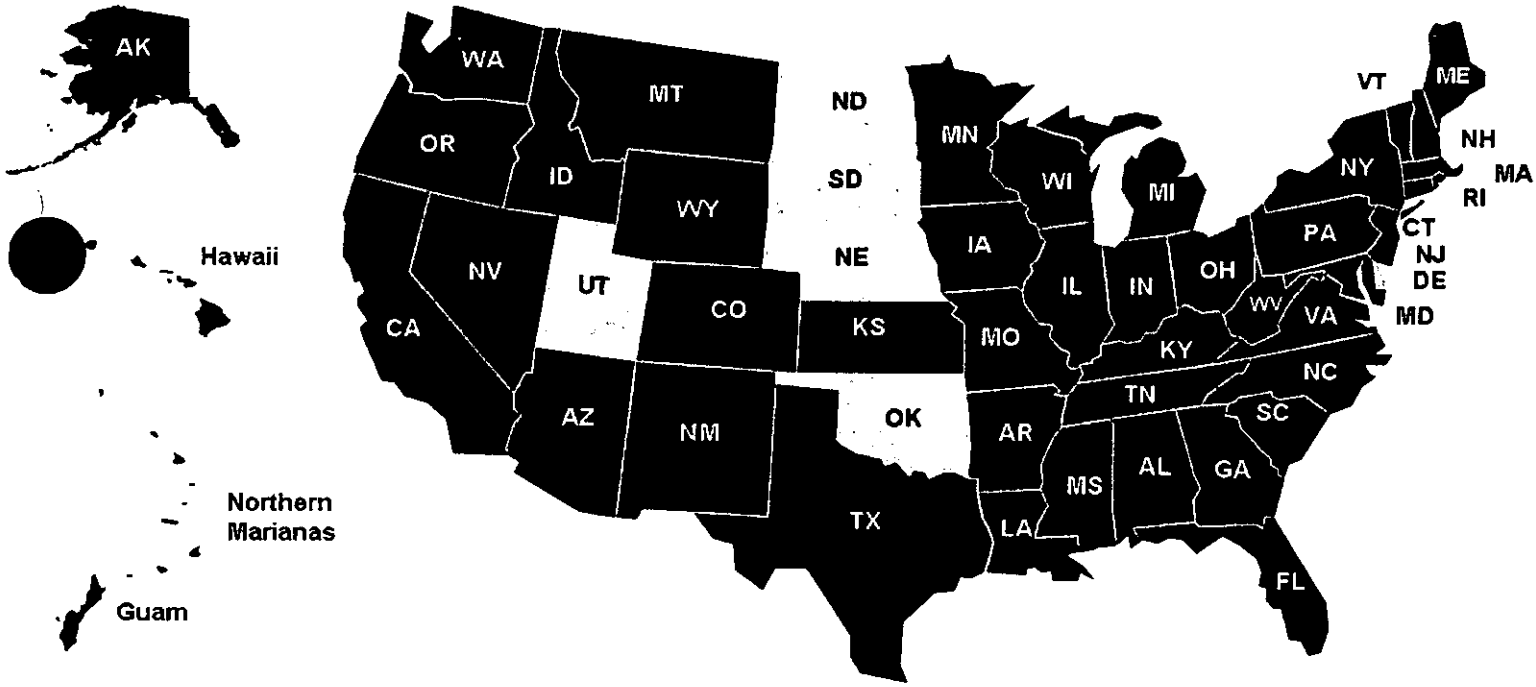
across the entire state. The map below indicates states that have been awarded ADRC grants and the year they received their award. In addition, the map below highlights states which are pursuing ADRC efforts even without receiving specific ADRC grant funds.

ADDITIONAL INFORMATION

For additional information on the ADRC initiative, please visit The ADRC Technical Assistance Exchange website at www.adrc-tae.org. The website includes contact information for AoA and CMS ADRC project officers, summary information on each of the grantees, and a variety of resources related to this initiative.

You can also find additional ADRC information on the AoA website at www.aoa.gov or the CMS web site at www.cms.hhs.gov/newfreedominitiative.

AGING AND DISABILITY RESOURCE CENTER AWARDEES



For More Information

AoA recognizes the importance of making information readily available to consumers, professionals, researchers, and students. Our website provides information for and about older persons, their families, and professionals involved in aging programs and services. For more information about AoA, please contact: US Dept of Health and Human Services, Administration on Aging, Washington, DC 20201; phone (202) 619-0724; fax (202) 357-3523; Email: aoainfo@aoa.gov or contact our website at www.aoa.gov

C

AGING AND DISABILTY RESOURCE CENTER (ADRC) COMPONENTS

This document was drafted by the North Dakota
Real Choice Rebalancing Grant Steering Committee

An Aging and Disability Resource Center (ADRC), also called a single point of entry, is designed to provide an identifiable place where people can get information, objective advice, and access to a wide range of community supports.

The ADRC must address the following criteria:

1. Ensure "one-stop access" for clients to services; eliminating duplicative assessments and numerous agency contacts.
2. Will serve all adults needing long term care services, targeting older persons and persons with disabilities (non DD). This includes both private pay and public funded individuals.
3. Will serve entire designated service area.
4. Will enter into collaborative agreements with other service providers in the service area.
5. Will coordinate with case management service providers.
6. Will advertise and conduct public education regarding the single point of entry.
7. Will conduct an initial brief assessment (screening) of each individual.
8. As appropriate, will conduct an in-depth assessment utilizing an electronic assessment document compatible within the state system.
9. Will coordinate with the Senior Info-Line, 211, First Link, and any other information and referral services.
10. Will recruit and train volunteers to act as referral sources and sources of basic information in each community.
11. Will provide face to face service to individuals in their own homes in the community, in medical care settings and in long term care facilities.
12. Will utilize a multi-disciplinary approach, to include medical, financial, and social expertise to develop an individual's option/service plan.
13. Will utilize both the formal and informal support networks in meeting the needs of the client.
14. Will determine eligibility for various services (both functional and financial).
15. Will be available 24/7, not to take the place of a crisis management system but to instead ensure timeliness of needed information and services and to streamline the process.
16. Provide follow-up services to include quality assurance.
17. Advocate on behalf of the consumer in securing services.
18. Assure that the service is consumer directed (person-centered approach) and all decisions are made by the consumer or their legal representative.
19. Ensure that consumers and their family members have access to all the information necessary to make decisions regarding continuum of care services.
20. Will provide disclosure of conflict of interest.
21. Create a community advisory committee.

Functions of an ADRC

Awareness & Information

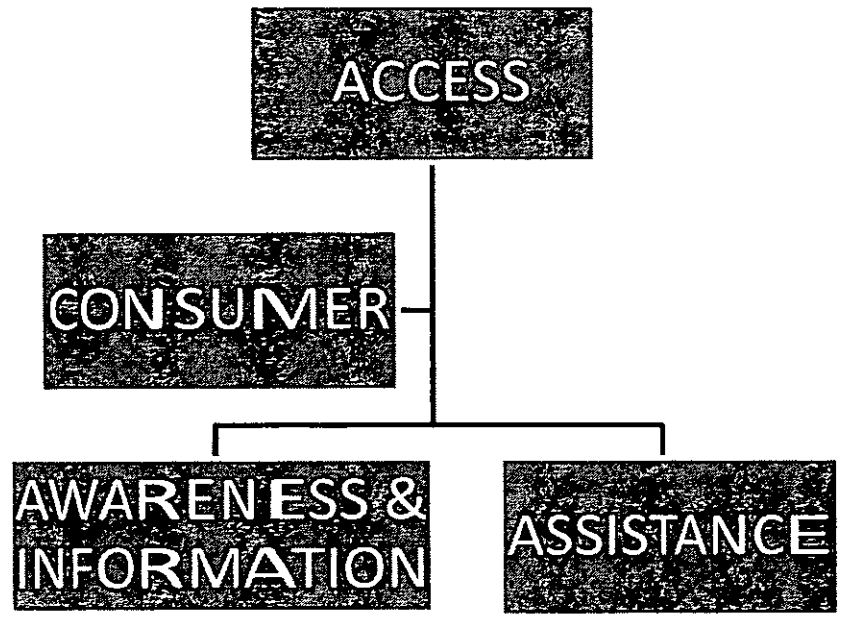
- Public Education
- Information on Options

Assistance

- Options Counseling
- Benefits Counseling
- Employment Options Counseling
- Referral
- Crisis Intervention
- Planning for Future Needs

Access

- Eligibility Screening
- Private Pay Services
- Comprehensive Assessment
- Programmatic Eligibility Determination
- Financial Eligibility Determination
- One-Stop Access to all public programs



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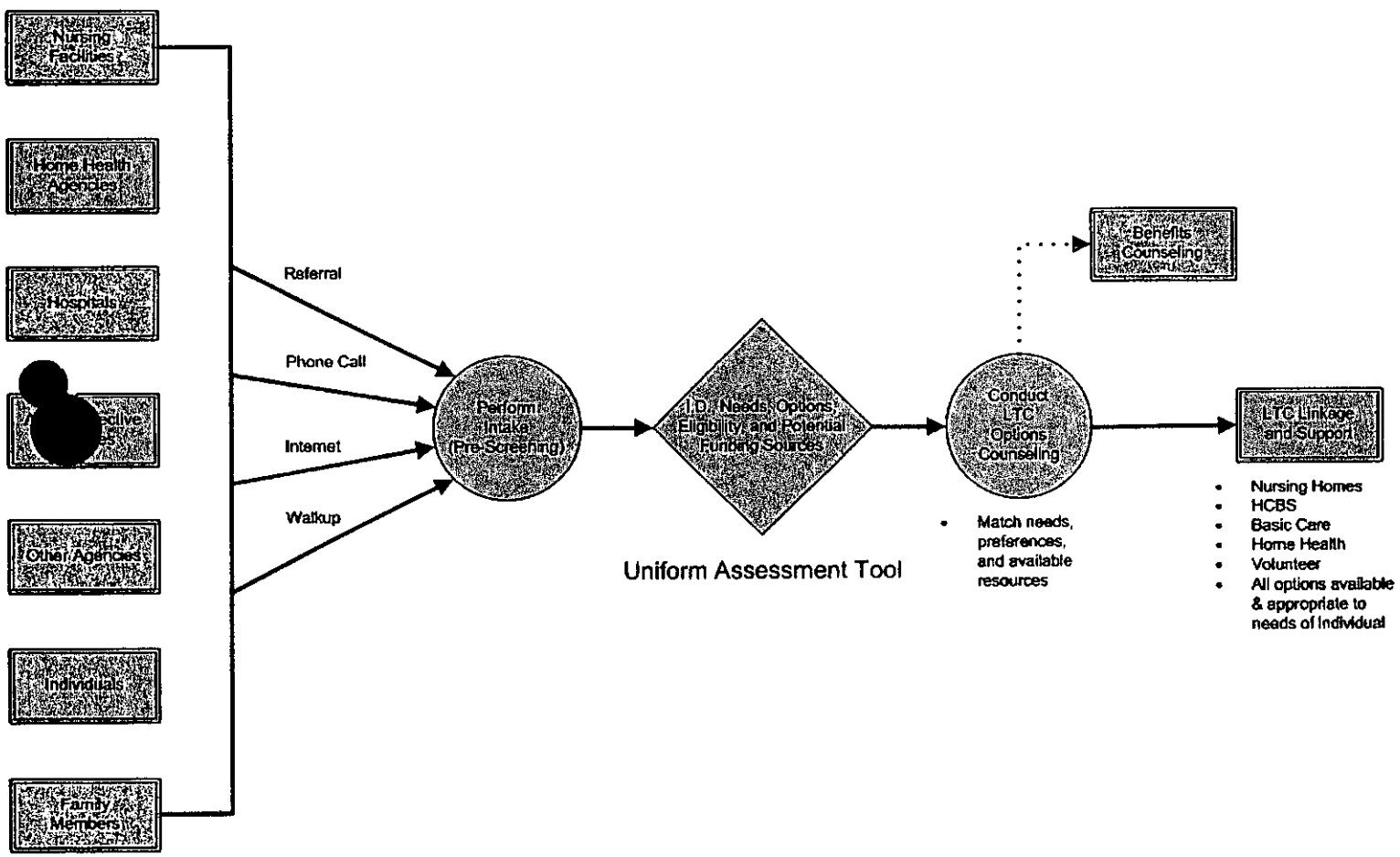
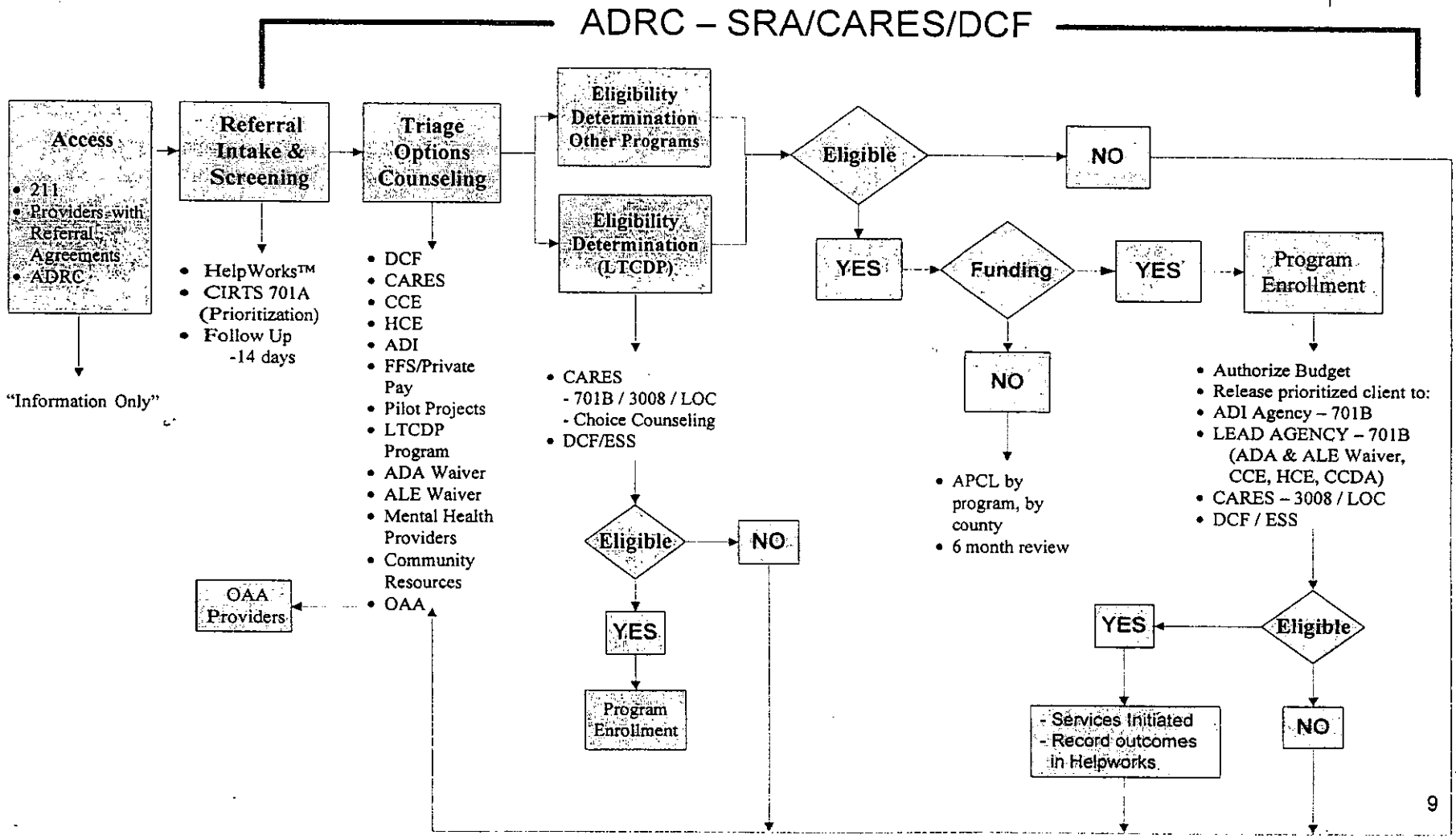
Draft 6.12.06

Example Single Point of Entry (SPE) Operational Flowchart



ADRC Centralized Model



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Aging & Disability Resource Center

An Initiative of the U.S. Department of Health and Human Services

Aging and Disability Resource Center Successes 2008

- ADRCs play an active role in **helping consumers access public benefits** for long term services and supports, making the application process less onerous and more seamless for consumers. **Among the 24 states** awarded grants in 2003 and 2004:
  - **all** assist consumers with **completing financial applications** for Medicaid,
  - **over half** have **functional** eligibility assessors **co-located** with the ADRC,
  - **one-third** have **financial** eligibility assessors **co-located** and
  - **three-quarters** can **track** the **eligibility status** of applicants as they move through the system.

- **Building on the strong existing networks** for Senior Information and Assistance, State Health Insurance Assistance Programs, and Independent Living Centers has resulted in **147 ADRCs serving 28 percent of the U.S. population** with only $39.8 million of federal seed money over a four year period.
  - States used this seed money to continue to **enhance the I&A infrastructure** to support cost-effective and efficient delivery of information.
    - **21 states** have statewide long term supports and services **resource directories** accessible to the public and professionals **via the internet** (twelve of them new since ADRC and another seven significantly enhanced through the ADRC project) and another **16** are **in the process** of developing similar statewide capability.
    - **34** of the 43 ADRC states have **Medicaid applications available on the internet** with **seven** of these (and another four in process) allowing consumers to complete the application online and **submit it electronically.**
    - **Five** ADRCs have **online consumer decision tools** and another **six** are in the process of **developing** such capability
    - ADRC pilot sites developed **information exchange protocols across partners** so consumers only have to tell their story once.
    - Several ADRCs use **portable technology** for data entry and scanning documents; eight states use laptops in the field and three employ portable scanning or photography.
  - ADRCs have furthered states' ongoing efforts to **improve access to long term supports** and services by strengthening **partnerships**, establishing **minimum standards** of service, fostering **consistency**, enhancing **professionalism**, and emphasizing the **consumers' perspective** in all activities.

- By **serving all income groups and across disabilities**, ADRCs **overcome the stigma associated with Medicaid** and can assist a wide range of individuals, including family

caregivers, in obtaining long term supports and services in the most desirable and appropriate setting.

- By intervening in **critical pathways** to long term services and supports, such as hospital discharge planners, physicians or other health professionals, or long term supports providers, through options counseling, ADRCs convey the range of alternative services and settings available, as well as methods to pay so individuals can both plan ahead and make informed decisions about current needs.
    - Nearly **one-half** of the individuals contacting ADRCs to date were **referred by critical pathway entities.**
    - While measuring **diversions from nursing facilities** is difficult, among the 13 states with a 25 percent decline in Medicaid nursing facility users per 1,000 elderly over the 1995-2005 period, **six** of them conducted **pre-admission screening through a single entry point** as of 2002 (Mollica and Gillespie, 2003). The **top three states** (Maine, Washington and Oregon, **all with declines greater than 35 percent** compared to a national average of 15.2 percent) all **have pre-admission screening through a single entry point.** In contrast, only six of the 23 states below the national average of 15.2 percent used pre-admission screening through a single entry point. [A total of 19 states used pre-admission screening through a single entry point for Medicaid entrants into nursing facilities in 2002].
    - ADRCs will play a **critical role in nursing facility transitions** under the Money Follows the Person Demonstration (MFP). Of the 31 **MFP states, 24 have ADRCs** and 18 of these ADRC have indicated that they **will play a role** in the grant implementation.

- States recognize the value ADRCs provide and:
    - **Over half** of the 43 ADRC grantees have passed **legislation,** developed **executive guidance,** and/or contributed **state funds** to enhance and expand ADRCs.
    - **State funding** contributions to date, not including the required match for the grants, **exceed $36 million.**
    - **Eleven ADRC grantees** have achieved **statewide coverage** with their ADRCs and
    - **Kentucky,** similar to **Wisconsin,** plans to use **the ADRC as the entry point to managed long term care** in the state.

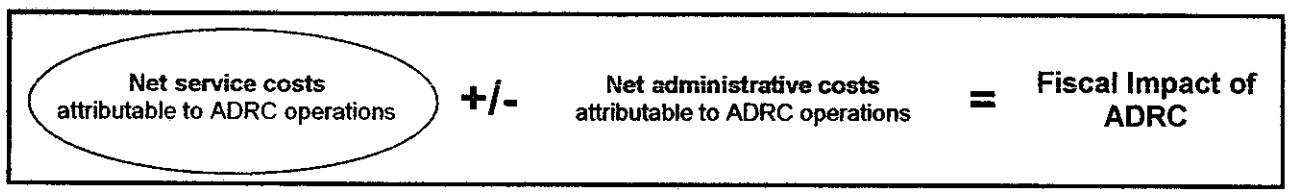
Options for Assessing the Impact of ADRCs on Long Term Care Costs

Measuring the effect of ADRCs and other initiatives that promote home and community-based services (HCBS) presents a major challenge. ADRCs comprise one component of complicated and constantly evolving state long term care (LTC) systems. States often simultaneously pursue multiple initiatives to promote HCBS, and the private market adapts to consumer preferences and financial opportunities, resulting in many intervening variables that make it difficult to determine the direct impact of specific initiatives. Nonetheless, there are multiple strategies for collecting evidence about the way ADRCs impact the broader LTC system.

This paper focuses on assessing the fiscal impact of ADRCs. While ADRCs might result in cost savings for Medicaid programs, many would argue that reducing unnecessary utilization and supporting community integration are important goals regardless of fiscal considerations. Nonetheless, policymakers in state and federal government have a major stake in better understanding the overall fiscal impact of implementing ADRCs.

As depicted in ***Exhibit 1,*** the fiscal impact of ADRC operations includes two components: net service costs attributable to ADRC operations (new service costs minus offsets for shifting utilization to more cost-effective services) and net administrative costs attributable to running the ADRC (new administrative costs minus new administrative efficiencies). This paper focuses on the net service cost component of this equation. Whether these costs are positive or negative will determine what effect the ADRC has on overall costs.

Exhibit 1: Fiscal Impact Equation



Methodologically, a randomized control trial that assigns one group of people to receive ADRC assistance and others to a control group that does not would be considered the best and most robust way to study the impact of ADRCs. In practice, however, such a trial is impractical and unethical, and as such, has not been implemented by any ADRC grantees. Other methods for assessing the fiscal effects of an ADRC, such as the pre/post analysis discussed below, have serious limitations. Therefore, we recommend that evaluators approach this issue from multiple perspectives. A body of suggestive evidence, drawn from multiple types of analysis, can be compelling to policymakers even if any single measure has methodological limitations.

In this brief, we discuss three basic strategies for assessing the service costs and cost savings attributable to ADRC operations due to reduced use of institutional LTC services. We focus on institutional service utilization most typical of older adults and people with physical disabilities (i.e., nursing facility services), although the same logic can generally apply for other populations.

The strategies presented here are intended to be broadly applicable, but each can be tailored to the circumstances of a particular state or ADRC site. We have made every effort to simplify the analyses, at the expense of some important methodological considerations. We encourage you to use these strategies as starting points for additional thoughts on methodological refinement.

STRATEGY #1: PRE / POST ANALYSIS

The pre/post analysis strategy focuses on changes in service utilization before and after ADRC implementation. There are several measures against which pre/post analysis can be applied to help assess the fiscal impact of an ADRC.

Overview: Comparing nursing facility and HCBS expenditures before and after ADRC implementation.

Theory: By helping clients connect with resources, assess their options, and plan for future needs, ADRC activities should result in a decrease in the use of nursing facilities and an increase in the use of HCBS services for people enrolled in public programs. Although public spending on LTC may continue to grow (due to demographic trends and rising costs of services), this shift in services may slow the rate of growth.

Limitations: There are many intervening variables that make it difficult to isolate the impact of ADRCs or to attribute any changes over time to the ADRC initiative specifically. The more changes in the LTC system that coincide with ADRC implementation, the more difficult it will be to interpret the results of the analysis and make any conclusions about the impact of the ADRC.

What would I need to make this strategy work?

- Information about Medicaid nursing facility costs before and after ADRC implementation – in the aggregate and per capita
- Information about costs for HCBS, including Medicaid waiver costs, before and after ADRC implementation
- An understanding of other changes in the LTC system and how they may be overlapping with or working against the effect of the ADRC
- Sufficient amount of time in operation as an ADRC

Exhibit 2 provides an example for an ADRC that began operations on the first day of 2003.

Exhibit 2: Total LTC Costs, Before and After ADRC Implementation

	Period before ADRC implementation			Period after ADRC implementation	
ADRC areas	2000	2001	2002	2003	2004
Medicaid nursing facility costs (state share only)	$190,000,000	$199,500,000	$209,475,000	$216,806,625	$221,500,000
Medicaid HCBS costs (state share only)	$25,000,000	$26,275,000	$27,500,000	$28,400,000	$32,000,000
State-funded LTC	$10,000,000	$10,500,000	$11,025,000	$11,410,875	$11,900,000
Total	$225,000,000	$236,275,000	$248,000,000	$256,617,500	$265,400,000
Percent Change in Total LTC Costs		5.0%	5.0%	3.5%	3.4%
Difference in Rate of Change ((average rate 2000-2002) - (average rate 2003-2004))					1.6%

In this example, the rate of change in LTC costs declined from 5.0 percent to 3.4 percent after ADRC implementation. Because the rate of increase declined, this may be seen as a cost-savings. This cost savings can be converted into a dollar value, as shown in *Exhibit* 3.

Exhibit 3: Savings from a Decline in the Rate of Cost Increases

Baseline costs before ADRC implementation	Costs if they continued to increase by 5%	Actual costs after ADRC implementation	Difference
$225,000,000	$273,488,906	$265,400,000	$8,088,906

When looking at aggregate numbers, it is important to control for changes in cost, which vary from year to year. Major fluctuations in reimbursement rates, especially for nursing facility services, and other new or changing factors in the reimbursement system (e.g., intergovernmental transfers, provider taxes, and upper payment limits) also warrant careful consideration.

Advantages: This approach is straightforward and intuitive. By focusing on aggregate LTC costs, it gives a high-level overview and factors out any cost-shifting between programs.

Disadvantages: Many variables affect the trajectory of LTC costs that are independent of ADRC implementation, including concurrent changes in the LTC system and changes in Medicaid payment rates and eligibility rules. For example, a large increase in Medicaid payment rates to

Testimony on House Bill 1476
House Human Services Committee
January 26, 2009

Presented by Marlowe Kro
Associate State Director, Community Outreach, AARP North Dakota

Chairman Weisz, members of the House Human Services Committee, I am Marlowe Kro, the associate state director for community outreach for AARP North Dakota. I am here today on behalf of AARP's 88,000 North Dakota members to speak in support of House Bill 1476.

AARP has advocated for establishment of state single point of entry to long-term care services and supports for several years and we fully support the creation of an Aging and Disabilities Resource Center pilot program in the next biennium. I also want to remind you of Senate Concurrent Resolution 4018 passed by the 2007 legislature. A copy is attached to my testimony.

You've seen the statistics. North Dakota's population is aging rapidly. Per capita, we already have the greatest percentage of people age 85 and older of any state. By 2020, 27% of the state's residents will be 60 and older. You also know that the vast majority of people want to remain in their own homes and in their communities as they age. That's why we can no longer delay establishing ADRC's in North Dakota beginning with this pilot project.

An ADRC should provide assistance to older and disabled North Dakotans in finding and accessing the help they need to remain in their homes and communities. A single agency or organization would serve as the entry point to all long-term support services and provide a neutral place where people can obtain information, objective advice, and access to a wide range of community supports. Those needing services and their family members could talk to someone face-to-face as well as access information by phone or online.

AARP believes an Aging and Disabilities Resource Center should:

- Serve any adult needing long-term care services.
- Offer comprehensive, consumer-friendly information and assistance that is without conflict of interest.
- Conduct both financial and functional eligibility determinations and eliminate duplicative assessments and numerous agency contacts.
- Conduct an initial assessment of each individual including medical, financial, and social support options to develop an individual care plan based on each person's needs and preferences.
- Provide face-to-face service to individuals in their own homes, in medical care settings, or in care facilities.
- Use formal and informal support networks in meeting needs of consumers.
- Advocate on behalf of the consumer in securing services.

- Assure the service is consumer directed and all decisions are made by the consumer or their legal representative.
- Coordinate case management services.

As we and many others have told state policymakers before, North Dakota's system of long-term care is out of balance. In North Dakota, 95 percent of Medicaid long-term care dollars are directed to institutional care, even though most people prefer to, and with appropriate services and supports, safely remain in their homes and communities.

AARP has worked closely with the Department of Human Services and other advocacy organizations to build awareness and a foundation of support for an ADRC system. We are committed to the successful implementation of the pilot project. We believe that the eventual establishment of ADRCs in each region of the state could help us ensure that those needing long-term care services would receive comprehensive, consistent information on all of the choices that are available, including services to allow them to remain in their own homes.

We encourage North Dakota policymakers in the strongest possible terms to embrace a philosophy of delivering services in a way that allows older people the greatest independence and greatest quality of life. We need to create a long-term care system in North Dakota that offers real choices in services and opportunity

for people to remain in their homes and communities allowing them to age with dignity and independence. An ADRC is part of the solution.

Members of the committee, we ask for your support for this ADRC pilot program. Thank you for your time and attention.

Filed April 20, 2007

CHAPTER 641

SENATE CONCURRENT RESOLUTION NO. 4018

(Senator J. Lee)
(Representative Boucher)

LONG-TERM CARE CHOICE SUPPORTED

A concurrent resolution expressing support for long-term care choices, including home and community-based services, for North Dakotans with disabilities and older adults.

WHEREAS, the public interest would best be served by a broad array of long-term care services that promote individual autonomy, dignity, and choice for older adults and those with disabilities, including more home and community-based services to give all North Dakotans who are older adults or who have a disability, free choice in planning and managing their lives; and

WHEREAS, the Legislative Assembly recognizes that nursing home care is also a critical part of the state's long-term care continuum and that such services should continue to promote individual dignity, autonomy, and a homelike environment to the greatest extent possible;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF NORTH DAKOTA, THE HOUSE OF REPRESENTATIVES CONCURRING THEREIN:

That the Sixtieth Legislative Assembly supports long-term care choices, including home and community-based services, for North Dakotans with disabilities and older adults to:

1. Plan and manage their own lives to the greatest extent possible;
2. Participate in the planning and operation of community-based services;
3. Receive information that will allow them to make informed care decisions;
4. Choose to remain in their communities and in their homes when appropriate to their needs and when it can be reasonably accommodated taking into account the resources available to the state and the needs of others with disabilities;
5. Meet their needs through a care system in a culturally sensitive way;
6. Support family members and other persons providing voluntary care; and
7. Make care choices from a long-term care continuum that is visible, trusted, and easily accessed.

Filed March 28, 2007

HOUSE HUMAN SERVICES COMMITTEE

HB 1476

REPRESENTATIVE MERLE BOUCHER

CHAIRMAN WEISZ AND MEMBERS OF THE HOUSE HUMAN SERVICES COMMITTEE. FOR THE RECORD, I AM REPRESENTATIVE MERLE BOUCHER REPRESENTING DISTRICT NINE (9).

HB 1476 RECOMMENDS THAT THE DEPARTMENT OF HUMAN SERVICES SHALL PLAN AND IMPLEMENT AN AGING AND DISABILITY RESOURCE CENTER FOR NORTH DAKOTA.

OVER THE YEARS THERE HAS BEEN A GREAT DEAL OF DISCUSSION REGARDING THE DEVELOPMENT OF A SINGLE POINT OF ENTRY PROGRAM TO:

1. INFORM CITIZENS OF SERVICE AND/OR CARE OPTIONS THAT ARE AVAILABLE.
2. TO HELP CITIZENS MAKE IMPORTANT SERVICE AND/OR CARE DECISIONS.
3. HELP CITIZENS ACCESS THEIR SERVICE/AND OR CARE NEEDS.

AS POLICY MAKERS WE HAVE COME TO UNDERSTAND AND SUPPORT OUR CITIZENS DESIRE TO PROTECT THEIR PERSONAL INDEPENDENCE. AN AGING AND DISABILITY RESOURCE CENTER WOULD SERVE AS A VITAL COMPONENT TO HELP OUR OLDER AND/OR DISABLED REALIZE THEIR DESIRED LEVEL OF FUNCTIONAL INDEPENDENCE.

THIS IS THE RIGHT THING TO DO FOR PEOPLE AND FROM A POLICY STANDPOINT IT IS MOVING IN THE RIGHT DIRECTION FISCALLY.

I URGE A DO PASS IN FAVOR OF HB1476.

THANK YOU.

TESTIMONY – PROTECTION AND ADVOCACY PROJECT

HOUSE BILL 1476 (2009)

HOUSE HUMAN SERVICES COMMITTEE

Honorable Robin Weisz, Chairman

January 26, 2009

Chairman Weisz, and members of the House Human Services Committee, I am Bruce Murry, a lawyer with the North Dakota Protection and Advocacy Project (P&A). P&A strongly supports the services proposed in HB 1476.

Many agencies we value and respect feel they offer a Single Point of Entry (SPE) into human services and long term care. Even P&A feels tempted to say our information and referral services offer SPE. After all, we offer information to anyone concerned with disability issues regardless of income. However, we must admit that our clients don't feel disability services are well coordinated.

Aging and Disability Resource Centers are a form of SPE. Different states have implemented many models of SPE or ADRC. P&A believes an ADRC should have the following features:

- Implement a no-wrong-door philosophy so consumers and families can navigate available services more efficiently and with fewer lost opportunities.
    - Lost Opportunities in long term care are often tragic and expensive for all involved.
    - The part of the system the person finds should become their single point of entry. Any referral should be monitored, or a "warm handoff."
- Reduce layers of bureaucracy -- perceived and funded.
    - Clarify relationship among the ADRL, ADRC, 211, County Social Services, the Centers for Independent Living, and others. North Dakotans and their legislators should demand these entities collaborate effectively. A strategic plan to this end should be part of any proposal.
        - Expect collaboration also of P&A, even if providing ADRC services conflicts with our primary mission of advocating legal rights.

    - Encourage partnerships among the foregoing in applying for the ADRC pilot. One entity could take the lead role, subcontracting to the others in a process that is seamless to the consumer.
    - Streamline application, evaluation, and eligibility processes, perhaps under one roof. County Social Service Agencies might excel in this area.
- Contain elements of consumer choice.
    - Consumers voting with their feet make programs responsive & effective.
    - An ADRC pilot could overlap with the territory or responsibility of the current case management system to demonstrate which program achieves better outcomes for the investment.
    - If North Dakota later implements an ADRC statewide, each county could authorize at least two ADRC providers to provide competition or choice.
- Fulfill the 21 principles of a Single Point of Entry developed by the Real Choices Rebalancing project, stated in Ms. Wright's testimony to the House Appropriations Committee, Human Resources Division. See especially conflict of interest.
    - Many stakeholders deliberated at length developing these principles.
    - The principles are based upon the our state's experiences and others.
    - The ADRC awards process should score proposals by these 21 principles.

Thank you for your consideration. P&A stands ready to provide individual and systemic advocacy to ensure an ADRC or other single point of entry can succeed. I welcome any questions.

#5

Testimony
House Bill 1476 – Department of Human Services
House Human Services Committee
Representative Weisz, Chairman
January 26, 2009

Chairman Weisz and members of the House Human Services Committee, thank you for the opportunity to present testimony in favor of *House Bill 1476*, which would provide funding for the implementation of an aging and disability resource center for the state.

I am Jane Strommen, Executive Director of the Community of Care program in rural Cass County.

My purpose here today is to briefly summarize the work of the Community of Care program as it relates to the importance of and need for an Aging and Disability Resource Center in the state. The Community of Care program began over five years ago with the mission of ensuring older adults and others in need in rural Cass County have access to health, human, and spiritual services essential to the maintenance of their well-being. The goals of the program are three-fold: (1) Identify and address significant gaps in essential services and information for elderly and disabled persons in rural Cass County; (2) Work collaboratively with others to maximize funding, expand service choices, and build support for a caring network for elderly and disabled persons in rural Cass County, and (3) Develop, implement, and maintain a permanent community-based model of care in rural Cass County that would be replicated for use in other rural areas of the country. Start-up funding for the program came from a state Olmstead Commission grant, the Good Samaritan Society and local donors. Today, Community of Care is an

independent, non-profit membership organization funded by grants, charitable contributions, United Way, and membership contributions from its 200+ members.

During the early stages, a 25-member Steering Committee, consisting of consumer and provider representatives, participated in a strategic planning process to identify the most critical issues for older adults and persons with disabilities in rural Cass County. The five critical issues were the following: (1) Need for a county-wide volunteer program; (2) Need for transportation for both medical and social purposes; (3) Need for education and information on long-term care issues, funding, and services; (4) Need for the building of collaborative relationships with both formal and informal stakeholders, and (5) Need to determine how services and care will be financed. From this planning process, numerous services have been developed, with the number of people requesting assistance from these services continuing to increase each year. In 2008, over 500 people received assistance from Community of Care. One service, the One-Stop Resource Center, meets many of the objectives of the proposed ADRC. It offers one place to call or visit for information and assistance with a variety of needs, such as financial, equipment, housing, in-home services, legal, medical, nutrition, transportation, mental health/ dementia, and support services. Trained staff, who know and understand the community, answer questions, provide information, make referrals, arrange for services, and complete paperwork. Our Volunteer Program has 40+ trained volunteers who provide medical and social transportation, minor home repairs, visitation, errands, and yard work. Other services include a monthly Caregiver Support Group, Resource Directories placed throughout the county, and education on long-term care topics through newsletters, newspaper columns, local seminars, presentations, and health fairs. State Health Insurance Counseling is another important service provided. During the last six weeks of 2008,

approximately 170 individuals were enrolled in a Medicare Prescription Drug Plan, which does not include the number of individuals who contacted us with questions about their plans.

Community of Care is unique in that it is a grassroots, locally driven effort to mobilize community members to work together to find local solutions to the needs of local people. The program is highly focused, efficient, non-bureaucratic, and flexible and is designed to be culturally sensitive. It complements, rather than duplicates, pre-existing services, and supplements only needed services that are lacking or insufficient. Collaboration and coordination with both formal and informal organizations helps to maximize current resources and minimize duplication. Last year, a formal interagency agreement was established between Community of Care and these key agencies in the Fargo metro area: Cass County Social Services, Fargo-Cass Public Health, Fargo Senior Services, and the Family Caregiver Program. The purpose of the collaborative agreement is to better assist individuals in accessing eligible services so they can remain in their home or the least restrictive setting. The intent is to simplify the process for the client, whether it is by reducing the number of phone calls made or by eliminating system barriers. The agreement provides for the utilization of a common screening/referral protocol, joint training for staff, inter-agency staffing regarding difficult client needs, and identification of unmet needs of elderly and physically disabled adults. The philosophy adopted by the representatives of the collaborative is a "no wrong door" approach, which is an efficient, common sense way of helping people. Regardless of which agency receives the initial client contact, the client is going to receive access to available services in the most simplified process possible.

So why is ADRC funding necessary to achieve the stated objectives of the ADRC legislation? First, the publicly funded agencies serving older persons and persons with disabilities provide the best service possible given limitations of time or financial resources. Because of their limited resources and the public's lack of awareness, these services are often underutilized by individuals who could benefit from them. Second, there are many individuals who "fall through the cracks" because they do not meet age, disability, or income eligibility criteria of existing programs or they have complex problems which fall outside of traditional services. These individuals have no place in which to turn to for help. Last, the formation of collaborative relationships or partnerships does not occur without the vision and commitment of local leaders to make it happen. The current long-term care system has a long history of being fragmented and uncoordinated and it will not change without intentional efforts.

Based on my experience with the Community of Care program, ADRC funding to support a pilot demonstration project is necessary for the Department of Human Services to determine the most effective and efficient way to support the service and information needs of older adults and persons with disabilities across the state. In my opinion, a successful ADRC program in North Dakota must be simple, local, flexible, and responsive to both the service and information needs of a diverse state. At the same, it needs to utilize existing services, instead of duplicating them, and explore new agency and staffing coalitions or partnerships in order to better serve clients. If the possibility exists, Community of Care would be interested in considering being a pilot project so it can use the knowledge that has been learned to help develop an ADRC model that best works for North Dakota.

I would be happy to answer any questions you may have.

#6

Testimony
North Dakota Disabilities Advocacy Consortium
HB 1476
House Human Services Committee
Chairman Representative Robin Weisz

Chairman Weisz and members of the House Human Services Committee, my name is James M. Moench, Executive Director of the North Dakota Disabilities Advocacy Consortium (NDDAC). The Consortium is made up of 23 member organizations concerned with addressing the issues that affect people with disabilities. (See attached list of members).

NDDAC supports the establishment of an Aging and Disabilities Resource Center (ADRC) to address the need for a one-stop information and service center in North Dakota as envisioned in House Bill 1476.

NDDAC believes that an ADRC would greatly simplify the complexities of accessing the many programs that North Dakota provides for it citizens. For example, families have reported that they must fill-out a new and separate entry form for every program just to find out if they qualify or not. Each agency's entrance form while similar has different requirements for backup information and paperwork. An ADRC could serve as the single entry point where a client would fill-out a single document that would contain the information necessary for the initial assessment by an agency.

North Dakota should join the many other states that have successful implemented an Aging and Disabilities Resource Center. Those states have found the ADRC an effective tool and we will too.

We urge your support of HB 1476
Thank you.

NORTH DAKOTA DISABILITIES ADVOCACY CONSORTIUM

2008-09 Membership

1. AARP
2. American People Self Advocacy Association
3. Autism Society of North Dakota
4. Experience Works, Inc.
5. Fair Housing of the Dakotas
6. Family Voices of North Dakota
7. Independence, Inc.
8. Mental Health America of North Dakota
9. Metro Area Transit – Fargo, ND
10. ND APSE: The Network on Employment
11. ND Association for the Disabled
12. ND Association of Community Facilities
13. ND Association of the Blind
14. ND Center for Persons with Disabilities
15. ND Children's Caucus
16. ND Consumer & Family Network
17. ND Federation of Families for Children's Mental Health
18. ND IPAT Consumer Advisory Committee
19. Protection & Advocacy Project
20. Senior Health Insurance Counseling/Prescription Connection
21. The Arc of Bismarck
22. The Arc of Cass County
23. The Arc of North Dakota

1-16-09

#7

Amy B. Armstrong
North Dakota Medicaid Infrastructure Grant (ND MIG),
North Dakota Center for Persons with Disabilities (NDCPD)
at Minot State University
Testimony - HB 1476
House Human Services Committee
Representative Robin Weisz, Chairman
Monday, January 26th, 2009

Chairman Weisz and members of the Human Services Committee, I am Amy Armstrong, Project Coordinator for the North Dakota Medicaid Infrastructure Grant (ND MIG) at the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. Thank you for the opportunity to present testimony in favor of House Bill 1476 for the development and implementation of an Aging and Disability Resource Center for the elderly and people with disabilities of North Dakota. An ADRC would provide North Dakota's seniors, adults with disabilities, and their family members a streamlined and coordinated system for accessing continuum of long term care services.

Previously, from 2005-2007, I served as the project director for the Department of Human Service's – Aging Services Division, Real Choice Rebalancing (RCR) Grant. One of the primary goals of this grant was to consider ways to improve and streamline access to continuum of care services for all seniors and adults with disabilities. The RCR Grant gathered and analyzed previously completed research and gathered more current data related to North Dakota's continuum of care system. Much information has been gathered and studied over the past 20 years regarding continuum of care issues. These studies are listed in Appendix A.

As part of the RCR Grant, past reports and data from 1987 through 2004 were analyzed. These reports contain an abundance of recommendations of which to drawn upon as North Dakota considers ways to improve its continuum of care system. Several noteworthy themes throughout these past reports include *recurring* recommendations for improving access to case management, development of a streamlined single point of access to services; and assuring that

consumers have informed options and better access to services, particularly home and community based services and qualified services providers (QSPs).

The RCR Grant also developed and implemented a research project to gather the more current information from North Dakota consumers of home and community based services, nursing home residents, family members, and providers of continuum of care services. This more recent data also highlights the lack of a streamlined continuum of care service system in North Dakota. Revealed through numerous interviews, focus groups and surveys, this lack of a coordinated system has clearly caused confusion and barriers to accessing services for ND seniors and adults with disabilities. The culmination of the RCR Grant recommended the development and implementation of an ADRC. In addition the RCR Grant also laid much of the ground work and planning stages of an ADRC for ND as highlighted in Linda Wright's testimony.

More recently in 2008, as part of my work on the ND MIG Grant at NDCPD, a complete report of HCBS in ND was compiled by Mr. Dave Zentner titled, *At a Crossroad, North Dakota Home and Community Based Services – An Overview and Recommendations*[1]. After careful analysis of past and more current data including surveys of QSPs and HCBS providers and analysis of state HCBS data; this report also contains the following recommendation: "Ensure that each individual needing long term continuum of care services receives adequate information to make informed decisions regarding how to access available services through the implementation of an assessment/screening tool using a coordinated single point of entry or no wrong door process." These are examples of ways to implement an ADRC.

Currently, ADRCs are successfully implemented in 45 states. A streamlined system for accessing services is important in order to assure that North Dakotans are aware of all of their long-term care options and thus are able to make informed

[1] Zentner, D., Consultant. (2008). North Dakota Medicaid Infrastructure Comprehensive Employment Systems Grant, *At a Crossroad, North Dakota Home and Community Based Services – An Overview and Recommendations.* Minot, ND: North Dakota Center for Persons with Disabilities, Minot State University.

decisions about their care. The purpose of an ADRC is not to set up a new bureaucracy, but to help those service agencies and providers that are currently in existence to work together, streamline their work, and make accessing long-term support services a simpler and less confusing process for North Dakotans. Implementing an ADRC will help North Dakotans learn about all of their long-term care options and then make informed decisions about their care. Being able to make informed decisions about long-term care options also means seniors and adults with disabilities are better equipped to make sound financial decisions about their current and future care needs. Senate Bill 1476 would go quite far in assisting consumers who are aging and/or have a disability. The implementation of an ADRC would address many of the needs and issues highlighted in years of research.

Once again, thank you for the opportunity to share this information. I would be happy to answer any questions at this time.

Contact information:
Amy B. Armstrong, Project Coordinator, ND MIG
NDCPD at Minot State University
Email: amy.armstrong@minotstateu.edu
Ph: 1-800-233-1737 or 701-858-3578

Appendix A

A List of Studies Regarding Continuum of Care Services in North Dakota

1987

Long Term Care: Issues and Recommendations, 1987, ND Interagency Task Force on Long Term Care

1996

Report of the Task Force on Long Term Care Planning 1996,

1998

Report of the Task Force on Long Term Care Planning 1998,

2000

Report of the Task Force on Long Term Care Planning 2000,

White Paper: Olmstead Workgroup, Nov. 6, 2000

Report of the ND Governor's Task Force on Long Term Care Planning Expanded Case Management, June 30, 2000

2002

A Study of North Dakota's Nursing Facility Payment System Study, Oct. 2002

Needs Assessment of Long Term Care, ND: 2002,

Initial Report & Policy Recommendations, Nov. 2002

Cost Containment Alternatives for ND Medicaid, Nov. 1, 2002

2003

Real Choices in North Dakota, 2003

Informal Caregivers: 2002 Outreach Survey, 2003

Community of Care Baseline Survey, 2003

National Family Caregiver Support Program: ND American Indian Caregivers, June 2003

2004

2004 AARP ND Member Survey: Support Services, June 2004

Senate Bill 2330 Workgroup Final Report, Dec. 2004

2005

Community of Care Olmstead Grant, August 2003 - 2005 Final Report

Final Report Real Choice Systems Change Grant Cultural Model, May 05-06

2006

Home and Community Based Services Planning Project Survey Results, June 2006

ND Real Choice Systems Change Grant-Rebalancing Initiative: Focus Groups and Personal Interviews- Research Report One, June 2006

ND Real Choice Systems Change Grant-Rebalancing Initiative: Hospital Discharge Planner Questionnaire – Research Report Two, Aug. 2006

ND Real Choice Systems Change Grant- Rebalancing Initiative: ND Consumers of Continuum of Care Services Questionnaire – Research Report Three, Dec. 2006

An Overview and Recommendations: Medicaid Services in ND, Dec. 2006

2007

The Economic Impact of the Senior Population on a State's Economy: A Case Study of ND, Jan. 2007

An Overview and Recommendations: Long-Term Care in ND, February 2007

2008

At a Cross Road, North Dakota Home and Community Based Services, Sept. 2008

Report of Questionnaires Administered to North Dakota Individual and Agency Qualified Service Providers, 2008

(For details regarding these reports please contact Linda Wright, DHS Aging Services Div. or Amy Armstrong, NDCPD at MSU.)