# Colorado's Three-Year No Wrong Door Implementation Plan

**Prepared by**



COLORADO
Department of Health Care Policy & Financing

# Sample of Quotes from No Wrong Door Focus Groups, 2015

In February 2015, Nonprofit Impact conducted four focus groups with individuals and family members who accessed Long-Term Services and Supports (LTSS) and three focus groups with frontline staff from agencies that enroll individuals in LTSS. Over 40 individuals, family members and advocates and 27 frontline workers participated in the focus groups to share their thoughts on what does and does not work in the LTSS enrollment process. The quotes below provide a sample of common experiences among focus group participants.

*From individuals, family members and advocates trying to access LTSS:*

"I wish I could go back to independent living again, that's all I want to do."

"I was really fortunate – through a man [who]…had a business that helped people with the process – not only did he help expedite the process, he also sat down with me and said here are some other things you'd want to consider – I think that's unusual – I had to pay for his service – so it wasn't through a government agency."

"…I've experienced a lot of waiting – that's the hardest part – and the paperwork…."

"There's no uniformity. There ought to be…once you're in some system somewhere and it's the State of Colorado – that information ought to be available when you want it to be."

"Information [should be] available across the service provider continuum – the same message, the same language, parity – if Suzy Q in Denver gets told that she has these options, people in rural areas should get that message, too."

"I would ask for consistency. I know that's hard when you are dealing with people. When you train say the SEP vs. the CCB, you get very, very different answers. Why is there not consistency across the domain? Regardless of how I get into the system, everyone should have that same roadmap."

"…in terms of the NWD concept – one of the things that needs to happen, … is to get rid of all these silos so you [don't] have to run around all over."

"When you go to one door, they can help you with a piece of it, but you run around to get the other piece."

"Something like a common intake process – it needs to be the same for everyone…."

*From frontline staff who are employees of agencies that help enroll individuals:*

"A lot of applications don't make it start to finish – I think in part there's no relationship with someone who can help them, help them understand what that letter from the county means."

"A lot of people give up, it is complicated."

"The system is so broken and we have band aids."

"We know there are a lot of benefits once you get in the door – but there are so many more hurdles than open doors."

"It is hard enough getting someone to accept help – but then to go through all these hoops and then sometimes not get it – I can't help them – I sound like I don't know what I'm talking about – the trust gets lost."

"I think it's a lot of hurry up and waiting – you're just waiting – progress is put on hold waiting."

"We have exceedingly high caseloads – we are doing the best we can."

"We run into those issues where the financial piece takes forever – mostly around the Medicaid Buy-In program – people don't really understand it."

"One thing we've noticed in the last few months, people's situations are way more complicated than they used to be."

"More need and fewer resources."

"Turnover seems to go up and down; more recently…three people had left our 12 person team in three months."

"It's supposed to be family friendly, you're supposed to be able to do this without an advocate."

"I think turnover in our area [is the biggest issue.] We see a lot of that and it creates a ripple effect – a case manager is working on something – we find ourselves re-creating the wheel a lot."

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## Glossary

ACL means the Administration for Community Living.

BUS is the Benefits Utilization System, Colorado's LTSS case management software system.

CDHS means the Colorado Department of Human Services.

CDLE means the Colorado Department of Labor and Employment.

Colorado Choice Transitions, or CCT, a Money Follows the Person initiative (MFP), is a program to help transition Colorado Medicaid members out of long-term facilities and into home and community-based settings.

CCLP means Colorado's Community Living Plan, Colorado's Response to the Olmstead Decision.

CLAG means Community Living Advisory Group.

Critical pathway providers are providers involved with supporting someone in the transition process from one care setting, such as a hospital or nursing home, to another. Examples of critical pathway providers include:

- Hospitals
- Long-term care facilities
- Community-based provider agencies
- Case management agencies
- Regional Care Collaborative Organizations

Department means the Colorado Department of Health Care Policy and Financing.

DVR means the Colorado Division of Vocational Rehabilitation.

EBD means the HCBS program for the elderly, blind and people with physical disabilities.

Entry point functions means the six functions of a NWD system, as defined by the ACL:

1. Information, referral and community awareness
2. Person-centered counseling
3. Streamlined eligibility determination for public programs
4. Person-centered transition support
5. Consumer populations, partnerships and stakeholder involvement
6. Quality assurance and continuous improvement

Entry point organizations are any agency that receives funding for entry point functions to connect individuals to LTSS. These organizations include:

- Aging and Disability Resources for Colorado (ADRCs)
- Area Agencies on Aging (AAAs)
- Single Entry Points (SEPs)
- Community Centered Boards (CCBs)
- Centers for Independent Living (CILs)
- County Departments of Social Services (DSS)

And in some cases, the following organizations may serve as entry points for behavioral health services:

- Behavioral Health Organizations (BHOs) and
- Community Mental Health Centers (CMHCs)

HCBS means Medicaid Home and Community-Based Services.

Lead agency means one of the entry point organizations from each regional pilot site that will ensure all six functions of a No Wrong Door system are carried out, convene the other local entry point organizations to implement the NWD pilot site and will serve as the primary contact in communicating with the Department and other stakeholders. Following the pilot phase, the lead agency will oversee operations of the regional No Wrong Door entities and establish partnerships with local Long-Term Services and Supports entry point organizations to carry out the six functions.

LTSS means Long-Term Services and Supports.

Medical Assistance (MA) Sites are sites designated and certified by the Department to accept and process the state authorized medical assistance application for the programs that are administered by the Department.

MMIS means the Medicaid Management Information System.

Most integrated setting means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible, as defined in the Code of Federal Regulations.

NWD means No Wrong Door.

NWD Project Team means state staff and contractors who will oversee and work with the regional pilot sites.

OCL means the Office of Community Living at the Colorado Department of Health Care Policy & Financing.

Olmstead decision is the U.S. Supreme Court ruling which requires people with disabilities to be served in the most integrated setting appropriate to their needs, with their agreement or choice.

PEAKPro is Colorado's online communication platform for eligibility determination available to case management agencies and county offices of social services.

Pilot phase means the period when regional NWD pilot sites are operating to help the state refine the implementation model for NWD statewide.

RCCOs, or Regional Care Collaborative Organizations, are Colorado Medicaid care coordination organizations that connect Medicaid clients to Medicaid providers and help clients find community and social services in their area.

Referral Network means any individual, advocacy group, community organization or other entity that refers individuals to or receives referrals from the partnering agencies making up the regional NWD system.

Regional pilot sites means a network of LTSS entry point organizations within a defined geographic area that will receive grant funds from the Department to implement a NWD system within said geographic area; to work with the Department and its contractors to develop, test and refine best practices in carrying out NWD functions at a regional level; and to identify systemic constraints and barriers to implementing a fully functional NWD system statewide.

SAMS means the Social Assistance Management System, the information technology system Area Agencies on Aging (AAAs) use for care management and client tracking.

Stakeholder means anyone with a vested interest in No Wrong Door. Examples of a stakeholder include:

- An individual seeking or receiving LTSS
- A family member
- An advocate or advocacy organization
- Case Management Agency, or
- Any other organization impacted by NWD

SUA means the State Unit on Aging, a Division with the Office of Community Access and Independence at the Colorado Department of Human Services.

Targeting criteria means a target population or populations within parameters of diagnosis or disability of Medicaid eligibility groups for HCBS.

## Executive Summary

Colorado faces a demographic sea change over the ensuing decades. Projections call for the number of seniors to reach 1.5 million by 2040, more than doubling from 700,000 in 2015. Current trends indicate that 69 percent of seniors will need to use Long-Term Services and Supports (LTSS) in their lifetime. Meanwhile, advances in technology and medicine are helping people with disabilities live longer. All Coloradans will be affected in one way or another by these changes, some profoundly. The state's LTSS entry point system(s) will face unprecedented demand. The current entry point system(s) is fragmented, lacks capacity to respond to current demand and is not prepared to handle the expected influx of users based on anticipated demographic shifts. To respond to these systemic issues facing the entry point system(s), the state has crafted a cutting-edge plan for a more efficient and consumer-friendly LTSS entry point system, known as a No Wrong Door (NWD) system.

The framework for developing a NWD system comes from recommendations in Colorado's Community Living Plan (CCLP) — the state's response to the Olmstead decision — as well as from the Community Living Advisory Group (CLAG), which was established by Governor John Hickenlooper in 2012. These recommendations include:

- Identifying and supporting people in long-term care facilities who want to move to a community.
- Preventing unnecessary placement in long-term care facilities.
- Improving communication among LTSS entry point agencies to ensure the provision of accurate, timely and consistent information about service options in Colorado.
- Creating common entry points, where people can obtain information and assistance and be connected to community LTSS, regardless of age, pay source or disability.

After gathering input from a wide range of stakeholders, including Colorado citizens and professionals in this field, the consensus is that the system needs to make the following changes:

1. Provide accurate and timely information delivered in a courteous and easily understandable format for anyone that needs information about how to get help in the home or community with the effects of aging or living with a disability.
2. Allow access to a person to help individuals in need of LTSS, or their loved ones, understand what programs and resources are available so that each individual/family can make informed choices. The goals are to connect people to the right services in the right place at the right time and, to the extent possible, to help individuals remain in their homes and communities.
3. Accelerate changes to current systems and processes so that an individual that might qualify for publically funded programs, such as Medicaid, can apply and enroll easily so that they can quickly receive needed services.

Provide direct assistance to individuals transitioning from one care setting to another or help transition from one program to another as their needs or eligibility requirements change.

To make these changes, the Department of Health Care Policy and Financing (the Department) chose to adopt the six functions of a fully functioning NWD system created by the Administration on Community Living (ACL). The NWD implementation plan detailed in this report describes the proposed model, developed in partnership with stakeholders, which will ensure the six functions are conducted statewide by the NWD system:

- **Information, Referral and Awareness:** NWD will work with partners to create a robust referral network to create formal linkages with LTSS entry point organizations.
- **Person-Centered Counseling:** At the core of Colorado's NWD model is a person-centered planning process for accessing LTSS that puts individuals in the driver's seat and provides them with all of their options.
- **Streamlined Eligibility:** If an individual appears to be eligible for public programs, a streamlined enrollment process will be initiated.
- **Person-Centered Transition Support:** NWD will smooth transitions for people as they move between care settings or public programs.
- **Individual Populations, Partnerships and Stakeholder Involvement:** An ongoing feedback loop will help stakeholders share their ideas.
- **Quality Assurance and Continuous Improvement:** Developing strong metrics that measure both the individual and staff experience will be essential for success.

Through a grant provided by the ACL, Colorado plans to test the model presented in the implementation plan by financing three to five regional NWD systems as pilot sites. By carrying out the six functions of a NWD system to serve individuals seeking LTSS, these pilots will illuminate best practices, identify barriers to a seamless and individual-friendly experience and inform the best possible framework for a statewide NWD system that will make a difference in the lives of Coloradans. To carry out the function of continuous quality assurance and improvement, the system must involve those who use it and those who work in it. The implementation plan proposes a way for individuals and other interested people to share ideas and be involved at all levels. The NWD system when taken to scale will address the CCLP and CLAG recommendations by creating a streamlined entry point system that provides information, a full range of options for LTSS programs and eligibility determinations for seniors, people with disabilities and caregivers, regardless of their pay source.

## NWD Mission and Vision

### Mission:

Colorado's No Wrong Door (NWD) system, through collaborative partnerships, increased communication and shared technology, ensures that all Coloradans with disabilities and older adults are connected to the supports and services they need to live dignified and self-determined lives in the community of their choice, regardless of pay source.

### Vision:

Coloradans with disabilities and older adults can easily obtain comprehensive information and streamlined access to personalized supports and services that promote dignity, respect and freedom of choice from wherever they enter the system and for as long as they need services through the system.

### General Principles

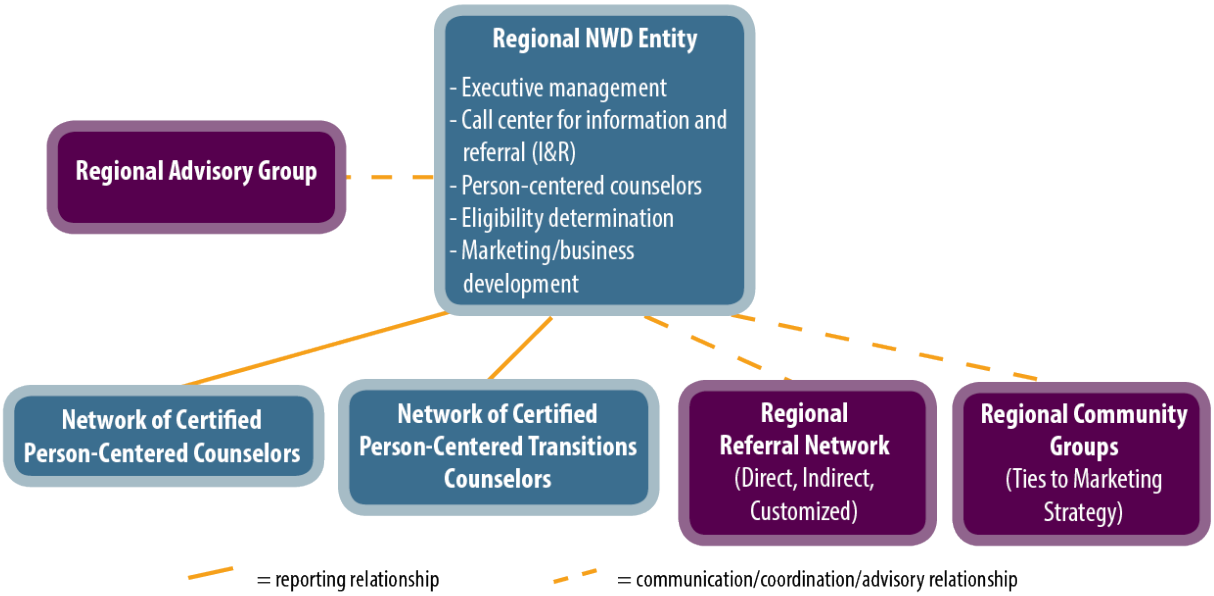
- NWD is a highly visible, efficient and trusted resource for accessing information on long-term services and supports (LTSS).
- NWD provides information on all available options to all Coloradans with functional limitations, such as people that may need help with bathing, dressing, and housekeeping, or people who have trouble remembering things like taking medications.
- NWD serves Coloradans who are trying to access both public and private supports and services.
- All NWD counseling about available supports and services is personalized.
- Access to public programs is streamlined.
- NWD uses technology to improve the availability of comprehensive information and to streamline access to supports and services.
- NWD relies on individual input to help ensure the highest quality service.
- NWD requires that all state agencies and access points communicate, coordinate and collaborate so individuals seeking or receiving LTSS receive a consistent experience and information from all systems and agencies.

### Regional No Wrong Door Entities

To implement the mission and vision for the NWD system, the Department and its partnering state agencies will implement regional NWD entities to have responsibility for ensuring that all six functions of a NWD system are carried out. (See Appendix A, Six Functions of a Fully Functional Aging and Disability Resource Center.) This model was developed in collaboration with stakeholders during the NWD planning phase. See graphic 1 for the model.

This model will be piloted through three to five sites to refine the model for taking it statewide. This pilot will be financed through the NWD implementation grant provided by the ACL.

*Graphic 1. NWD Regional Structure*




The model, when fully implemented, assumes that existing LTSS entry point organizations will be replaced or reorganized to carry out the functions of an NWD system. Operationalizing this model will alleviate many of the issues with communication and information sharing that currently exists among LTSS entry point organizations. These regional entities will partner with local LTSS entry point organizations to conduct NWD functions. Additionally, in the event that a person is applying for a Medicaid HCBS program, the regional entity will have responsibility for assisting the individual with waitlist placement and providing updates to the individual regarding their status on the waitlist. Ultimately, the regional entities will be accountable to the state for meeting outcomes and for ensuring all functions of the NWD system are carried out.

The regional NWD entities will also be responsible for maintaining a network of certified person-centered counselors and person-centered transition coordinators in their region. The network may take various shapes, but will likely involve contracts between the NWD regional entities and local organizations that are interested in being a part of the network to provide options counseling and transition support. The person-centered counselor and person-centered transition coordinator networks and peer mentors will leverage existing capacity and expertise across Colorado to ensure all populations are

served. The network will be encouraged to employ people with disabilities with lived experience in these positions.

As Colorado moves forward with fully implementing the model, the state agencies will put in place contracts with requirements that make certain the regional entities have a strategy to recruit relevant local LTSS entry point organizations to participate in the network. If the LTSS entry point organizations want to provide these services and receive publicly-funded reimbursement, they must be part of the NWD network. Additional requirements will be developed in the contracts to incentivize the regional entities and LTSS entry point organizations at the regional level to employ people with disabilities. These contract requirements will be developed during the pilot phase.

The regional entities will be responsible for ensuring that any staff designated by the LTSS entry point organizations to be part of the networks will complete all necessary training and be certified to provide person-centered counseling and transition support. During the pilot phase, the NWD Project Team, in collaboration with the staff from the pilot sites, will develop the qualifications, training and certification that will be necessary to fully implement the NWD model. The regional entities will be expected to ensure that counselors have a minimum of a bachelor's degree or experience in customer service. Counselors will embody certain qualities and skills, including:

- People skills, such as empathy, compassion and the ability to build rapport
- The ability to remain calm and composed under pressure, especially during crisis intervention
- Excellent communication and listening skills
- Research and interview skills, particularly motivational interviewing
- Critical thinking and problem-solving skills
- Adaptability and quick-thinking
- A high degree of customer service skills
- Computer skills
- The ability to multi-task
- Detail-oriented, and
- Cultural competence, including a disability competence component.

Regional entities will also be responsible for garnering awareness and support of NWD to include:

- Executive management who oversees strategic direction and sets regional goals for improvement and greater public awareness for NWD
- A call center for information and referral that is staffed to receive initial phone calls from the community and referral sources
- Person-centered counselors
- Communication between organizations that ensures complete functional and financial eligibility determinations occur

- Work with state agencies to develop and implement shared marketing strategies to raise public awareness of the NWD system at the regional level
- Identify and implement business development strategies that utilize growth opportunities beyond public funds, such as a process for individuals who can privately pay or establishing contracts with private entities
- Establish a referral network of people who may refer to the NWD system or who the NWD system may refer to
- Make connections with regional community groups that can provide opportunities for business development and marketing, and
- Manage a regional advisory group that meaningfully engages stakeholders, including individuals receiving services and families, to advise on what is and is not working in the implementation of the six NWD functions. The advisory group will need to establish rules for how the regional NWD system will respond to and implement feedback from the group.

At the state level, graphic 2 illustrates the relationship between state level oversight of the regional NWD entities. The state management level, identified within the structure, will be responsible for managing the contracts with and performance of the regional NWD entities. At the state executive level, decisions makers will be office directors from the partnering state departments and will provide strategic direction and alignment with state priorities.

Eventually, NWD system oversight may include a private-public partnership board as more people who are seeking LTSS in Colorado privately pay for their services. If implemented, this board will serve in an advisory capacity to ensure that all relevant interests are involved in shaping the structure of the NWD system statewide. This public-private board will be put in place after the conclusion of the pilot phase and as the model is more inclusive of private pay opportunities. These discussions of how the board will be structured and who will manage the board will occur closer to implementation.

The NWD model envisions that a Community Access Ombudsman (CAO) program is created. The purpose of the CAO is to investigate and resolve complaints made by, or on behalf of, individuals who utilize the NWD system. For example, if an individual is considered ineligible for publicly-funded LTSS, the individual may appeal the decision and may contact the CAO for assistance with the appeal process. The CAO could also assist individuals who believe the NWD entity misinformed the individual on their options or individuals who feel like their goals were not taken into consideration in the person-centered counseling process. In continuing to improve the NWD system after the pilot phase, state-level managers will consider information from stakeholders, the NWD regional entities and the CAO.

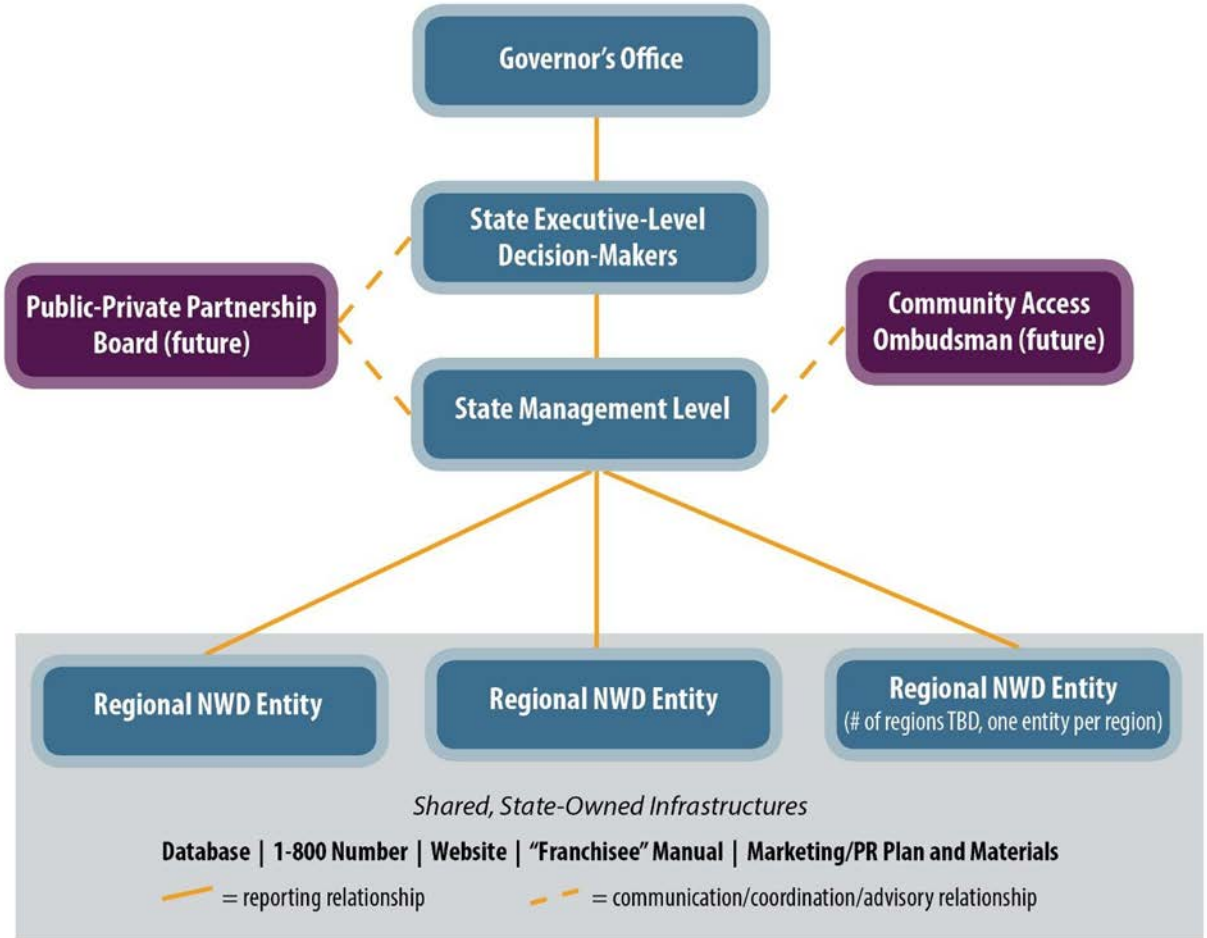
Stakeholder input will be essential to understanding what is and is not working and when mid-course corrections may be necessary. An ongoing process to gather and

incorporate feedback will be developed during the pilot phase and when the model is fully implemented.

State personnel will manage operations and state-owned infrastructure to support NWD, including:

- A statewide website for individuals seeking LTSS
- A shared information management platform for LTSS entry point organizations;
- A toll-free phone number;
- Marketing and public awareness campaigns and materials;
- Training and protocol manuals;
- Developing Contracts to carry out NWD functions at a local level;
- Regulations;
- Identifying Statutory changes; and
- Approaches to financing NWD activities.

*Graphic 2. NWD Governance Structure*



## Person-Centered Planning

A person-centered planning process for accessing LTSS is at the core of the state's NWD plan. The process is rooted in the following principles, identified by Planning Advisory Group members:

A person-centered planning process for accessing LTSS is at the core of the state's NWD plan. The process is rooted in the following principles, identified by Planning Advisory Group members:

- Individuals are always in the driver's seat and can be directed to non-LTSS services or connected to peer assistance or advocate services at any point in the process.
- NWD is flexible enough to meet all individual needs as people will come to NWD at different points in their lives,.
- The NWD process meets the highest standards of customer service.
- The NWD process is supported by staff who are well trained and well paid.
- IT systems are integral and will ensure individual information is captured and shared to track quality.
- The individual experience is consistent statewide.
- Accessibility, such as wheelchair ramps, proximity to public transportation and bilingual staff, is essential to NWD. Accessibility also includes program accessibility and a system that understands the requirements of the Americans with Disability Act (ADA) to make reasonable modifications to policies, practices and procedures when necessary to accommodate the most integrated setting for the delivery of LTSS.

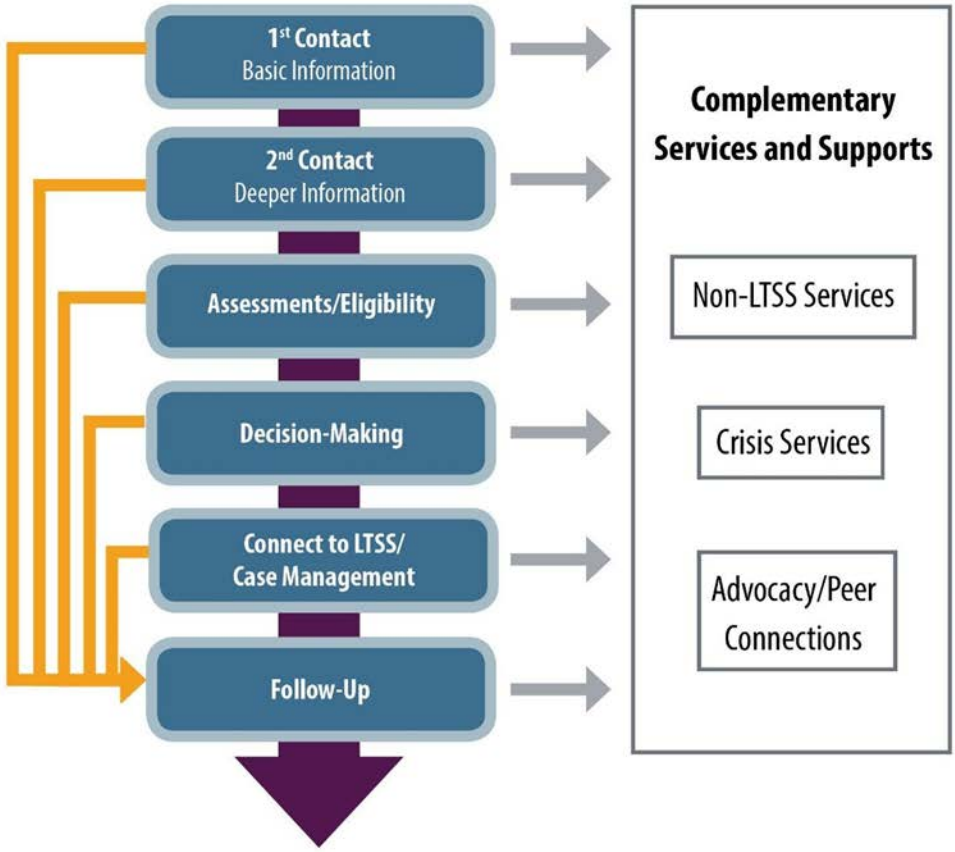
These guidelines provide a framework that ensures consistency in the quality of the counseling, but injects enough flexibility to meet the unique preferences and needs of each individual. The person-centered counseling process, illustrated in Graphic 3, was developed with these guiding principles in mind. The primary responsibility of the NWD Regional Entity is to ensure that the individual wanting to access LTSS experiences this person-centered planning process on a consistent basis.

### *First Contact – Initial Information Gathering*

A person will access the NWD system through a variety of methods, depending on where he or she is along the continuum of services and supports.

Some people in crisis may need immediate help, while others will be interested in exploring options for the future. In some cases, a caregiver or discharge planner will contact NWD on behalf of the individual needing LTSS. In other cases, the person needing LTSS will contact NWD directly. In all scenarios, the first contact will be used to gather initial information, such as demographics and contact information, and to identify any immediate needs.

*Graphic 3. Person-Centered Counseling Process*




Ideally, the first contact can be online in the form of a questionnaire or chat function, on the phone through a 1-800 number or in person at an NWD-affiliated agency. If the individual leaves a voicemail or sends an email, the NWD agency has 24 hours to respond. If the individual is in crisis or needs services outside LTSS, a referral and warm handoff will be made to the appropriate organization, such as crisis services.

Since people will be coming to the NWD with different needs, several scenarios can occur. If the individual is at high risk of placement in a hospital or long-term care facility or health and safety is at risk, the NWD process should be expedited and the person connected to available resources as soon as possible. If the person is interested in a specific service and needs no further assistance based on an initial screening, he or she may simply be provided with a referral. If the individual is stable and exploring options, a person-centered counseling session should be scheduled.

*Second Contact – Person-Centered Counseling*

The second contact is either by phone or in person, depending on the person's choice. The individual is introduced to the person-centered counselor who will guide him or her through the process. If needed, the person-centered counselor will make appropriate

referrals and warm handoffs for people in crisis or at high risk. If the individual is stable and ready, the person-centered counseling session begins.

During the session, the person-centered counselor talks with the individual about the current situation and the individual's needs and preferences.

Family, friends or caregivers identified by the individual or direct caregiver are also involved. Throughout the conversation, the person-centered counselor compiles a list of potential service options based on the information gathered and shares it in whatever format works best for the individual: in person, over the phone, through email or through a hard-copy letter.

With support from the person-centered counselor, the person decides which options to pursue. This step can happen during the person-centered counseling session or whenever the individual is ready to make a decision.

Once the individual has settled on an option(s), the person-centered counselor and the individual will create an action plan to obtain services. The person-centered counselor will then support the individual in implementing the action plan.

If the individual appears to be eligible for public programs and chooses that option, the person-centered counselor will guide him or her through a streamlined application process where financial and functional eligibility is determined. As part of the discussion of publicly funded options, the person-centered counselor will include other Medicaid eligibility options, such as the option to create a Medicaid Trust if financial assets are above the minimum allowed by Medicaid.

If the individual is pursuing private pay options, the action plan will include all information about the service provider of choice and, if the individual chooses, a warm handoff by the person-centered counselor. For individuals with private pay sources for services, NWD will charge the individual for the person-centered counseling session, including action plan development and warm handoffs. However, because research on the private pay market will be conducted after the pilot period, the process for developing an action plan template is unlikely to be fully developed when the pilot phase concludes.

*Follow-Up*

After the individual is connected to services, the person-centered counselor will conduct a follow-up appointment. The follow-up will include a phone call to ensure the individual is satisfied with supports and services, and an email with a link to an individual satisfaction survey. This will ensure the individual is connected with services and help NWD collect information to refine and improve its processes. Follow-up procedures are considered part of the person-centered counseling process.

## NWD Pilot Program

In September 2015, Colorado was awarded a three-year grant to develop a model for implementing NWD statewide by piloting regional NWD entities. LTSS entry point organizations within a self-defined geographic region are expected to collaborate in applying to serve as a NWD regional pilot site. Three to five Colorado communities will be selected by the end of 2016 as pilot sites under contract with the state. They will be used to test the regional NWD model and person-centered counseling planning process described in this section. Additionally, they will help identify best practices and barriers to developing a fully functional statewide NWD system. They will also help the Department to:

- Identify regulatory and policy barriers and create an action plan to address those barriers
- Create a financial model for regionally-based NWD networks
- Develop a toolkit that includes NWD operating protocols and training and technical assistance guidelines for implementing NWD regionally, and
- Gain insights from pilots that will help refine NWD before it is implemented on a statewide basis.

Pilot sites are expected to be comprised of the following LTSS entry point organizations:

- Area Agency on Aging (AAA)
- Aging and Disability Resources for Colorado (ADRC)
- Center for Independent Living (CIL)
- Single Entry Point (SEP)
- Community Centered Board (CCB) and
- The area county department of social or human services office (DSS)

Additionally, Community Mental Health Centers (CMHCs) or Behavioral Health Organizations (BHOs) may also be included in the network of entry point organizations if they haven strong partnerships with the LTSS entry point organizations mentioned above.

One organization from each applicant is expected to serve as the lead agency. The lead agency will be accountable to the state for ensuring the pilot carries out the six functions of an NWD system. The lead agency will also be responsible for ensuring that the pilot has effective mechanisms in place for soliciting feedback from individuals who access LTSS to help shape best practices.

The pilot sites will be selected through a competitive request for application (RFA) process. Through this process, applicants will be awarded grant funds to serve as a supplement to the applicant organizations' existing funding sources for activities related to helping a person access LTSS. A team of reviewers will score the applications to determine which applicants are selected as pilot sites. The review team will include stakeholders representing individuals accessing LTSS and family members.

The pilot sites will be expected to fulfill the six functions of a fully-functioning NWD as best they can within the current funding and regulatory environment. Achieving all aspects of an NWD system will likely require additional funding and time beyond the three-year pilot phase. For example, IT system redesign will likely occur after the conclusion of the pilot phase due to the amount of time that must be dedicated to planning, development, financing and implementation.

Establishment of the pilots will enable the Department to implement many of the action items delineated throughout this plan, including:

- Governance and Administration: Colorado can begin to establish the governance structure during the three-year pilot that is outlined in graphic 2, NWD Governance Structure. The pilot sites will serve as the NWD regional entity described in Vision and Mission Section and will have comparable responsibilities. The NWD Project Team will work closely with the governing body to monitor implementation of the pilot and make course corrections as necessary. The learning communities will be one of several opportunities for stakeholders and the pilot sites to provide input to the NWD decision-making team.
- Public Outreach and Referral: The first step to improving the referral process is strengthening relationships with referral partners. Pilot sites will be expected to build and grow their referral network while educating referring organizations on when and how to make appropriate referrals and establishing protocols with local agencies that the NWD will refer individuals for immediate or additional support. Pilot sites will collect baseline information about the existing referral process and work to standardize the referral approach.
- Person-Centered Counseling: The pilot sites will hire or train existing staff from partnering organizations to provide person-centered counseling. The person-centered counselor network will leverage existing capacity and expertise at the local level to ensure all populations are served.
- Streamlined Access to Public Programs: Pilot sites are charged with exploring creative ways to streamline access to public programs. Improved communication and collaboration across entry-point agencies conducting the functional and financial Medicaid eligibility determinations will be a first step in accelerating this process.
- Plan Performance: A Project Team from the Center on Network Science (CNS) at the University of Colorado at Denver will be hired as an evaluation contractor to complete rigorous evaluation of the pilots that will yield important information about the success and challenges of an NWD system. The NWD model will be refined based on the pilots' experience and evaluation, which will include feedback from individuals who have accessed the regional NWD system and from the referral network. The pilot program, with input from people accessing LTSS, may inform what metrics are used for evaluating the NWD system in the future.
- Communications and Marketing: The pilot program is the first step in building awareness around NWD. During the pilot period, the technical assistance

contractor, Nonprofit Impact, will be working with the pilot sites to develop, test and refine communication and marketing strategies. By the end of the pilot period, Colorado will incorporate communications and marketing strategies in the statewide NWD implementation plan.

- Stakeholder Engagement: Engaging a wide range of stakeholders at the state and regional level is a critical component for successfully implementing the pilot. The NWD Project Team and pilot sites will be expected to have a plan for keeping stakeholders meaningfully engaged throughout the pilot phase along with a plan for incorporating stakeholder feedback into the change management process and shaping the metrics for evaluating the NWD pilots.

By starting at a small scale the Department can learn from successes and make course corrections where challenges exist. By 2018, the state will be well-positioned to pursue the financing, statutory and regulatory changes necessary to implement a statewide NWD system.

### Budget

Colorado will explore options to braid all funding streams in order to create a seamless individual experience of NWD.

The NWD Project Team is exploring Medicaid funding for the current ADRC network. Should the Project Team determine how to reimburse current ADRC activities through Medicaid, this knowledge will serve as a foundation for reimbursing agencies involved in a future NWD network. The Project Team will consider options for drawing down additional Medicaid funding for LTSS access functions, including Medicaid administrative claiming and possibly obtaining a 90/10 match for developing new data systems.

Developing earned income opportunities through a fee-for-service payment model is a high priority for NWD implementation. NWD entities will make sure their outreach efforts include all potential LTSS clients, including those willing and able to privately pay. In the future, the NWD Project Team will also explore opportunities to receive reimbursement from long-term care insurance companies or businesses through Employee Assistance Programs for employees seeking LTSS information for a loved one.

### Technology and Quality

The LTSS entry point system is currently plagued with inefficient information sharing. As a result, individuals frequently make multiple phone calls to entry point organizations and repeat their stories in order to gain access to LTSS. Colorado needs an information technology (IT) system that captures and shares vital information across the broad spectrum of individuals and organizations involved in making NWD work and minimizes duplicate data gathering or referral information for individuals. It is important that individual information is collected at each step of the process and is accessible to those who need it, when they need it, including the individuals receiving services. Ideally, the

IT system would automate the business processes associated with eligibility determination that are currently manual.

Quality indicators will be developed during the pilot phase and will continue to be refined when the NWD system is fully operational. The technology platform will capture the information based on the quality indicators that will help inform ongoing improvement. These quality indicators may include satisfaction with NWD responsiveness, timeliness of eligibility determinations and other indicators in measuring the effectiveness of NWD processes. An emphasis will be placed on individual privacy and protections.

## NWD Assessment

### Introduction

Colorado is working to create a seamless entry point system for LTSS, known as a No Wrong Door system. To understand what Colorado needs to do to implement NWD, it is essential to understand where Colorado's entry point system currently stands. This assessment provides an overview of the current system and compares it to the six fully functioning Aging and Disability Resource Center (ADRC) criteria identified by the Administration for Community Living (ACL). These criteria align with the functions needed to create a NWD system.

Much of the information included in this assessment was gathered by the Colorado Health Institute and presented in "The First Step: Solving Colorado's LTSS Puzzle" (see Appendix B). The "LTSS Puzzle" was created through independent research and key informant interviews with Colorado experts as well as workers on the LTSS front lines. Each interviewee provided a look into the various silos that comprise the system. Further, as part of the NWD planning process, Nonprofit Impact conducted focus group discussions with more than 40 individuals, advocates and caregivers, as well as 27 frontline staff workers, to inform the NWD assessment and planning process. These discussions were invaluable to rounding out the NWD assessment and validating the "LTSS Puzzle." To complement the LTSS Puzzle, Appendix C provides maps for the geographic regions for each type of entry point agency operating in Colorado.

### Why Now?

Across the country, many efforts are underway to make the LTSS system more person-centered while preparing for rising demand for services. The ACL is continuing its commitment to help states redesign how people receive services. The Affordable Care Act (ACA) provides funding to pilot ideas for people who are eligible for both Medicaid and Medicare. The Veterans Administration is funding projects to provide LTSS for veterans in community-based settings. With these various initiatives and funding opportunities, states are finding innovative ways to serve people who need LTSS.

Such initiatives share a common goal: to better coordinate services and supports while reducing the burden on individuals who must navigate a complicated system during a vulnerable time in their lives. The idea is that improved coordination of LTSS will reduce duplication of efforts among publicly funded programs and community agencies, creating a better experience for individuals. While some of these principles have been around for years, they have recently reemerged with renewed energy and aligned with the Governor's priority to provide efficient, effective and elegant services across state government.

The growing demand for LTSS is driving the momentum around entry point redesign. The number of Coloradans who are 65 and older will more than double, from approximately 700,000 in 2015 to 1.7 million in 2050. Nearly 70 percent of Coloradans age 65 and older will use LTSS. Additionally, people with disabilities are living longer than previous generations, and they continue to use services and supports as they age. The current LTSS system has neither the capacity nor the sustainable funding to handle the expected influx of users. The need for an LTSS delivery system that is more efficient and individual-friendly is pressing.

In light of these trends, Colorado has begun to take action. Over the past decade, several commissions have worked to redesign the LTSS system to better serve individuals. Colorado's No Wrong Door system builds on the recommendations made in Colorado's Community Living Plan (CCLP) from July 2014 — Colorado's response to the Olmstead decision — as well as the September 2014 report by the Community Living Advisory Group (CLAG). Recommendations from CCLP and the CLAG laid the groundwork for the NWD mission and vision.

*Colorado's Community Living Plan*

Colorado's NWD project is also a key component to developing strategies and achieving goals in Colorado's Community Living Plan (CCLP), signed by the executive directors of the Colorado Department of Health Care Policy and Financing (the Department), the Colorado Department of Human Services (CDHS) and the Department of Local Affairs (DOLA) (see Appendix B). CCLP is a comprehensive approach to meeting the requirements of the U.S. Supreme Court ruling in Olmstead v. L.C., which requires people with disabilities to be served in the most integrated setting possible that is of their choice. The starting point for CCLP was the 2010 report, "Olmstead: Recommendations and Policy Options for Colorado." The final CCLP plan merged objectives from the 2010 report with new ideas and principles embraced by individual advocacy organizations and state departments. The report has key provisions directly related to the NWD project, such as identifying and supporting people in long-term care facilities who want to move to a community; preventing unnecessary placement in long-term care facilities, improving communication among LTSS agencies to ensure the

provision of accurate, timely and consistent information about service options in Colorado.

*Community Living Advisory Group*

The CLAG, the most recent commission, was established by Governor John Hickenlooper in 2012 through Executive Order D-2012-027 to recommend ways to redesign the LTSS system in Colorado. The CLAG recommendations were developed with assistance from six subcommittees, including an Entry Point/Eligibility Subcommittee and a Care Coordination Subcommittee. The recommendations emphasized the importance of creating a person-centered LTSS delivery system.

The CLAG approved a recommendation from the Entry Point/Eligibility Subcommittee to create "common entry points, where people can obtain information and assistance and be assessed for community LTSS, regardless of age or existing disability." This recommendation to build a comprehensive LTSS entry point system is the basis for the NWD mission and vision. The CLAG sent its final report to the governor in September 2014 (see Appendix B).

Colorado took a first step toward implementing these two sets of recommendations by pursuing an NWD planning grant from the ACL. The state was then awarded a three-year implementation grant to develop a model for implementing NWD statewide by piloting a series of NWD regional entities.

## NWD Assessment: Colorado's Progress Towards a Fully Functioning System

This section takes a look at Colorado's progress toward achieving the six functions of a NWD system:

- Function 1: Information, Referral and Community Awareness
- Function 2: Person-Centered Counseling
- Function 3: Streamlined Eligibility Determination for Public Programs
- Function 4: Person-Centered Transition Support
- Function 5: Individual Populations, Partnerships and Stakeholder Involvement
- Function 6: Quality Assurance and Continuous Improvement

Function 1: Information, Referral and Community Awareness

*The LTSS entry point system must serve as a highly visible and trusted place where people of all ages, disabilities and income levels turn for unbiased information on LTSS options. The entry point system must promote awareness of options available in the community and be able to link people with needed services and supports — both public and private.*

Information, Assistance and Referral System

Presently, individuals seeking LTSS must navigate a fragmented system for providing information, assistance and referrals. They typically must make multiple contacts with different agencies to get the information they need to make informed decisions about possible options available to them. Medicaid pays some organizations to provide these types of services, while others are funded through other federal, state and local resources. Furthermore, funding for information, assistance and referral activities often comes with requirements for serving only specific populations. For example, federal funding for ADRCs through the Older Americans Act and state funding from the Older Coloradans Act must be used for people age 60 years and older. However, some ADRCs also serve some younger adults with disabilities. This restriction creates a funding silo within a single organization. Essentially, Colorado has created entry point systems around funding streams and disability type rather than for the people trying to access information about LTSS options.

Myriad agencies provide information, assistance and referral services, but there is inconsistency in the quality, scope and comprehensiveness of those services. Often, agencies are limited in their capabilities to provide information, assistance and referral because of their limited training about the services and supports offered at other agencies. Different state agencies, through different funding streams, have invested in information technology (IT) systems to support this function on behalf of entry point agencies. In some cases, local agencies have invested in these technologies on their own. The various systems perpetuate the silos among agencies and the inconsistent information about possible options for individuals seeking LTSS. With the implementation of these different systems, the state is hindered in its ability to create a centralized, statewide website, to create a statewide 1-800 number and to have a shared IT platform for agencies to coordinate NWD functions. Having a shared IT platform with a 1-800 number and a statewide website allows agencies and individuals to initiate applications for and obtain information about LTSS and to share information among agencies. Having such an infrastructure reduces the burden on individuals in telling their story multiple times to different agencies, completing redundant application processes or getting lost in the system.

To illustrate the current fragmented entry point systems, the LTSS Puzzle by CHI provides a map of the existing entry point organizations in Colorado and their relationships. Colorado's current entry point agencies include:

- **Sixteen Aging and Disability Resources for Colorado (ADRCs)** provide information, assistance, and referral services, though the market penetration and quality vary. Only some of these agencies are contracted with the Department to provide entry point functions for Medicaid Home & Community-Based Services (HCBS) and nursing home admissions. As of April 2015, the Department has

contracts with most of the ADRCs to provide information about HCBS for nursing home residents who request to learn more about community-based options. In many cases, because of the funding ADRCs are run as programs of the Area Agencies on Aging.

- **Sixteen Area Agencies on Aging (AAAs)** provide information, assistance and referral for programs and services to older adults. They are funded by the state of Colorado and the Older Americans Act.
- **Nine Centers for Independent Living (CILs)** provide information and referrals, peer counseling, independent living skills and advocacy for people with disabilities. They are funded through federal grants, state money, fundraising and local governmental support.
- **Twenty four Single Entry Point (SEP)** agencies and **20 Community Centered Boards (CCBs)** also provide information, assistance and referral. However, funding varies between each agency. SEPs are access points for the majority of people with disabilities and older adults seeking HCBS and nursing home care through Medicaid and a state-funded LTSS program called Home Care Allowance. Some of these organizations are ADRCs; some are private agencies and others are integrated in the local county department of social services or human services office (DSS) which also conduct financial eligibility. CCBs are private agencies that provide access to HCBS specifically targeted to people with intellectual and developmental disabilities (I/DD) through Medicaid and the state general fund. (See Appendices A and B for more on Colorado's entry point system.)
- People with long-term behavioral health needs are often connected to services through the **17 Community Mental Health Centers (CMHCs)**, **five Behavioral Health Organizations (BHOs), substance use disorder providers** and **other service organizations**. BHOs are managed care entities that contract with local mental health centers and private providers to provide mental health support and substance use treatment for Medicaid clients. BHOs are financed through Medicaid through a capitated carve out. For clients who are not Medicaid eligible, Colorado has General Fund dollars available to cover institutional and community-based behavioral health services. A statewide behavioral health crisis hotline now serves as a new entry point for individuals and families. Many individuals are accessing services in both the Behavioral Health System and LTSS delivery system, but linkages between the two systems remain tenuous. Colorado has received a State Innovation Model (SIM) grant to integrate behavioral and physical health care.

Individuals can be further confused by fragmented responsibilities among entry point organizations. For example, each entry point has separate business processes for applications as well as intake and screening. These organizations are often disconnected from one other, making it difficult to streamline referrals. Even when an agency refers someone for help, there is often no way to share information, forcing

individuals to retell their stories. Additionally, follow-up procedures after successful referrals are inconsistent across the state, sometimes leaving individuals to navigate the system alone after they receive a referral.

Colorado has made some initial efforts to put in place the infrastructure necessary for information, referral and assistance. In some regions of the state, there are some ADRCs who have established 211 as the number to call to obtain information, referral and assistance about LTSS and in some cases, initiate intake and screening procedures for publicly funded programs. Additionally, the State Unit on Aging (SUA), Office of Community Access and Independence at the Colorado Department of Human Services (CDHS) established a statewide 1-800 number for the ADRCs to access information about LTSS. This toll-free number connects individuals to a local ADRC agency. However, it is limited exclusively to ADRCs and has not gained traction statewide.

The state has also formally acknowledged the importance of strengthening the information, assistance and referral system within CCLP. The plan highlights the importance of improving communication among agencies to ensure accurate, timely and consistent information about LTSS service options and recommends creating a statewide database of resources and programs that is searchable by individuals, families and LTSS agencies. To best support the linking of individuals with the available resources in their communities will require that the database not only identify the physical address of the agencies that are providing services, but also the service area for these agencies.

Because the state's entry point system was developed around funding streams, it is characterized by fragmentation. To better serve people trying to access LTSS as Colorado moves toward an NWD system, the current expertise of the entry point agencies can be leveraged during the pilot phase to shape the model presented in this report. This model will include a strong statewide information, assistance and referral system. By the end of the pilot phase, Colorado will have a roadmap to implementing a strong statewide information, assistance and referral system. This system will increases coordination among NWD agencies and visibility of the NWD system for all people in need of services and supports.

Community Awareness

As a result of the complex network of entry points, many people in need of LTSS do not know where to turn for information, referral and assistance. It will be crucial to develop a marketing plan that clearly informs people of all ages, disabilities and income levels about what is available both on a statewide basis as well as unique resources in their communities. Citizens need clear information on where they can go for assistance.

Some organizations already market their services to residents in their communities. However, these strategies vary in their sophistication and effectiveness. Existing marketing campaigns lack evaluation and oversight. Some marketing efforts could expand their reach and strengthen the message. Other organizations cannot afford

marketing campaigns, forcing them to rely on less sophisticated advertising. Marketing for an NWD system will require collaboration across agencies and input from individuals and frontline staff about the best ways to raise awareness in the community about the NWD system and why they would access it. Engaging marketing professionals is imperative.

A well-functioning information, assistance and referral system requires a comprehensive LTSS resource list that is regularly updated. However, organizations today use different formats for compiling resource lists. Some use web-based platforms while others use printed materials. Colorado does not have one comprehensive database of resources. And the organizations that do have resource lists struggle to maintain the accuracy of the information.

One bright spot is that Colorado has recently created a statewide behavioral health crisis hotline. The hotline is an immediate connection point for many families and individuals who are seeking help for acute behavioral health care needs. This hotline has been successful at creating awareness through its use of specific outreach efforts and ads and its use of data to evaluate the effectiveness of the efforts. The hotline is perceived as a trusted resource because of these outreach efforts and because it has accurate information and resources. The agencies in the system also hire peers so that anyone who calls can choose to talk to one. The NWD system could learn from the experience of the crisis services hotline by examining the outreach efforts used and by hiring peers as staff in the NWD system.

Function 2: Person-Centered Counseling

*Person-centered counseling is defined as the ability of the entry point system to provide one-on-one assistance and decision support to people and their family members, guardians and caregivers. The main purpose of person-centered counseling is to help people understand their needs and available resources to meet those needs and to assist them in making informed decisions about their LTSS choices.*

Within the current system, an individual seeking services will need to contact or meet with several organizations before fully learning about all possible options available. It is not uncommon that an individual or family member may enroll in a particular program by contacting one of the entry point organizations but learn about other options available through individual advocates or other families or individuals who have lived experience with LTSS. The function of person-centered counseling is to ensure that individuals learn about all of their available options and make informed decisions in accessing LTSS.

The first step in providing robust person-centered counseling is to ensure that all staff serving people in need of LTSS are well-versed in all options available to individuals. This includes hospital discharge planners and staff from the entry point organizations mentioned above. Unfortunately, there is a significant barrier to achieving this objective: Colorado's entry point organizations serve distinct populations characterized

by age, income level and disability. This situation is often dictated by an organization's funding sources because the system is built around funding streams, not people. Thus a person who receives person-centered counseling from an organization that only serves Medicaid clients might learn about some Medicaid LTSS but very little about other options. Even within the Medicaid entry point system, clients might not receive the full range of Medicaid options depending on where they receive counseling.

There are no training requirements or standards for person-centered counseling, or even to assure that people giving information understand the rules and programs. Staff at different organizations often have disparate levels and types of training. This issue creates varying approaches in providing information to individuals seeking LTSS and creates barriers to person-centered counseling. Furthermore, different organizations serve different and, in some cases, overlapping regions in Colorado, which can add to the inconsistency in an individual's experience with the LTSS system. (See Appendix C for a map of all entry point regions)

In addition, Colorado's entry point organizations do not share a common awareness of person-centered counseling. As previously mentioned, the current entry point system is comprised of multiple types of agencies. Each type of agency has developed its own business processes based on its unique regulations and local experience. Aspects of these business processes may lend themselves to person-centered counseling. For example, there are no existing standard intake and screening forms to collect an individual's information. However, Colorado is currently developing a standardized intake and screening form to use across Medicaid entry point agencies, such as SEPs and CCBs, as part of an initiative to develop a comprehensive assessment tool for Medicaid-funded LTSS. The ADRCs have developed standardized protocols for person-centered counseling. However, they are unavailable outside of the ADRC network.

What's more, entry point organizations cannot easily pass on what they know about clients because many agencies use different information management systems to capture individual information. For example, AAAs use the Social Assistance Management System (SAMS) for care management and client tracking. But SAMS does not interface with any Medicaid systems, forcing individuals to retell their stories when they go through both the AAA and a Medicaid entry point, which uses the Benefits Utilization System (BUS). (See Appendix D for an infographic of Colorado's LTSS data systems.) All of these data systems are publicly funded and require state and federal resources to be maintained.

Finally, entry point organizations do not have a uniform process to follow up on person-centered counseling to ensure that clients are able to access services.

With all of these variables, the quality of information an individual receives depends on where that individual lives, and his or her age and disability. Also, individuals who visit more than one entry point organization might have very disparate experiences and receive conflicting and varied information. To address these issues, it is vital that the state implements a strong, coordinated person-centered counseling network that helps

people learn about their options at times when it matters most. It is important that this network is available when people are making LTSS decisions, particularly in times of crisis, in planning a discharge from the hospital and in attempting to prevent unnecessary placement in long-term care facilities. For people on the waitlists for certain programs or people in life transitions, the NWD system should be able to provide comprehensive options counseling. An important feature of this network is that the person-centered counselors within the system are thoroughly trained to support a standardized, individual experience across the state. Having a person-centered counseling network supports Colorado's efforts to implement the goals of CCLP.

Function 3: Streamlined Eligibility Determination for Public Programs

*LTSS are funded by a variety of government programs administered by an array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. An entry point system must offer an NWD to all publicly funded LTSS, including Medicaid, the Older Americans Act (OAA), the Rehabilitation Services Act and other state and federal programs and services. Entry point organizations should facilitate a streamlined intake and screening and eligibility determination process for individuals accessing publicly funded LTSS.*

Individuals seeking publicly-funded LTSS must navigate multiple intake and screening application processes to access the services they need. Specifically, in the Medicaid Program, individuals must complete financial and functional eligibility determinations. County DSS determine a person's financial eligibility independent of organizations that assess the person's functional eligibility for Medicaid LTSS. Also, the regulations for completing the financial eligibility determination allow for a longer timeline for completion than the regulations overseeing the functional eligibility determination. This lack of a seamless process for eligibility determinations creates confusion for the individual applying for Medicaid LTSS and delays in eligibility determination because of miscommunication or lack of coordination between the agencies. Even within the Medicaid program, different organizations determine functional eligibility depending on an individual's type of disability. For example, a CCB determines functional eligibility for individuals with I/DD that are applying for one of the DD programs, while SEP agencies determine eligibility for individuals with other types of disabilities or people with I/DD who are applying for a non-DD program.

Additionally, the data system used in determining financial eligibility for Medicaid does not interface with the systems used for functional eligibility determination. The lack of data system integration means agencies are not automatically notified when a client receives an eligibility determination, which can result in delays in enrollment. Currently, communication between the agencies completing the financial and functional eligibility determination is manual, relying on faxes, emails and telephone calls to update each other. However, the Department is working on changes to an online communication platform for eligibility determination (PEAKPro) that will allow for bilateral

communication and information sharing among agencies that determine functional eligibility and DSS/DHS agencies at the local level that complete financial eligibility.

Colorado has in place a web-based application called PEAK, where individuals can complete a Medicaid financial application online. This same system allows for clients to complete an initial screen for LTSS functional eligibility and will generate a referral in the PEAKPro system to a SEP that will complete the intake process for Medicaid LTSS.

Colorado's Medicaid program uses a uniform tool, the ULTC 100.2, for determining functional eligibility for all individuals who are applying for Medicaid LTSS. However the ULTC 100.2 is a state-developed tool without established reliability. The individual items of the assessment only address activities of daily living (ADLs) for eligibility determinations. Because the current assessment tool lacks reliability and because training on the tool has been sporadic, agency staff members may make subjective determinations of an individual's eligibility. Anecdotally, individuals and families have expressed concerns about the inconsistency of decisions around functional eligibility determinations based on the subjectivity of the assessor.

For example, Medicaid HCBS programs require a medical professional to complete a professional medical information page (PMIP) to determine the need for LTSS and to determine if the client meets the targeting criteria for a specific HCBS program. Each program requires that the state establish targeting criteria based on the type of disability. For HCBS for the elderly, blind and people with physical disabilities (HCBS-EBD), the form does not require anything specific. For other programs, it requires physicians to restate that the client has a permanent diagnosis or disability annually. Medicaid entry point agencies spend an inordinate amount of time following up with a medical professional to complete the paperwork. To address these issues, a more comprehensive and dynamic assessment tool, currently being developed and anticipated to be piloted in 2016, could reduce the subjectivity of eligibility decisions as well as address a new approach to determine targeting criteria that is more broadly defined across disabilities and age. This may lead to the elimination or repurposing of the PMIP.

In many instances, incoming Medicaid clients who are functionally eligible may wait 45 days or longer for financial eligibility determination. At this time, counties vary widely in the time it takes to make a financial eligibility decision for LTSS programs. Entry points and county agencies do not have a consistent approach, if any, to triage clients so that those most at risk might have an expedited financial eligibility determination. Because entry point organizations are not automatically notified upon determination of financial eligibility, some have developed manual internal tracking systems to monitor applications. Many individuals that are already enrolled in Medicaid and are moving to LTSS or transitioning from long-term care facilities to community-based services are required to go through a new financial eligibility determination even though it is not necessary. In many cases, when an individual is already enrolled in Medicaid and meets the functional eligibility and targeting criteria for an LTSS program, a simple

administrative change in the financial eligibility system is all that is necessary to reflect the current program status

Even with all of the difficulties, there are processes that work well in Colorado. Some DSS/DHS agencies, which conduct the financial eligibility determinations, are also SEPs, which can improve the coordination of the financial and functional eligibility determinations. The Department has also invested resources in facilitating process improvement efforts among the counties to streamline financial eligibility determinations. The Department has provided funding to five agencies to serve as Medical Assistance (MA) sites that can complete Medicaid LTSS applications with individuals and make financial eligibility decisions on behalf of DSS/DHS agencies. One of the agencies, Colorado Access, is an MA site and a SEP agency. By having these two contracts, Colorado Access hopes to improve communication and coordination between the financial and functional eligibility determination processes.

Another promising practice in Colorado is the process used for admitting people to nursing homes. Colorado is one of the few states in the country that requires SEPs to determine eligibility for a nursing home admission. Involving the entry point agency in this process creates an opportunity for a conversation with individuals about community-based options. This opportunity could be leveraged as Colorado designs an NWD model that provides informed choices for LTSS during the pilot phase. In many cases, the SEP approves the admission for a short period of time and reassesses the individual and discusses community-based options if appropriate.

During the pilot phase, the Department and its partnering state agencies will work with the pilot sites to identify best practices in streamlining eligibility determination. It will involve the following:

- Leveraging successful practices and resources that are currently available to communities, such as the county grants available for improving partnerships and process improvement resources
- Reviewing existing regulations and contracts regarding both functional and financial eligibility determinations to find opportunities to improve alignment, coordination and communication of business processes among the impacted agencies, and
- Moving forward with improvements in the information management systems.

At different points in the pilot phase, partnering state agencies and the pilot sites (working with contractors) will solicit feedback from individuals who need to access LTSS regarding their experience in applying for publicly-funded programs. This input will help inform the changes necessary to improve eligibility determination. As the pilot phase comes to a close, Colorado will have a plan that identifies the regulatory changes, the requirements for information management systems and protocols for business processes that will support streamlined eligibility determinations.

Function 4: Person-Centered Transition Support

*To effectively deliver person-centered transition support, the entry point system must be able to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program to another. The entry point system can play a pivotal role in these transitions to ensure that people understand their options and receive LTSS in the setting that best meets their needs and preferences.*

Individuals who may need LTSS typically face three types of critical transitions:

- Transitions from one care setting to another, e.g., hospital discharge to a long-term care facility or a transition from a long-term care facility to the community;
- Transitions from one life stage to another, e.g., a youth with special health care needs or developmental disabilities may need to transition from programs for children to programs for adults; and
- Transition from one program to another, e.g., an individual may be on one LTSS program, has been on a waitlist for another program that better meets his or her needs and needs to enroll in the program that is better fit because he or she is the next person on the waitlist.

The entry point system can play a pivotal role in these transitions to ensure that people understand their options and receive LTSS in the setting that best meets their needs and preferences. However, without a clear statewide approach, relationships between entry point organizations and critical pathway providers, such as hospitals, long-term care facilities, community-based provider agencies, case management agencies and Regional Care Collaborative Organizations (RCCOs), varies widely across Colorado. Promoting formal and robust partnerships would go a long way towards meeting the objective of comprehensive and consistent person-centered transition support.

The Department supports multiple mechanisms to facilitate transitions from long-term care facilities. The Colorado Choice Transitions (CCT) initiative, supported by the federal Money Follows the Person program, is already working to support people during transitions. Under CCT, Medicaid provides transition services to individuals in long-term care facilities. In addition to CCT, Community Transition Services is a benefit of the HCBS-EBD program. These services are provided through CILs, CCBs and other community-based agencies. The Department is exploring adding a community transition services benefit to other HCBS programs available through Medicaid. Finally, the Department contracts with 13 ADRCs in Colorado to provide person-centered counseling to nursing home residents who request information about community-based services. If individuals are interested in transitioning, the ADRCs refer them to CCT or other community transition services to help coordinate a return to community living.

CCT is helping to build an infrastructure that fosters partnerships between local agencies to support transitions. Lessons learned from CCT can provide a foundation for informing how person-centered transition support can work in an NWD system.

Beyond CCT, the Denver-region AAA has partnered with hospitals to provide transition support for patients discharging from the hospital in an effort to reduce hospital readmissions. This effort, as with CCT, is currently unsustainable because it is grant-funded. To implement a fully functional NWD system, the state needs to make sustained efforts to support transitions.

Through the focus groups that Nonprofit Impact conducted during the planning phase, parents of children with disabilities particularly expressed frustration with transitions for their children who reach a certain age. In many cases, children with disabilities reach a certain age and may need to transition to new programs for adults, which have different benefits or may involve the loss of certain Medicaid benefits that the family was not prepared to lose. Additionally, parents felt that they were not always adequately prepared with transitions from secondary education to a post-secondary life that keeps the children integrated in the community, such as employment, post-secondary education or other opportunities. The NWD system needs staff who can provide person-centered counseling with the skills and expertise to help youth with disabilities and their families navigate these transitions.

To support transitions from one program to another, the agencies in the NWD system must develop business protocols that identify when individuals may have the opportunity to transition to a program that better meets their needs. The protocols must also ensure that these individuals receive information about their new options and ensure a transition without a gap in the provision of critical services. For example, there is a process in place for people who are on the waitlist for the Medicaid HCBS program for people with developmental disabilities (HCBS-DD) to enroll in the HCBS-EBD program in the meantime. However, this option is not always presented to individuals nor does an individual always meet targeting criteria for both programs.

CCLP addresses the need for transition services. The plan recommends Colorado determine ways to identify qualified people who are interested in moving from long-term care facilities and calls for a person-centered approach to meet their needs. It also recommends the development of systems and supports to avoid being readmitted to a long-term care facility when it is the individual's choice and it can be accommodated. These supports include housing and community-based services.

For example, someone who is in a nursing facility and wants to return home usually needs some extra help to make this work successfully. Similarly, if someone decides they want to move from a home to a senior community they might need assistance to make sure the new setting meets their financial, medical and social needs. There are many other moves or "transitions" one may make and the goal is to provide personalized assistance to any senior or Coloradoan with a disability during these changes.

Function 5: Individual Populations, Partnerships and Stakeholder Involvement

*Entry point systems must serve persons with all types of disabilities regardless of age and income. To achieve this outcome, a wide variety of stakeholders, including individuals, LTSS programs and providers and state agencies, must actively participate in not only designing and refining the entry point system but also in providing the services.*

Under the current entry point system, competency varies in serving all ages, types of disabilities, cultures and ethnicities. Often, organizations only serve certain populations, a niche approach that results in a series of right and wrong doors for individuals. While a few staff members at some organizations are trained in cultural and disability sensitivity, there is no requirement for such training. At this time, the Department and its partners do not have visibility on the competency of the trainers or the effectiveness of the training at a local agency level.

All of the entry point organizations have requirements through either contracts or regulations that they must form advisory councils that include individual populations and other stakeholders and form partnerships to coordinate their activities related to informing the client about possible options and to assist with enrollment in various LTSS programs. Advisory councils for all of the different entry point organizations vary significantly in structure and governance responsibilities. Moreover, this contract provision may not be strictly enforced and does not specify what level of engagement of individuals and families with lived experience is required. Very few partnerships are formalized through contracts or memorandums of understanding. The disparate advisory councils do not always bridge the service and communication gaps among organizations. Typically in rural communities, the same individuals are staffing these various councils established by the different entry point organizations, creating inefficient use of a stakeholder's time. Anecdotally, the Department has heard from stakeholders that some of these councils are unable to meaningfully engage them.

Beyond advisory groups, some of the entry points have additional requirements for engaging individuals receiving services, partners and stakeholders. For example, some organizations such as mental health centers, CILs and CCBs are required to have a certain percentage of individuals receiving services on their board of directors or their advisory councils. Every few years or annually, several entry point agencies, such as AAAs, CCBs and CILs must complete a needs assessment and a plan to identify and address needs of the people they serve in their regions. These plans require various methods for gathering input from individuals receiving services, stakeholders and partners.

At the state level, departments are beginning to work together to bridge networks and break down silos, as evidenced by the creation of CCLP and the CLAG report to the governor. Another major development was the transfer of the Division for Intellectual and Developmental Disabilities (DIDD) from the Department of Human Services to the Department. This move has led efforts to better integrate and coordinate HCBS programs and operations. State agencies are coordinating and collaborating together on shared interests and priorities that affect people who use LTSS. While coordination with the Department of Veterans Affairs (VA) and other federal programs is limited, four ADRCs are working with the VA and ACL to implement the veteran-directed HCBS program.

Function 6: Quality Assurance and Continuous Improvement

*Quality assurance and continuous improvement must be a part of every entry point system to ensure services are available, are of high quality, meet people's needs and are sustained statewide. Entry point systems should use integrated IT systems to track customers, services, performance and costs, and to continuously evaluate and improve on the results.*

Colorado faces significant challenges in constructing a standard, high-quality entry point system. Quality assurance and continuous improvement depend on established measures, defining what quality means, adequate coordination, enforcement and staff capacity as well as an integrated IT solution or interoperability to support data sharing.

Because funding varies and different state agencies have authority over different community entry point organizations, there is no overall quality improvement strategy for entry point activities. The Department oversees Medicaid, including Medicaid behavioral health, while offices within CDHS oversee state aging services, mental health and substance abuse community programs and providers and, until July 2016, vocational rehabilitation services. This means that entry point organizations are responding to different quality measurements and reporting requirements. Some streamlining of entry point efforts has already occurred within the Medicaid system when DIDD moved from CDHS to the Department.

State agencies overseeing the entry point organizations do not use a uniform set of metrics to evaluate entry point services. The metrics they do have are not linked to assessment or case management in a meaningful way. Some organizations track process measures but do not assess the impact on the individual experience. Few publicly available quality indicators on entry point providers exist.

Some LTSS organizations carry out individual satisfaction evaluations and surveys voluntarily, but the results are not collated to provide a big-picture look at how well the system is working. The Department does an annual satisfaction survey of SEPs in Colorado, although this data is not necessarily used in a meaningful way to drive quality improvement. The survey only reaches a few individuals, and the collection

methodology varies. Often the agencies being assessed are calling the individuals and asking for input. The power dynamic may be leading to inaccurate results. Moreover, metrics such as length of time between first request for assistance and date of first service are not being collected. The Department is in the process of piloting or has implemented different tools to assess the impact of community services on quality of life, but these tools do not have measures for evaluating entry point operations.

At the local level, staff capacity, which is crucial for implementing continuous improvement activities, varies across entry point organizations. Some organizations are understaffed, with large workloads and limited funding for entry point services. Anecdotally, turnover among entry point staff is high. Local organizations are largely responsible for staff training, but there is no common set of qualifications or training protocols. The lack of standardized training programs or certification may lead to significantly different experiences for individuals trying to access LTSS. The development and provision of training based on identified training needs rarely involves individuals with lived experience in accessing LTSS. These individuals, based on their experience, may be in the best position to understand what the problems are in navigating the system.

IT systems that are used to track clients within the Medicaid system are not integrated and are limited in their information sharing capabilities. Many systems are also dated and lack flexibility and interoperability. Separate systems exist for financial and functional eligibility, and only the financial system communicates with the Medicaid Management Information System (MMIS), which tracks utilization information. However, the Department is in the process of replacing its current MMIS system and the BUS (the LTSS case management software system) with an integrated information management platform. The new system is expected to launch in late 2016.

That effort will help. However, data systems used outside of Medicaid by AAAs, CILs and other agencies are also disconnected from one another and from Medicaid. Integrating these data systems will be a challenge, because many organizations have invested significant resources in their own software to track and report entry point activity.

**Summary: Assessing Colorado's Progress**

As Colorado works toward creating an NWD system of LTSS entry points, it is important to understand the current status of the LTSS entry point system.

Colorado has numerous types of LTSS entry point organizations. However, the system is uncoordinated and confusing for individuals. It is hobbled by disconnected IT systems, disparate training requirements for entry point staff, fragmented service delivery and funding that promotes the status quo.

To overcome these challenges, individuals receiving services, advocates, LTSS entry point staff, LTSS providers, state departments and other stakeholders must work collaboratively to create a system that is inclusive of all ages, disability types, income

levels and pay sources and is easy to navigate for people at vulnerable points in their lives.

## NWD Governing Body

Colorado will determine the right structure for governance as the state works towards the NWD vision. Because Colorado is committed to redesigning many aspects of the LTSS system, a governing body that oversees reform efforts as a whole is a high priority. The governing body that oversees NWD will also oversee broader LTSS reforms. State partners who led the development of this implementation plan will be part of the governing body. Those partners include the Department and CDHS. Both departments worked together in identifying strategies for fixing the state's LTSS system. Leadership from the departments will collaboratively govern the NWD system. Each member department of the governing body brings unique interests and resources to NWD and represents different populations that access LTSS. As a whole, the governing body is charged with ensuring the goals and recommendations from the CLAG and CCLP are implemented.

Throughout implementation, both departments will:

- Share their performance measures with the governing body to identify any issues that need to be addressed;
- Leverage their data systems to track and monitor the progress of the NWD system;
- Use internal resources to provide guidance to and solicit input from stakeholders as the NWD functions are implemented; and
- Use contracting and policy mechanisms within their authority to make necessary changes to ensure the success of the NWD system.

Day-to-day operational and implementation recommendations and decisions within their authority will be made by the NWD Project Team, made up of Department and CDHS staff. The Project Team will be responsible for providing regular updates to executive-level leadership at both departments. Staff will support implementation operations by participating in regular meetings to:

- Make decisions regarding operations of the pilots and future policy implications;
- Monitor NWD system implementation;
- Coordinate implementation and evaluation;
- Plan and develop pilot infrastructure and future efforts to take the model to scale; and
- Provide input throughout all stages of implementation, including the pilot phase.

Executive-level leadership will be responsible for jointly deciding to pursue policy changes and budget requests. Certain aspects of implementation may require statutory changes or budgetary actions. The departments cannot guarantee the passage of

future legislation or budget actions to fully implement all components of the NWD model.

*Colorado Department of Health Care Policy and Financing*

The Colorado Department of Health Care Policy and Financing (the Department) is the single state Medicaid agency tasked with delivering high-quality health care to the residents of Colorado through the administration of the Medicaid and Child Health Plan *Plus* programs, as well as a variety of other programs for Colorado's low-income families, older adults and persons with disabilities. The Department will serve as the lead agency on the NWD project.

The Department's Office of Community Living (OCL) was formed by executive order in July 2012 with the goal of redesigning all aspects of the state's LTSS delivery system and implementing the goals and recommendations from the CLAG and CCLP. Its primary responsibilities include developing and implementing strategies to promote self-direction and person-centered services and supports for persons with disabilities and aging Coloradans. Additionally, the OCL oversees the Department's operations for all Medicaid LTSS.

The OCL encompasses the DIDD and the Long-Term Services and Supports (LTSS) Division. DIDD manages all HCBS and state-funded programs for people with intellectual and developmental disabilities, except for one HCBS program for children in the foster care system (this program is managed by the Department of Human Services). The LTSS Division manages the HCBS programs for all other target populations, the Program for All-Inclusive Care for the Elderly (PACE) and policy for nursing facilities and intermediate care facilities for individuals with intellectual and developmental disabilities policy. The Community Options Section, within the LTSS Division, will be the lead for the NWD initiative. During the pilot phase, a project manager, policy lead and administrative assistant will support this project. Additionally, third-party consultants will be hired for technical assistance and evaluation for the selected pilot sites. Throughout the implementation process, the Community Options Section will leverage other grants, both federal and non-federal, including Money Follows the Person (MFP) and the Testing Experience and Functional Tools (TEFT) in Community-Based Long-Term Services and Supports, to further the implementation of the NWD model.

*Colorado Department of Human Services*

CDHS's Office of Behavioral Health (OBH) and the Office of Community Access and Independence (OCAI) are committed to participating in the NWD implementation process to streamline access to entry points for individuals and caregivers seeking LTSS. Additionally, the NWD initiative supports and assists in achieving CDHS's Wildly Important Goal to create choices and avenues to live and thrive in communities throughout the state.

OBH is the state's behavioral health authority. OBH is responsible for policy development, service provision and coordination, program monitoring and evaluation and administrative oversight for the public behavioral health system. OBH will collaborate in the development and implementation of the three-year plan to create linkages between the mental health system and the NWD system.

The Office of Community Access and Independence contains the Division of Aging and Adult Services, Division of Vocational Rehabilitation (DVR), Division of Regional Center Operations, Division of Veterans Community Living Centers and the Division for Disability Determination Services. The Office directs programs and facilities that assist veterans, older individuals and people with disabilities. Policy, performance management, fiscal and administrative tools and directions are provided to AAAs, 64 county departments of social services and three regional centers for people with intellectual and developmental disabilities and vocational rehabilitation.

The State Unit on Aging (SUA) is housed in the Division of Aging and Adult Services and administers the Older Americans Act, State Funding for Senior Services and the ADRC programs. The SUA has been involved during the planning grant and has participated in the regional forums to design the NWD implementation plan. Additionally, the SUA has been involved in the development of CCLP and the CLAG.

During implementation, the SUA will work with the statewide network of ADRCs to leverage Older Americans Act and State Funding for Senior Services to expand NWD. Since non-federal funds provide the majority of the money for the ADRCs, the SUA will work with HCPF to explore the use of state dollars to draw down Medicaid Administrative Claiming where appropriate. The SUA will also participate in the planning, training, and identification of community partners from the aging and disability communities.

The SUA leadership will monitor the progress of its AAA and ADRC networks relative to the implementation of the NWD system. Depending on the roles of the AAAs and the ADRCs, the SUA will provide the technical support, training and follow-up to ensure the work of the aging network supports the NWD initiative.

DVR assists persons with disabilities to succeed at work and live independently. They also administer state and federal funds for CILs in Colorado. Throughout the implementation process, DVR will work with the CILs to promote their role in the NWD system. They also serve as the Designated State Entity for the Statewide Independent Living Council (SILC). SILC and the CILs in the state develop a State Plan for Independent Living (SPIL). While DVR is located in the OCAI at the time of this report, it is relocating to the Colorado Department of Labor and Employment (CDLE) in July 2016.

**Proposed Members of the NWD Governing Body**

| Department | Office | Division |
|---|---|---|
| Colorado Department of Health Care Policy and Financing | Jed Ziegenhagen, Director, Office of Community Living | Barb Ramsey, Director, Division for Intellectual and Developmental Disabilities;<br><br>Vacant, Director, Long-Term Services and Supports Division |
| Colorado Department of Human Services | Mark Wester, Director, Office of Community Access and Independence | Mindy Kemp, Director, Division of Aging and Adult Services |
| Colorado Department of Labor and Employment (as of July 2016) | N/A | Steve Anton, Director, Division of Vocational Rehabilitation. |

## NWD Stakeholder Engagement

Both the Department and CDHS have strong stakeholder outreach efforts, as demonstrated during the initial stakeholder engagement during the NWD planning process in early 2015. Colorado used the Planning Advisory Group, comprised of 40 stakeholders, to develop this NWD implementation plan over the course of four full-day meetings. After it was developed, the implementation plan was then presented at five regional forums to gather feedback from the public. The departments plan to build on these relationships throughout implementation of NWD.

The Department, CDHS and CDLE, after DVR relocates, will engage stakeholders through in-person meetings, updates on state agency websites, conference calls, regular check-ins and a web-based frequently asked questions (FAQ) tool that will be updated as stakeholder questions are posed and answered. The Project Team may evaluate the use of social networking to communicate and engage with stakeholders. A top priority is to ensure that communications are accessible to everyone. As the lead agency, the NWD staff at the Department will have primary responsibility for distributing communications to stakeholders. During the pilot phase, the Department will have a contractor, Nonprofit Impact, to develop communication strategies to be used during the pilot phase and as Colorado moves forward with full implementation of the NWD model. To engage stakeholders, particularly individuals using the system, the NWD evaluation contractor, the Center on Network Science from the University of Colorado at Denver (CNS), will conduct focus groups within each regional site with those people who have accessed the NWD system during the pilot. This feedback will help refine the model before statewide implementation.

The NWD Project Team will create a mechanism to share implementation updates with stakeholders during the pilot phase. Updates will be disseminated to a regularly

maintained list of recipients and provided through other venues, such as pre-established stakeholder meetings and webinars. The NWD project has one project manager who is easily accessible and prepared to answer questions. Stakeholders have specifically requested that they receive updates on:

- What aspects of NWD implementation do and do not work during the pilot phase;
- New ideas that emerge from the pilot sites;
- New funding opportunities;
- New job descriptions for NWD staff;
- Individual satisfaction with the pilots;
- How the pilot staff are trained;
- How feedback from the pilot sites compares with the feedback the Planning Advisory Group gave to the Project Team; and
- The impact of NWD on individuals and service providers compared to other parts of the state.

The Project Team will partner with stakeholders throughout the NWD pilot phase. The Project Team will operate with a high level of transparency and accountability, including explaining budget constraints as they relate to implementation and the state's rationale for making decisions. Stakeholders will be engaged to:

- Work with the Project Team to develop customized messaging and tools for specific LTSS market segments;
- Provide insights about the potential implications, ripple effects and unintended consequences of NWD implementation;
- Provide feedback on what is working and what is not working during the pilot phase; and
- Assist in developing linkages to referral networks, whether they are direct (i.e. hospital discharge departments, nursing homes), indirect (i.e. the Program for All-Inclusive Care of the Elderly (PACE), RCCOs, AAAs) or customized referral organizations (i.e. schools and local nonprofits).

Stakeholders will bring diverse perspectives to the implementation process. To ensure successful NWD implementation, targeted input from individuals and organizations representing the following stakeholder groups will be essential:

- Individuals receiving services and family members: This demographic includes older adults, children with special health care needs, people with disabilities, including intellectual and developmental disabilities, people with mental illness and family members.
- Entry point agencies: These agencies will include AAAs, ADRCs, CCBs, SEPs and CILs. Individuals use these agencies to access both Medicaid and non-Medicaid LTSS.
- Referral Network: These organizations will make referrals to or receive referrals from the NWD system and include LTSS provider agencies, BHOs, hospitals,

nursing facilities, mental health centers and other community-based organizations that may encounter a potential LTSS individual.

- Individual advocacy organizations: These organizations typically represent the interests of individuals who will use and access NWD to ensure that the system is responsive to their constituents. They will include groups representing older adults, people with disabilities, people with intellectual and developmental disabilities, people with mental illness, family members, individual-led advocacy groups and disease-specific advocacy groups.
- Professional Provider Associations: These organizations represent the interest of specific types of provider agencies who may receive referrals from or make referrals to an NWD agency. Associations exist for hospitals, nursing homes, HCBS providers, home health services and other types of providers.
- Veterans Service Organizations: Organizations that provide services to veterans may include hospitals and community-based programs and providers.
- Private pay market: The Department will consider using a contractor to conduct market research of the private pay market.

## Stakeholder Group Members

| Stakeholder Types |
|---|
| Individual Advocacy Organizations |
| HCBS Providers |
| CILs |
| SEPs |
| CCBs |
| AAAs |
| ADRCs |
| Veteran Health Providers |
| Individuals and Family Members |
| Advocates |
| Nursing Facilities |
| Hospital Discharge Planners |
| CMHCs |
| BHOs |
| Home Health Care Agencies |
| County DSS |
| PACE Organizations |
| Hospice Providers |
| Medicaid Case Management Agencies (includes SEPs and CCBs) |
| RCCOs |
| Senior Health Insurance Programs who help seniors obtain information about their Medicare benefits |

## Goals and Action Items by NWD Function

## Governance and Administration

**Overall Goal:** Execute the NWD mission through collaboration and communication among three state departments - the Department, CDHS and CDLE. Create a structure will that enable decision-making and operational oversight at the state level and regional responsibility and collaboration among the NWD regional entities.

**Action Steps:**

Governance:

1. Maintain a strong NWD Project Team.
    - Define roles, responsibilities and expectations of team members.
    - Identify any representation gaps on the Project Team.
    - Recruit new members as necessary.

2. Create a governing body for NWD.
    - Develop representation requirements for the governing body that includes leadership from involved government agencies.
    - Propose members of the governing body.
    - Establish expectations for the members of the governing body.
    - Establish mechanisms to recruit and engage individuals accessing LTSS and families during the pilot phase.

3. Establish regional No Wrong Door entities.
    - Solicit stakeholder input on the boundaries for Colorado's NWD regions.
    - Finalize regions based on stakeholder feedback.
    - Solicit applications for organizations to serve as regional NWD entities.
    - Select regional NWD entities with stakeholder input.

Administration:

4. Complete necessary contracts and funding agreements with the regional entities.
    - Establish expectations for the regional entities.
    - Develop and refine contracts between the state and each regional entity.
    - Sign contracts.
    - Develop and refine contracts between regional entities and local organizations to conduct NWD functions.
    - Sign contracts.

5. Develop a toolkit for regional NWD entities.
    - Create a list of technical assistance resources, aids and materials that should be included in the NWD toolkit.

- Identify which resources exist and which will need to be created.
- Compile existing resources and develop additional resources for the toolkit.
- Refine the toolkit after the conclusion of the three-year pilot period.

6. Set up a process for stakeholders to provide meaningful input on the development of NWD.
   - Share Project Manager contact information and NWD website information with stakeholders.
   - Solicit feedback from stakeholders regarding how they would like to provide input.
   - Set up formal processes for every different stakeholder group to share input.
   - Communicate how stakeholder input was incorporated into the program.
   - Identify how stakeholders who are not paid by any agency will be reimbursed for participation if travel and time are involved.

7. Identify opportunities for improved coordination of existing public resources.
   - Map out all existing funding streams being used to complete NWD functions.
   - Identify opportunities for improved efficiencies.

8. Maximize Medicaid funding
   - Research whether there is additional Medicaid funding available for NWD.
   - Explore whether there are Medicaid funds that are not already being matched.
   - Create a plan for maximizing Medicaid funding based on this review.
   - Secure a Medicaid federal match for NWD activities associated with Medicaid LTSS enrollment.
   - Secure a federal Medicaid match for any IT systems needed to support the NWD system.

9. Provide updates to the Office of the Governor on the progress of NWD.
   - Compile annual report for the Governor's Office to share updates about NWD, including information about the program design, financing, and measurable outcomes.

**Goal #1: Establish multiple community organizational pilot sites.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Draft RFA | Project Manager | 1/2016 |

| Action Item | Responsible | Target Date |
|---|---|---|
| Obtain approval for releasing the RFA | Project Manager | 5/2016 |
| Issue RFA | Project Manager | 6/2016 |
| Convene Review Panel | Project Manager | 7/2016 |
| Evaluate proposals received | Review Panel | 8/2016 |
| Select proposals | Review Panel | 8/2016 |
| Determine final award | NWD Project Team | 9/2016 |
| Draft contracts | Project Manager | 9/2016 |
| Negotiate final terms of contract with awardees | Project Manager | 10/2016 |
| Obtain final approval of contracts | Project Manager | 11/2016 |
| Pilot sites launched | Project Manager | 1/2017 |

**Goal #2: Create an action plan to address identified policy barriers that have implications for NWD agencies.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Identify and collect sources for policy guidance related to NWD agencies | Policy Lead | 1/2017 |
| Develop a matrix that cross-walks policies across the different NWD agencies | Policy Lead | 2/2017 |
| Conduct review of existing policies and determine policy barriers incorporating pilot site experience and feedback | Policy Lead | 6/2018 |
| Complete an action plan with a timeline to implement strategies to address barriers | Policy Lead | 9/2018 |

**Goal #3: Determine the financial model along with an action plan for implementing the regional NWD system.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Secure contract for an evaluation contractor | Project Manager | 2/2016 |

| Action Item | Responsible | Target Date |
|---|---|---|
| Conduct an inventory of current funding streams for NWD agencies | Policy Lead | 3/2017 |
| Establish methodology for pilot sites to track time spent by funding stream (Medicaid vs. other funding sources) | CNS | 8/2017 |
| Track data on current and projected state spending on NWD activities | Policy Lead | 9/2017 |
| Examine operational expenses for pilot sites, including supplies, personnel, equipment, work space, etc. | Project Manager | 12/2017 |
| Develop a financial model for implementing the regional NWD system | Contractor | 9/2018 |
| Develop an action plan to implement the financial model | Contractor | 9/2018 |

**Goal #4: Establish a learning community, composed of representatives from the pilot sites, state staff and other stakeholders.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Revise scope of work and contract for Nonprofit Impact | Project Manager | 4/2016 |
| Define structure for the learning communities, determine their purpose and role in the implementation process | Project Team | 6/2016 |
| Decide on the frequency of learning community sessions to be held throughout the implementation period | Nonprofit Impact | 6/2016 |
| Establish protocols for collecting and analyzing feedback received during learning community sessions | Nonprofit Impact | 1/2017 |
| Analyze feedback and decide to modify or not modify procedures and protocols | Project Team | 3/2017 |

**Goal #5: Complete an evaluation of NWD operations during the pilot phase.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Draft scope of work and secure contract for an evaluation contractor | Project Manager | 2/2016 |

| Action Item | Responsible | Target Date |
|---|---|---|
| Define evaluation metrics | CNS | 7/2016 |
| Develop a survey to assess individual and referral source satisfaction with NWD operations | CNS | 7/2016 |
| Determine the evaluation methodology for collecting performance data related to metrics | CNS | 8/2016 |
| Develop the process for reporting procedures for pilot sites | CNS | 9/2016 |
| Determine protocols and set schedule for evaluator to conduct site visits | CNS | 9/2016 |
| Develop a process for preparing follow-up summary reports after each site visit | CNS | 9/2016 |
| Conduct site visits | CNS | 6/2017 |
| Prepare a summary report of site visits | CNS | 6/2018 |
| Determine follow-up site visit schedule for the remainder of the implementation period | CNS | 6/2018 |
| Write evaluation report | CNS | 9/2018 |
| Obtain approvals for progress and final reports by end of implementation period | Project Manager | 9/2018 |

## Public Outreach and Links to Key Referral Sources

**Overall Goal:** Establish a robust and effective referral network that will help everyone who could benefit from LTSS receive timely information about NWD. The referral network will support Coloradans who are actively seeking LTSS. It will also identify and educate residents who aren't currently exploring LTSS options, but who could benefit from them if they knew they were available.

**Action Steps:**

1. Identify opportunities for improving the existing referral network and referral process.
    - Conduct key informant interviews with community partners and individuals to better understand the current referral system.
    - Learn about existing referral relationships and referral processes as well as standards that are being implemented.
    - Explore referral networks and processes in other states.
    - Document areas where the system can be improved.

- Conduct activities, such as secret shopper activities or site visits, to document current individual/applicant experience.

2. Establish a standard referral approach that provides a common experience across agencies and regions.
    - Convene members of the existing referral network to discuss best practices as well as challenges in receiving information and making referrals.
    - Share lessons learned from other states.
    - Agree on a set of standards for referrals. Ensure that these standards provide consistency for individuals while maintaining some flexibility for organizations to provide referrals in a way that best meets the needs of individuals.
    - Implement new referral approach that incorporates best practices and individuals' needs.
    - Pilot and test before finalizing
    - Educate partners about when and in what circumstances to refer an individual to NWD.
    - Create a regional "map" that offers a visualization of the proposed NWD referral network. Update as necessary.

3. Collect data to measure the impact of the NWD's new referral process.
    - Develop metrics to be tracked on an ongoing basis. They may include:
        - ➢ An individual utilization and satisfaction survey.
        - ➢ A survey for referral network organizations.
        - ➢ A system to track where referrals are coming from and to identify how many referrals are being made by each referral organization.

4. Evaluate the new referral systems.
    - Analyze data on an ongoing basis.
    - Create useful and actionable reports based on the data.
    - Work with the pilot sites to discuss challenges, share individual satisfaction survey data and discuss any improvement steps.

**Explanation:**

Regional NWD entities will call upon all of their partners – hospitals, nursing homes, case management organizations, schools and community organizations – to develop a robust referral network. This network will help ensure that everyone who needs LTSS can access the NWD system. This process will start during the three-year pilot period and will continue throughout implementation.

Referral relationships may vary depending on the organization and each individual's needs so there will be a systematic approach when helping individuals with their unique needs. The goal is to provide a common experience across all agencies and all counties throughout the state.

The three main types of referrals are direct, indirect and custom.

*Direct Referrals*

Direct referrals occur when a referring entity contacts NWD on behalf of an individual. Such referrals are typically made by hospital discharge coordinators, nursing facility staff or county eligibility staff. Direct referral organizations often handle individuals in times of crisis or confusion.

*Indirect Referrals*

Indirect referrals typically result from informal conversations in which an individual receives information about NWD. These referrals will be made by many sources, primarily AAAs, CILs, RCCOs, advocacy groups and community members.

*Custom Referrals*

Custom referrals will be made by schools, community groups, human services organizations, homeless organizations, BHOs and other groups. Staff members will create these custom referrals after talking to individuals to learn their desired outcomes and concerns. If the client wants to immediately contact NWD, the custom referral source will provide a warm handoff. If the individual does not want a direct referral, the organization will provide information and education about the NWD process.

**Goal #1: Determine additional stakeholders who access LTSS.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Work with learning community to identify potential stakeholders to include in engagement | Project Manager | 12/2016 |

**Goal #2: Foster meaningful communication between the Department and stakeholders.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Develop communication process to engage stakeholders and communicate how feedback will be used throughout the implementation period | Project Team and Nonprofit Impact | 5/2016 |

**Goal #3: Create branding materials with learning community and stakeholders as part of the toolkit.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Work with learning community to develop a single message | Project Team and Nonprofit Impact | 12/2016 |
| Create advertising materials | Project Team and Pilot Sites | 12/2016 |
| Decide where to place advertising materials | Project Team and Pilot Sites | 1/2017 |
| Distribute materials | Project Manager and Pilot Sites | 2/2017 |
| Track which messaging reached individuals | Project Team, CNS and Pilot Sites | 12/2017 |
| Use feedback to strengthen advertising | Project Team. Nonprofit Impact and Pilot Sites | 12/2017 |
| Include materials as part of NWD toolkit | Project Manager | 9/2018 |

**Goal #4: Create workflow for referrals with pilot programs.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Identify when each referral type is necessary | Project Team and Pilot Sites | 3/2017 |
| Create uniform process for each referral type | Project Team and Pilot Sites | 4/2017 |
| Include workflow in NWD toolkit | Project Manager | 9/2018 |

## Person-Centered Counseling

**Overall Goal:** Create a person-centered planning process for accessing LTSS that recognizes the unique needs of each individual and responds to those needs in a way that honors the individual's preferences.

**Action Steps:**

1. Standardize the training process for person-centered counselors and transition coordinators.
    - Review the training and certification programs used in Colorado and in other states, such as the Alliance of Information and Referral Systems (AIRS) certification.
    - Write a report that synthesizes the findings from that review.
    - Work with NWD stakeholders to select a standard training and certification program based on the review findings.
    - Vet the proposed standards with stakeholders.
    - Develop standardized continuing education requirements for person-centered counselors.
    - Write a standard job description for person-centered counselors that clearly explains the skills, educational background and professional experience that will set them up for success.
    - Identify ways that people with disabilities and lived experience with accessing LTSS may be employed to provide person-centered counseling.
    - Develop a recruiting plan to seek and hire the most qualified person-centered counselors.

2. Establish best practices for retaining person-centered counselors.
    - Set an appropriate salary range for person-centered counselors.
    - Develop a sustainable funding plan to ensure they are appropriately compensated.
    - Identify a reasonable caseload for each person-centered counselor and communicate what that caseload is.
    - Develop an action plan for steps to take when caseloads exceed that limit.
    - Plan a semi-annual meeting to have interactive discussions with person-centered counselors about their caseloads and training requirements.
    - Agree on concrete steps for how leadership at the state and local level can further support them.

3. Create a user-friendly online platform with dedicated portals for staff, individuals and LTSS providers.
    - Establish requirements for the information management system for NWD during the pilot phase.
    - Research and compile a comprehensive database of information about NWD in Colorado, including public programs and providers.
    - Design a user-friendly online format for the information. Contract with an experienced web developer if necessary.

- Customize the system for each NWD individual, ensuring that their unique information is password-protected and available across platforms, including cell phones, tablets, laptops and home computers.
- Incorporate an initial screen for potential LTSS eligibility for publicly funded programs that can be completed online by individuals and generates referrals for eligibility determination.
- Create functionality that supports business processes associated with information and referral and person-centered counseling, such as create, edit, maintain and save individual records for each person who is helped by NWD to access LTSS.
- Test the online system on user groups representing all stakeholders to make sure that it is intuitive. Pay special attention to vulnerable individuals and those that are not computer savvy.
- Incorporate feedback from the 2015 focus groups.
- Post the system online.
- Set expectations for updates and assign the work.
- Monitor the use of the database with web-based analytics.
- Identify what systems will need to be compatible with the NWD online platform and create a plan for interoperability.
- Develop an online questionnaire for potential LTSS clients that can help them understand their eligibility for programs.

4. Implement a 1-800 number for NWD. The call center will connect individuals to entry point agency staff so that the individuals can learn about LTSS options, request information or schedule appointments for an assessment.
    - Set up a 1-800 number that is accessible to all, including non-English speakers and people with disabilities.
    - Develop job descriptions for call center staff, including a director, supervisors and staff members.
    - Develop training for call center staff and include training on cultural and disability competence and effective communication.
    - Create a manual for call center staff that includes protocols and a list of entry point resources and LTSS providers.
    - Ask regional NWD entities to work with community partners to create and maintain a region-specific resource list, which will be included and maintained in the online information management system.
    - Recruit and train call center staff.
    - Set up the infrastructure for the call centers.
    - Publicize the 1-800 number and the website through ad campaigns and information sharing through community partners.

- Explore options for sustainable funding of the 1-800 number.

5. Measure the impact of changes to the person-centered counseling process, including implementation of the NWD online portal and 1-800 number.
    - Develop a questionnaire for an individual satisfaction survey to assess whether NWD is meeting the needs of all individuals. Vet the survey with person-centered counselors, individuals, and other key stakeholders before fielding it.
    - Administer the individual satisfaction survey to each person who receives person-centered counseling. This survey will be ongoing.
    - Create an online feedback form for NWD website users.
    - Develop a phone survey for callers to NWD's 1-800 number.
    - Every three months, share feedback from the individual satisfaction survey with person-centered counselors. Discuss whether findings resonate with their experience.
    - Work with counselors to create a plan for continued improvement to counseling.

**Goal #1: Develop an initial toolkit of NWD person-centered counseling operations for pilot sites.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Revise scope of work and contract for Nonprofit Impact | Project Manager | 4/2016 |
| Brainstorm and prioritize possible tools | Project Team and Nonprofit Impact | 7/2016 |
| Establish stakeholder workgroups to assist in developing tools | Project Manager | 7/2016 |
| Draft tools with stakeholders | Nonprofit Impact | 7/2016 |
| Review and approve toolkit products that were developed with stakeholders | Project Team | 8/2016 |
| Obtain approval for releasing the toolkit | Project Manager | 8/2016 |
| Release the initial toolkit | Project Manager | 9/2016 |
| Establish the change management process for amending the toolkit and for retraining of pilot sites | Nonprofit Impact | 9/2016 |
| Determine the process for soliciting ongoing feedback on toolkit from pilot sites | Nonprofit Impact | 9/2016 |

| Action Item | Responsible | Target Date |
|---|---|---|
| Finalize toolkit of NWD operations | Nonprofit Impact | 9/2018 |
| Obtain approvals for final revisions from leadership at departments | Project Manager | 9/2018 |
| Develop a template for regional contracts going forward | Project Manager | 9/2018 |

**Goal #2: Create satisfaction surveys for individuals and person-centered counselors.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Engage stakeholders to identify appropriate measures to include in satisfaction surveys. | CNS | 6/2016 |
| Develop survey instruments. | CNS | 6/2016 |
| Create protocols for administering surveys. | Project Manager and CNS | 6/2016 |
| Capture necessary information from surveys to refine quality of NWD experience and address issues as they arise. | CNS | 6/2018 |

## Streamlined Access to Public Programs

**Overall Goal:** Improve access to public LTSS programs for all eligible Coloradans by streamlining the eligibility determination process.

**Action Steps:**

1. Develop a robust and efficient IT system that tracks eligibility determinations and documents system performance while reducing duplication of processes.
    - With stakeholders, identify the most important elements of the IT system.
    - Identify evaluation metrics to ensure that the new IT system is able to support quality improvement efforts. Vet metrics with stakeholders.
    - Set budget and interim and final deadlines for system development.
    - Contract with an IT firm to develop and maintain the new IT system.
    - Conduct intermediate and final testing of new IT system.
    - Ensure that the new system will be able to share information with IT systems used for other public programs, such as PEAK.
    - Evaluate the impact of the system, both qualitatively with user input and quantitatively with metrics.

2. Braid public funding streams to pay for streamlined access functions.
    - Clearly quantify existing funding for streamlined access and identify opportunities for maximizing public funding.
    - Identify potential new funding streams.
    - Research financial models being used by other states that braid funding streams for streamlined access to LTSS.
    - Synthesize the information.
    - Decide on a sustainable funding model.

3. Educate person-centered counselors about their role as the primary contact in the new streamlined eligibility process.
    - Develop training materials for person-centered counselors that describe their role in the streamlined functional and financial eligibility process.
    - Create the expectation that each person-centered counselor will conduct functional and financial assessments to determine Medicaid eligibility.
    - Establish the process in which person-centered counselors make a warm handoff of Medicaid enrollees to the appropriate case management agency.
    - If the individual is not eligible for Medicaid, review alternate options.
    - Train person-centered counselors to help individuals navigate the eligibility process for other public programs, including Older Americans Act programs, veteran benefits and State Funded Senior Services.

4. Continually evaluate the new streamlined access process.
    - Using feedback from stakeholder forums, CNS and the NWD Project Team will develop metrics to evaluate the following during the pilot phase:
        - ➢ Individual satisfaction with eligibility determination process.
        - ➢ Maximization of funding streams.
        - ➢ Regulatory barriers to a streamlined eligibility process.
        - ➢ Number of Coloradans who are eligible but not enrolled in LTSS programs.
    - Vet metrics with stakeholders and governing body.
    - Finalize the evaluation plan, including metrics and the schedule of data collection.
    - CNS will collect and analyze data.
    - Conduct semi-annual meetings with pilot sites to discuss findings and opportunities for programmatic improvements.

**Goal #1: Identify barriers to streamlined access.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Determine if Medicaid funds can be leveraged for funding NWD system | Project Manager | 9/2016 |
| If Medicaid funds can be leveraged, determine how | Project Manager and Policy Lead | 12/2016 |
| Organize policies by authority (i.e. state statute, federal regulations, etc.) and look for policies that can easily be adjusted | Policy Lead | 12/2016 |
| Develop matrix that crosswalks funding streams across NWD agencies | Policy Lead | 5/2017 |
| Identify potential policy barriers to implementing a fully functional NWD system | Policy Lead | 10/2017 |
| Identify strategies to mitigate or eliminate policy barriers | Policy Lead | 4/2018 |

**Goal #2: Evaluate pay source processes.**

| Action Item | Responsible | Target Date |
|---|---|---|
| Develop reporting protocols for the pilot sites to report financial programmatic data | CNS | 9/2016 |
| Conduct market research of the private pay market | Contractor | 9/2017 |
| Conduct a comparative financial analysis of other states that have implemented an NWD System | CNS | 3/2018 |
| Develop resource allocation methodology to allocate expenses by funding stream | Contractor | 4/2018 |

## Overall NWD Plan Performance

**Overall Goal:** Monitor and evaluate NWD implementation to identify and correct any issues that arise, keep the project on task and ultimately ensure that each eligible Coloradan receives the best service possible.

**Action Steps:**

1. Hire an evaluation contractor.
    - Develop expectations for the contractor.
    - Choose best applicant.
    - Set budget as well as interim and final deadlines.

2. Develop an evaluation plan, including a Quality Assurance Program.
    - Empower CNS to lead this work in collaboration with the NWD Project Team and the governing body.
    - Collaborate with evaluator to establish evaluation question(s).
    - Identify data that are already being collected in order to build NWD evaluation metrics from existing datasets.
    - Identify new data that will need to be collected to answer research question(s).
    - Compile a list of plan performance measures. Metrics should measure both the individual and staff experience of NWD.
    - Vet the metrics with stakeholders.
    - Develop methods for collecting data to support the performance metrics and analyzing the findings.
    - Review and approve the final evaluation plan.

3. Collect and analyze performance data.
    - Ensure that CNS compiles relevant data that has already been collected by entry point agencies and LTSS providers.
    - Collect additional data.
    - Conduct focus groups and key informant interviews.
    - Synthesize qualitative and quantitative data.
    - Publish summary report of findings that highlights successes and areas for improvement. Develop recommendations for programmatic changes based on evaluation findings.
    - Compile evaluation findings as specified in sections public outreach and links to key referrals, person-centered counseling, and streamlined access to public programs in aggregated evaluation report.
    - Present findings to Project Team and governing body.

4. Refine the NWD system as needed.
    - Hold regular meetings with the NWD Project Team, CNS and the governing body to discuss any necessary course corrections. When necessary, include impacted stakeholders in meetings.
    - Update and refine the toolkit after the pilot period.
    - The governing body will be responsible for making final decisions on refining systems as problems are identified.

## NWD Communications and Marketing Plan

**Overall Goal:** Bring all eligible individuals into the system by building awareness of NWD through an effective communications plan.

**Action Steps:**

1. Identify target markets for the NWD system.
    - During the pilot period, identify target markets for NWD.
    - Identify best strategies for outreach to these markets.
    - Develop messaging around each target market.
    - Engage stakeholders throughout the process to test the strategies.

2. Develop written materials

*Overall Strategy*

Building awareness of NWD will be key to bringing individuals into the system. NWD will leverage community resources and use referral partners as sources to provide information to individuals. A broad public outreach campaign will focus on NWD's offerings.

The NWD planning process identified important segments of Colorado's population that are likely to access NWD. These individuals and other individuals who can benefit from NWD will be targeted.

*Marketing Strategy*

Public relations and awareness campaigns will target select groups and locations, with the goal of reaching people most likely to need NWD services. These efforts will include a widespread message to create awareness of NWD, information on its programs and information on how people can connect.

Individuals will be able to access informational materials when visiting local organizations that work with NWD and other LTSS organizations. This outreach method will allow individuals to get quality advice from trusted sources, not just generic advertising material, and leverage existing resources to build brand awareness.

*Target Markets*

Identifying who will use NWD and why will be an important step in creating brand awareness. The Planning Advisory Group identified common traits of potential NWD individuals. When performing outreach, NWD should identify people who want independence, who want assistance caring for themselves or a loved one, who want help in maintaining or improving health and who need answers to questions about LTSS. These traits cross genders, incomes, ages and disabilities. Because these traits

are so broad, it will also be important to recognize key points in life where NWD and LTSS information can help set the stage for success.

Four major groups of Coloradans comprise the target markets for NWD:

People Looking to Maintain the Status Quo

These are people who want to maintain their current situation or level of independence. They want to stay in their homes and communities and avoid nursing homes and hospitalization. These people may need more, or different, services than they already receive. Barriers to accessing services include a loss of consistency, either in their lives or the services they receive, feelings of isolation, difficulty dealing with a complex health system and trusting that their interests will be foremost.

People in Transition

These are people who are moving between housing, providers or health programs. They want to improve their situation and may need help managing change. For example, someone turning 18 will need to transition to a public program for adults. A patient discharged from a hospital may face relocation to a community-based setting or a nursing home. A nursing home resident may indicate they wish to speak with someone about community-based options.

People in this segment can face challenges beyond health struggles. Vulnerability during crisis situations and relocation can make navigating a complex health system even more difficult. Transitions can occur quickly, leaving little time for counselors to learn what the individual wants. When that happens, individuals may become distrustful and wonder whether their needs will be met. To avoid these problems, it is important that people in transition learn about their options for getting care and services before a crisis.

People at Risk

These are people who are at risk of physical injury or are on the verge of returning to a nursing facility or hospital. They often avoid services because they perceive them as a loss of independence. These individuals are able to manage their days but are often at greater risk for crisis. It can be a challenge to reach this population because they often do not know they are eligible for more services or are unaware that a worsening condition requires additional supports. Many preventable injuries occur among this population.

Within this segment, some people want more services and others avoid them. People in the first group are seeking stability by accessing services and supports because of a worsening condition or a near-crisis. People in the second group are usually wholly unaware that they need assistance, leaving them at risk.

People Who Are Unaware

These are people do not know about LTSS or NWD and are unaware of the services that may be available to them. These people may have had little to no experience with LTSS. In other instances, people haven not sought information about services because of cultural or family aversion to accepting public assistance.

These individuals may want information to aid in crisis management and looming situations. They may also be interested in learning what options are best for them based on their current or future health concerns, or they may simply want to find out what is possible through NWD.

Untapped Markets

According to the most recent US Census data, 590,159 Coloradans indicated that they have some level of disability. However, only a small fraction of these people are currently utilizing publicly funded LTSS programs, indicating there is a largely untapped market of people in need of these services. In addition to people who are unaware, this market is comprised of people who are potentially ineligible for publicly-funded LTSS and people with private pay sources. NWD presents a new opportunity for the Project Team to determine how to tap into this market.

| **NWD Marketing Strategies** | | **Target Markets** | | | |
|---|---|---|---|---|---|
| | | Maintain | Transition | At Risk | Unaware |
| Design NWD with individuals in mind | | X | X | X | X |
| Statewide public relations/awareness building campaign | | X | | X | X |
| Education and ongoing communication | Agency / direct referral | | | X | |
| | Customized / Indirect referral | | X | | |
| Connect with individuals where they are in the community | | X | | X | X |

## Conclusion

The problems with Colorado's LTSS entry point system have been identified. Entry point organizations currently operate with poor communication between agencies. The system is based largely on funding streams instead of individual needs. Individuals are often forced to retell their stories as they navigate the LTSS system at a difficult point in their lives.

Fortunately, efforts are underway to address these issues. Through the CLAG and CCLP the framework was introduced for creating a true NWD system that responds to the needs of all individuals, regardless of age, disability or pay source. This system will carry out the six functions of a fully functioning NWD system. The Office of Community Living at the Department will incorporate NWD implementation into its broader LTSS reform efforts. Partners at CDHS and CDLE will provide additional support. All impacted departments built on their extensive stakeholder networks to develop the implementation plan and will continue to rely on stakeholder input throughout the implementation process.

Now that Colorado has received an implementation grant, the next step is to create three to five regional NWD pilots. The state will use the pilots to determine how to develop a fully functioning statewide NWD system. This work includes developing a financial model for implementing NWD regionally, identifying regulatory and policy barriers along with an action plan to address these barriers and developing a toolkit of job descriptions, operational protocols and decision support tools for regional implementation.

Due to limited time and funding, some of the larger components of implementation will have to wait until after the pilot phase. These components include an NWD website, a 1-800 number and an IT system that captures and shares vital information to all relevant organizations in the NWD system. There will be an ongoing marketing campaign throughout implementation to build awareness of NWD and to reach out to all demographics that are likely to access NWD.

Whether it is during implementation or once the system is up and running, a key principle of NWD is to keep the individuals in the driver's seat and to ensure their goals and needs are met. A standardized, consistent process will be in place to gather initial information during an individual's first contact with the system and then for person-centered counselors to collect in-depth information and a discussion of available options through additional contact. Once the individual is determined to be eligible for LTSS, the individual will have complete authority over which options to pursue. Once the individual is connected to services and supports, the person-centered counselor will conduct a follow up appointment to ensure the individual is satisfied with them.

While Colorado has a rich history of providing a multitude of LTSS options, particularly community-based options, the current system in place to access LTSS is difficult to navigate from the perspective of the individual who needs LTSS. At the end of the pilot

phase, funded through a grant from ACL, Colorado will have an action plan to fully implement the NWD model statewide. This model will improve the overall individual experience for accessing LTSS and maximize the federal match through Medicaid and other funding streams. The action plan will include steps to take to secure financing for the NWD system, requirements for an information management platform to support the NWD system and a 1-800 number, training and qualifications for person-centered counselors and transition coordinators and actions necessary to modify existing statutes and regulations to enable NWD. Fully implementing the NWD system statewide will align with the Governor's call for making government more efficient, effective and elegant and will support Coloradoans to make informed decisions about LTSS they may need to live their lives with dignity and respect.

# Appendix A

**Criteria of Fully Functioning Aging and Disability Resource Centers**

## Criteria of Fully Functioning Aging and Disability Resource Centers

## March 2012

These criteria were developed to assist states and stakeholders to measure and assess state progress toward developing fully functioning Aging and Disability Resource Centers (ADRCs), sometimes referred to as "single entry point" or "no wrong door" systems for long term services and supports. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. The term "ADRC" in this document may be interpreted to represent one organization in each community, a network of operating organizations or operating partners in each community, or a combination of state level and local level organizations operating in partnership to serve the entire state. Metrics that should be interpreted or applied differently to different types of ADRC models are noted.

If there is one a single organization designated as the ADRC and serving as the single entry point in a designated area, that one organization must provide or contract with others to provide all the ADRC functions for all populations. If there are multiple organizations designated as ADRC operating partners providing multiple entry points in a designated area, each organization does not necessarily need to perform every function for all populations. It is the combination of the organizations' highly coordinated efforts which results in a fully-functional ADRC.

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| **Information, Referral and Awareness** | The *Information, Referral and Awareness* function of an ADRC is defined by the ADRC's ability to serve as a highly visible and trusted place where people of all ages, disabilities and income levels know they can turn for objective and unbiased information on the full range of long-term service and support options. It is also defined by its ability to promote awareness of the various options that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to plan ahead for their long-term needs.<br><br>Finally, ADRCs should have the capacity to link individuals with needed services and supports – both public and private - through appropriate referrals to other agencies and organizations. | <u>Outreach and Marketing</u><br>• ADRC has a proven outreach and marketing plan focused on establishing operating organizations as highly visible and trusted places where people can turn for the full range of long-term support options as well as raising awareness in the community about long term service and support options. The outreach and marketing plan includes:<br>1. Consideration of all the populations they serve including different age groups, people with different types of disabilities, culturally diverse groups, underserved and unserved populations, individuals at risk of nursing home placement, family caregivers and professionals;<br>2. A strategy to assess the effectiveness of the outreach and marketing activities; and<br>3. A feedback loop to modify activities as needed.<br>• ADRC actively markets to and serves private pay individuals in |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | | addition to those that require public assistance.<br><br><u>Information and Referral</u><br><br>• ADRC uses systematic processes across all operating organizations to provide information and referral/ assistance.<br><br>• ADRC consistently conducts follow-up with individuals receiving I&R/A to determine whether more assistance is needed.<br><br>• Whether the ADRC has single or multiple operating organizations in the service area, all organizations use the same comprehensive resource database with information about the range of long term supports and resources in the service area and:<br><br>1. A system is in place for updating and ensuring the accuracy of the information provided;<br><br>2. Resources in the database conform to established inclusion/exclusion policies; these policies specifically address inclusion of resources and providers for private paying individuals and families; and<br><br>3. The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. |
| **Options Counseling** | The Options Counseling function is defined by the ADRC's ability to provide person-centered one-on-one assistance and decision support to individuals and others they may wish to include in the process such as family members and/or caregivers/support persons. The main purpose of Options Counseling is to help individuals understand and assess their situation, assist them in making informed decisions about long-term service and support choices in the context | <u>Options Counseling</u><br><br>• Standards and protocols are in place that define what options counseling entails and who will be offered options counseling based on draft national Options Counseling standards. At a minimum, this will include any individual who requests it and individuals who go through a comprehensive assessment. Options Counseling should be incorporated into all state and local rebalancing efforts, systems integration activities, transition supports activities, and participant-directed programs. |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | of their preferences, strengths, and values.<br><br>Options Counseling also entails working with individuals to develop action plans and, if requested, arranging for the delivery of services and supports, including hiring and supervising their own direct service workers. Individuals and families who receive options counseling should be able to make service and support choices that optimally meet their needs and preferences, and use their own personal and financial resources more efficiently and more effectively. | • ADRC has the capability, through one or multiple operating organizations, to provide objective, accurate and comprehensive long term support options counseling to individuals of all income levels and with all types of disabilities.<br><br>• All ADRC operating organizations that serve as entry points for individuals use standard intake and screening instruments.<br><br>• Options counseling sessions are conducted by staff trained and qualified to provide objective, person-centered assistance and decision support to individuals, as evidenced by certification, minimum qualifications and/or training/cross-training practices.<br><br>• ADRC provides intensive support to individuals in short-term crisis situations until long term support arrangements have been made.<br><br>• ADRC consistently conducts follow-up with individuals receiving options counseling to determine the outcome and whether more assistance is needed.<br><br>• ADRC provides individuals and families with assistance in planning for future long term support and service needs directly or contractually by staff that possess specific skills related to LTSS needs planning and financial counseling. |
| **Streamlined Eligibility Determination for Public Programs** | Long-term services and supports are funded by a variety of different government programs administered by a wide array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. The Streamlined Eligibility Determinations for Public Programs component of an ADRC is defined by its ability to serve as a single point of entry/no wrong door, to all publicly funded long-term supports, including those funded by Medicaid, the Older Americans Act (OAA), the | <u>Intake and Screening</u><br><br>• ADRC has a standardized process for helping individuals access all publicly-funded long term services and supports programs available in the state.<br><br>• In multiple entry point systems, the intake and screening process is coordinated and standardized across operating organizations and key partners so that individuals experience the same process wherever they enter the system.<br><br><u>Financial and Functional Eligibility Processes</u> |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | Rehabilitation Services Act, and other state and federal programs and services. This requires ADRCs to have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to performing the following administrative functions for all public programs (including both home and community-based services programs and institutional-based programs):<br>• consumer intake<br>• screening<br>• assessing an individual's needs<br>• determining programmatic, functional/clinical and financial eligibility<br>• developing service/care plans<br>• ensuring that people receive the services for which they are eligible<br>The goal is to create a process that is both administratively efficient and seamless for individuals regardless of which program they end of being eligible for or the types of services they receive. | • Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by the ADRC, so individuals experience it all as one process.<br>• ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk.<br>• Staff located on-site within the ADRC conduct level of care assessments that are used for determining functional/clinical eligibility, or ADRC has a formal process in place (e.g. MOUs, written protocols) for seamlessly referring individuals to the agency that conducts level of care assessments.<br>• ADRC staff assist individuals as needed with initial steps in completing the application (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews).<br>• Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of applicants.<br><u>Tracking Eligibility Status</u><br>• ADRC is able to track individuals' eligibility status throughout the process of eligibility determination and redetermination.<br>• ADRC is routinely informed of individuals who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals to provide further options counseling.<br>• In localities where waiting lists for public LTC programs or services exist, the ADRC is routinely informed of individuals who |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | | are on the waiting list and conducts follow-up with those individuals. |
| **Person-Centered Transition Support** | The Person-Centered Transitions component is defined by an ADRC's ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person ends up in a nursing home or is transitioned back to their own home.<br><br>The ADRC can play a pivotal role in these transitions to ensure that people understand their options and receive long term services and supports in the setting that best meet their individual needs and preferences, which is often in their own homes. ADRC staff can be present at these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and to help them quickly arrange for the supports and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a nursing home or other institution. They can also break the cycle of readmission to the hospital that often occurs when an individual with chronic illness is discharged to the community | • ADRC has formal agreements with local critical pathway providers such as hospitals, physician's offices, nursing homes, rehabilitation centers, other community residential housing and service providers, and ICFs-MR that include:<br>(1) An established process for identifying individuals and their caregivers who may need transition support services;<br>(2) Protocols for referring individuals to the ADRC for transition support and other services; and<br>(3) Regular training for facility administrators and discharge planners about the ADRC and any protocols and formal processes that are in place between the ADRC and their respective organizations.<br>• ADRC works with the State Medicaid Agency to serve as Local Contact Agencies (LCAs) to provide transition services for institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment. |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | without the social services and supports they need. | |
| **Consumer Populations, Partnerships and Stakeholder Involvement** | Many ADRCs started out serving older adults and one other target population, such as adults with physical disabilities, intellectual or developmental disabilities, or mental illness. ADRCs should work toward the goal of serving persons with all types of disabilities regardless of age.<br><br>To be truly person-centered, ADRCs must meaningfully involve stakeholders and individuals they serve in planning, implementation and quality assurance/quality improvement activities.<br><br>In order to function efficiently and serve as the single entry point / no wrong door for the full array of long term service and support programs in the state, ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving people with disabilities. Examples of other important state partnerships could include the State Health Insurance Assistance Program (SHIP), Brain Injury Associations, and the State Mental Health Planning Councils. ADRCs should be operated by or establish strong local partnerships with Area Agencies on Aging, Centers for Independent Living, and other community-based organizations instrumental to ADRC activities such as Departments of Veterans Affairs, Adult Protective Services, Information and Referral/2- | <u>Consumer Populations</u><br>• ADRC serves individuals with all types of disabilities, either through a single operating organization or through close coordination with multiple operating organizations.<br>• ADRC staff demonstrates competencies relating to serving people of all ages and types of disabilities and their families, including people with dementia and people of different cultures and ethnicities.<br>• There are formal mechanisms for involving consumers on state/local ADRC advisory boards or governing committee and in planning, implementation and evaluation activities.<br><u>Medicaid</u><br>• ADRC has formal partnership agreements at the local level (or at the state level if applicable across all sites) with Medicaid agency(ies) that describe explicitly the role of each partner in the eligibility determination process and information sharing policies.<br>• ADRC staff are involved as partners or key advisors in other state long term support and service system reform initiatives (e.g. Money Follows the Person initiatives)<br><u>Aging and Disability Partners</u><br>• In multiple entry point systems, the ADRC has formal service standards, protocols for information sharing, and cross-training across all ADRC operating organizations.<br>• In single entry point systems, there is strong collaboration, including formal agreements, at the state and local levels between the ADRC and all other critical aging and disability agencies and service organizations serving the same area that |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | 1-1 programs, Benefit Outreach and Enrollment Centers, One Stop Employment Centers, Vocational Rehabilitation, Developmental Disabilities Councils, Long-Term Care Ombudsman programs, Alzheimer's disease programs, housing agencies, and transportation authorities. | are not ADRC operating organizations.<br><u>Other Partners and Stakeholders</u><br>• State Health Insurance Assistance Program (SHIP), Adult Protective Services, and 2-1-1 programs are operated by the ADRC, or there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals between the ADRC and these three programs.<br>• ADRC operating organizations (e.g., AAA or SUA) have a Provider Agreement with a VA Medical Center to provide Veteran-Directed HCBS or there is a formal agreement at the state or local level between the ADRC and VA system outlining a protocol for linking Veterans with needed long term services and supports and making mutual referrals.<br>• There is evidence of strong collaboration with other programs and services instrumental to ADRC activities. |
| **Quality Assurance and Continuous Improvement** | Quality Assurance and Continuous Improvement are a part of every ADRC system to ensure services are available, are of high quality and meet the needs of individuals, and are sustained statewide. They ensure that services adhere to the highest standard, as well as ensure the public and private investments in ADRCs are producing measurable results.<br>ADRCs should be using electronic information systems to track their customers, services, performance and costs, and to continuously evaluate and improve on the results of the ADRC services that are provided to individuals and their families, as well as to other organizations in the community. This may include linkages with other data systems, such | <u>Sustainability</u><br>• State operates in accordance with a formal written plan (e.g., the ADRC 5-Year Plan) that details how ADRC services will be made available statewide and sustained through a diverse set of public and private funding sources.<br><u>Management and Staffing</u><br>• In multiple entry points systems, the ADRC has one overall coordinator or manager with sufficient authority to maintain quality processes across operating organizations.<br>• ADRC has adequate staff capacity to assist individuals in a timely manner with long term support requests and referrals, including referrals from critical pathway providers.<br><u>IT/MIS</u><br>• ADRC operating organizations use management information |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | as Medicaid information systems and electronic health records.<br><br>The Quality Assurance and Continuous Improvement component of an ADRC should also involve formal processes for getting input and feedback from individuals and their families on the ADRC's operations, services used, and on-going development. Every ADRC should have measurable performance goals and indicators related to its visibility, trust, ease of access, responsiveness, efficiency and effectiveness. | systems that support all program functions.<br>• ADRC has established an efficient process for sharing resource and client information electronically across ADRC operating organizations and with external entities, as needed, from intake to service delivery.<br><br><u>Continuous Improvement</u><br>• ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered such as consumer satisfaction evaluations and surveys.<br>• ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances.<br><br><u>Performance Tracking</u><br>• At the local or programmatic level, ADRC routinely tracks service delivery and individual outcomes and can demonstrate:<br>1. That the ADRC serves people in different age groups, with different types of disabilities and income levels in proportions that reflect their relative representation in the community;<br>2. That options counseling provided enables people to make informed, cost-effective decisions about long-term services and supports;<br>3. The number of individuals diverted from nursing home/institutional settings; and<br>4. The number of individuals successfully transitioning from institutional settings (i.e. number of people assisted through formal coordinated or evidence- |

| Program Component / Core Function | Definition and Purpose | Recommended Criteria / Metrics |
|---|---|---|
| | | based transitions programs).<br>• States evaluate their ADRCs' overall impact in the following areas:<br>1. Reduction in the average time from first contact to eligibility determination (both functional/clinical and financial) for publicly funded home and community-based services;<br>2. Impact on the use of home and community based services vs. institutional services; and<br>3. Documentation of the cost impact to public programs, including Medicaid. |

# Appendix B

**Links To Supporting Documents**

**Colorado Health Institute, The First Step: Fixing Colorado's System of Long-Term Services and Supports**

This September 2013 report provides the framework for understanding why Colorado needs a No Wrong Door system. It explains how Colorado's LTSS puzzle was developed over the years and its implications for clients. It also discusses some of the state's efforts to redesign the fragmented LTSS system.

The report can be found at http://www.coloradohealthinstitute.org/uploads/downloads/LTSS_First_Step_publication_for_web.pdf.

**Colorado's Community Living Plan, Colorado's Response to the Olmstead Decision**

This July 2014 report details Colorado's efforts to ensure that people with disabilities and older adults have the resources they need to live independent lives.
The report can be found at https://www.colorado.gov/pacific/sites/default/files/Colorado%20Community%20Living%20Plan-July%202014.pdf.

**Community Living Advisory Group**

The Community Living Advisory Group considered and recommended changes to the Long-term Services and Supports (LTSS) delivery system. The Advisory Group worked closely with the Colorado Commission on Aging and other planning groups to carry out this work and build on previous discussions and recommendations. Per Executive Order, the Advisory Group worked from August 2012 to September 2014 developing its recommendations, which can be found on our website: https://www.colorado.gov/pacific/hcpf/community-living-advisory-group-report

# Appendix C

## Maps of Entry Point Agencies in Colorado

# STATE OF COLORADO AREA AGENCIES ON AGING (AAA)

**Region 1 Northeastern Colorado Assoc. of Local Gov.**

Robert (Bob) Held, AAA Director
970.867.9409
Logan, Morgan, Phillips, Sedgwick, Washington, Yuma

**Region 2A Larimer County Office on Aging**

Lynda Meyer, AAA Director
970.498.7750
Larimer

**Region 2B Weld County AAA**

Eva Jewell, AAA Director
970.346.6950
Weld

**Region 3A DRCOG AAA**

Jayla Sanchez-Warren, AAA Director
303.455.1000
Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Gilpin, Jefferson

**Region 3B Boulder County Area Agency on Aging**

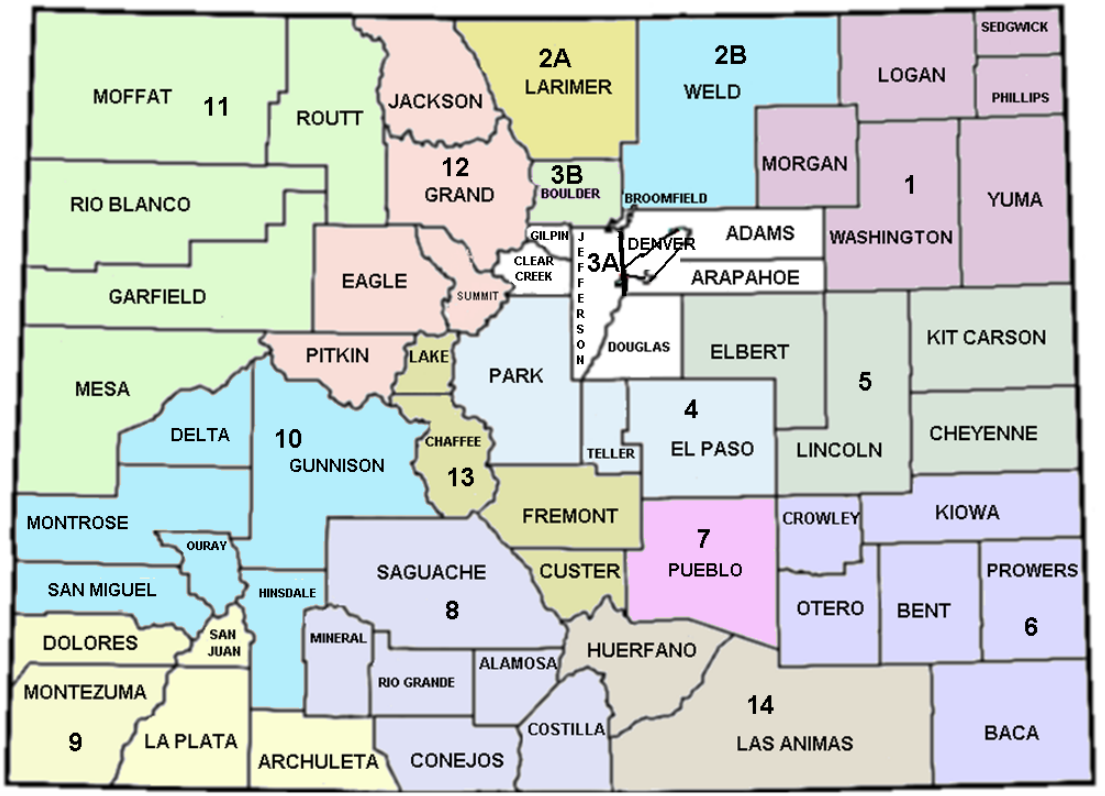
Sherry Leach, AAA Director
303.441.3570
Boulder

**Region 4 PPACG Area Agency on Aging**

Joe Urban, AAA Director
719.471.2096
El Paso, Park, Teller

**Region 5 East Central Council of Governments**

Terry Baylie, AAA Director
719.348.5562 Ext. 5
Cheyenne, Elbert, Kit Carson, Lincoln




**Region 6 Lower Arkansas Valley AAA**

Melody Dowell, AAA Director
719.383.3166
Baca, Bent, Crowley, Kiowa, Otero, Prowers

**Region 7 Pueblo AAA**

Mike Espinosa, Program Coor.
719.583.6120
Pueblo

**Region 8 South-Central Colorado Seniors Inc.**

Frances Valdez, AAA Director
719.589.4511
Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache

**Region 9 San Juan AAA**

Christina Knoell, AAA Director
970.264.0501
Archuleta, Dolores, La Plata, Montezuma, San Juan

**Region 10 League for Economic Assistance & Planning**

Eva Veitch, AAA Director
970.249.2436
Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel

**Region 11 Assoc. Governments of Northwest Colorado**

Dave Norman, AAA Director
970.248.2717
Garfield, Mesa, Moffat, Rio Blanco, Routt

**Region 12 Alpine AAA**

Erin Fisher, AAA Director
970.468.0295
Eagle, Grand, Jackson, Pitkin, Summit

**Region 13 Upper Arkansas AAA**

Steve Holland
719.539.3341
Chaffee, Custer, Fremont, Lake

**Region 14 Huerfano/Las Animas Area COG**

Veronica Maes, AAA Director
719.845.1133
Huerfano, Las Animas

# COLORADO AREA AGENCIES ON AGING REGIONS

**1 Robert (Bob) Held, AAA Director**
**Single Entry Point (SEP)**
Northeastern Colorado Association of Local Governments
231 Main Street, Suite 211
Fort Morgan, CO 80701
Phone: 970.867.9409
Fax: 970.867.9053
Email: bheld@necalg.com
Website: www.NortheasternColorado.com
Northeastern Region
Counties: Logan, Morgan, Phillips, Sedgwick, Washington, Yuma

**2-A Lynda Meyer, AAA Director**
Larimer County Office on Aging
Larimer County Human Services
2601 Midpoint, Suite 112
Fort Collins, CO 80524
Phone: 970.498.7750
Fax: 970.498.7605
Email: meyerle@co.larimer.co.us
Website: www.larimer.org/seniors
Northeastern Region
Counties: Larimer

**2-B Eva Jewell, AAA Director**
**Single Entry Point (SEP)**
Weld County Area Agency On Aging
P.O. Box 1805
315 C. N. 11th Ave.
Greeley, CO 80631
Phone: 970.346.6950
Fax: 970.346.6951
Email: EJewell@co.weld.co.us
Website: www.co.weld.co.us
Northeastern Region
Counties: Weld

**3-A Jayla Sanchez-Warren, AAA Director**
DRCOG Area Agency on Aging
1290 Broadway, Suite 700
Denver, CO 80203
Phone: 303.455.1000
Fax: 303.480.6790
Email: jswarren@drcog.org
Website www.drcog.org
Northeastern Region
Counties: Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Gilpin, Jefferson

**3-B Sherry Leach, AAA Director**
Boulder County Area Agency on Aging
P. O. Box 471
3482 North Broadway
Boulder, CO 80306
Phone: 303.441.3570
Fax: 303.441.4550
Email: bcaaa@bouldercounty.org
Website: www.bouldercountyaging.org
Northeastern Region
Counties: Boulder

**4 Joe Urban, AAA Director**
PPACG Area Agency on Aging
15 South 7th Street
Colorado Springs, CO 80905
Phone: 719.471.2096
Fax: 719.471.1226
Email: jurban@ppacg.org
Website: www.ppacg.org
Southern Region
Counties: El Paso, Park, Teller

**5 Terry Baylie, AAA Director**
East Central Council of Governments
P. O. Box 28
128 Colorado Avenue
Stratton, CO 80836
Phone: 719.348.5562, ext. 5
Fax: 719.348.5887
Email: baylie@prairiedevelopment.com
Website: ecaaa.tripod.com
Northeastern Region
Counties: Cheyenne, Elbert, Kit Carson, Lincoln

**6 Melody Dowell, AAA Director**
**Single Entry Point (SEP)**
Lower Arkansas Valley Area Agency on Aging
P.O. Box 494
13 West Third St Room 110
La Junta, CO 81050
Phone: 719.383.3166
Fax: 719.383.4607
Email: melody.dowell@state.co.us
Website: www.oterogov.com
Southern Region
Counties: Baca, Bent, Crowley, Kiowa, Otero, Prowers

**7 Mike Espinosa, Program Coor.**
Pueblo Area Agency on Aging
Southern Region
2631 E. 4th Street
Pueblo, CO 81001
Phone: 719.583.6120
Fax: 719.583.6323
Email: espinosam@co.pueblo.co.us
Website: www.co.pueblo.co.us
Southern Region
Counties: Pueblo

**8 Frances Valdez, AAA Director**
South-Central Colorado Seniors, Inc.
P.O. Box 639
1116 3rd Street
Alamosa, CO 81101
Phone: 719.589.4511
Fax: 719.589.2343
Email: francesv@qwestoffice.net
**Website: No website**
Southern Region
Counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache

**9 Christina Knoell, AAA Director**
San Juan Basin Area Agency on Aging
P.O. Box 5456 (451 Hot Springs Blvd.)
Pagosa Springs, CO 81147 – Western Region
Phone: 970.264.0501
Fax: 1.888.290.3566
Email: christinaknoell@sjbaaa.org
Website: www.sjbaaa.org
Counties: Archuleta, Dolores, LaPlata, Montezuma, San Juan

**10 Eva Veitch, AAA Director**
Region 10 League for Economic Assistance & Planning
300 N. Cascade Ave., Suite #1
Montrose, CO 81401 – Western Region
Phone: 970.249.2436
Fax: 970.249.2488
Email: eveitch@region10.net
Website: www.region10.net
Counties: Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel

**11 Dave Norman, AAA Director**
Associated Governments of Northwest Colorado
P.O. Box 20000-5035
510 29 1/2 Road
Grand Junction, CO 81502 – Western Region
Phone: 970.248.2717
Fax: 970.248.2702 or 970.248.2849/2883
Email: dave.norman@mesacounty.us
Website:
http://humanservices.mesacounty.us/AdultServices/template.aspx?id=168
Counties: Garfield, Mesa, Moffat, Rio Blanco, Routt

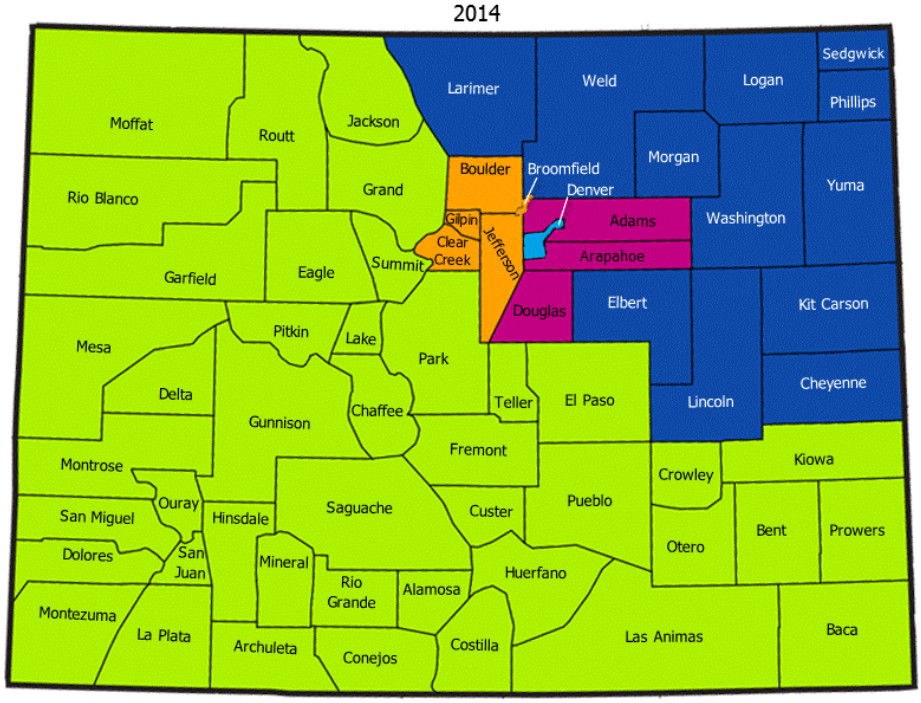
**12 Erin Fisher, AAA Director**
Northwest Colorado Council of Governments
Alpine Area Agency on Aging
P.O. Box 2308, 249 Warren Ave.
Silverthorne, CO 80498 – Western Region
Phone: 970.468.0295
Fax: 970.468.1208
Email: aaa12@nwccog.org
Website: www.nwccog.org
Counties: Eagle, Grand, Jackson, Pitkin, Summit

**13 Steve Holland, AAA Director**
**Single Entry Point (SEP)**
Upper Arkansas AAA – Southern Region
139 East 3rd Street
Salida, C0 81201-2612 – Southern Region
Phone: 719.539.3341
Fax: 719.539.7431
Email: stephen.holland@uaacog.com
Website: www.upperarkansasareaagencyonaging.org
Counties: Chaffee, Custer, Fremont, Lake

**14 Veronica Maes, AAA Director**
Huerfano/Las Animas Area Council of Governments
d/b/a South Central Council of Governments AAA
300 South Bonaventure Avenue
Trinidad, CO 81082 – Southern Region
Phone: 719.845.1133
Fax: 719.845.1130
Email: vmaes@sccog.net
Website: www.sccog.net
Counties: Huerfano, Las Animas

# Colorado's Behavioral Health Organizations

Colorado Medicaid
Community Behavioral Health Services Program
Geographic Service Areas
2014




- Colorado Access/Access Behavioral Care Northeast (ABC)
- Behavioral Healthcare, Inc. (BHI)
- Colorado Health Partnership (CHP)
- Foothills Behavioral Health Partners (FBHP)
- Colorado Access/Access Behavioral Care Denver (ABC)

COLORADO
Department of Health Care Policy & Financing

# Colorado's Community Centered Boards

**(1)** **Blue Peaks Developmental Services**
703 Fourth Street
Alamosa, CO 81101
(719) 589-5135

**(2)** **Colorado Bluesky Enterprises**
115 West 2nd Street
Pueblo, CO 81003
(719) 546-0572

**(3)** **Community Connections**
281 Sawyer Drive, #200
Durango, CO 81303
(970) 259-2464

**(4)** **Community Options**
336 South 10th Street
Montrose, CO 81402
(970) 249-1412

**(5)** **Developmental Disabilities Resource Center**
11177 W. 8th Avenue
Lakewood, CO 80215
(303) 233-3363

**(6)** **Developmental Pathways**
325 Inverness Drive South
Englewood, CO 80112
(303) 360-6600

**(7)** **Eastern Colorado Services**
617 South 10th Ave.
Sterling, CO 80751
(970) 522-7121

**(8)** **Envision**
1050 37th Street
Evans, CO 80620
(970) 339-5360

**(11)** **Imagine!**
1400 Dixon Avenue
Lafayette, CO 80026
(303) 665-7789

**(12)** **Inspiration Field**
612 Adams Avenue
La Junta, CO 81050
(719) 384-8741

**(13)** **Mountain Valley Developmental Services**
700 Mount Sopris Drive
Glenwood Springs, CO 81602
(970) 945-2306

**(14)** **North Metro Community Services**
1001 West 124th Ave.
Westminster, CO 80234
(303) 252-7199
or (303) 457-1001

**(15)** **Rocky Mountain Human Services**
9900 E. Iliff Ave.
Denver, CO 80231
(303) 636-5600

**(16)** **Southern Colorado Developmental Services**
1205 Congress Drive
Trinidad, CO 81082
(719) 846-4409

**(17)** **Southeastern Developmental Services**
1111 South Fourth Street
Lamar, CO 81052
(719) 336-3244

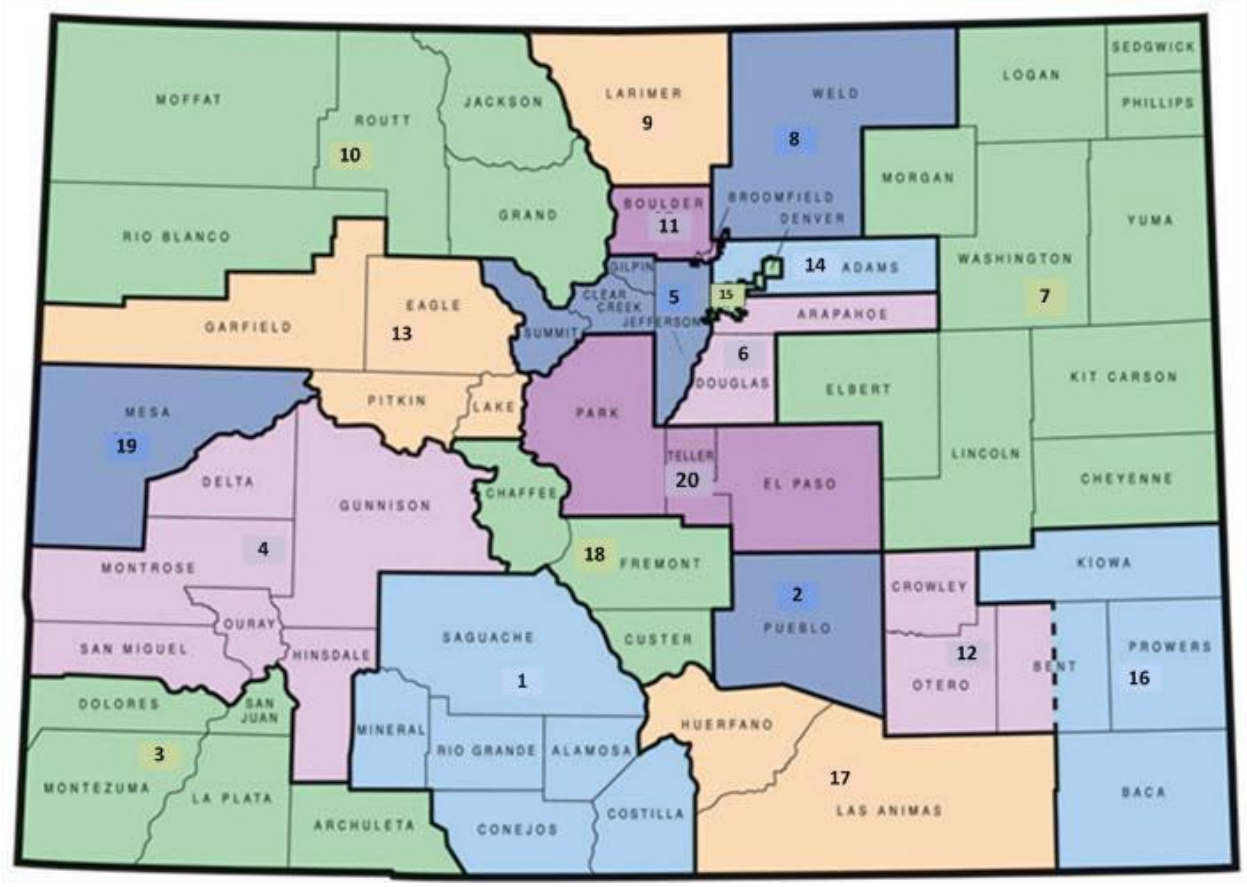
**(18)** **Starpoint**
700 South 8th Street
Canon City, CO 81215
(719) 275-1616

**(9)** **Foothills Gateway**
301 Skyway Drive
Fort Collins, CO 80525
(970) 226-2345

**(10)** **Horizons Specialized Services**
405 Oak
Steamboat Springs, CO 80477
(970) 879-4466

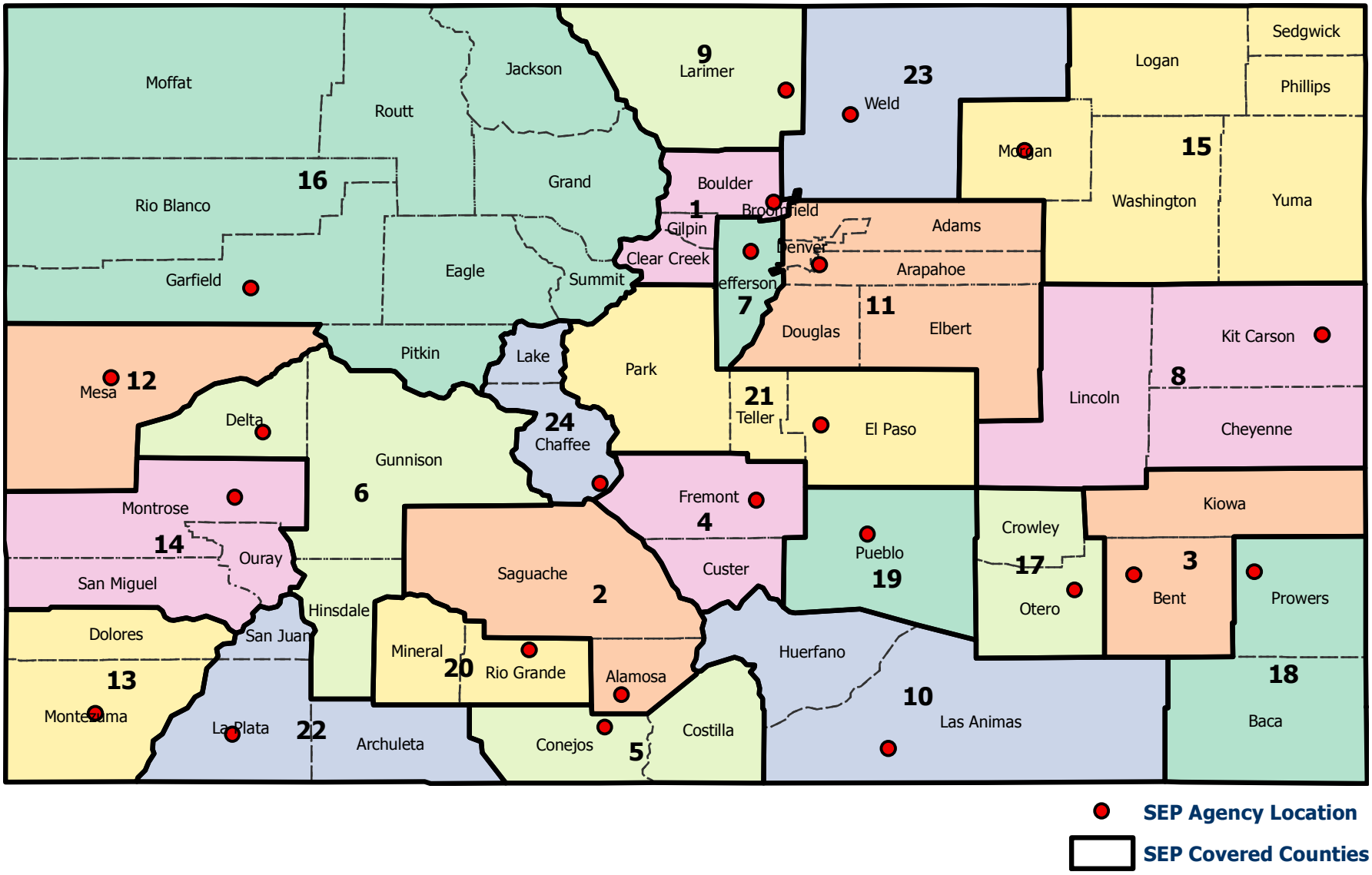
**(19)** **Strive**
950 Grand Avenue
Grand Junction, CO 81502
(970) 243-3702

**(20)** **The Resource Exchange**
418 South Weber
Colorado Springs, CO 80903
(719) 380-1100



COLORADO
Department of Health Care Policy & Financing

# Single Entry Point (SEP) Agency Locations & Covered Counties




**SEP Agency Location**

**SEP Covered Counties**

Single Entry Point (SEP) Agencies provide case management, care planning, and make referrals to other resources for clients with the following qualifying needs: elderly, blind and disabled, mental health, persons living with AIDS, brain injury, spinal cord injury, children with a life-limiting illness, and children with a physical disability.



Map Created on: 3/27/2015

**(1) Boulder/Broomfield/Clear Creek/Gilpin**
Adult Care Management, Inc.
1455 Dixon Avenue, Suite 105
Lafayette, CO 80026
(303) 439-7011

**(2) Alamosa/Saguache**
Alamosa County Public Health Dept.
8900 Independence Way
Alamosa, CO 81101
(719) 589-6639

**(3) Bent/Kiowa**
Bent County Public Health
701 Park Avenue
Las Animas, CO 81054
(719) 456-0517

**(4) Custer/Fremont**
Central Mountain Options for Long-Term Care (OLTC)
172 Justice Center Road
Canon City, CO 81212
(719) 275-2318

**(5) Conejos/Costilla**
Conejos County Nursing Services
19023 State Highway 285, PO Box 78
La Jara, CO 81140
(719) 274-4307

**(6) Delta/Gunnison/Hinsdale**
Delta County Health and Human Services
196 W. Hotchkiss Ave
Hotchkiss, CO 81419
(970) 872-1000

**(7) Jefferson**
Jefferson County Dept. of Health and Human Services
900 Jefferson County Parkway, Suite 170
Golden, CO 80401
(303) 271-4216

**(8) Cheyenne/Kit Carson/Lincoln**
Kit Carson County Health and Human Services
252 S. 14th Street
Burlington, CO 80807
(719) 346-7158

**(9) Larimer**
Larimer County Dept. of Human Services
2601 Midpoint Drive, Suite 112
Fort Collins, CO 80524
(970) 498-7780

**(10) Huerfano/Las Animas**
Las Animas County Dept. of Human Services
204 S. Chestnut
Trinidad, CO 81082
(719) 846-2276

**(11) Adams/Arapahoe/Denver/Douglas/Elbert**
Colorado Access
3033 S. Parker Road, Suite 800
Aurora, CO 80014
(877) 710-9993

**(12) Mesa**
Mesa County Dept. of Human Services
510 29 1/2 Road, PO Box 20000
Grand Junction, CO 81504
(970) 248-2888

**(13) Dolores/Montezuma**
Montezuma County Public Health Dept.
106 W. North Street
Cortez, CO 81321
(970) 564-4768

**(14) Montrose/Ouray/San Miguel**
Montrose County Dept. of Health and Human Services
1845 S. Townsend Ave.
Montrose, CO 81401
(970) 252-7076

**(15) Logan/Morgan/Phillips/Sedgwick/ Washington/Yuma**
Northeast CO Area Agency on Aging
231 Main Street, Suite 211
Fort Morgan, CO 80701
(888) 696-7213

**(16) Eagle/Garfield/Grand/Jackson/Moffat/ Pitkin/Rio Blanco/Routt/Summit**
Northwest Options for Long-Term Care (OLTC)
195 W. 14th St.
Rifle, CO 81650
(970) 963-1639

**(17) Crowley/Otero**
Otero County Dept. of Human Services
13 W. 3rd, PO Box 494
La Junta, CO 81050
(719) 383-3166

**(18) Baca/Prowers**
Prowers County Public Health and Environment
1001 S. Main Street
Lamar, CO 81052
(719) 336-1015

**(19) Pueblo**
Pueblo County Dept. of Social Services
201 W. 8th Street, Suite 120
Pueblo, CO 81003
(719) 583-6857

**(20) Mineral/Rio Grande**
Rio Grande County Dept. of Social Services
925 6th Street
Del Norte, CO 81132
(719) 657-4208

**(21) El Paso/Park /Teller**
Rocky Mountain Options for Long-Term Care (OLTC)
310 S. 14th St.
Colorado Springs, CO 80904
(719) 457-0660

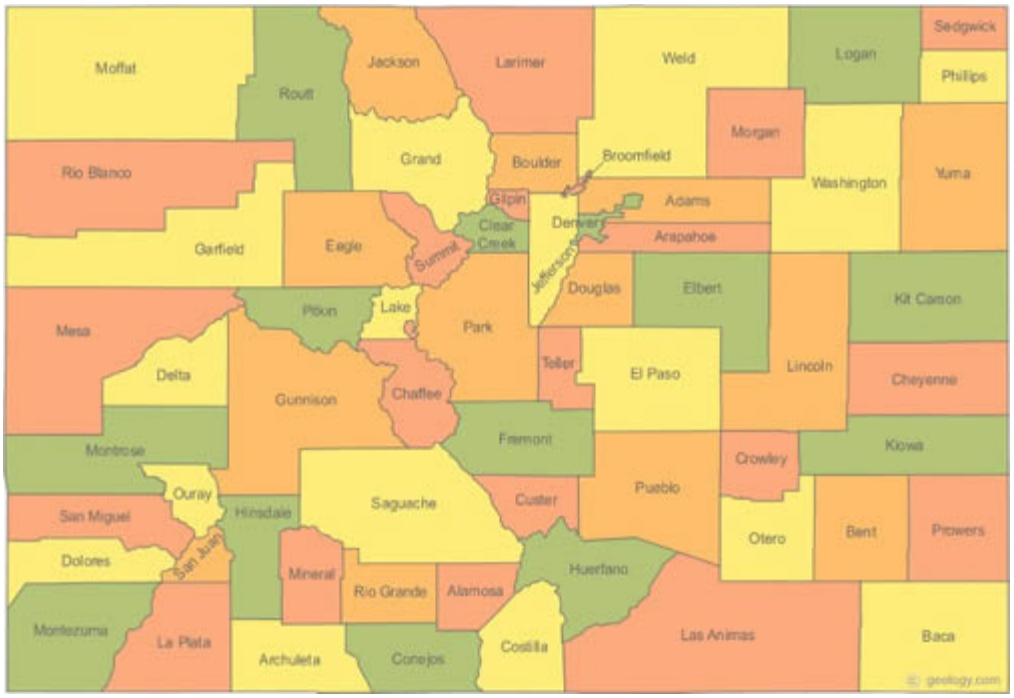
**(22) Archuleta/La Plata/San Juan**
San Juan Basin Health Dept.
281 Sawyer Drive
Durango, CO 81301
(970) 247-5702

**(23) Weld**
Weld County Area Agency on Aging
315 N. 11th Avenue, PO Box 1805
Greeley, CO 80632
(970) 346-6950

**(24) Chafee/Lake**
Chaffee County Human Services
448 East 1st Street
Salida, CO 81201
(719) 530-2505

COLORADO
Department of Health Care Policy & Financing

# Colorado's Centers for Independent Living by County




**Atlantis Community, Inc. (http://www.atlantiscommunity.org/)**

Denver, Douglas, Jefferson (shared), Arapahoe, Adams (shared), Clear Creek

**Center for Disabilities (http://www.ilcpueblo.org/)**

Baca, Bent, Crowley, Custer, Fremont, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo, Alamosa, Saguache, Costilla, Rio Grande, Conejos


**Center for Independence (http://cfigj.org/)**

Mesa, Delta, Eagle, Garfield, Gunnison, Hinsdale, Lake, Montrose, Ouray, Pitkin, San Miguel, Chaffee


**Center for People with Disabilities (http://www.cpwd-ilc.org)**

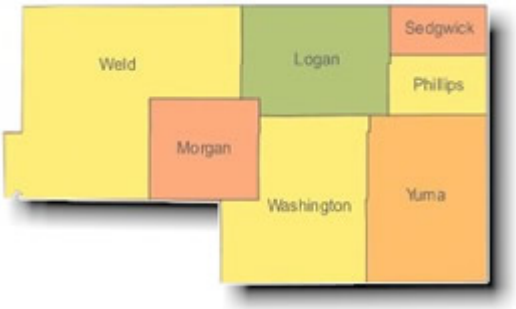
Boulder, Broomfield, Gilpin, Jefferson (shared), Adams (shared)

**The Independence Center (http://www.theindependencecenter.org/)**

Lincoln, El Paso, Kit Carson, Cheyenne, Teller, Park


**Connections for Independent Living**
**http://www.connectionsforindindependentliving.org)**

Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma




**Disabled Resource Services (http://www.disabledresourceservices.org)**

Larimer, Jackson

**North West Colorado Center for Independence (http://www.nwcci.org/)**

Moffat, Routt, Grand, Rio Blanco, Summit


**Southwest Center for Independence (http://www.swilc.org)**

Archuleta, Dolores, La Plata, Montezuma, San Juan

# Appendix D

## Infographic For NWD Data Systems

## Colorado's Long-Term Services and Supports Data Systems

### Benefits Utilization System (BUS)

**Function:** LTSS intake and referral (ULTC 100.2) and service planning

**Users:** SEPs and CCBs

**Links to:** Does not link to any system

### Community and Contracts Management System (CCMS)

**Function:** Service planning for people with developmental disabilities

**Users:** CCBs

**Links to:** MMIS

### Colorado Benefits Management System (CBMS)

**Function:** Financial assessment

**Users:** County Human Service Departments (CHSDs) and Medical Assistance Sites

**Links to:** MMIS

### Medicaid Management Information System (MMIS)

**Function:** Medicaid claims payment system

**Users:** HCPF

**Links to:** CBMS, CCMS

### Social Assistance Management System (SAMS)

**Function:** Care management and client tracking (non-Medicaid)

**Users:** AAAs

SOURCE: Analysis by Sara Schmitt, Director of Community Health Policy, Colorado Health Institute, April 2014