HAWAII STATE PLAN ON AGING

October 1, 2011 - September 30, 2015

Executive Office On Aging

"E Loa Ke Ola"
May Life Be Long

Hawaii State Plan on Aging: Four Year Plan

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VERIFICATION OF INTENT

The Executive Office on Aging hereby submits the Hawaii State Plan on Aging for the period October 1, 2011 to September 30, 2015. The Executive Office on Aging has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Older Americans Act, as amended in 2006, and is primarily responsible for the coordination of all state activities related to the purposes of the Act. The plan charts the direction over the next four years and includes the development of a comprehensive and coordinated system of services. The Executive Office on Aging serves as an effective and visible advocate for the older adults in the State.

The State Plan on Aging is hereby approved by the Governor and constitutes authorization to proceed with activities under the plan upon approval by the U.S. Assistant Secretary for Aging, Administration on Aging. The plan, as submitted, has been developed in accordance with all Federal statutory and regulatory requirements.

7/5/11
Date

Wesley Lum, PhD, MPH
DIRECTOR, EXECUTIVE OFFICE ON AGING
STATE OF HAWAII

I hereby approve the State Plan on Aging and submit it to the Assistant Secretary for Aging for approval.

7.21.11
Date

Neil Abercrombie
GOVERNOR
STATE OF HAWAII

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

SEP 27 2011

Wesley Lum, PhD, MPH
Director
Hawaii Executive Office on Aging
No. 1 Capitol District
250 South Hotel Street, Suite 406
Honolulu, HI 96813-2831

Dear Dr. Lum:

I am pleased to inform you that the Administration on Aging (AoA) has approved the Hawaii State Plan on Aging. The official Plan period is now FY 2012-2015 with a start date of October 1, 2011 and an end date of September 30, 2015.

We are pleased with a number of the goals in the Hawaii State Plan including your plans to implement fully functional Aging and Disability Resource Centers statewide, to enhance elder rights in the state, implement the Lifespan Respite program, improve disaster preparedness and expand evidence-based health promotion and disease prevention among other objectives.

AoA recognizes and applauds the extensive efforts of your staff and partners in working together in the development of this State Plan.

We look forward to working with you and your staff in the implementation of the Hawaii State Plan on Aging. Should you have any questions and/or concerns, please do not hesitate to contact us. Your dedication and commitment towards improving the lives of Hawaii's older adults and caregivers is appreciated.

Sincerely,

Kathy Greenlee
Assistant Secretary for Aging

EXECUTIVE SUMMARY

The Executive Office on Aging is submitting this Hawaii State Plan on Aging, October 1, 2011 - September 30, 2015, to the U.S. Administration on Aging, Department of Health and Human Services. The plan describes the goals and strategies that will be followed for the years 2011-2015 in order to ensure that the long-term supports and strategies of older adults and individuals with disabilities, along with their caregivers, are met. The plan subscribes to the general framework drawn from the Older Americans Act, the U.S. Administration on Aging goals and strategies, and Chapter 349 of the Hawaii Revised Statutes.

Hawaii's older adult population (60+) continues to increase. Between 1980 and 2010, the older population increased by 139.8% while the total population only grew by 34.2%. The growth in the number of older adults 85 years or older is even more dramatic. This population grew by 431.5% for the same 30 year period. By 2035, the older adult population (projected to be 474,586 individuals, 60 years or older) will represent 29.7% of the total population, a 310.3% increase during the 55 year period from 1980 - 2035, whereas the total population is projected to increase 65.1% during this same 55 year period. The 85+ group will increase 1157.5% during this 55 year period, again illustrating decreasing mortality and greater life expectancy.

The older population served by the Older Americans Act grants is rapidly changing, especially as we enter the first year of the baby-boom era (birth years 1946-1964) when the large number of children born in 1946 turn 65 years of age in 2011. By 2035, close to one in three individuals will be an older adult.

In order to address current and anticipated needs, the Executive Office on Aging and Hawaii's four Area Agencies on Aging will pursue the following goals:

1. Empower older adults to stay healthy, active and socially engaged, using prevention and disease self-management strategies.
2. Enable older adults to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.
3. Develop Hawaii's Aging and Disability Resource Center to its fully functioning capacity to serve as a highly visible and trusted place where all persons regardless of age, income and disability can find information on the full range of long-term support options.

4. Manage funds and other resources efficiently and effectively, using person-centered planning to target public funds to assist persons at risk of institutionalization and impoverishment.
5. Ensure the rights of older people and prevent their abuse, neglect and exploitation.
6. Ensure Hawaii's elders will be included in emergency and disaster planning at the State and local levels.

This plan is based on the proposals of the Executive Office on Aging and Area Agencies on Aging. All the identified goals and strategies will be carried out through partnerships and collaboration with public and private sector organizations, community, volunteers and the older adults. The Executive Office on Aging and Area Agencies on Aging are working together to help prepare for Hawaii's aging society.

Chapter I: Background

Introduction:

The Executive Office on Aging is submitting this Hawaii State Plan on Aging, October 1, 2011 - September 30, 2015 to the U.S. Administration on Aging, Department of Health and Human Services, for approval. This plan complies with the requirements of the Older Americans Act, as amended in 2006, and the Administration on Aging Program Instruction 10-05 which outlines criteria by the Assistant Secretary for Aging.

The Older Americans Act passed by Congress in 1965 established a social services and nutrition services program for American's older adults. State and area offices were established and a nationwide "Aging Network" to assist older adults in meeting their physical, social, mental health, and other needs, and also to maintain their well-being and independence, was created.

The Administration on Aging heads the Aging Network on the federal level, directed by the Assistant Secretary for Aging. The Administration on Aging awards Older Americans Act Title III, IV, and VII funds to the states and monitors and assesses state agencies that administer these funds. The agency also develops, coordinates and administers programs nationwide; provides leadership, direction, technical assistance and advocacy; and develops policy to meet the needs of elderly individuals.

At the State level, the designated lead agency or State Unit on Aging in the network is the Executive Office on Aging, that is required to plan for and offer leadership at the state and local levels in the coordination of access to home and community-based services to the older adult population including:

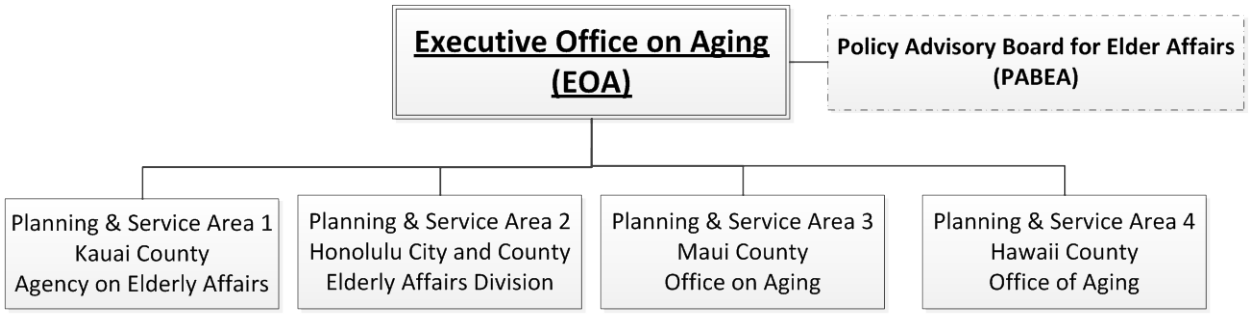
- Planning
- Policy and program development
- Advocacy
- Research
- Information and referral
- Coordination of services provided by public and private agencies for our elders and their families

The mission of the Executive Office on Aging is to promote and assure opportunities for Hawaii's older adults to achieve dignified, self-sufficient and satisfactory lives. The office pursues its mission by advocating, developing, and coordinating federal, state, and local resources for adults 60 years and older, and also their caregivers.

Chapter 349, Hawaii Revised Statutes, defined the purpose and functions of Executive Office on Aging and, in Section 4, established the Policy Advisory Board for Elder Affairs, which assists the Executive Office on Aging Director by advising on the development and administration of the State Plan by representing the interests of older persons including grandparents raising grandchildren, and by reviewing and commenting on other State plans, budgets and policies which affect older persons.

The Executive Office on Aging has delineated the State into distinct planning and service areas for purposes of planning, development, delivery, and the overall administration of services. These four Planning and Services Areas include the counties of Hawaii, Honolulu, Kauai, and Maui. Kalawao County of the island of Molokai is included in the Maui Planning and Service Area.

Chart 1
State Network on Aging



The following agencies have been designated by the Executive Office on Aging as Area Agencies on Aging:

- **Kauai Agency on Elderly Affairs (KAEA)**
  County of Kauai
  4444 Rice Street, Suite 330
  Lihue, HI 96766
  Kealoha Takahashi, County Executive
  Telephone: (808) 241-4470

- **Elderly Affairs Division (EAD)**
  Department of Community Services
  City and County of Honolulu
  715 South King Street, Suite 200
  Honolulu, HI 96813
  Elizabeth Bethea, County Executive
  Telephone: (808) 768-7705

- **Maui County Office on Aging (MCOA)**
  County of Maui
  2200 Main Street, Room 547
  Wailuku, HI 96793
  Deborah Arendale, County Executive
  Telephone: (808)270-7755

- **Hawaii County Office of Aging (HCOA)**
  County of Hawaii
  1055 Kino'ole Street, Suite 101
  Hilo, HI 96720
  Alan Parker, Director
  Telephone: (808) 961-8600

The Area Agencies on Aging are responsible for implementing the Older Americans Act at the local level, in their respective counties. Each Area Agency on Aging carries out a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development and enhancement of comprehensive and coordinated community based systems which will enable older persons to lead independent, meaningful and dignified lives in their own homes and communities as long as possible, as documented in their 4-Year Plans. Each Area Agency on Aging establishes an advisory council to advise the agency on the development and administration of the area plan, conducting public hearings, representing the interests of older persons, and receiving and commenting on all community policies, programs and actions which affect older persons.

Under the Aging Network are other organizations that provide direct services to older adults, and higher education institutions that are contracted for services. Recipients for these services in the Aging Network are older adults 60 years of age and older, and their caregivers, including grandparents raising grandchildren.

The Executive Office on Aging receives formula funds based on population from the Administration on Aging under Title III and VII, and discretionary funds under Title IV, of the Older Americans Act. Based on the State's Intrastate Funding Formula, Title III and VII funds are allocated to the four Area Agencies on Aging. The Executive Office on Aging also receives funds from the State Legislature for aging services (Kupuna Care and other programs), which are also allocated to the Area Agencies on Aging. Area Agencies on Aging contract out both Federal and State funds to service providers that deliver services at the local level, in their geographical area. Services contracted include: personal care, homemaker services, chore services, home-delivered meals, adult day care/health, case management, congregate meals, nutrition counseling, assisted transportation, transportation, legal assistance, nutrition education, information and assistance, outreach, and caregiver support services (counseling, respite, supplemental services, access assistance, and information services). The Executive Office on Aging also receives Title VII funds from the Older Americans Act and other federal grants to carry out elder rights and benefits programming. Furthermore, the Executive Office on Aging and the Area Agencies on Aging will better coordinate Title III services and programs with Title VI grantees in Hawaii in the near future by referring Native Hawaiians, via our Aging and Disability Resource Center, to Title VI grantee providers such as Alu Like, Inc., and Hana Health, for the full range of services if they meet qualifications.

Table 1 indicates the numbers of older adults served under Older Americans Act, Title III funds and State funds. "Total Clients" is a duplicated number of people that is derived from every contact made with an older individual, such as phone calls and contacts made during health fairs as well as service delivery to registered persons. "Total Registered Clients" is an unduplicated number of older individuals that have registered with one of the Area Agency on Aging, have given the Area Agency on Aging demographic and registration information, and have received one or more of the services offered. A comparison of years 2008 versus 2010 indicates only a small percentage increase of .22% for registered clients, most likely due to the increasing cost of services while funding has remained static.

Table 1. Client Characteristics - Numbers Served

CLIENT CHARACTERISTICS	2008	2009	2010	3 Yr Avg.	2008 vs. 2010	
					Difference	% Change
Total Clients	94,777	97,615	87,920	93,437	(6,857)	-7.23%
Total Registered Clients	8,801	8,920	8,820	8,847	19	0.22%
% Minority Clients	73.62%	71.76%	71.39%	72.26%	(0.02)	-3.03%
% Rural Clients	53.16%	55.55%	56.64%	55.12%	0.03	6.55%
% Clients Below Poverty	28.80%	27.80%	26.22%	27.61%	(0.03)	-8.96%
# Clients with 3+ ADL	1,642	1,952	2,214	1,936	572	34.84%
# of Persons Served at High Nutrition Risk	2,684	2,800	3,627	3,037	943	35.13%

Source: Executive Office on Aging State Program Report - Federal Fiscal Year: 2008, 2009, 2010

Table 2 depicts examples of annual average service usage, utilizing a three year average (Federal Fiscal Years 2008-2010) for the number of clients served and the units of service used.

Table 2. Annual Service Usage Examples

*SERVICE EXAMPLES	UNIT MEASURE	CLIENTS SERVED 3-Year Avg. FY '08-'10	UNITS OF SVC. 3-Year Avg. FY '08-'10	ANNUAL AVERAGE PER INDIVIDUAL
Personal Care	1 Hour	853	59,005	69.2 Hours
Homemaker	1 Hour	531	14,035	26.4 Hours
Chore	1 Hour	322	2,489	7.7 Hours
Home Delivered Meals	1 Meal	3,270	463,405	141.7 Meals
Congregate Meals	1 Meal	4,116	248,546	60.7 Meals
Adult Day Care	1 Hour	151	35,325	233.8 Hours
Case Management	1 Hour	1,547	25,758	16.7 Hours
Assisted Transportation	One-Way Trip	96	2,884	30.0 Trips

* Other Services Offered: Transportation, Legal Assistance, Nutrition Education, Nutrition Counseling, Attendant Care, Information and Assistance, Outreach (See Appendix E - Glossary).

Source: EOA State Program Report - Federal Fiscal Year: 2008, 2009, 2010

State Plan Purpose:

Section 307(a) of the Older Americans Act requires that each State, in order to be eligible for grants under Title III, develop a State Plan on Aging conforming to criteria outlined by the Assistant Secretary for Aging.

The State Plan on Aging incorporated in its strategies, the needs, expectations and choices of older individuals as determined by the Area Agencies on Aging in the development of their area plans, and describes how Hawaii's systems of services and access to these services will meet the challenges of our aging population.

The State Plan strategies are based on principles in the Older Americans Act, which form the direction over the next four years. These principle areas are:

- Activities for disease prevention and social engagement;
- Support for caregivers;
- In-home and community-based programs and services;
- Access to information and care options;
- Person-centered approaches for at-risk older adults;
- Elder rights and benefits; and.
- Disaster/Emergency Preparedness Plans.

With the 2006 amendments to the Older Americans Act, the Administration on Aging, in its efforts to rebalance the system of long-term supports and services, has outlined additional strategic principles and objectives in Choices for Independence, which will enable the Network to become more participant-directed. These additional strategic principles were also incorporated into the State Plan strategies:

- Empower participants to make informed decisions about their care options;
- Help aged at high risk of nursing home placement, but not eligible for Medicaid, to remain in their own homes and communities through flexible financing and service models (including consumer-directed models); and
- Build evidence-based prevention into community based systems of services, enabling older people to make behavioral changes that reduce risk of disease, disability and injury.

Activities that relate to four federal, Administration on Aging goals, were also included in the plan strategies:

- Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term supports and service options;
- Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers;
- Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare; and
- Ensure the rights of older people and prevent their abuse, neglect and exploitation.

The FY 2012 Administration on Aging Program Instruction requirements under 10-05, further listed focus area activities that were also addressed:

- Disaster Preparedness Plans;
- Coordination between Title III and Title VI;
- Elder Rights Programs; and
- Health Care System Coordination.

The purpose of the plan is to set the direction for the years October 1, 2011 through September 30, 2015, for the development of a comprehensive and coordinated system in accordance with all federal requirements, to serve older adults and persons with disabilities, and their caregivers.

Planning Process:

From January to June 2010, the University of Hawaii, Center on Aging conducted nine training sessions with professionals in the Hawaii Aging Network, in order to provide these professionals with increased knowledge and skills in planning and research, and increase their capacity to identify, deliver and evaluate services to older adults in the state, with the intended purpose of facilitating and supporting the development of the State and Area Plans.

Major planning activities included the following:
1. Pre-Planning - Mapping out the who, what, why and how of the process.
2. Strategic Analysis - Identifying major trends, issues, resources and needs.
3. Setting Strategic Direction - Figuring out where to go.
4. Action Planning - Figuring out how to get there.

The Area Agency on Aging Planning Process includes the following:

1. Assess the Needs of Older Persons
2. Evaluate Effectiveness of Existing System of Services
3. Identify Areas of Concern
4. Develop List of Possible Alternative Approaches
5. Investigate Alternatives and Funding Sources
6. Establish Priorities
7. Develop Area Plans

October 1, 2011 through September 30, 2015 State Plan Goals:

As a result of the planning process and consideration of the requirements in Section 307(a) of the Older Americans Act, the 2006 amendments to the Older Americans Act, the activities that relate to the four federal Administration on Aging goals, and the current Administration on Aging focus area activities, the Executive Office on Aging established the following six goals to help guide development of the Area Agencies on Aging plans and also the Hawaii State Plan on Aging (See Chapter 3):

- **Empower older adults to stay healthy, active and socially engaged, using prevention and disease self-management strategies.**

- **Enable older adults to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.**

- **Develop Hawaii's Aging and Disability Resource Center to its fully functioning capacity to serve as a highly visible and trusted place where all persons regardless of age, income and disability can find information on the full range of long-term support options.**

- **Manage funds and other resources efficiently and effectively, using person-centered planning to target public funds to assist persons at risk of institutionalization and impoverishment.**

- **Ensure the rights of older people and prevent their abuse, neglect and exploitation.**

- **Ensure Hawaii's elders will be included in emergency and disaster planning at the State and local level.**

The Director of the Executive Office on Aging is an Ex-Officio member of the Long-Term Care Commission representing the Hawaii Department of Health, and as such, will consider and suggest adopting recommendations from the Hawaii Long-Term Care Commission that affect and relate to the population served by the Executive Office on Aging.

Chapter 2: Hawaii's Aging Population

Population Profile:

In 1980, the older adult population in Hawaii (60 years or older) was 115,670, and represented 11.9% of the total population (Table 3). By 2010, there were 277,360 older adults that represented 21.4% of the total population. The overall increase in the 60 years or older population in Hawaii from 2000 to 2010 was 34%, 10% points higher than the national rate of growth for this age group. Over a thirty year period (1980 - 2010), the older adult population increased by approximately 139.8% while the total population only increased by 34.2%. Moreover, older adults are living longer. In 1980, there were only 5,692 individuals 85 years or older, that represented 0.6% of the population. By 2010, this 85 years or older group increased to 30,238, or 2.3% of the population. The overall increase in the 85 years or older population in Hawaii from 2000 to 2010 was 72%, or 42.6% points higher than the national rate of growth for this age group. This increase has serious implications for the long term care systems in Hawaii. Only Alaska and Nevada had higher rates of growth. Over the thirty year period (1980 - 2010), the 85+ population increased by 431.5% while the total population only increased by 34.2%.

The Hawaii Department of Business, Economic Development and Tourism estimates that by 2035, the older adult population (474,586 individuals, 60 years or older) will represent 29.7% of the total population, a 310.3% increase during the 55 year period from 1980 - 2035, whereas the total population will only increase 65.1% during this same 55 year period. The 85+ group will increase 1157.5% during this 55 year period, again illustrating decreasing mortality and greater life expectancy.

Table 3. Hawaii State Total Resident Population (60+, 85+), 1980-2035

Age Group	1980	1990	2000	2010	2020	2025	2030	2035
(Population in 1000s)								
Total 60+	115.67	174.05	207.00	277.40	373.65	415.67	448.71	474.59
% Total Pop.	11.9%	15.6%	17.1%	21.4%	26.1%	27.9%	29.0%	29.7%
# Change from 1980		58.38	91.33	161.73	257.98	300.00	333.04	358.92
% Change from 1980		50.5%	79.0%	139.8%	223.0%	259.4%	287.9%	310.3%
Total 85+	5.69	10.22	17.56	30.24	42.76	45.37	54.61	71.55
% Total Pop.	0.6%	0.9%	1.5%	2.3%	3.0%	3.0%	3.5%	4.5%
# Change from 1980		4.53	11.87	24.55	37.07	39.68	48.92	65.86
%Change from 1980		79.6%	208.6%	431.5%	651.5%	697.4%	859.8%	1157.5%
Total Pop.	968.50	1113.49	1211.48	1299.57	1432.54	1492.25	1547.46	1598.68
# Change from 1980		144.99	242.98	331.07	464.04	523.75	578.96	630.18
% Change from 1980		15.0%	25.1%	34.2%	47.9%	54.1%	59.8%	65.1%

Source: Hawaii Department of Business, Economic Development and Tourism, DBEDT 2035 Series (July 2009) - Years 2020 and above are projections. Years 2000-2010 (60+ and 85+) – U.S. Census bureau.

As has been the case with previous Department of Business, Economic Development and Tourism's long-range projections, the Neighbor Island counties are projected to have higher population growth than Honolulu. The resident population of the City and County of Honolulu is projected to increase at an annual rate of about 0.5 percent from 2007 to 2035, while Hawaii County is projected to grow at about 1.7 percent annually, Maui County at 1.2 percent, and Kauai County at 1.0 percent (Table 4).

Although Kauai has the smallest overall population of the four counties, Kauai County's percentage of older adults, compared to their total population, represents the largest proportion relative to the other counties within the State (Figure 1). This large percentage of older adults will present challenges for Kauai in their future planning.

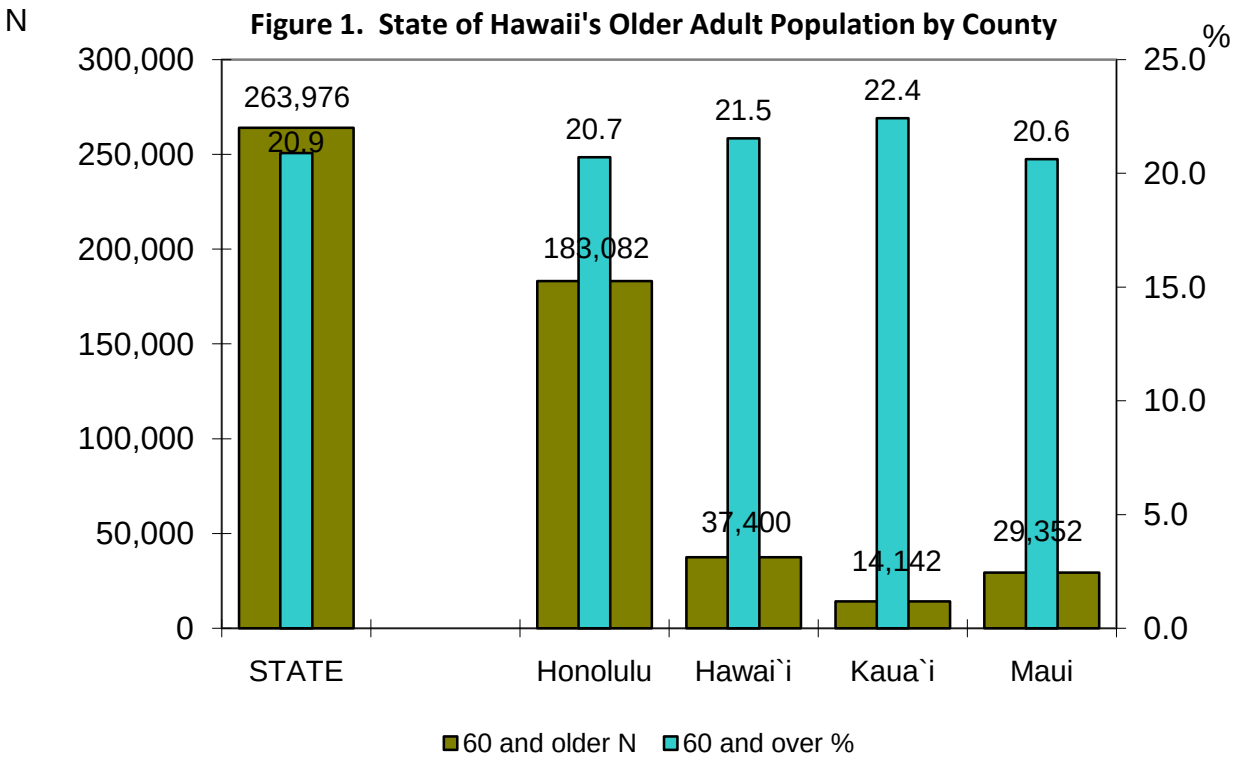
Table 4. Resident Population by County: 1980-2035

Year	State Total	Hawaii County	Honolulu County	Kauai County	Maui County
1980[1/]	968,500	92,900	764,600	39,400	71,600
1985[1/]	1,039,700	105,900	804,300	44,400	85,200
1990[1/]	1,113,500	121,600	838,500	51,700	101,700
1995[1/]	1,196,900	140,500	881,400	57,100	117,900
2000[1/]	1,211,500	149,100	875,100	58,500	128,900
2005[1/]	1,264,500	164,500	900,000	61,600	138,700
2010[2/]	1,299,600	176,700	911,800	64,600	146,500
2015[2/]	1,367,800	199,500	941,800	68,400	158,000
2020[2/]	1,432,500	221,900	969,500	72,200	169,100
2025[2/]	1,492,300	242,600	994,600	75,600	179,400
2030[2/]	1,547,500	261,800	1,017,600	78,800	189,300
2035[2/]	1,598,700	279,700	1,038,300	81,900	198,700

[1/] Source: Population Division, U.S. Census Bureau.

[2/] Forecasts by the Department of Business, Economic Development and Tourism.

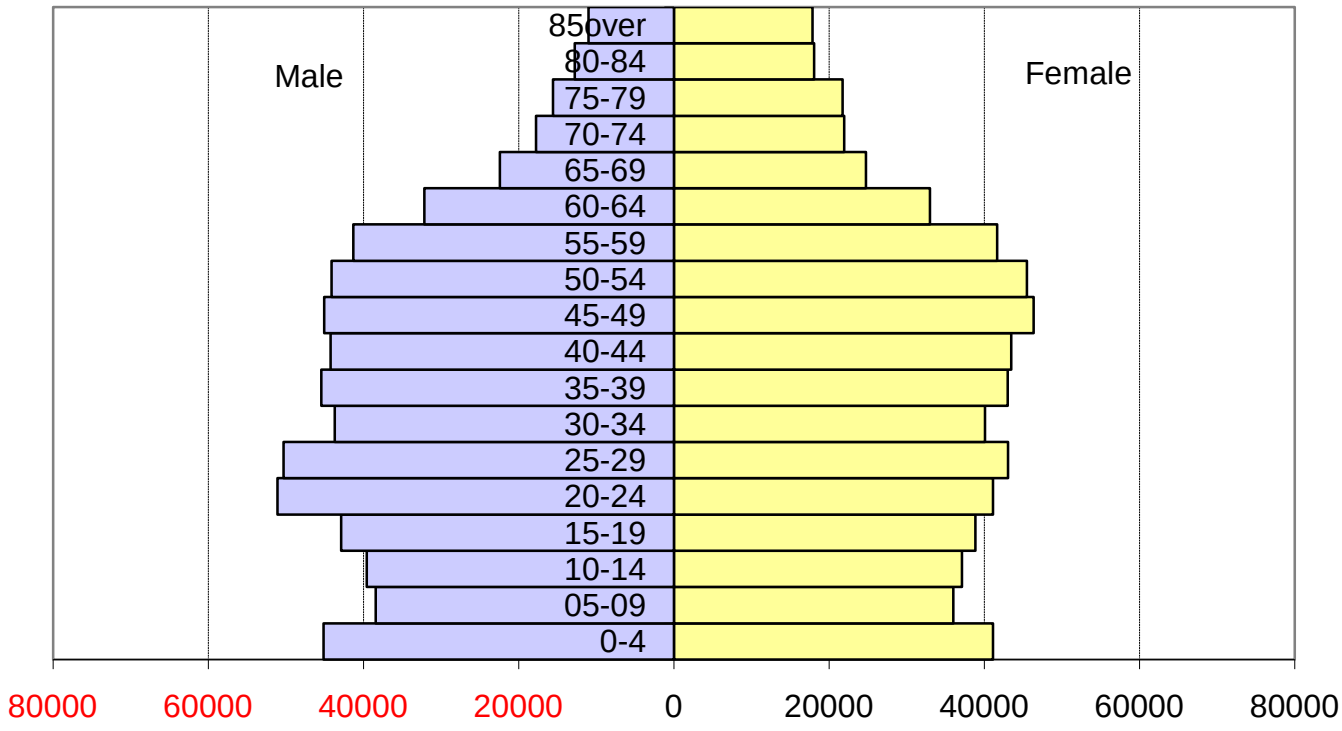
Figure 1. State of Hawaii's Older Adult Population by County



Source: Hawaii Health Survey, Department of Health, Special Run (2007-2008), February 2010.

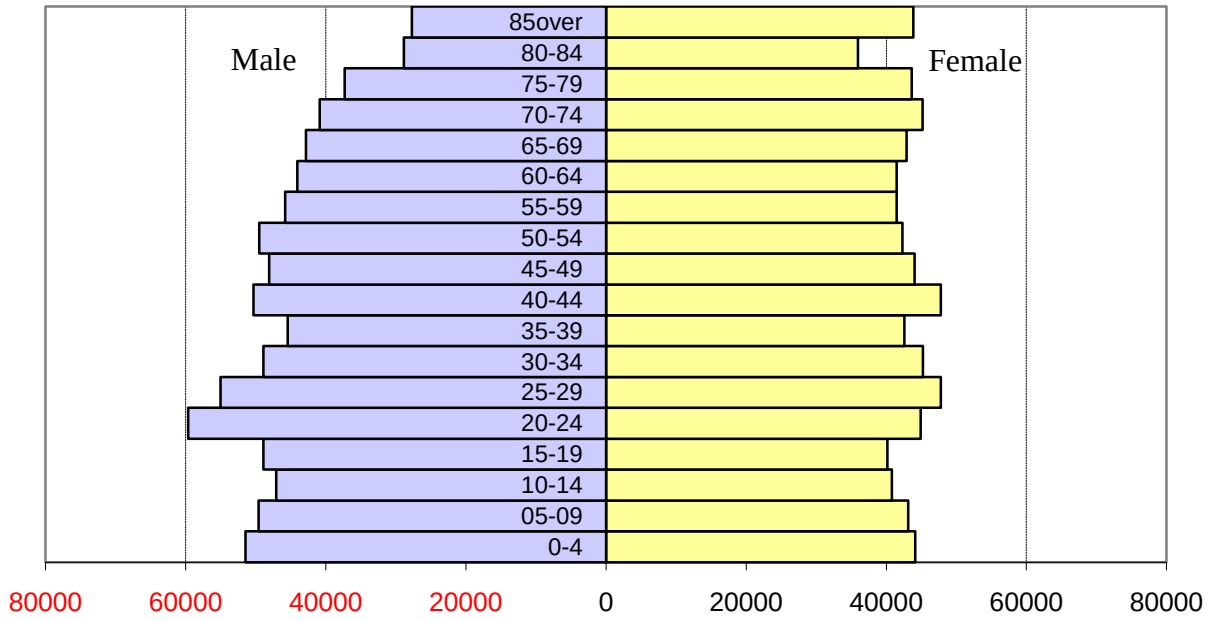
The older population served by the Older Americans Act and Administration on Aging Title III grants is rapidly changing, especially as we enter the first year of the baby-boom era (birth years 1946-1964) when the large number of children born in 1946 turn 65 years of age in 2011. By 2035, close to one in three individuals will be an older adult. The growth in older adults will change the population age structure from pyramid shape as shown in Figure 2, 2007 by gender, to a square shape where all age brackets will become closer in number, as shown in Figure 3, 2035 by gender. As seen in the figures, the aging of Hawaii's population is more evident for the female population.

Figure 2. Age Distribution for the Resident Population of Hawaii: 2007



Source: Population Division, U.S. Census Bureau.

Figure 3. Age Distribution for the Resident Population of Hawaii: 2035



Source: Department of Business, Economic Development and Tourism Projections.

Aging of the baby-boomers will place a burden on the Aging Network and existing programs and services for this population. The demand for long term supports and community-based services will increase, associated with the need for housing, transportation, caregiver services, disease prevention and health promotion services, mental health services, nutrition, education, recreation and other services. However, cause for optimism exists because the boomers represent the healthiest and best-educated generation to retire, but will nonetheless need services. Seniors need to be made aware through education, communication, and public awareness campaigns, that keeping healthy using preventive techniques, can often delay the need for long term supports and services.

Adult Population by Ethnic Categories

Caucasians (white) make up the largest ethnic adult population (18 and over) in Hawaii (292,441 individuals or 30.1%) as shown in Tables 5 and 6. Japanese make up the second largest ethnic adult population (207,631 or 21.3%). However, after age 75, Japanese become the largest ethnic adult population (35,662 or 38.0%) and Caucasians become the second largest (32,268 or 34.4%).

Table 5. Adult Population by Ethnic Categories

		Selected Age Groups			
STATE	**All Adults**	**18-54**	**55-59**	**60-74**	**>75**
White	292,441	158,935	35,909	65,329	32,268
Native Hawn/Part	182,846	138,024	13,860	22,506	8,456
Filipino	122,364	92,987	7,196	17,105	5,076
Japanese	207,631	103,642	24,495	43,832	35,662
Other Race	167,750	118,302	15,887	21,293	12,268
Total	**973,032**	**611,890**	**97,347**	**170,065**	**93,730**

Source: Department of Health Hawaii Health Survey (2007-2008)

Table 6. Adult Population by Ethnic Categories in Percentages

		Selected Age Groups			
STATE	**All Adults**	**18-54**	**55-59**	**60-74**	**>75**
White	30.1%	26.0%	36.9%	38.4%	34.4%
Native Hawn/Part	18.8%	22.6%	14.2%	13.2%	9.0%
Filipino	12.6%	15.2%	7.4%	10.1%	5.4%
Japanese	21.3%	16.9%	25.2%	25.8%	38.0%
Other Race	17.2%	19.3%	16.3%	12.5%	13.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: Department of Health Hawaii Health Survey (2007-2008)

Adult Population by Poverty Level

The U.S. Census Bureau estimated that across the nation, almost 3.4 million elderly persons (8.9%) were below the poverty level in 2009. Table 7 indicates that 20,882 older adults (7.9%) in the State, 60 years or older, live at or below the federal poverty level.

The largest percentage of older adults within the four counties, living at or below the poverty level, resides in Hawaii County (11.2%), whereas the smallest percentage resides in Honolulu County (6.9%).

Table 7. 60+ Below Poverty Level by State and County

	State of HI	Hawaii	Honolulu	Kauai	Maui
60+ Below Poverty	20,882	4,187	12,538	1,410	2,745
Percentage	7.9%	11.2%	6.9%	10.0%	9.4%

Source: Department of Health Hawaii Survey (2007-2008)

Rural

The Bureau of the Census defines urban as comprising all territory, population, and housing units located in urbanized areas and in places of 2,500 or more inhabitants outside of urbanized areas. Territory, population and housing units that the Census Bureau does not classify as urban are classified as rural. In the 1990 Census, 24.8% of the national population was classified as rural. The rural proportion has decreased since 1870, even while the total number of people classified as rural has increased along with the increase of the nation's population.

The U.S. Administration on Aging was required by the 1992 Amendments to the Older Americans Act to produce a standard definition of rural. The definition reads: rural--an area that is not urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) and incorporated place or a census designated place with 20,000 or more inhabitants.

According to the Rural Assistance Center, Hawaii covers 6,423 square miles, with a 2009 estimated population of 1,295,178, of which 387,604 (29.9%) lived in rural Hawaii. Within this rural population, about 21% were 60 years or older.

According to the National Advisory Committee on Rural Health and Human Services' 2008 Report, two population trends in the United States have contributed to the growth in the percent of elderly Americans living in rural areas: 1) The out-migration of young adults from farm-dependent counties have led to an older average age for remaining residents; 2) Rural America is becoming a more popular retirement destination, especially for the baby boomer generation.

The rural factor remains an integral part of the Intrastate Funding Formula. The Area Agencies on Aging will continue to target older individuals in rural areas.

Accessing Services and Supports – Present and Future:

Publicly-Funded Long-Term Supports and Services (present model):

Currently, much of the long-term supports and services (approximately 80%) older individuals receive come from unpaid caregivers such as family and relatives, friends, churches, neighbors, insurance, and private self-paying means. The balance of long-term supports, are publicly funded.

Publicly-funded long-term supports and services can be accessed either through the Executive Office on Aging, and attached agency of the Department of Health, or through Medicaid within the Department of Human Services:

- **Executive Office on Aging (Attached to the Department of Health)**
  - The 4 county-based Area Agencies on Aging (Kauai, Honolulu, Maui, Hawaii) oversee delivery of:
    - Kupuna Care - State-funded program serving individuals 60+ providing a range of home and community-based support.
    - Older Americans Act services, including Title III for home and community-based services.
  - State Health Insurance Assistance Program – Sage PLUS – provides access and information for Medicare beneficiaries, their family and caregivers.

- **Medicaid (Department of Human Services)**
  - All home and community-based waivers, except for the developmental disabilities waiver, were folded into the managed care option called Quest Expanded Access in 2009.
  - Home and community-based waiver services are delivered by 2 managed care organizations: EverCare and Ohana Health Plan (WellCare).

Hawaii System Change 5 Year Operation Plan for the Aging and Disability Resource Center - (See Appendix B)

In the present long-term supports and services model, older adults and their caregivers access publicly-funded information and health and social supports through each funding stream such as Medicaid, Kupuna Care, or Title III.

In 2011, a different model is being implemented where information, services, and supports will be centralized for single-point entry to streamline access to publicly funded support, and the Aging and Disability Resource Center serves as the highly visible and trusted place where people of all incomes and ages can get information on the full-range of long-term support option.

The State of Hawaii, Executive Office on Aging, the four county Area Agencies on Aging, and HCBS Strategies Inc. serving as the Systems Change Developer, have developed a five-year plan for implementing the following three initiatives:

- Statewide expansion and enhancement of the Aging and Disability Resource Center effort that will meet the Administration on Aging criteria for a fully-functioning Aging and Disability Resource Center;

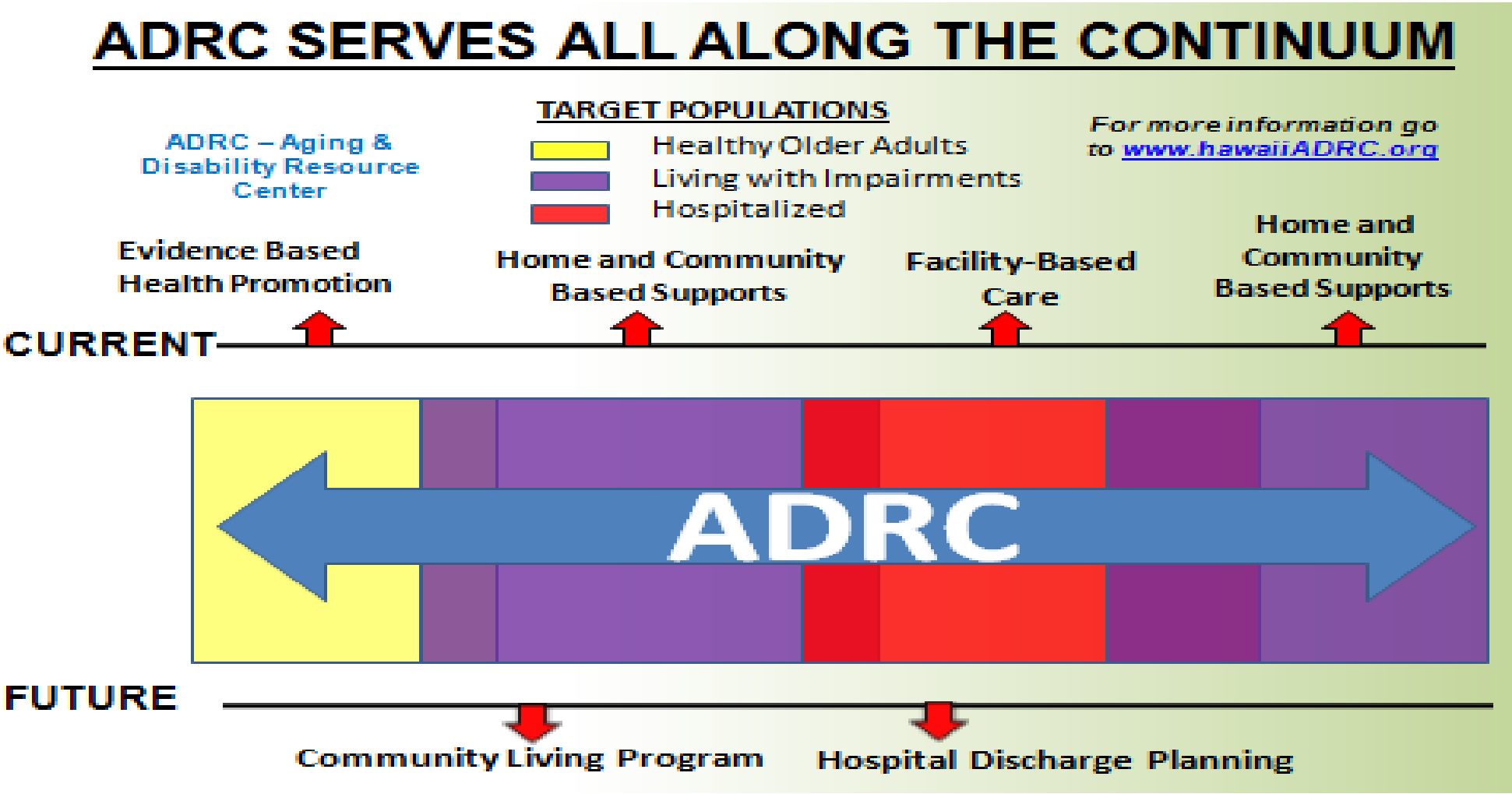
- The Community Living Program;

- The person-centered Hospital Discharge Planning initiative.

The central vision of the Aging and Disability Resource Center is for the Area Agencies on Aging sites to become a single point of entry for individuals to access supports and services. The Aging and Disability Resource Center will be the gateway for older adults to access Kupuna Care and Older American Act services, as well as private pay options for all populations. The Area Agencies on Aging will also provide information, referrals, and linkages for persons with disabilities that include physical disabilities, developmental disabilities or mental illness, and children with long-term support needs. The Aging and Disability Resource Center will also screen and link individuals to the state Medicaid agency, MedQuest, if the individual requesting assistance is likely to be eligible for Medicaid. Figure 4 illustrates the single entry point system.

The entire Hawaii Systems Change Five Year Plan, including detailed implementation tasks and corresponding timelines necessary to implement the components of the five-year plan, is available in Appendix B.

Figure 4. ADRC SINGLE ENTRY POINT SYSTEM



Statewide Phone Number: 643-ADRC (643-2372)

Chapter 3: Goals/Strategies

Hawaii's Goals:

Goal 1: Empower older adults to stay healthy, active and socially engaged, using prevention and disease self-management strategies.

The Executive Office on Aging systematically deploys two evidence-based interventions, namely Stanford's Chronic Disease Self-Management Program in all four counties and EnhanceFitness in seven communities on Kauai and future implementation on Oahu.

Strategy 1-1: Continue to promote and support evidence-based programs in Hawaii such as Chronic Disease Self-Management Program and EnhanceFitness.

Objectives:

1-1:1 By 10/1/2012, provide evidence-based interventions with fidelity, to older adults and persons with disabilities in all four counties.

1-1:2 By 10/1/2013, extend evidence-based interventions to thirteen (13) new communities targeting 532 low-income minority older individuals and older individuals with limited English proficiency.

1-1:3 Extend and maintain evidence-based interventions referral linkages with health clinics, health care providers, hospital discharge planners and other community service providers.

Strategy 1-2: Strengthen and encourage Healthy Aging Partnerships at the State and Area Agencies on Aging levels.

Executive Office on Aging established the statewide Healthy Aging Partnership in 2003 by bringing together representatives from the Area Agencies on Aging, District Health Offices, and public and private aging services and healthcare providers, to guide the process of embedding evidence-based interventions throughout the state. Also, partnerships have been developed and are being strengthened and sustained in each Planning and Services Area.

Strategy 1-3: Continue to seek and use federal evidence-based health promotion grants, and other non-federal resources to sustain Hawaii's healthy aging efforts.

Hawaii has been awarded several grants to establish, continue and sustain evidence-based and disability prevention programs.

Objective:

1-3:1 By 10/1/2013, embed and sustain evidence-based interventions in a minimum of 50 settings such as health centers, congregate meal sites, community centers, senior centers, etc., where older adults and persons with disabilities normally congregate.

Strategy 1-4: Create opportunities to help guide baby-boomers and active retirees towards healthy, productive and vital aging activities, and to help support the community inter-generationally with an volunteer-based older adult work force.

Objective:

1-4:1 By 10/1/2012, coordinate statewide with the Area Agencies on Aging, an attachment to their Senior Handbook focusing on active and productive aging, consistent with the Health - Older Adults and Aging section of the Governor's "A New Day in Hawaii" plan.

<u>Goal 2:</u> Enable older adults to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.

Strategy 2-1: Working closely with all service providers, administer existing Older Americans Act Title III home and community-based support programs such as adult day care, assisted transportation, attendant care, case management, chore, home-delivered meals, homemaker tasks, transportation, and personal care. Expand information and referral and better focused supports through the new Systems Change initiatives (Aging and Disability Resource Centers) to older adults, persons with disabilities, and their caregivers.

Objective:

2-1:1 By 12/31/2012, adequate information on provider capacity and provider quality will be integrated into Maui's Aging and Disability Resource Center's information and referral database to help reduce complaints regarding providers by 50%.

Strategy 2-2: Working closely with all service providers, administer current Kupuna Care services including adult day care, assisted transportation, attendant care, case management, chore, home-delivered meals, homemaker tasks, and personal care, and expand service areas based on the Kupuna Care Re-Visioning process of 2010 and the implementation of participant direction.

Strategy 2-3: Administer Older Americans Act Title III Part E supports for family caregivers including grandparents raising grandchildren, such as support groups, counseling, caregiver training (nutrition, health, decision-making), access assistance, and respite care.

Objective:

2-3:1 By 12/31/2013, assess the needs of family caregivers including grandparents raising grandchildren, and develop referral protocols for the Aging and Disability Resource Centers.

Strategy 2-4: Expand caregiver training to caregivers of the various residential alternative homes (adult residential care homes, adult foster homes, etc.) that also care for older adults.

Objective:

2-4:1 By 12/31/2012, develop in collaboration with Kapiolani Community college, a caregiver training curriculum for caregivers of residential alternative homes that also care for older adults.

Strategy 2-5: Assure through support for home modifications, that the homes of older adults remaining in their homes through the provision of home and community-based services are accessible and safe.

Objective:

2-5:1 By 12/31/2012, collaborate with the Disability and Communications Access Board on the Home For Life task force recommendations of 2010, and adopt the appropriate recommendations for accessibility and safety in homes that help promote independent living for older adults.

Strategy 2-6: Apply for funds through the Alzheimer's Disease Supportive Services Program at the next funding cycle.

Objectives:

2-6:1 By 10/1/2013, provide evidence-based support programs for persons with Alzheimer's disease and related disorders and their caregivers.

2-6:2 By 9/30/2015, extend evidence-based support programs for Alzheimer's disease related disorders to all counties.

<u>Goal 3:</u> Develop Hawaii's Aging and Disability Resource Center to its fully functioning capacity to serve as a highly visible and trusted place where all persons regardless of age, income and disability can find information on the full range of long-term support options.

Strategy 3-1: In 2011, begin the implementation phase of the Hawaii Systems Change Five-Year Plan submitted to Administration on Aging on March 31, 2011 (Appendix B).

Objective:

3-1:1 Administer and adhere to the detailed implementation tasks and corresponding timelines in the Hawaii Systems Change Five-Year Plan, resulting in fully functioning Aging and Disability Resource Center sites in all Planning and Services Areas (Maui County - 4/2012, Kauai County - 1/2013, Hawaii County - 3/2015, Honolulu County - 7/2015).

Strategy 3-2: Obtain resources to achieve and sustain the Aging and Disability Resource Center's staffing patterns needed to carry out the Hawaii Systems Change Five-Year Plan.

Objectives:

3-2:1 By 11/30/2011, develop a State funding proposal based on the Aging and Disability Resource Center's Five-Year Operation Plan and Budget as well as other funding sources, and submit the proposal via the Executive Branch for inclusion in the Governor's 2013 budget proposal.

3-2:2 By 11/1/2011, determine the ability to draw down Medicaid administrative Federal Financial Participation for Aging and Disability Resource Center functions.

Strategy 3-3: Develop, implement and improve a statewide protocol for options counseling.

Objective:

3-3:1 By 12/1/2011, initiate training Sage PLUS personnel (Hawaii's designated State Health Insurance Assistance Program) and Aging and Disability Resource Center staff members in all Planning and Services Areas to implement the statewide protocol for options counseling in their initial contacts with callers.

Strategy 3-4: Administer the participant-directed service option under the Community Living Program.

Objective:

3-4:1 By 9/1/2012, implement the participant-directed service option.

3-4:2 Beginning in 2012 as each county's Aging and Disability Resource Center becomes fully functioning (Maui County - 4/2012, Kauai County - 1/2013, Hawaii County -3/2015, Honolulu County - 7/2015), Veteran Directed Home and Community Based Services programs will be developed 6 months after a county's Aging and Disability Resource Center is fully functioning.

Strategy 3-5: Partner with stakeholders to enroll individuals in appropriate Medicare plans.

Sage PLUS is Hawaii's designated State Health Insurance Assistance Program. Sage PLUS is a volunteer peer-based organization, and is funded by a grant from the Centers for Medicare and Medicaid Services. Their program goals are to provide information and assistance to members with Medicare, their families, caregivers, and agencies throughout the State.

Objectives:

3-5:1 Continuing through the four-year State Plan on Aging period, Sage PLUS staff and volunteers will distribute annual information at local community events, provide counseling to at least 2,500 individuals, and provide at least 85 presentations to the community.

3-5:2 Continuing through the four-year State Plan on Aging period, Sage PLUS staff and volunteers will annually provide information on long-term supports insurance and financing and other Medicare benefits that enable them to remain in their own home.

Strategy 3-6: Promote state of the art management practices, including the use of performance-based standards and outcomes, and management information systems.

Objectives:

3-6:1 By 12/31/2011, the Executive Office on Aging and Area Agencies on Aging will begin to identify measurable performance indicators for monitoring and making program improvement decisions such as timeliness of delivery of core Aging and Disability Resource Center functions by the Area Agencies on Aging, and satisfaction with Aging and Disability Resource Center services.

3-6:2 By 7/1/2015, Management Information System will automate all Aging and Disability Resource Center's core operations such as receiving referrals, information and referral, intake, assessment, support planning, case management, and continuous quality improvement.

<u>Goal 4:</u> Manage funds and other resources efficiently and effectively, using person-centered planning to target public funds to assist persons at risk of institutionalization and impoverishment.

EOA obtained a discretionary grant from the Administration on Aging to provide a pilot program of participant-directed supports, Hawaii's Community Living Program, to at least ninety adults with limited incomes, but not Medicaid eligible, who may be at risk of placement in a nursing facility due to functional challenges. The purpose of the program is to help the targeted adults remain living in their own homes and avoid impoverishment.

Participant-direction is a service model that empowers public program participants and their families by expanding their degree of choice and control over the long-term services and supports they need to remain in their homes. The program will serve participants living in Kauai, Maui, and/or Hawaii counties by providing the individual a monthly budget to purchase supports such as employing personal assistance in the home or purchasing goods that support the participant to remain living at home. Approximately $500,000 is allocated as the aggregate budget to provide direct supports (funding the individual monthly budgets) for at least ninety individuals in the 12 month period of the project.

The Executive Office on Aging also obtained a hospital discharge planning discretionary grant that will meaningfully engage and solicit patient input and participation, and maximize the opportunity for Medicaid and non-Medicaid patients to return home with home and community-based services upon discharge. The evidence-based model will: 1) put the patient and caregiver(s) at the center of the discharge planning process; 2) focus on discharging patients to home and community-based services, via the Aging and Disability Resource Centers; 3) reduce the number of patients retained in acute care beds past the point of clinical discharge; and 4) reduce the number of default discharges from acute care units to nursing facilities.

The Community Living Program will identify at-risk individuals through the Aging and Disability Resource Centers, while the hospital discharge program will ensure referrals from hospital discharges to the Aging and Disability Resource Centers will be person-centered. Both programs will link these individuals to long-term services and supports to retain them in community living.

Strategy 4-1: Focus targeting tools to aim public funds toward interventions that will assist persons to remain at home who are at risk for more restrictive levels of care and are Medicaid ineligible, but at risk for spend down.

Objectives:

4-1:1 By 9/1/2012, 90 individuals who are not eligible for Medicaid but who are at risk of institutional placement and spend down to Medicaid, will have enrolled in Hawaii's Community Living Program and been offered participant-direction as an option.

4-1:2 90% of surviving enrollees will remain living in the community (avoiding placement in a facility) at the end of 12 months in the Community Living Program.

4-1:3 90% of surviving enrollees will avoid impoverishment as evidenced by income and assets in excess of the amounts for Medicaid financial eligibility.

Strategy 4-2: Encourage participants to take ownership of their support planning, with the assistance of family, caregivers and professionals as appropriate.

Objective:

4-2:1 By 4/1/2012, complete training and implementation of statewide assessment and support planning protocols and tools for Aging and Disability Resource Center's intake and options counseling.

Strategy 4-3: Develop and implement tools and practices necessary to offer participant-directed support models for persons using state, federal and/or private pay resources.

Objectives:

4-3:1 By 1/1/2013, recruit skilled, trained participant-direction coaches and financial management services to assist participants in all Planning and Services Areas to make full use of the participant-directed support model.

4-3:2 By 7/1/2013, older adults enrolled in the Kupuna Care state-funded support program will be offered the option of participant-directed supports.

4-3:3 By 7/1/2013, improve coordination between the Aging and Disability Resource Centers and Title VI Native Hawaiian grantee providers such as Alu Like, Inc., and Hana Health, by developing specific referral protocols for the Aging and Disability Resource Centers.

Strategy 4-4: Develop and implement care transition support via the Aging and Disability Resource Centers, for persons discharging to home after an acute care hospitalization.

Objectives:

4-4:1 By 12/31/2011, stakeholder workgroups will collaboratively design and embed in the Aging and Disability Resource Centers, a person-centered discharge planning model plus its associated tools, procedures and protocols.

4-4:2 By 12/31/2012, establish partnerships with at least one acute care hospital in each Planning and Services Area, and initiate delivering care transition support through the Aging and Disability Resource Centers, using the person-centered discharge planning model, tools, procedures and protocols developed by the Aging Network through the hospital discharge planning model grant.

<u>Goal 5:</u> Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Strategy 5-1: Advocate for older adults in long term care facilities.

The Long Term Care Ombudsman Program counsels, advocates and responds to complaints and problems on behalf of residents of nursing homes, adult residential care homes, expanded adult residential care homes, assisted living facilities and community care family foster homes. The Long Term Care Ombudsman Program works with residents and their families, facility staff, various advocacy organizations, provider groups, the media, legislators, family members and facility staff. The goal is to improve the quality of care and quality of life for Hawaii's 11,381 long term care residents by providing advocacy, information, referrals, and consultations to residents and families, service providers and the general public. The Long Term Care Ombudsman Program also works with national and state licensing and certification agencies to improve quality of care in the long term care facilities.

Objectives:

5-1:1 By 10/31/2012, the Executive Office on Aging and Department of Health will develop and agree to a Memorandum of Agreement or Understanding adopting policies regarding the Long Term Care Ombudsman Program consistent with Hawaii Revised Statutes 349, Sections 21-25, and the Older Americans Act, as amended, which reflect recent recommendations made by the Administration on Aging and the National Association of State United for Aging and Disabilities.

5-1:2 By 10/31/2012, the Long Term Care Ombudsman Program will have hired and trained a volunteer coordinator to recruit, screen, train and help supervise all ombudsman representatives.

5-1:3 By 9/30/2015, the Long Term Care Ombudsman Program will respond to 100% of complaints related to all long term care facilities within 72 hours.

5-1:4 By 9/30/2015, the Long Term Care Ombudsman Program will have posters up in 100% of every nursing home, assisted living facility and Aging and Disability Resource Center, with information on how to contact the Long Term Care Ombudsman Program if they feel their rights have been violated.

5-1:5 By 9/30/2015, the Long Term Care Ombudsman Program will have enacted a plan to expand its services across the State in protecting the rights of residents in all long term care settings.

5-1:6 By 9/30/2015, the Long Term Care Ombudsman Program, Executive Office on Aging, Area Agencies on Aging, Department of Health, Department of Human Services, Aging and Disability Resource Centers and community stakeholders will establish a

partnership to ensure that 25% of all residents are informed of their rights and protected from abuse, neglect and exploitation.

5-1:7 By 12/2014, increase the number of hospitals that use a statewide standardized guideline or hospital discharge to improve transition of care in all settings for acute care, from 0 to 14 (number of acute care hospitals in Hawaii).

5-1:8 By 12/2012, develop a policy statement to advocate for local and national efforts to simplify the administration of prior authorization of durable medical equipment and resources.

The Long Term Care Ombudsman Volunteer Program assists the Long Term Care Ombudsman Program in meeting the requirements stated in HRS 349, Section 21-25, and the Older Americans Act, as amended. Trained and certified volunteers in the Long Term Care Ombudsman Program are designated as representatives who have the capability and responsibility to support, educate, and empower residents with information and assistance to protect themselves from abuse, neglect, exploitation and advocate for their rights and quality of life.

5-1:9 By 9/30/2015, the Long Term Care Ombudsman Program, Executive Office on Aging, Area Agencies on Aging, and community stakeholders will partner and create a plan for recruiting, training and supporting 20 new volunteers to speak on behalf of residents in long term care settings who can no longer, or are afraid to, do so on their own.

5-1:10 By 9/30/2015, there will be at least one Long Term Care Ombudsman Volunteer Representative for each nursing facility and assisted living facility in the State to advocate on behalf of residents who can no longer do so on their own.

5-1:11 By 9/30/2015, there will be at least one Long Term Care Ombudsman Volunteer Representative for every 20 Adult Residential Care Homes and every 20 Community Care Foster Family Homes in the State to advocate on behalf of residents who can no longer do so on their own.

5-1:12 By 9/30/2015, at least 50% of all older adults residing in a long term care setting will be informed of their rights, benefits and services as a result of face-to-face visits by an ombudsman representative.

Strategy 5-2: Develop and offer legal services, information, and assistance to older adults (Older Americans Act *Title VII Chapter 4).*

Objective:

5-2:1 By 6/30/2012, have in place a Legal Services Developer within the Executive Office on Aging to address the provisions of Older Americans Act Title VII Chapter 4, ensuring:

- State leadership in securing and maintaining the legal rights of older individuals;
- State capacity for coordinating the provision of legal assistance;
- State capacity to provide technical assistance, training, and other supportive functions to area agencies on aging, legal assistance providers, ombudsmen, and other persons, as appropriate;
- State capacity to promote financial management services to older individuals at risk of conservatorship;
- State capacity to assist older individuals in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law, and maintaining the rights of older individuals at risk of guardianship; and
- State capacity to improve the quality and quantity of legal services provided to older individuals.

Strategy 5-3: Partner with stakeholders to prevent fraud, waste and abuse.

Senior Medicare Patrol Hawaii recruits and trains retirees as volunteers to conduct education to help prevent Medicare and Medicaid fraud. Senior Medicaid Patrol Hawaii volunteers and staff disseminate information about Medicare and Medicaid fraud through outreach campaigns, assist beneficiaries in correcting billing errors, and make referrals of suspected cases of fraud and abuse to appropriate enforcement and compliance agencies.

Senior Medicare Patrol Hawaii will embark in 2012 on a media campaign that includes volunteer recruitment through radio public service announcements to 1) recruit bilingual volunteers who speak English and Ilocano, Tagalog, Cantonese, or Vietnamese by broadcasting public service announcements on radio programs aimed at those language populations in Hawaii; 2) recruit baby boomers by broadcasting public service announcements on a public radio station in Hawaii; and 3) recruit males by broadcasting public service announcements on a sports radio station, to rebalance the current four-to-one ratio of females to males in the Senior Medicare Patrol Hawaii project. Public service announcements will also be broadcasted on the Olelo public access TV channel.

Objectives:

5-3:1 By June 2012, Senior Medicare Patrol Hawaii will expand its outreach capacity by recruiting 30 new volunteers statewide through a campaign spearheaded by a new volunteer recruitment public service announcement that will be televised statewide.

5-3:2 By June 2012, Senior Medicare Patrol Hawaii will have completed a stand-alone website, also linked to HawaiiADRC.org, that will provide access to fraud alerts, means to easily contact Senior Medicare Patrol Hawaii, and a more efficient method to submit volunteer reports.

5-3:3 By June 2012, Senior Medicare Patrol Hawaii will have a volunteer management system that will include a standard Senior Medicare Patrol Volunteer Foundations Training program and a volunteer Senior Medicare Patrol program risk management policy developed by the Administration on Aging for implementation by all Senior Medicare Patrols.

Strategy 5-4: Partner with stakeholders to develop culturally-appropriate materials, recruit bilingual volunteers, and educate limited English proficient populations about Medicare and Medicaid errors, fraud, and abuse.

Various data indicate that Native Hawaiian, Pacific Island, and Southeast Asian populations are vulnerable to healthcare fraud schemes due to language and cultural barriers. Senior Medicare Patrol Hawaii, in partnership with the Office of Language Access in the Department of Labor and Industrial Relations, State of Hawaii, will identify limited English proficient populations to target for: 1) recruitment of bilingual volunteers, 2) translation of educational materials for use in outreach, and 3) implementation of a statewide campaign to educate limited English proficient populations about Medicare and Medicaid errors, fraud, and abuse.

Objectives:

5-4:1 By 12/2011, through a partnership with the Office of Language Access, Senior Medicare Patrol will have resource material translated into the language of a targeted limited English proficient population in Hawaii.

5-4:2 By 12/2012, four fraud prevention meetings will have been held in limited English proficient communities on Kauai, Lanai, Maui, and Hawaii.

5-4:3 By June, 2012, all Senior Medicare Patrol Hawaii volunteers will be trained in cultural competency and use of interpreters in order to expand outreach to limited English proficient populations in Hawaii.

5-4:4 By June 2014, Senior Medicare Patrol Hawaii will recruit and train at least 10 bilingual volunteers, encompassing all four Hawaii counties, to bolster outreach to a targeted limited English proficient population.

Goal 6: Ensure that Hawaii's Elders will be included in Emergency and Disaster Planning at the State and Local Levels.

Strategy 6-1: The Director of the Executive Office on Aging will coordinate and align with the Federal Emergency Management Agency, State Civil Defense, County Civil Defense Agencies, Department of Health, American Red Cross, Disability and Communication Access Board, and other agencies involved with emergency and disaster planning.

Objectives:

6-1:1 Starting in October, 2011 and thereafter, the Executive Office on Aging will participate biannually with the planning group of the Interagency Action Plan For the Emergency Preparedness of People with Disabilities and Special Health Needs sponsored by the Disability and Communication Access Board and State Civil Defense, to help update the plan and give input on older adults and individuals with disabilities (August 2009 Plan - Appendix D).

6-1:2 By December, 2011 the Executive Office on Aging will revise its Continuity of Operations Plan, which details the operations and resources needed to ensure Executive Office on Aging continuity of operations during a disaster or national emergency.

6-1:3 Starting in January, 2012, the Executive Office on Aging will assist and coordinate with the Area Agencies on Aging, evacuation, relief and disaster emergency response programs to meet the needs of the older adults during disasters, utilizing the State Aging and Disability Resource Center website as a means to educate and communicate with older adults on emergency preparedness.

6-1:4 The Executive Office on Aging and Policy Advisory Board for Elder Affairs (Legislative Committee) will submit in the 2012 Legislative Session, a bill requiring condominium managers to develop and upkeep registries of vulnerable persons and have plans for assistance in case of emergencies.

Chapter 4: Expenditure Plan

Intrastate Funding Formula (See Appendix D)

The Executive Office on Aging is the designated State agency with the responsibility for developing an Intrastate Funding Formula to distribute Older Americans Act Title III funds to its Planning and Service Areas. The Intrastate Funding Formula reflects the best available data on the geographic distribution of the characteristics of individuals aged 60 and older in the State of Hawaii.

Under the Older Americans Act, older adults with the "greatest economic need" and "greatest social need" are given preference. The "greatest economic need" is defined as the need resulting from an income at or below the poverty line as defined by the Office of Management and Budget and adjusted by the Secretary for the U.S. Department of Health and Human Services. The "greatest social need" is defined as the need caused by non-economic factors which include: physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently.

The entire revised Intrastate Funding Formula, approved by the Assistant Secretary for Aging in September, 2009, is available in Appendix D.

Appendices:

Appendix A: Assurances and Required Activities
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through

contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older

individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after

assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

INFORMATION REQUIREMENTS

Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))

The term “in-home services” includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

Section 305(a)(2)(E)

Provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Section 306(a)(17)

Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Section 307(a)

(2) The plan shall provide that the State agency will:

(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

Section (307(a)(3)

The plan shall:
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8)) (Include in plan if applicable)

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Section 307(a)(21)

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Section 307(a)(28)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Section 307(a)(29)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies

responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Section 307(a)(30)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

Signature and Title of Authorized Official

Wesley Lum, PhD, MPH

DIRECTOR, EXECUTIVE OFFICE ON AGING

7/22/11

Date

Appendix B: Hawaii Systems Change Five Year Plan

Hawaii Systems Change Initiative

FIVE-YEAR PLAN FOR IMPLEMENTING:

Aging and Disability Resource Center (ADRC)

Community Living Program (CLP)

Person-centered Hospital Discharge Planning (HDP) Initiatives

March 15, 2011

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Hawaii Systems Change: Five-Year Plan

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Executive Summary

The State of Hawaii, Department of Health, Executive Office on Aging (EOA), the four county Area Agencies on Aging (AAAs), and HCBS Strategies serving as the Systems Change Developer (SCD), have developed a five-year plan for implementing the following three initiatives:

- A statewide Aging and Disability Resource Center (ADRC) effort that will meet the Administration on Aging's (AoA) criteria for a full-functioning ADRC,
- The Community Living Program (CLP), and
- The person-centered Hospital Discharge Planning (HDP) initiative.

This five-year plan is the result of collaboration and workgroup discussions with EOA, the four county AAAs (Honolulu, Hawai'i, Maui, and Kauai counties), and other respective stakeholders. The overall five-year implementation plan in this document consists of:

- A detailed description of the key operations that will be built and adapted to the existing county and statewide infrastructure.
- The identification of enhancements needed to management information systems (MIS) tasks and the plan for making these enhancements.
- A description of the effort to estimate staffing and infrastructure costs necessary to implement the five-year plan, including the ability to reallocate existing resources and draw down Medicaid Administrative Federal Financial Participation (FFP) to offset these costs.
- A detailed plan identifying the dependent tasks and proposed timeframes for implementing the statewide ADRC operational model.
- An ongoing planning process to guide the implementation of the plan.

When successfully implemented, these systems change efforts will help the state by:

- Improving operations across counties through standardization of tools and the adoption of common performance standards.
- Ensuring that older adults and individuals with disabilities can make informed choices about how to meet their long-term care needs.
- Positioning the state to respond to federal initiatives and requirements affecting health care and long term care services.
- Helping residents of Hawaii keep their loved ones in the community by building programs that support the spirit of 'ohana.

Chapter I: Background

Introduction

The State of Hawaii, Department of Health, Executive Office on Aging (EOA), the four county Area Agencies on Aging (AAAs), and HCBS Strategies serving as the Systems Change Developer (SCD), have developed a five-year plan for implementing the following three initiatives:

- A statewide Aging and Disability Resource Center (ADRC) effort that will meet the Administration on Aging's (AoA) criteria for a full-functioning ADRC,
- The Community Living Program (CLP), and
- The Person-centered Hospital Discharge Planning (HDP) initiative.

Folding these initiatives together, this systems change effort marks a substantial change in how EOA and the AAAs will conduct their business. The primary benefits of these changes include:

1) **Improving operations across counties through standardization of tools and the adoption of common performance standards**: The counties currently have dramatically different ways of fulfilling their role in assisting older adults to make informed decisions about long-term care options and overseeing state Kupuna Care (KC) and federal Older Americans Act (OAA) funded programs. The effort standardizes core pieces of operational infrastructure, such as intake and assessment tools, while allowing the counties to have flexibility in designing program operations that reflect each county's structure and the needs of its citizens.

2) **Ensuring that older adults and individuals with disabilities can make informed choices about how to meet their long-term care needs**: This effort increases the capacity within each county to provide unbiased, useful information and counseling to help individuals and their families make independent and informed choices. Currently, in some counties, individuals may have to refer to multiple resources to discover available options for meeting their long-term care needs. In many cases, decisions regarding what services an individual can get are made by private sector agencies also providing these services. This creates an inherent conflict-of-interest for providers, as there may be strong incentives to recommend their own services or to turn away individuals who may be difficult and costly to serve.

3) **Positioning the state to respond to federal initiatives and requirements affecting health care and long term care services:** Health reform and other federal initiatives are creating pressure for states to create an independent single point of entry that will assist individuals to navigate long-term care choices. This effort will help the state comply with the following federal guidance and requirements:

    a. The Administration on Aging's (AoA) criteria for a full-functioning ADRC.

    b. AoA guidance regarding the need to develop infrastructure to target OAA services to individuals at greatest risk of institutionalization and spend down to Medicaid.

c. The Centers for Medicare and Medicaid Services' (CMS) requirement for "conflict-free" case management included in regulations for Targeted Case Management and from provisions of the Affordable Care Act.

d. CMS guidance for a single point of entry included in the requirements for the Money Follows the Person Demonstration and the upcoming Medicaid State Balancing Initiative.

e. CMS requirements for implementing Section Q of the CMS' mandated Minimum Data Set (MDS) for nursing facilities requiring that each state be able to provide guidance to individuals in nursing facilities who would like to move back to the community.

f. Positioning the state to have a neutral party available to assist individuals with core decisions related to the Community Living Assistance Services and Support Act (CLASS Act) provision in the Affordable Care Act.

4) **Helping residents of Hawaii keep their loved ones in the community by building programs that support the spirit of 'ohana**: These efforts will provide individuals and their families with the information and guidance needed for finding a way to support loved ones in the community. In addition, the participant-directed option will provide individuals and their families with more control over the support they receive by allowing them to hire people from their communities.

This document details the integration of these three initiatives into a statewide operational model. This five-year plan was developed as a result of collaboration and workgroup discussions with EOA, the four county AAAs (Honolulu, Hawai'i, Maui, and Kauai counties), and other respective stakeholders. The overall five-year implementation plan in this document consists of:

- A detailed description of the key operations that will be built and adapted to the existing county and statewide infrastructure.
- The identification of enhancements needed to management information systems (MIS) tasks and the plan for making these enhancements.
- A consolidated budget that identifies the staffing and infrastructure costs necessary to implement the five-year plan, including the ability to reallocate existing resources and draw down Medicaid Administrative Federal Financial Participation (FFP) to offset these costs.
- A detailed plan identifying the dependent tasks and proposed timeframes for implementing the statewide ADRC operational model.
- An ongoing planning process to guide the implementation of the plan.

Developing the Plan

The systems change effort to develop the ADRC operational model and five-year implementation plan included a review of the current operations at each county AAA, the exploration of promising practices to enhance the ADRC, establishment of workgroups to focus on ADRC operations, and use of the workgroups to build consensus and a model for the core operations of the ADRC.

Review of current operations

An initial discovery and review of the current operations at the state and at each individual county AAA was conducted through onsite interviews. A SWOT analysis was used to review the Strengths, Weaknesses, Opportunities, and Threats at both the state and county levels. These initial findings offered a starting point for discussions about the systems change effort needed to implement the vision of a full functioning ADRC.

ADRC Recharge Conference

To kick-off the systems change effort, the state hosted a daylong ADRC Recharge Conference event for stakeholders and representatives from the state and counties. The conference provided information and gathered feedback about the three federal grants that would be part of the systems change effort: The Community Living Program, The Person Centered Hospital Discharge Planning Model and ADRC Expansion grants. The conference also provided an opportunity for the stakeholders to start providing input to the planning process.

Background research on promising practices

In developing a unified operational model, HCBS Strategies conducted extensive background research on promising practices to provide options for adaptation in Hawaii. Examples of these promising practices include standardized intake and assessment tools, development of common definitions, targeting and triage protocols, person-centered principles, and continuous quality management strategies. While some information was presented and introduced at the kick-off ADRC Recharge Conference, the bulk of the information was presented during the 36 workgroup meetings. These promising practices and concepts were points of discussion leading to integration of the concepts into the operational model.

Operational Workgroups

To focus on specific areas and components of the five-year operational plan, workgroups discussed the core operational functions of the systems change effort. Each workgroup included representatives from EOA, the county AAAs, and other state/county stakeholders familiar with specific topic areas. The workgroups include:

- **Core ADRC Operations** (ten meetings lasting 2.5 hours each): This workgroup achieved consensus regarding the core business processes, requirements, and tools that will help standardize and streamline ADRC operations.
- **Enhancing ADRC Centrality** (six meetings lasting 2 hours each): This workgroup set expectations regarding the role of the AAAs and their ADRC operations in key processes such as eligibility determinations, individual support plan development, and the management of waitlists and service provision. The members of the workgroup also explored the county operational changes required in order to meet these new requirements, including necessary staffing increases and changes in qualifications.

- **Hospital Discharge Planning** (three meetings lasting 1.5 to 3 hours each): This workgroup developed the operational model for the person-centered hospital discharge planning effort.
- **Participant Direction** (seven meetings lasting 2.5 hours each): This workgroup made decisions regarding core systems infrastructure necessary to offer a participant-directed option. Examples of infrastructure include the model for fiscal management services (FMS) provider and support brokers, and tools necessary to assist program participants with managing individualized budgets.
- **Management Information Systems** (MIS) (four meetings lasting 2.5 hours each): This workgroup identified MIS requirements necessary to support the proposed operations. This included work with Harmony Information Systems, Inc. to develop a plan for meeting these requirements using upgrades to the current Harmony SAMS product.
- **Financing and Sustainability** (six meetings lasting 2.5 hours each): This workgroup identified the estimated costs of implementing the systems change efforts and developed plans for reallocating existing funds and securing Medicaid administrative federal financial participation (FFP) to offset some of the funding requirements of the operational model.

The workgroup discussions and materials are documented on dedicated blogs for each workgroup and serve as a historical log of the development process of the systems change effort.

The decisions and standards recommended by the workgroups form the basis for the five-year implementation plan. Because the workgroups achieved consensus on the core operational model, they were able to make specific recommendations in many areas.

Primary Enhancements

A core decision includes consensus on the vision of each county AAA serving as the single point of entry (SEP) for Kupuna Care and Older Americans Act (OAA) services under the common ADRC operational model. Kupuna Care and OAA services and supports help older adults live independently and safely in the community for as long as possible.

This vision and the adoption of a common model require operational refinements and restructuring in all counties – with some counties requiring more expansive changes than others. While this transformation will present challenges, the result will help ensure a more comparable approach to providing assistance and services, while recognizing the differences in each county's infrastructure and resources.

Statewide implementation will occur by transitioning counties over time. Maui will be the first to implement the plan, followed by Kauai, Hawai'i county, and finally to Honolulu county. Some implementation activities may occur concurrently across the state.

The following areas outline the major enhancements and shared vision for the five-year implementation plan.

Establish a Single Entry Point

A central vision of the ADRC is for the AAA to become a single point of entry for individuals to access supports and services. While the ADRC will be the gateway for older adults to access Kupuna Care and Older Americans Act services, as well as private pay options for all populations, the AAA will also provide information, referrals and linkages for disability groups that include adults with physical disabilities, individuals with developmental disabilities or mental illness, and children with long-term support needs. The ADRC will also screen and link individuals to the state Medicaid agency, Med-QUEST, if it is determined that the individual requesting assistance is likely to be Medicaid eligible.

Exhibit 1 summarizes the core ADRC services provided for the following groups.

Exhibit 1: Summary of ADRC Services for Aging and Disability Populations

Services	Individuals ages 60 and older	Adults with physical disabilities	Developmental Disabilities	Mental Health	Children
Kupuna Care	◆				
OAA Title III	◆				
Medicaid Eligiblity Screening	◆	◆	◆	◆	
Enhanced I&R and Referral	◆	◆	◆	◆	
Referral					◆

Common Protocols for Core Operational Functions

Core operational functions include the capacity to perform intakes, assessments, eligibility determination, support planning, and case management services. The use of common protocols and tools will allow core ADRC operations to be streamlined, reducing the likelihood of gaps in program participant information, and prevent possible delays in providing services and supports. It will also improve the ability of the state and county AAAs to better monitor programs and services. For example, the state will be able to monitor and compare the effectiveness of the support programs across counties, measure utilization to assign appropriate resources, and conduct other quality and performance measures.

Reorganization in Counties

A key task in the system change is the reorganization necessary in each county to accomplish the implementation of the ADRC operational model. Counties will need to alter the staff size and/or skill sets to support the AAAs ability to perform the core ADRC functions. ***Exhibit 2*** summarizes the core reorganization tasks.

Exhibit 2: Summary of core changes each county will need to make to their operations to comply with the ADRC Full-Functioning Criteria

County AAA	Reorganization Tasks
Maui	• Increase Qualifications of Staff Conducting Assessments • Bring Case Management in-house
Kauai	• Increase Qualifications of Staff Conducting Initial Intake • Increase Qualifications of Staff Conducting Assessments
Hawai'i	• Increase Qualifications of Staff Conducting Initial Intake • Increase Qualifications of Staff Conducting Assessments • Shift assessment function into AAA from Coordinated Services • Bring Case Management in-house
Honolulu	• Increase Qualifications of Staff Conducting Initial Intake • Increase Qualifications of Staff Conducting Assessments • Shift assessment and eligibility functions into AAA from providers • Bring Case Management in-house

Leadership and guidance from EOA

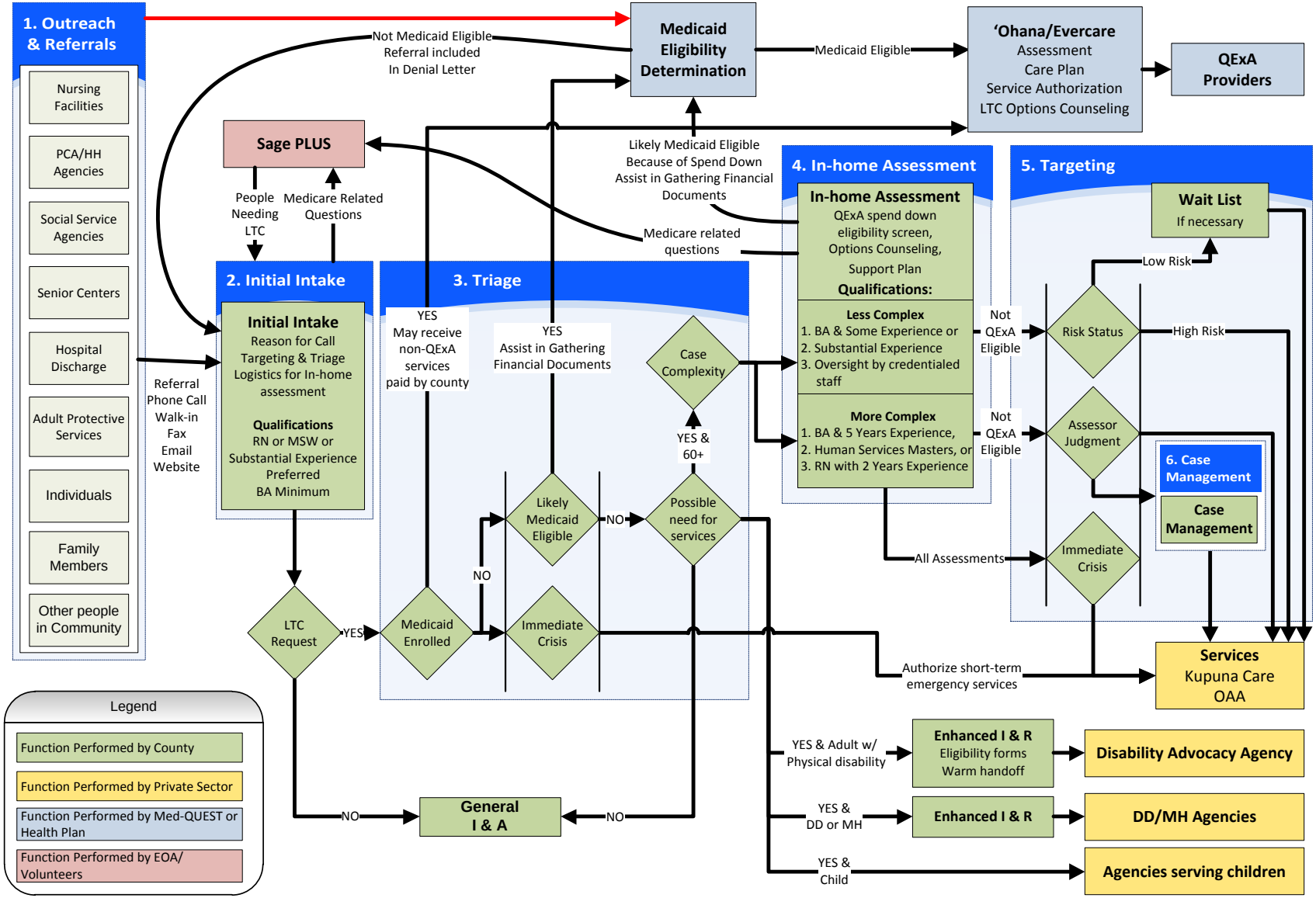
EOA's leadership and continued partnership with each AAA is vital to achieving the organizational changes and sustainability for the systems change efforts. EOA will provide committed leadership and guidance through supporting the county AAAs in justifying infrastructure changes and requesting additional resources and approval from each respective county executive and legislative bodies. EOA will assist the county AAAs to pursue grants and funding opportunities that enhance the sustainability and functions of the ADRC. Other EOA activities will include facilitating training, connecting the AAAs to other state agencies, and providing other supports that will lead to a more effective and efficient ADRC.

Chapter II: Operational Model

This chapter summarizes the key operational components of the systems change effort. To assist in understanding the core operations, a visual depiction of the ADRC model is included as part of this plan. (See ***Exhibit 3***) The numbering of core ADRC functions (numbered 1, 2, 3, 4, 5, and 6) in the flowchart (Exhibit 3) corresponds to the heading sections numbering scheme in this chapter.

[***Exhibit 3*** on next page]

Exhibit 3: Full Functioning ADRC Operations Model



1. Referrals

Develop protocols for referrals to ADRC

As the single entry point for older adults to access to Kupuna Care and OAA supports and services, the AAA must have a process to receive inquiries and referrals from various referral entities. While individuals may contact the county AAA directly, the standards and protocols on referral information received will enhance the process in appropriately connecting individuals with available supports and services.

Exhibit 4 outlines the basic referral information that should be collected when developing the referral protocol.

Exhibit 4: Core information to be collected about referrals to the ADRC

Information	Description
Client Name	First Name, Last Name, Middle Initial
Phone Number	Home, Work, Mobile Number(s)
Email	Email address
Physical Address	Client Residence
Contact Preference	Preferred time and method of contact
Point of Contact	E.g., referral agency name, outreach event, etc.
Referral Made By	E.g., referred by family/guardian, agency, etc.

Establish common methods for referral submissions

Although referrals to the ADRC from entities in the community or partner agencies may occur through the AAA website, phone, fax, or via email, the operations will be designed to encourage referrals through the ADRC website whenever practicable. Web-based referrals will allow information to be imported directly within the Harmony for Aging system (HfA), reducing staff time and minimizing data entry errors.

The Core ADRC Workgroup classified common referral sources by the expected volume of referrals to the ADRC (see ***Exhibit 5***). These were also broken down by whether efforts to establish memorandums of understanding (MOUs) and training with the referral source was better conducted at the state or county level.

Exhibit 5: Sources of Referrals to the ADRC by Expected Volume

High Volume: State Level Referral Agencies		
211	Adult Protective Services	Evercare/'Ohana
Hawaii CIL	Mental Health Access Line	Private Health Plans
Public Health Nursing	Social Security Administration	Veteran's Affairs
High Volume: County Local Level Referral Agencies		
Adult Day Care	Contracted Service Providers	County Agencies
Friendly Visiting	Health Clinics	Home Health/Personal Care
Homeless Shelters	Hospice	Hospitals
Native Hawaiian Health System	Physician Offices	Rural Health Organizations
Senior Centers	Senior Housing	Skilled Nursing Facilities
Low Volume: Referral Agencies		
ARC	Employers	Faith Based Organizations
Hawaii Disability Rights Center	Nutrition Sites	Other Health Care Agencies
Pharmacies	Service Based Organizations	Visitors Bureau

EOA will establish a state level MOU with statewide agencies and organizations. This includes a common referral process to each county AAA. Each county AAA will establish agreements with the other identified high volume referral sources. These agencies are local by county; and therefore are best suited for local level MOUs. Under these arrangements, EOA and the AAAs will provide training to each referral source on a regular basis regarding the purpose of the ADRC and the process for making a web-based referral. The agency making the referral will be expected to make web-based referrals wherever possible, but they will be encouraged to follow-up with a phone call if they feel it would be helpful to share additional information with the AAA.

Low volume referral sources that tend to serve populations outside the typical AAA referral will be provided with ADRC contact information and outreach materials. MOUs and regular training are not expected for these agencies.

HIPAA compliance regulations for transmitting client information

The county AAAs and EOA will establish HIPAA compliance protocols for transmitting and receiving participant information. HIPAA compliance protects an individual's sensitive health information and establishes assurances that information is shared only with authorized and appropriate entities. Accomplishing HIPAA compliance may involve securing participant information and building proper protections such as authorized access to information systems and establishing document storage and document destruction procedures. Compliance protocols will need to be in place at both the agency making the referral and at the county AAA.

Referrals from Med-QUEST

An MOU will be established by EOA with Med-QUEST, the state Medicaid agency, for making referrals to the county AAAs. Med-QUEST will make referrals to the ADRC for individuals who are not eligible or become ineligible for Medicaid services and are in need of support services or linkages. Med-QUEST will use the denial letters that it sends to individuals as the primary mechanism for making these referrals. Initially, Med-QUEST will add language that describes the ADRC effort and provides contact information for individuals ages 60 and older who receive a rejection letter. As the AAAs increase their capacity to provide support to other disability populations, the scope of this effort will expand.

2. Initial Intake

Initial intake involves collecting key information during the initial contact and determining what action, if any, should be taken. This first contact can occur when an individual contacts the AAA directly (e.g., phone call or walk-in) or when AAA intake staff follows up on a referral made from an agency in the community. The range of actions during the first contact can include:

- Information and assistance only;
- Information and referral to another agency;
- Referral to Med-QUEST to start the Medicaid eligibility determination process and assistance in completing necessary forms; and
- Determination that an in-home assessment is justified.

The systems change effort for the initial intake will be to create common intake tools and processes, as well as, a common baseline for intake staff qualifications.

Qualifications for Intake Staff

Building the staffing capacity to achieve the ADRC operational initial intake function will require that each county adopt a common set of minimum qualifications, competencies, and training requirements for their intake staff. Minimum qualifications for initial intake staff include:

- A bachelor's degree
- Preference for a MSW, RN or comparable degree in human services

- May substitute substantial experience and demonstrated skill to perform intake tasks in lieu of a degree
- Alliance of Information and Referral Systems (AIRS) certification (training after hire is acceptable)

New staff hires will be subject to these qualifications. Existing staff may have these qualifications waived and training will be provided to bridge any skill gaps. With an increase and standardization of intake staff qualifications, the AAAs will propose increases in the pay grades to correspond to these qualifications. These changes will require some restructuring of staffing guidelines, involving legislative and executive approvals for each respective county.

I & R Database and Resources

For the initial intake staff to be effective, they must have access to a searchable database containing information about the range of long-term care programs and providers. To support the information and referral functions, the state will develop a consolidated resource database on the Harmony for Aging management information system (HfA). All the counties have already started this effort by entering basic information about their providers into the Harmony system. The systems change effort will enhance this work through the creation of a statewide consolidated database that will be shared by the AAAs. This database will contain standardized information and descriptions, detailed information about the range of eligibility criteria, and information about provider capacity and quality. The state will procure technical assistance from Harmony to configure the HfA to support the ADRC operational model.

Information to be included in database

The implementation of the information and referral database will include information that is organized using the AIRS taxonomy. The AIRS taxonomy is a standard for classifying information and referral resources. AIRS certification will be a skills requirement for appropriate AAA staff. ***Exhibit 6*** lists the information about provider capacity that will be collected for the Information & Referral resource database. Finalization of the list will occur as part of the ADRC implementation and integration into the HfA will occur as part of the MIS plan.

Exhibit 6: Information about Provider Capacity that Will Be Included in the Information and Referral Database

Provider Information	Description
Contact information	Agency name, address, phone, email
Eligibility criteria	E.g., program requirements including minimum age, income, service area, etc.
Languages spoken	Listing of languages spoken by staff/volunteers
Business hours	Days and times of operation
Payment Type	Type of payment including sliding scale, set rates, average costs, etc.
Accepted Payment Forms	Forms of payment accepted, e.g. Medicare, Medicaid, and/or private pay
Accessibility	Is the office location ADA accessible?
Catchment area	Area and population that agency provides services
Organization status	For-profit, not-for-profit, or government agency
Licensures and certifications	Status on licensures, certifications, and whether the agency is bonded
Intake	Contact points to begin intake and linkage with agency
Service description	Services and supports that are provided by the agency
Area of specialization	Any specific target groups that agency specializes (e.g., older adults, developmental disabilities/mental health, physical disabilities, etc.)
Complaints and grievances	Mechanisms for consumer to submit complaints
Oversight agencies	Agencies and resources that monitor the provider agency , verifying that the business is conducted under applicable laws and guidelines

In addition to collecting information on provider capacity, the work plan calls for integrating information on provider quality. The scope of provider quality information will expand over time. The following are the initial categories of provider quality information to be incorporated:

- CMS/Federal provider review data (e.g., for nursing facilities and home health agencies).
- Information collected by the HI Department of Health on Adult Residential Care Homes: This effort will involve advocating for making these data publicly available and incorporating them into the database.
- Information collected by the HI Department of Human Services on Community Care Family Foster Homes.

- Data collected as part of AAA reviews of local providers: This effort will require that the AAAs first develop a standardized tool or tools for use in monitoring and collecting data about providers.
- Reports providers create about their own quality assurance efforts: The AAAs will likely want to establish a standardized mechanism for reporting.

At a later point in time, EOA and the providers will also explore incorporating the ability for individuals who use services to provide their own input into the database, similar to the star ratings and customer reviews used by Amazon.com or the many other online resources that incorporate consumer reviews. If the state chooses to go in this direction, it will need to establish mechanisms for vetting these reviews and allowing providers to respond to those consumer reviews.

Maintaining the database

EOA and the county AAAs will be responsible for gathering and verifying the information entered on the consolidated I&R database and ensuring the data are up-to-date. Information and resources for statewide agencies and programs will be entered by EOA, while county specific information will be entered and verified by the respective county AAA. As part of this task, EOA and the AAAs will explore opportunities for providers to submit basic agency information and updates to the database. EOA and the AAAs will develop a process to verify and maintain the accuracy of the information in the database.

Information on programs and other supports

In addition to provider information, the I&R database will include information about long-term care services and other supports that benefit older adults and individuals with disabilities. The database will include information such as service or benefit options, and eligibility criteria. These resources will supplement the ability of the ADRC staff to direct individuals inquiring about disability services, mental health, or Veteran services.

The systems change effort will seek to incorporate information from other databases, including the following:

- 211 Information and Referral Hotline database
- Behavioral Health, Network of Care database
- DCAB resource directory and information

There will be an effort to integrate links on webpages from other sources, such as those provided on the DHS, DOH Office of Health Care Assurance, and Medicare.gov websites. In addition, Maui County will be taking the lead in cataloguing the eligibility criteria and services and benefits offered by these entities, such as the Division on Developmental Disabilities (DDD).

Streamlining Access for Disability Populations beyond Older Adults

While the AAAs primarily provide supports and services for older adults, meeting AoA's full functioning ADRC criteria will require the AAAs to be a resource to link and refer individuals with disabilities to needed services. The AAAs will meet this requirement by offering enhanced information and referral to

those individuals. This requires developing a knowledgebase and understanding about the range of needs and service options for various disability populations. This includes such tasks as training AAA staff on basic supports for disability populations, verifying accessibility of the ADRC website, a familiarity with disability agencies, protocols to transmit referral information to disability agencies, and an understanding of respective consent protocols (e.g., guardian consent for some individuals with developmental disabilities or parental consent for children).

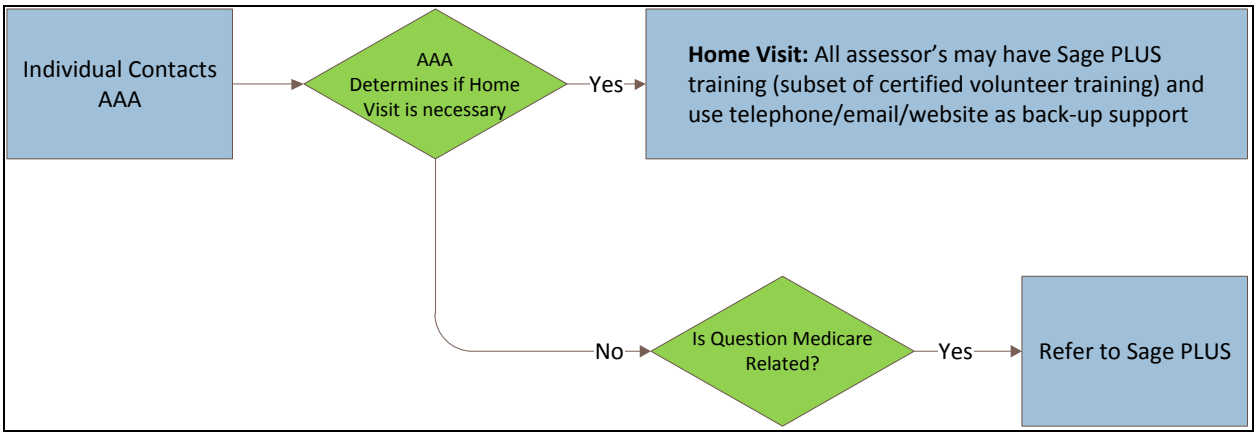
As outlined in ***Exhibits 1 and 3***, under the ADRC model, the AAA will provide enhanced information and referral to adults with physical disabilities, developmental disabilities, mental illness, and children needing long-term care supports. This enhanced I&R will include providing specific information about the programs and services they may be eligible to receive. Under the systems change effort, EOA and the AAAs will be working with their disability partners to ensure that individuals are referred to the appropriate entity and that problems with system navigation are minimized. For example, EOA has already reached a preliminary agreement with DDD that will allow the AAA staff to directly transfer calls to the DDD intake unit.

Integration with Sage PLUS

Sage PLUS provides one-to-one assistance with Medicare related inquiries and questions to individuals, their families, caregivers, and other agencies throughout Hawaii. Sage PLUS has a limited number of paid staff and a network of trained volunteers to assist them in this role. Because Sage PLUS also plays an information and assistance role, it was necessary to clarify how it would intersect with the AAAs in this ADRC operational model.

Exhibit 7 shows the proposed workflow between the AAAs and Sage PLUS. During the initial intake, individuals calling the ADRC who are not referred for an in-home assessment and only have a Medicare related question will be referred to Sage PLUS. For other individuals, the AAA staff conducting the in-home assessments will receive a modified version of the Sage PLUS training so that they can answer common Medicare related questions. If a question arises that the in-home assessment staff cannot answer, the staff will be able to call one of the Sage PLUS paid staff to obtain an answer, ideally, during the home visit. Sage PLUS volunteers will also receive training regarding the services offered under the ADRC model so that they can appropriately refer individuals to whom they provide counseling.

Exhibit 7: Proposed Integration between the ADRC Effort and Sage PLUS



Common Intake Tool

The implementation of the initial intake requires the development or adaptation of a common intake tool and protocol. EOA and the AAAs will explore the interRAI screening tool and develop the initial intake criteria. InterRAI (www.interRAI.org) is a collaborative network of researchers who have developed evidenced based assessment tools, such as the MDS-Home Care (now known as the interRAI-HC). EOA and the AAAs are considering using the interRAI-HC as the primary tool for in-home assessments discussed in section 4 of this chapter. This interRAI screening tool will document an individual's first contact with the AAA. The protocol will assist the intake staff on determining whether the individual has a general information request or the individual is in need of an assessment for support services.

3. Triage

The initial intake staff will need to triage contacts into one of the following:

- Information and assistance only;
- Information and referral to another agency;
- Referral to Med-QUEST to start the Medicaid eligibility determination process and assistance in completing necessary forms; and
- Determination that an in-home assessment is needed.

Exhibit 3 shows the order of this triage process. The steps in the process are described below.

Determine if LTC request or general I & A

During the initial intake stage, the AAA intake staff will determine if the individual is requesting assistance for long-term care supports or if the request is more general, such as information as the location of the hospital, senior center, or medical clinic. The triage protocol will include a limited number of items to ask in this screen.

Screen for Medicaid enrollment

The next step will be for the AAA intake staff to determine if the individual is enrolled in Medicaid. While the individual may self-report enrollment, the AAAs will build the capacity to verify an individual's Medicaid enrollment on the DHS Medicaid Online (DMO) system. If the person is a verified Medicaid recipient, the intake staff will refer and link the individual to the Health Plan responsible for meeting the individual's needs.

Screen for Medicaid eligibility

If an individual is not enrolled in Medicaid, the AAA intake staff will screen for an individual's likeliness to be Medicaid eligible based solely on income and assets. If the individual's self-reported income and assets suggest the individual is likely Medicaid eligible, the AAA intake staff will help the individual prepare an application packet for a Medicaid eligibility determination by Med-QUEST. The AAA will monitor the status of the Medicaid application.

Screen to determine if short-term services are necessary because of a crisis

The AAA may provide temporary services should an individual have an immediate threat to his or her health or safety, or a situation that places the person in immediate jeopardy of being placed in an institution. EOA and the AAAs will establish an operational definition of an immediate crisis situation and define the services that can be provided. These will be short-term services designed to protect health and welfare until a more permanent and stable arrangement can be made. The planning will include mechanisms to monitor short- term services and transition to the new arrangement.

For individuals receiving short-term services while waiting for Medicaid eligibility and who are then approved, the AAA will work with the Medicaid provider to transition the individual to receive services from the Medicaid Health Plan. If the individual is determined ineligible for the Medicaid program, the AAA will arrange for available supports and services and inform the individual of other community-based long-term care options.

Screen to determine if possible need for services

If the initial intake screening determines that an individual requesting long-term care supports is not likely eligible for Medicaid but has a need for services the intake worker will determine if an in-home assessment is needed. If there is a need for services and the individual is 60 years or older, the AAA intake staff will schedule a follow-up in-home assessment to be conducted by the AAA's assessment staff.

For individuals under the age of 60 and with a disability, the AAA will be direct these individuals to respective agencies that include Hawaii's Centers for Independent Living, Developmental Disability or Mental Health agencies, or children services.

Screen to assess case complexity

If an in-home assessment is indicated, the intake staff will conduct a brief screening to determine the likely complexity of the individual's needs. This screen will determine the appropriate staff skillset

needed to conduct the assessment. Individuals having multiple functional impairments and/or complex medical or chronic conditions will receive an assessment by professionals with more specialized evaluation skills and experience. Individuals identified as needing supports and services, but having few functional impairments, will be scheduled for a common less-complex assessment.

4. In-Home Assessment, Eligibility Determination, and Development of Support Plan

The AAAs will use a standardized tool and protocol for all in-home assessments. The use of standardized definitions and protocols enhances the ability of the state and local AAAs to profile individuals using services statewide. A standardized assessment process will also help to facilitate a more streamlined transition of services if an individual relocates or has a change in status.

The common assessment tool to be adapted for use is the nterRAI-HC. This is a validated tool currently used in more than 20 states nationwide.

There will be two additions to the interRAI-HC. One, there will be an effort to make the assessment process more person-centered. This effort may include adding a short interview about the participant's experience with receiving supports. This information can be incorporated in developing the individual's support plan.

Two, a screen will be added to determine whether someone is likely to be Medicaid eligible because he or she may meet the medically-needy criteria. In Hawaii, individuals having assets and/or income over the threshold for Medicaid eligibility may be eligible if he or she has high medically related expenses. Thus, it will be necessary to develop a protocol to determine if an individual is likely to meet these criteria. This protocol will not be applied to individuals with combined assets and income that suggest that they are not likely to be Medicaid eligible even when considering medically related expenses (they will be deemed not at risk of Medicaid spend down). This differs from the screen conducted during the initial assessment that only considered income and assets. This issue is discussed in greater detail in the Medicaid FFP section in the Finance and Sustainability chapter (Chapter 4).

The Initial criteria to classify individuals at risk of Medicaid spend down will be set at a combined income and assets ceiling of $43,200. This criteria was based upon the average costs in Hawaii of 135 days in a nursing facility as derived by the University of Hawai'i School of Social Work[1]. This value will be adjusted and more detailed criteria may be developed as the program collects and analyzes data.

Other tasks and activities may be amended to the in-home assessment protocol. This assessment protocol will be integrated into an electronic assessment tool on the Harmony for Aging information system as part of the MIS plan.

[1] " Report on Options for and Requirements for Hawaii's Community Living Program," prepared by: Pam Arnsberger, PhD and Wes Lum, PhD, University of Hawai'i School of Social Work, June, 2010.

Qualifications for Assessment Staff

Building the staffing capacity for assessments performed by the AAA includes establishing minimum qualifications, competencies, and training requirements. Assessment staff will be required to have skills in identifying an individual's functional impairments and have the aptitude to document support needs to develop an appropriate set of long-term care supports and services.

There will be two skill levels of assessment staff. There will be baseline assessment staff to conduct assessments for individuals with basic support needs. Current county assessment staff can be grandfathered into the baseline assessment staff qualifications if necessary. Complex assessments, most likely for individuals having multiple functional impairments and complex medical/chronic conditions, will be assigned to assessors with greater experience and/or advanced degree.

With an increase and standardization of assessment staff requirements, the AAAs will increase the pay grades to correspond to these qualifications. These changes will restructure some staffing guidelines, requiring legislative and executive approvals for each respective county.

Minimum criteria for basic and advanced assessment staff are summarized in ***Exhibit 8***.

Exhibit 8: Minimum Qualifications for Staff Conducting In-home Assessments

Minimum Assessment Staff Criteria (Baseline – Basic Assessments)
A bachelor's degree with human services experience
May substitute substantial experience and demonstrated skill to perform intake tasks in lieu of degree
Conducts assessment under clinical oversight and guidance by appropriately credentialed staff
Minimum Assessment Staff Criteria (Advanced – Complex Assessments) **Must satisfy one of the following:**
A bachelor's degree with at least five years of experience in community case management or hospital discharge
Master's degree in human services
RN with at least two years of experience in community case management or hospital discharge planning

Support Plan

The assessment will result in a Support Plan that identifies the services and supports the individual will need. The term Support Plan was chosen over similar terms, such as Care Plan and Services Plan, to convey the idea that the plan is to support the individual in maintaining her or his independence in the community. The term "support" has also been used by CMS and AoA in much of the guidance they have provided.

The Support Plan will take into account the individual's existing supports and assistance from family, guardians, and services in developing a holistic support plan. The individual will also be afforded options

and other supports outside Kupuna Care and OAA Title III entitlements should other needs be determined from the in-home assessment.

The systems change effort will also explore incorporating Clinical Action Plans (CAPS) that can be created using algorithms derived from the interRAI-HC. These CAPS could provide recommendations and guidance to the development of the Support Plan, but they will not determine the allocation of services.

5. Targeting

A key outcome of the assessment will be to target services to individuals at the greatest risk of a negative outcome such as going into a nursing facility or experiencing an unnecessary hospitalization. To address this, the systems change effort will establish criteria to assist in identifying individuals:

- Who should be provided services as soon as possible in order to prevent a likely negative outcome;
- Who have complex service needs and/or are medically complex and, therefore, could benefit from receiving case management in addition to services (this is discussed in greater detail below).

This task will involve establishing criteria for making these determinations. One of the reasons for the selection of the interRAI-HC as the assessment tool is that there are established algorithms that may be adapted to meet these definitions.

This task meets a core objective of the Community Living Program (CLP), targeting high-risk individuals and expediting long-term care services and supports to divert the individual from entering a crisis. In addition, AoA guidance recommends adoption of targeting criteria for OAA funded services.

The systems change effort will also monitor the targeting of the participant-directed option to individuals with income and assets that place them at risk of Medicaid spend down. At a later point, these criteria may be applied more broadly to Kupuna Care and Title III services.

Waitlists

The system change effort will shift the management of waitlists from private sector agencies to the county AAAs. To comply with this, the AAAs must build the capacity to control, manage, and monitor program waitlists. The counties will establish a common protocol to manage individuals waiting to receive services. These protocols will help the AAA to expedite services or purge the waitlist responding to changes in an individual's status and support needs.

6. Case Management

The criteria for assigning case management as part of the support plan will consider evaluating unmet ADLs and IADLs, informal supports, cognitive/behavior impairments, financial status, living arrangements, medical conditions, and abuse/neglect concerns.

In-house Case Management

Maui, Hawai'i, and Honolulu county AAAs currently contract for case management services with an outside agency. As part of the ADRC implementation plan, the AAAs will build staff capacity to bring case management in-house. The resources for doing this will come from a combination of reallocation of existing funds and supplemental funds obtained through new appropriation requests.

Each county AAA will need to get county executive and legislative approvals to restructure case management into an in-house agency function. By bringing case management in-house, the AAA will be able to better monitor services and identify individual status changes receiving long-term care supports and services. Also, it helps to ensure that individuals receive counseling about options that are free from provider interests.

7. Options Counseling

According to the ADRC Technical Assistance Exchange, "Long-term support options counseling is an interactive decision support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances." Options counseling will be integrated into the following core functions:

- Initial intake
- In-home assessment
- Case management

The aim of incorporating options counseling for these encounters will be to educate and empower individuals to make informed choices about long-term care supports and benefits.

Exhibit 9 summarizes the counseling topics to be addressed at each type of interaction. It is important to note that while all of the subject areas are germane to more than one function, the protocols will be tailored to that specific function. For example, the initial intake will include collecting a limited amount of information to assist in making the key decisions shown in ***Exhibit 3***. In contrast, the in-home assessment is more comprehensive and addresses multiple domains, such as functioning, health, environment, and psychosocial concerns. Thus, the Options Counseling regarding service and support options will likely be much more general at the initial intake. In contrast, as part of the in-home assessment and support plan development process, this counseling can be focused to address how potential options may or may not meet specific needs, preferences, and strengths identified during the assessment.

Exhibit 9: Subject Areas by ADRC Function

	Initial Intake	In-Home Assess-ment	Case Manage-ment
Existing Long-Term Services and Support Options	◆	◆	◆
Planning Ahead for One's Long-Term Care	◆	◆	◆
Selecting and Managing Participant-Directed Services and Supports	◆	◆	
Medicare Benefits and Options	◆	◆	◆
Other Services and Benefits	◆	◆	◆

Common Set of Options Counseling Procedures

Options counseling protocols will be created and integrated into the core functions of the ADRC to ensure that individuals receive consistent information and guidance about the array of available long-term care supports and services. The options counseling procedures will be tailored for intake, assessment, case management, and SHIP counseling – such that the depth of options counseling is appropriate for the encounter. Guides and resources for options counseling will be integrated on the Harmony for Aging system in order to be streamlined with the core ADRC functions.

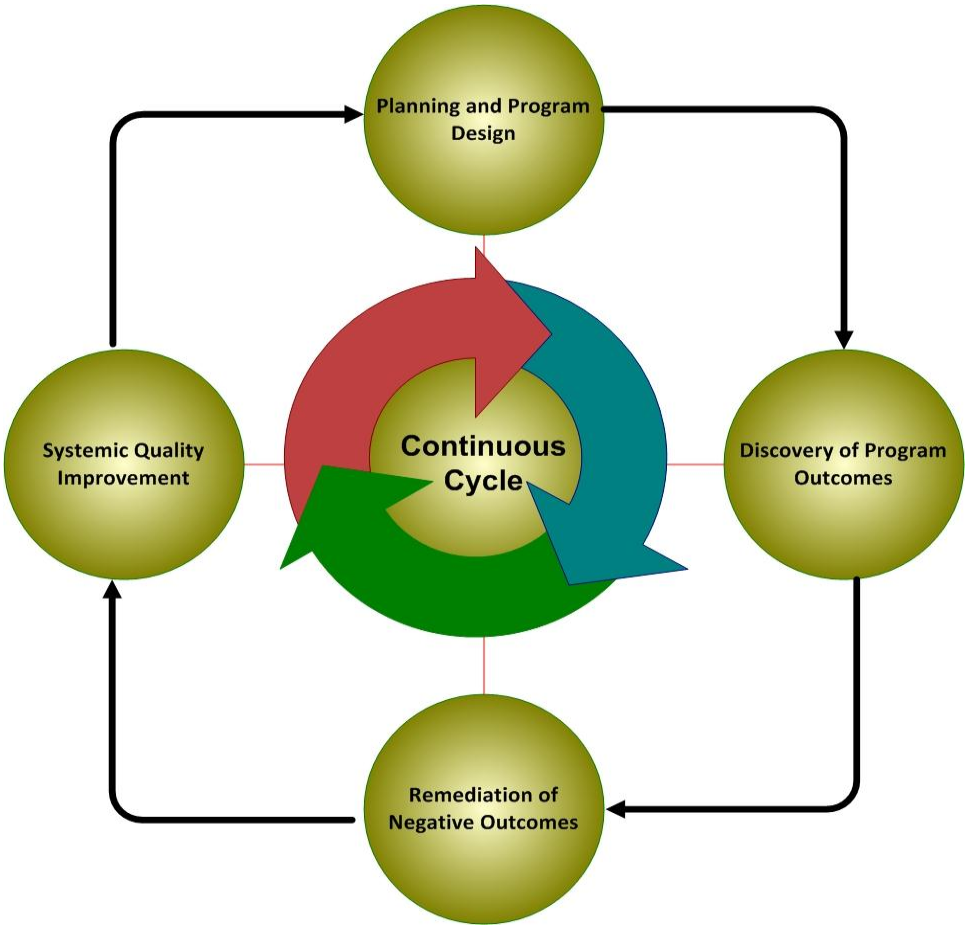
Staff Capacity for Options Counseling

Options counseling will be conducted by the AAA staff performing core ADRC functions and engaging with individuals on long-term supports. This requires staff training on how to conduct options counseling. EOA and the AAAs will establish competencies for options counseling and build these competency into staff training.

Continuous Quality Improvement

As a component of the systems change effort, EOA and the AAAs will adopt a Continuous Quality Improvement (CQI) approach. This approach includes: 1) design; 2) discovery; 3) remediation, and; 4) improvement (see ***Exhibit 10***).

Exhibit 10: Quality Framework



In the *discovery* step of the quality process, EOA and the AAAs will collect and report data on key performance indicators. In order to be useful, the data will be summarized into a series of management reports tailored specifically for key actors in a position to influence quality at different levels:

- Initial intake, in-home assessment and case management staff
- AAA management and supervisory staff
- EOA
- EOA/ Med-QUEST/AAA interagency effort
- External stakeholders

The systems change effort will also include the creation of corresponding quality committees that will interpret and act upon the data in these reports.

Performance Indicators

To conduct a continuous quality improvement initiative for the ADRC, EOA and the county AAAs must identify measurable performance indicators that are meaningful for monitoring and making program improvement decisions. Some initial indicators have been outlined during the systems change development process. These identified performance indictors track the timeliness of the AAAs to deliver core ADRC functions including assessment, service provision, and Medicaid application. Other indicators include participant experience and satisfaction with ADRC services. EOA and the AAAs will formalize these indicators and determine the measurable threshold a corrective action will occur for each indicator.

Exhibit 11 outlines initial performance indicators for which a consensus was reached during the workgroups. These indicators will be further delineated and possibly expanded during implementation.

Exhibit 11: Draft Performance Indicators

Area of Performance	Performance Indicator
Timeliness of in-home assessment	• In-home assessment will occur within 3 days (account for staff capacity limitations) • Potentially set shorter threshold for high risk
Timeliness on provision of services	• Services will start within two weeks after the completion of the support plan • Potentially set shorter threshold for high risk
Timeliness on Medicaid application completion and eligibility determination	• To be determined
Participant experience and satisfaction	• To be determined

Management Reports

Management reports will aggregate the data collected in measuring the identified performance indicators. Updating will occur on a regular basis and will employ the Harmony for Aging functionality to automate the generation of management reports. The data collected will be warehoused and available on the Harmony management information system. Once the report templates are created on the Harmony system, management reports will be readily available for users authorized to generate management reports.

Review and Remediation Processes

The continuous quality improvement process requires EOA and the AAAs to have a protocol to review the management reports and evaluate the performance indicators to make appropriate program and service improvements. To achieve this, the systems change effort will establish standards and expectations for quality management meetings and processes for the following:

- Internal AAA CQI efforts including staff supervision.
- EOA-AAA CQI meetings and coordination.
- Interagency (notably AAA, EOA, and Med-QUEST) meetings and coordination.
- An advisory group consisting of external stakeholders.

These protocols will guide the frequency of meetings, and the processes for reviewing, interpreting, and acting upon the information in the management reports and other quality concerns.

Contracting

The county AAAs will explore whether it is reasonable to utilize procurement code 103F for the procurement of services on a fee-for-service basis as opposed to distributing money using grants. This approach, which is currently being used in Hawai'i County, may be more consistent with a person-centered model approach because it will allow counties greater flexibility in purchasing services that reflect the needs and preferences of individuals. To implement this, each county AAA will need to explore its own procurement code and work with the individual county procurement officer to determine the feasibility of using this approach.

Participant-Directed Services

Using CLP grant funds, the systems change effort will pilot a participant-directed option that is targeted to individuals a high risk of institutionalization and Medicaid spend down (using the ceiling of $43,200 described earlier). The participant-directed option will provide individuals and/or their representatives with a pool of dollars that they control, as opposed to providing services from an agency. The participants can then hire and fire whomever they choose and pay for items or services that would help to substitute for the need for personal care. Kauai, Hawai'i and Maui counties chose to participate in the pilot.

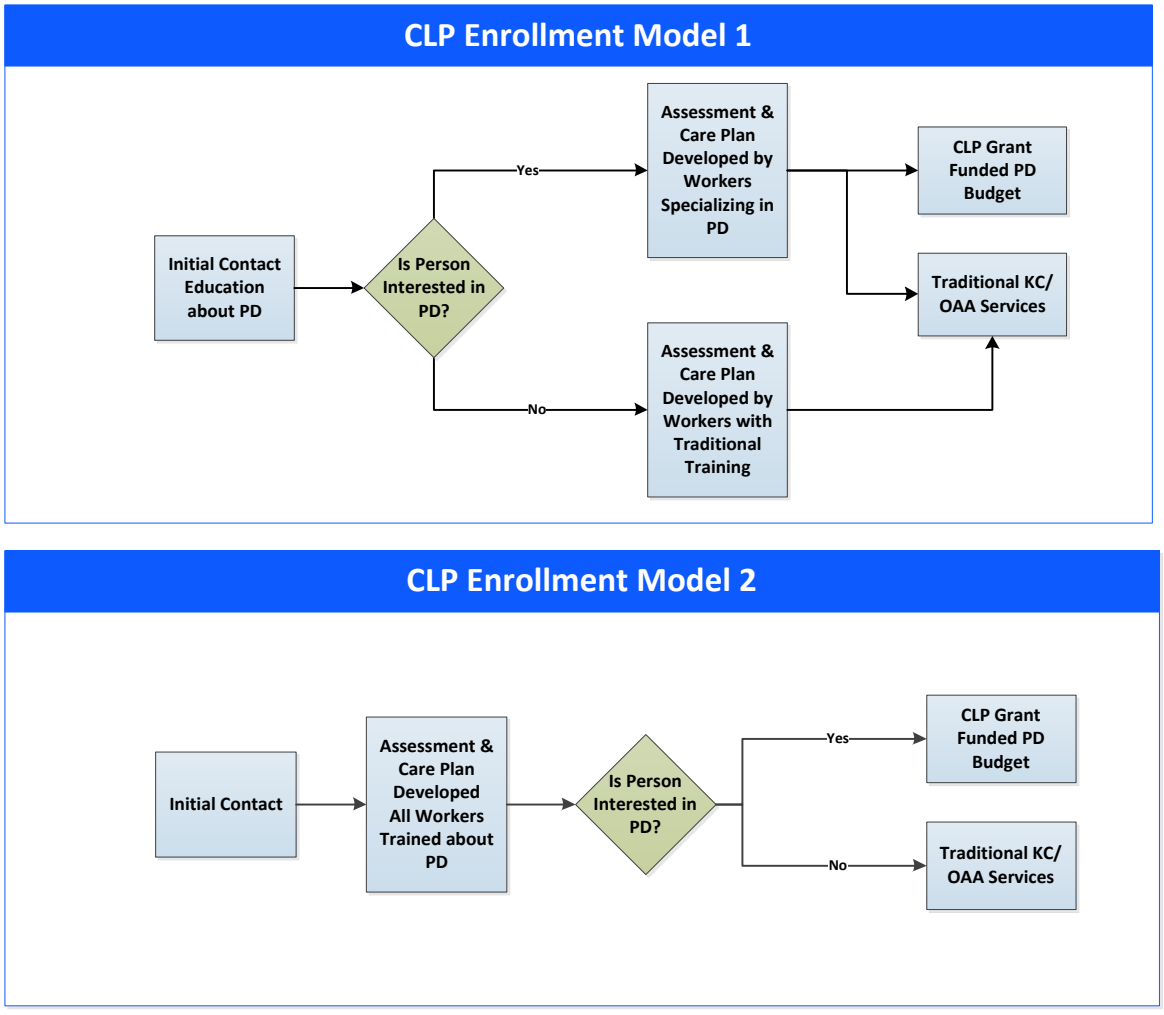
The core tasks in setting up this program include the following:

- Designing a system for enrolling individuals.
- Establishing a mechanism to assist participants with managing payroll requirements (i.e., fiscal management service (FMS)).
- Defining a process for setting budgets for individuals.
- Defining what may and may not be paid with the pool of funds.
- Establishing parameters for a support broker service to counsel program participants.
- Developing a mechanism to ensure that program participants or their representatives have the capacity to manage the pool of funds.
- Providing tools to assist participants and their representatives.

Enrolling Participants

Participating county AAAs will develop a mechanism to offer participant direction as an option and enroll individuals. ***Exhibit 12*** shows the proposed enrollment models the counties might use. There are two models because some counties might want to assign enrollment to staff that specialize in the participant-directed option, while this may not be an option for counties that rely on regional enrollment staff. Each county will be developing its own plan and submitting it to EOA for review and approval.

Exhibit 12: Models for Enrolling Participants



Fiscal Management Service

EOA will contract with a FMS agency to act as the fiscal/employer agent to perform payroll and reimbursement duties on behalf of the participant employer. As part of the contract, roles and functions between the FMS agency, EOA, and AAAs will need to be defined. EOA will determine how resources will flow from EOA to the FMS contractor to then be distributed to the providers. Performance measures will also be defined to monitor the fiscal management service and will be included in the FMS contract. EOA has already issued an RFP for this function.

Process for Setting Individual Budgets

The participating AAAs and EOA have agreed upon a framework for setting individual budgets based upon in-home assessments conducted by the AAA. The individualized budget amount will be set based upon a level the individual would otherwise receive through traditional services. The participating AAAs will work to develop a common protocol to standardize budget setting because there currently are variations in service availability and rates among the counties. The individual budget will be discounted by a certain percentage to reflect the following: (1) rates to agency provides include administrative costs that are not applicable in a participant-directed program and (2) individuals do not tend to use all of the allowed hours allocated under traditional arrangements, while individuals tend to use most if not all of their participant-directed budget.

Finally, EOA and participating AAAs will establish budget thresholds that trigger a review. These thresholds include proposed individualized budget amounts substantially above or below the norm. The purpose of the review is to ensure that service amounts are adequate to meet the needs of the individual.

Allowable and Unallowable Costs

Exhibit 13 shows the criteria that EOA and the county AAAs use to determine how funds can and cannot be used. In addition, EOA and the AAA set policies regarding the hiring of family members. Spouses providing services will be approved on a case-by-case basis. Additional criteria may be set for other family members to act as service providers.

Exhibit 13: Allowable and Unallowable Uses of Participant Directed Funds

Purchased goods and services must satisfy at least one of the following criteria	
Maintains independence for the participant to make choices	
Prevent institutionalization such as in a nursing facility, residential care home or hospital	
Benefits the individual to live in the community (may include supports to unpaid caregivers)	
Enhances the skill or ability of the caregivers	
Maintains the health, welfare, and safety of the individual	
General categories for allowed goods and services	**Examples**
• Personal Assistance • Treatment and training • Environmental modifications • Self-directed support activities	• Personal care • Housekeeping/Homemaker services • Transportation • Home delivered meals • Heavy chore services • Adult day care • Shopping • Attendant care • Financial management
Goods and services NOT allowed through participant directed budgets	
Insurance and insurance expenses (except for insurance to provide employee coverage)	
Drugs, alcohol, firearms	
Items paid for through other programs (e.g., Medicare)	
Experimental treatments	
Home modifications that add square footage	
Vehicle maintenance (except for vehicle modifications due to disability)	
Tickets to recreational events	
Vacation expenses	
Internet access (To be finalized)	

Support Brokerage

EOA and the county AAAs set parameters for support brokerage, including broker responsibilities and workflow. The support brokerage model will include: 1) the enrollment and outreach strategy to identify potential program participants; 2) enrollment assistance; 3) individualized support planning assistance; and 4) coaching/supports for accessing and managing services and staff.

EOA and the AAAs will establish support brokerage qualifications, competencies, and training. Training requirements for support broker include:

- Strong foundation in participant directed model
- Communication skills for working/talking with participants and families

- Budgeting and management of finances
- Process for enrolling and approving services and budget
- Techniques for recruiting, training, managing, and retaining staff/employees
- Employment law as it relates to domestic employees
- How to read fiscal reports/help the participant track and project costs
- Recognizing a change in status of the participant
- Screening for capacity or recognizing signs that capacity may have changed
- Knowledge of community resources and/or where to access information about resources
- Evaluating what is working/not working for the participant

EOA has issued an RFP to secure one or more support brokers. The support broker entity may be the county AAA.

Capacity for Self Direction

Because managing a budget requires that the individual or her or his representative manage budgets and staff, participant direction may not be a viable or sensible choice for all individuals. As a rule, any individual will be allowed to select the participant-directed option, with three exceptions:

- Individuals with cognitive deficiencies resulting in significant difficulty with decision-making who do not have a proxy or any support system to assist with decision-making.
- Individuals and/or representatives that have been in participant-direction and have committed fraud.
- Individuals that have a history of being exploited or abused (additional safeguards may be implemented).

Some individuals may require substantial support to self-direct and manage services. In this case, an authorized representative may be needed. Examples of where a representative might be needed include the following:

- The program participant is physically unable to assume all of the responsibilities of participant direction, such as performing training or signing/approving timesheets (e.g., someone with ALS may require someone else, such as a spouse, to direct care or provide instruction).
- The individual has a preference to have a proxy or representative.
- The individual has cognitive deficiencies or great difficulty with decision-making.
- The individual has a history of being victimized by exploitation, abuse or fraud. The representative must not have been involved in this exploitation, abuse or fraud.

The authorized representative will be subject to certain requirements and have responsibilities that distinguish the authorized representative/proxy from the support broker. The proxy or representative

should not be a person that is paid to provide care and must not have a history of exploitation, abuse or fraud.

In addition, EOA and the AAAs will implement a protocol to assist the individual in understanding and making an informed decision about participant-direction. This protocol will be adapted from Minnesota's Capacity for Self Direction tool.

Participant Tools

EOA and the AAAs will develop a manual and tools for managing participant-directed services. Materials may be adopted from other states, such as New Mexico, Rhode Island, Maryland, and Arkansas program manuals.

EOA will lead the drafting of the manual and it will be finalized in collaboration with the AAAs. The manual will be available as an electronic version and initially translated into Japanese and Ilocano versions. Additionally, a process to maintain and update the manual will be established. The manual will address the following subject areas:

- Description of target groups and criteria
- Process for enrolling or disenrolling/termination from CLP
- Fiscal Management Service standards and responsibilities
- Support broker guidelines
- Oversight and quality assurance (includes oversight of expenditures and participant satisfaction)
- Roles and responsibilities for CLP staff, support brokers, and participants
- Relationship between support broker and AAA
- Guidelines related to HIPAA and data sharing practices
- Data gathering and reporting requirements
- Allowable purchases and use of the individual budget
- Grievance and/or appeal process to address services or budget (including complaint resolution)
- Assessment, support plan, and assignment of the individualized budget

Participant tools will also be developed to assist with budget planning and management, employee recruitment, employee management, employee training, and employee criminal background checks.

Quality Management Strategy for CLP

Similar to the ADRC quality management strategy, the participant-directed initiative will incorporate protocols to measure and analyze performance measures to monitor and improve the functions of the program.

The areas for which performance indicators specific to the participant-direct will be developed include enrollment, individualized budget, support brokerage and planning, budget management, participant

satisfaction, and program outcomes. ***Exhibit 14*** summarizes the CLP operational area and specific measurement items. The Participant Direction Workgroup will further refine these indicators.

Exhibit 14: Draft Performance Indicators for the Participant-Directed Option

Participant-Directed Operational Area	Performance Indicator Areas (to be further defined)
Enrollment	• Effectiveness of outreach • Enrolled participant meeting CLP criteria
Individual Budget	• Timeliness of establishing individualized budget • Budget amount accuracy to budget setting methodology • Budget amount accuracy to reassessment
Support Planning	• Timeliness of support plan after being assigned an individualized budget • Support plan inclusion of allowable goods and services • Support plan within established budget
Budget Management	• Utilization range of approved budget • Fiscal Management Service meeting contractual requirements
Participant Outcomes	• Participant satisfaction scores (POSM or other measurements) • Participant disenrollment to enter SNF or Medicaid
Support Brokerage	• Timeliness of support brokerage assistance (in person meetings, phone calls, emails)
Health and Safety	• Completion of background checks • Risk assessment in support plans • Back-up services in support plans

Similar to the ADRC continuous quality management strategy, the participant-directed initiative will establish regular reporting mechanisms and conduct regular review and remediation processes. EOA and the AAAs will conduct monthly meeting in the first 6 months to ensure program functions are meeting expectations. Meetings will transition to quarterly program reviews. Support brokerage and fiscal management services will be monitored monthly through management reports and regular scheduled meetings.

As part of the quality improvement process, the participant-directed option will adopt a protocol to process participant disenrollment. This process, operating under established timelines, will include the

confirmation with the participant, meeting with the individual/AAA/support broker, and transitioning to other supports if appropriate.

Hospital Discharge Planning

The Person-Centered Hospital Discharge Planning (HDP) initiative is funded by CMS to develop a statewide person and family centered hospital discharge planning system. The HDP goals are to ensure that individuals with long-term support needs are offered services and supports to return home safely from a hospitalization and avoid preventable re-hospitalizations.

Each of the AAAs have already designated staff that are currently working with hospital discharge staff to facilitate the transition to the community. This effort will involve creating greater consistency across sites to establish model that used as part of an ongoing effort.

EOA and the AAAs will adopt the hospital discharge model into the core functions of the ADRC and will develop the capacity to run the HDP initiative. The primary target group includes individuals that are at least 60 years of age, including Medicaid enrollees and persons not enrolled in Medicaid. Additional criteria may be identified to more specifically target individuals leaving the hospital for the HDP initiative.

Hospital discharge planners located in the local hospitals will identify and refer targeted individuals to the AAA. The appropriate AAA staff will receive and process referrals received from the hospital. Training for the hospital discharge planners and AAA staff will be developed by EOA and AAAs.

Functions of AAA for Hospital Discharge

EOA and the county AAAs will finalize a basic set of common hospital discharge functions. EOA and the HDP lead from Hawai'i County are currently exploring specific discharge planning models from which one will be selected and adapted for use. The functions and person-centered support initiatives build upon the objectives of options counseling and supplement additional transitional supports specific for those returning from the hospital. Each county AAA will assist the HDP participant in identifying the appropriate supports and resources available in their respective county. The following list summarizes the proposed functions of the hospital discharge program:

- LTC options counseling
- Assessments
- Assisting families with plan development
- Facilitate making connections with needed supports
- Follow-up to make sure supports are in place
- Serve as a liaison between case manager and discharge planner
- Assisting with applications for Medicaid or other publicly funded programs

Referral Protocol from Hospital Discharge Planners to AAA

The HDP initiative will establish a formal relationship and referral procedure with each local hospital. Individuals meeting the HDP criteria will be referred from the hospital discharge planners to the AAA. The AAA will develop a tool to help manage hospital discharge activities.

Referral protocols will be adopted and will include more detailed supplemental information, such as:

- Insurance coverage
- Informal supports
- Diagnostic information
- Follow-up appointments made by the hospital
- Equipment needs for the home
- Likely supports after discharge
- Referrals made to other agencies
- Physician orders/notes
- Hospital discharge orders
- Information on communicable diseases, substance abuse, violence or suicide

Each county AAA will establish a MOU with its respective local hospital or hospitals. The MOU will outline the roles, responsibilities, and timeliness of the HDP initiative.

Chapter III: MIS Plan

This section details the implementation of the management information system (MIS) that will support the core operational functions outlined in Chapter 2: SCD Operational Model. This plan describes the information technology infrastructure that will support the systems change operational model. This MIS plan also incorporates the technical assistance proposed by Harmony Information Systems, Inc. (Harmony). The proposal by Harmony outlines the customization and integration of the Harmony for Aging system (HfA) that will be the core MIS infrastructure supporting the functions and activities of the AAA developed through the systems change effort.

MIS Implementation Plan

This MIS implementation plan outlines the major tasks that must be accomplished in order to have the information technology infrastructure to support the core functions of the ADRC. While the HfA has many default features designed to support the AAA operations, the objectives of this MIS implementation plan detail the necessary customizations of the HfA to be properly integrated with the ADRC operations. The MIS implementation plan includes the automation of core ADRC operations including:

- Receiving referrals
- Information and Referral
- Intake
- Assessment
- Support Planning
- Case Management
- Continuous Quality Improvement

Referrals

The MIS system will be customized to receive and process referrals based on the protocols and client information collected. These protocols and data elements will be finalized as part of the overall five-year implementation plan. To automate these referral protocols, the HfA will need to be capable of receiving and managing referrals from various referral sites in an automated, consistent, and timely manner. Information exchanged will be maintained on the HfA and accessible to appropriate AAA staff.

Information and Assistance

The MIS plan includes building the capacity for a consolidated information and referral database containing standard data elements and categories that describe available community resources, supports, and services. These standard data elements will be finalized and configured on the HfA. The AIRS taxonomy, a feature on HfA, will be applied on the information resource database.

The information and referral component of the MIS plan will have the capacity to be maintained and updated by authorized AAA and EOA users. The counties will utilize the AGIS Network to provide an interface to ADRC information and assistance resources for the public via the internet. AGIS is a website hosting service that provides information and resources for the aging network. AGIS is contracted by the county AAA's to provide information, resources, and tools for the county ADRC websites.

Additionally, a web-based module that links the AGIS ADRC website to the Harmony for Aging database will allow for up-to-date information to be shared with the public accessing the ADRC website. Information that may be shared includes provider and program information specific to the state and counties. The AGIS ADRC website will automate the ability to receive updated information; and once verified by the appropriate user, it will make the update to the consolidated Harmony database.

Initial Intake

The MIS plan calls for the implementation of an intake process designed to triage and direct individuals to the most appropriate supports and services. These individuals include those who have been referred to the ADRC or have directly contacted the AAA requesting assistance. Intake protocols and criteria will be finalized from the systems change effort. These protocols and criteria will be automated on the HfA. A qualified ADRC intake staff member should be able to enter participant information into the system and apply automated protocols to direct the individual to appropriate supports, or issue a request for an in-home assessment. The intake protocol will assist the following decisions:

- Whether the individual is inquiring about long term care supports
- Probable Medicaid eligibility determination based on income and assets
- Determine if the individual has a need for services
- Determine the complexity of the individual's needs and supports

Assessment

Through the systems change development effort, the decision was made to pursue a standardized assessment process as a core function of the ADRC. A standardized assessment tool to determine an individual's need for services will be automated within the MIS system. Automating and building assessment information onto the existing client information will enhance the tracking of individuals for whom intake and referral data have been collected.

The preliminary consensus is to implement the interRAI Home Care instrument as the standard assessment tool and automate it on the HfA. Harmony has confirmed that the interRAI suite of tools will be a feature built into the HfA. Additional assessment questions and criteria may be amended to this instrument to meet the needs and program requirements of the ADRC.

Support Planning

The support planning function in the ADRC identifies the supports and services an individual will receive based on the in-home assessment of the individual's needs. The HfA will be automated to help develop support plans based on those assessment findings. Support planning criteria may be added to reflect

the supports and services available in each county AAA and their policies. The effort will also explore including Clinical Action Plans (CAPs) developed as part of the interRAI integration on the HfA. These CAPS could provide guidance to the development of support plans in determining the type and allocation of available community supports and services.

Case Management

A core function of the ADRC will be to provide case management to aid individuals with complex functional and chronic medical needs to obtain supports and services and to remain living safely in the community. In some county AAAs, case management has been a contracted function; however, with the development of a common operational model, these AAAs will be bringing case management in-house.

Therefore, the MIS infrastructure will be customized to support the case management functions of the ADRC. The functions that will be configured on the HfA may include case note tracking, monitoring and supervision of case management services, and performance and quality management.

Continuous Quality Improvement

Consolidating and centralizing the ADRC MIS support functions onto the HfA will allow the state and county AAAs to analyze quality and performance from a common set of data elements. A regular process to produce reports, review performance, and respond to variances will enhance the quality and consistency of services provided by the ADRC.

This task of the MIS plans calls for implementing the tracking and reporting of identified performance indicators and data elements. Initial performance indicators have been identified as part of the system change effort and are described in the five-year implementation plan. These performance indicators include timeliness of assessments, timeliness in initiating services, client satisfaction, etc. Some data elements will be available through information recorded from the operational tasks, while other data elements will need to be added to provide a measurement in respect to the performance indicator. These data elements are to be collected to and extracted from the HfA.

In addition, the system will be configured to produce management reports that the state and counties can review as part of a continuous quality improvement process. EOA and AAA staff will be able to use customized reports to monitor and improve their respective operations and roles. EOA will be able to monitor and compare programs across counties, and respond to variations in each county to maintain a statewide standard of program services and supports. The AAAs will generate reports to monitor and conduct county-level quality improvement processes based on defined performance indicators and thresholds. Individual AAA staff will also receive management reports that will assist them in monitoring their own performance and identifying clients for whom timelines have not been met. The MIS automation in supporting these quality management functions will enhance the value and consistency of services provided by the ADRC.

MIS Implementation Timeline

The implementation timeline of the MIS plan (***Exhibit 15***) includes major MIS milestones and development tasks that will be completed. The MIS tasks are color-coded in the larger five-year implementation timeline that includes all of the tasks. The anticipated MIS implementation dates correspond to each of the respective ADRC components of the five-year plan.

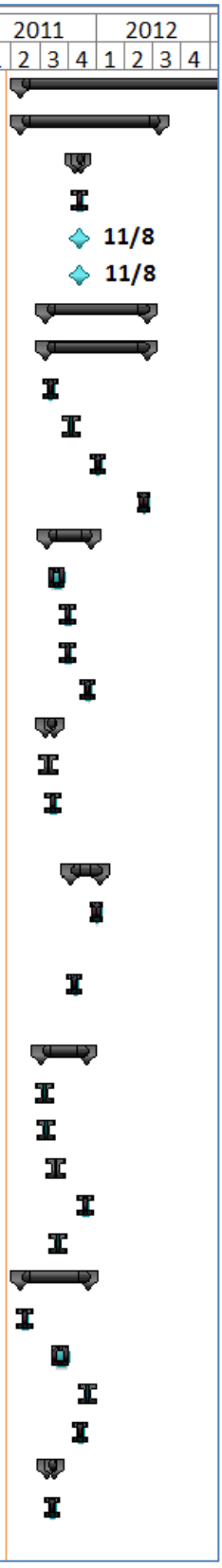
The development, implementation, and pilot of the MIS system will start in Maui County. The remaining counties will continue to use their existing MIS system (SAMS) and current county AAA operations until they are ready to transition to the common ADRC operational model. The implementation of the MIS functions will take place when the AAA transitions to the common operational model as scheduled in the implementation timeline.

The bulk of the MIS work to customize the HfA and the implementation of the MIS components will occur in Maui County. However, all AAAs and EOA will be active participants, as decisions on the MIS system and infrastructure configurations will apply to each county when they implement the ADRC operational model and the MIS plan.

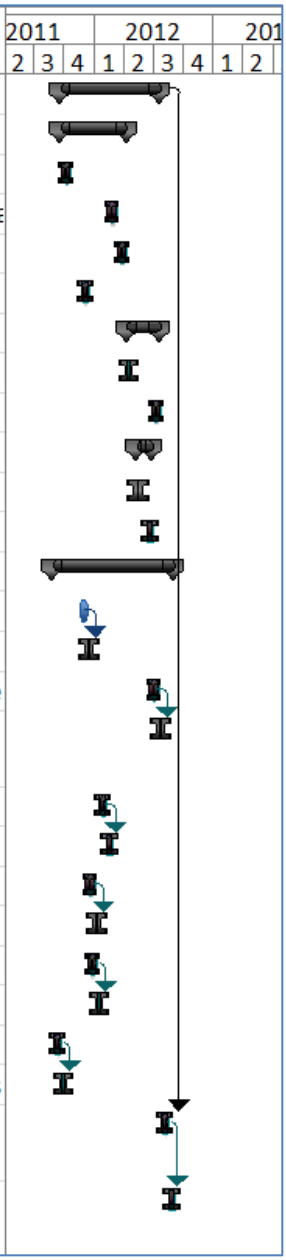
After the pilot and follow-up refinements are completed for Maui County; the ADRC and MIS implementation will take place next in Kauai County, followed by Hawai'i County, and finally to Honolulu County. As the MIS infrastructure will be on a consolidated information system, the MIS functions will be fully operating and in-place once Maui has finished its pilot. The counties that follow Maui County will be migrating information from their existing MIS system (SAMS) and onto the consolidated HfA. County specific integrations on the Harmony for Aging system are anticipated, but minimized due to the standardization of the ADRC model. The AAAs will need to train their staff to employ the MIS support functions prior to the rollout. Maui and other counties as they implement the common operational model will likely have the expertise to assist in training and provide guidance as other counties implement the ADRC model and implement the MIS functions.

Exhibit 15: MIS Implementation Timeline

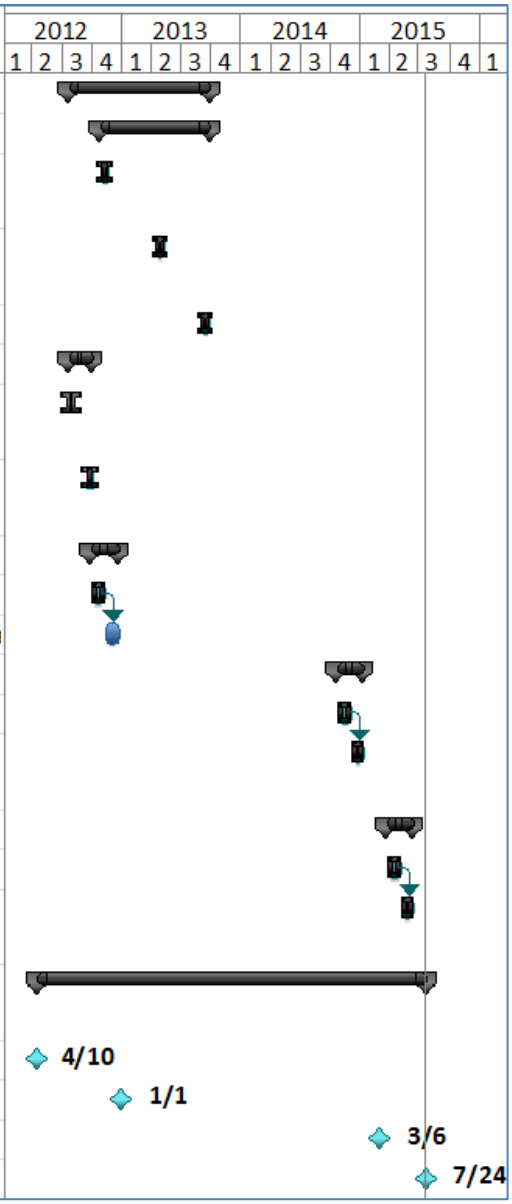
ID	Task Name
1	**MIS Implementation**
2	**Develop pilot system for Maui**
3	**Referrals**
4	Implementation of referral protocols on HfA
5	Referral protocols operating with high volume referral sour
6	Referral protocols operating with low volume referral sour
7	**Information and Assistance**
8	**Provider Information**
9	Configure data elements
10	Incorporate AIRS taxonomy
11	Incorporate data elements for disabilities
12	Incorporate data elements for provider quality
13	**Linkages to other disability populations**
14	Implement protocol for developmental disabilities
15	Implement protocol for mental health
16	Implement protocol for children and youth
17	Implement protocol for adults with physical disabilities
18	**Expansion to AGIS portal**
19	Implement mechanism for providers to submit informati
20	Implement protocol for AAAs to review and approve submitted information
21	**Initial Intake**
22	Implement Intake Screens on HfA (LTC need, QExA enrolled, Likely Medicaid eligible, Need for Services, Case
23	Implement protocol to assist with Medicaid application and status tracking
24	**Assessment**
25	Implement interRAI Home Care tool
26	Implement Medicaid spend down protocol
27	Implement person-centered planning
28	Integrate Options Counseling protocols
29	Implement waitlist protocols
30	**Support Planning**
31	Integrate participant direction protocols and tracking
32	Implement participant direction data elements
33	Implement support planning protocols and Clinical Action F
34	Implement management reports for participant direction
35	**Case Management**
36	Implement case management tools (case notes, monitoring and supervision, and performance/quality)



ID	Task Name
37	**Continuous Quality Improvement**
38	**Implement data collection of performance indicators**
39	Protocol to track timeliness of assessment
40	Protocol to track timeliness of QExA eligibility determina
41	Protocol to track timeliness of service delivery
42	Protocol to track participant experience
43	**Management Reports**
44	Implement queries to generate reports
45	Implement report templates
46	**Review Protocol**
47	Implement internal AAA review process and protocol
48	Implement EOA-AAA review process and protocol
49	**Refinement of Operations in Maui**
50	Review & Refinement of Referral MIS Operations
51	Implement Refinement of Referral MIS Operations
52	Review & Refinement of Information and Assistance MIS Ope
53	Implement Refinement of Information and Assistance MIS Operations
54	Review & Refinement of Initial Intake MIS Operations
55	Implement Refinement of Initial Intake MIS Operations
56	Review & Refinement of Assessment MIS Operations
57	Implement Refinement of Assessment MIS Operations
58	Review & Refinement of Support Plan MIS Operations
59	Implement Refinement of Support Plan MIS Operations
60	Review & Refinement of Case Management MIS Operations
61	Implement Refinement of Case Management MIS Operations
62	Review & Refinement of Continuous Quality Improvement MIS Operations
63	Implement Refinement of Continuous Quality Improvement MIS Operations



ID	Task Name
64	**Post Pilot Enhancements**
65	**Information and Assistance**
66	Incorporate data elements for residential care and nursing homes
67	Incorporate data elements for Community Care Family Foster Homes
68	Incorporate AAA provider reviews
69	**Continuous Quality Improvement**
70	Implement external stateholder review process and protocol
71	Implement interagency review process and protocol
72	**MIS Implementation in Kauai**
73	Implement core MIS operations
74	Integrate Kauai data into consolidated data
75	**MIS implementation in Hawai'i County**
76	Implement core MIS operations
77	Integrate Hawai'I County data into consolidated database
78	**MIS implementation in Honolulu County**
79	Implement core MIS operations
80	Integrate Honolulu County data into consolidated database
81	**MIS implementation milestones to support full-functioning ADRC**
82	Maui
83	Kauai
84	Hawai'i
85	Honolulu



Harmony Aging Services Proposal

Harmony Information Systems, Inc. has submitted a proposal to support the work of the initial pilot and implementation of the MIS support functions in Maui County. The proposal includes the MIS integration and data consolidation for Kauai County that follows the completion of the Maui pilot. As the Hawai'i County and Honolulu County ADRC operational implementation are slated for later years in the five-year plan (year 3 thru year 5), the MIS implementations in those counties are excluded in the Harmony Aging Services Proposal. An additional MIS implementation proposal in Hawai'i and Honolulu counties will be explored as their scheduled ADRC implementation timeframe nears. It is anticipated that the MIS implementation that will occur in Hawai'i and Honolulu counties will be similar to the rollout in Kauai.

The Harmony proposal outlines the specific activities that Harmony will conduct to customize the Harmony for Aging product to meet the MIS support functions defined in the ADRC operational plan.

These proposed activities include translating the operational plan into system specifications, implementing the operational protocols and procedures, testing and validation, training on how to use the system, data migrations/consolidation, and deployment of a full functioning HfA system. Harmony has outlined its integration process to include a six-phase approach starting with planning, to configuration documentation, setup, validation, training, and deployment. These phases are described in the Harmony proposal and detail the activities and tasks that will be completed in each phase of the proposal.

The planning, documentation, and setup phases will translate the components described in the MIS plan into functional requirements that will be configured on HfA. The validation, testing, and deployment phases will verify that the implementation of the MIS functions have met the operational specifications. The proposal outlines the tasks and approximate durations to complete each phase. Included in the proposal is the inclusive pricing for the implementation, support, and training for Maui and Kauai counties. In addition, timeline clarifications and assumptions for the proposal are provided. As a reference, licensing costs are included as reference in the proposal. It is assumed that the state (EOA) will be the client in this proposal and will procure a contract once a finalized ADRC implementation start date has been established.

Chapter IV: Finance and Sustainability Plan

This chapter details the finance and sustainability plan to support the operations described in the 5-year implementation plan. The bulk of the costs associated with this systems change are related to transforming business operations within the county AAAs so that they can meet AoA's definition of a full-functioning ADRC. Meeting this definition requires that the ADRC act as the single point of entry for Kupuna Care (KC) and Older Americans Act (OAA) services. Key functions include serving as the initial point of contact, conducting assessments, streamlining access to Medicaid funded services, determining eligibility, establishing support plans, and managing the provisioning of KC and OAA services.

Because each county has structured its current operations in very different ways, the degree of change necessary to meet these requirements (and the cost associated with these changes) varies substantially. Kauai has the fewest changes necessary to meet the full-functioning criteria. Maui is the next closest. Maui plans to bring case management services in-house as a function of the AAA and increase the qualifications for staff conducting assessments.

Hawai'i County must make several major structural changes to meet the full-functioning criteria. It must establish the Hawai'i County Office on Aging (HCOA) as the single point of entry by bringing in-house the intake and assessment functions currently performed by the Coordinated Services division of the County Department of Parks and Recreation and private sector case management agencies. HCOA also plans on bringing case management functions in-house.

The City and County of Honolulu Elderly Affairs Division (EAD) will require the greatest investment in resources to meet the full-functioning criteria. Currently, most intake, assessment, and eligibility determinations and all case management are done by private sector organizations that concurrently provide services to those individuals. This creates a substantial potential conflict of interest because these providers may make decisions based on payroll and staffing rather than the needs and preferences of the individuals. EAD will require a substantial increase in the number of staff necessary to comply with full-functioning requirements.

Working with the Finance and Sustainability Workgroup, county specific estimates of the funds necessary to implement the full-functioning ADRC model were developed. The process included the following steps:

1. Each county identified the changes in the number and qualifications of staff necessary to implement the ADRC operational model.

2. A budget template was developed that corresponded to Hawaii specific accounting requirements. Each county completed the template using the proposed staffing as a basis.

3. The workgroup identified current funding resources that could be reallocated to the ADRC effort.

4. A model was proposed for drawing down Medicaid Administrative Federal Financial Participation (FFP) to support implementation of the ADRC operational model.

EOA is currently working with each of the counties to refine these estimates in the anticipation that they can be included in the 2012/2013 budget request as well as future federal grant applications.

Potential Funds that Can Be Reallocated from Existing Spending

As a part of this effort, each of the counties explored whether any existing funds should be reallocated to fund the activities in this ADRC operational model. The three counties that currently contract with external agencies to provide case management, Hawai'i, Honolulu, and Maui, all plan to bring case management in-house and indicated that these funds should be reallocated to fund AAA staff positions performing these functions. **Exhibit 16** presents the estimated funds available for reallocation in each county.

Exhibit 16: Reallocation of Case Management Funds

County	Case Management Funds to be Reallocated
Kauai	$0
Maui	$71,000
Hawai'i	$319,028
Honolulu	$691,000
Total	**$1,081,028**

The Finance and Sustainability workgroup also explored whether it would be feasible to reallocate funds used for assessments and eligibility determinations in the two counties where these functions are currently done externally (Hawai'i and Honolulu Counties). Hawai'i County indicates that the outreach and assessment funds currently allocated to Coordinated Services are all county funds. HCOA stated that there is only a small amount of funds allocated for these activities and it would be very difficult to disentangle these funds; the Coordinated Services staff that conduct assessments also perform other tasks such as providing transportation and chore services. In Honolulu, the costs for assessments are included in a unit rate. EAD indicated that there was no easy way to untangle the reassessment amount from the unit rate at this time.

Potential for Drawing Down Medicaid Administrative Federal Financial Participation (FFP)

EOA is working with Med-QUEST to determine the feasibility of drawing down Medicaid administrative federal financial participation (FFP) for the ADRC effort. Many other states, notably Florida, Washington, Wisconsin, and Montana, are drawing down administrative FFP to partially fund these operations.

Many, if not most, of the ADRC functions are potentially eligible for matching Medicaid administrative funds. States can receive FFP from the federal government for costs associated with the "efficient and effective" administration of the Medicaid program. Generally the administrative match rate is 50%.[2] Medicaid administration activities can include the following:

- Outreach and enrollment,
- Case management,
- Provider monitoring,
- Planning and development,
- Network development,
- Auditing, and
- Quality improvement activities.

Most of the relevant ADRC functions for which FFP may be available will likely fall into the outreach and enrollment category, but some of the other categories are also relevant. Generally, the ADRC could receive FFP for services provided to someone who is Medicaid eligible. How the state and the ADRC define the eligibility determination process may affect the ability to draw down FFP for individuals who are ultimately determined not to be Medicaid eligible.

Under the proposed operational model for Hawaii's ADRC, the AAA staff will implement a two-tiered screening process to determine if someone might be eligible for Medicaid. During the initial intake, the AAA staff will screen to determine if someone is likely Medicaid eligible based solely on an individual's income and assets. The AAA will help establish Medicaid eligibility for people meeting this screen.

Under Hawaii's Medicaid eligibility criteria, individuals who have income and or assets above the eligibility threshold may be eligible if they have medical expenses that, when accounted for, reduce their income and assets to the point where they are eligible (i.e., they are eligible because they are medically needy). Therefore, the proposed model has identified a threshold for individuals who may be eligible or may be at risk of spending down to Medicaid eligibility. For these individuals, the AAA will conduct an in-home assessment that will include a cataloguing of their expenses to determine if they may be Medicaid eligible under the medically needy criteria.

Exhibit 17 provides a summary of these determinations and the proposed activities for which FFP may be claimed. ***Exhibit 18*** provides a breakdown of the potential to secure FFP for AAA staff performing core ADRC functions.

[2] Higher match rates theoretically could be obtained, such as compensation and training of skilled professional medical personnel performing administrative tasks that are medically related. Typically, these rates have been applied to utilization reviews.

Exhibit 17: Functions Potentially Eligible for Medicaid Federal Financial Participation (FFP)

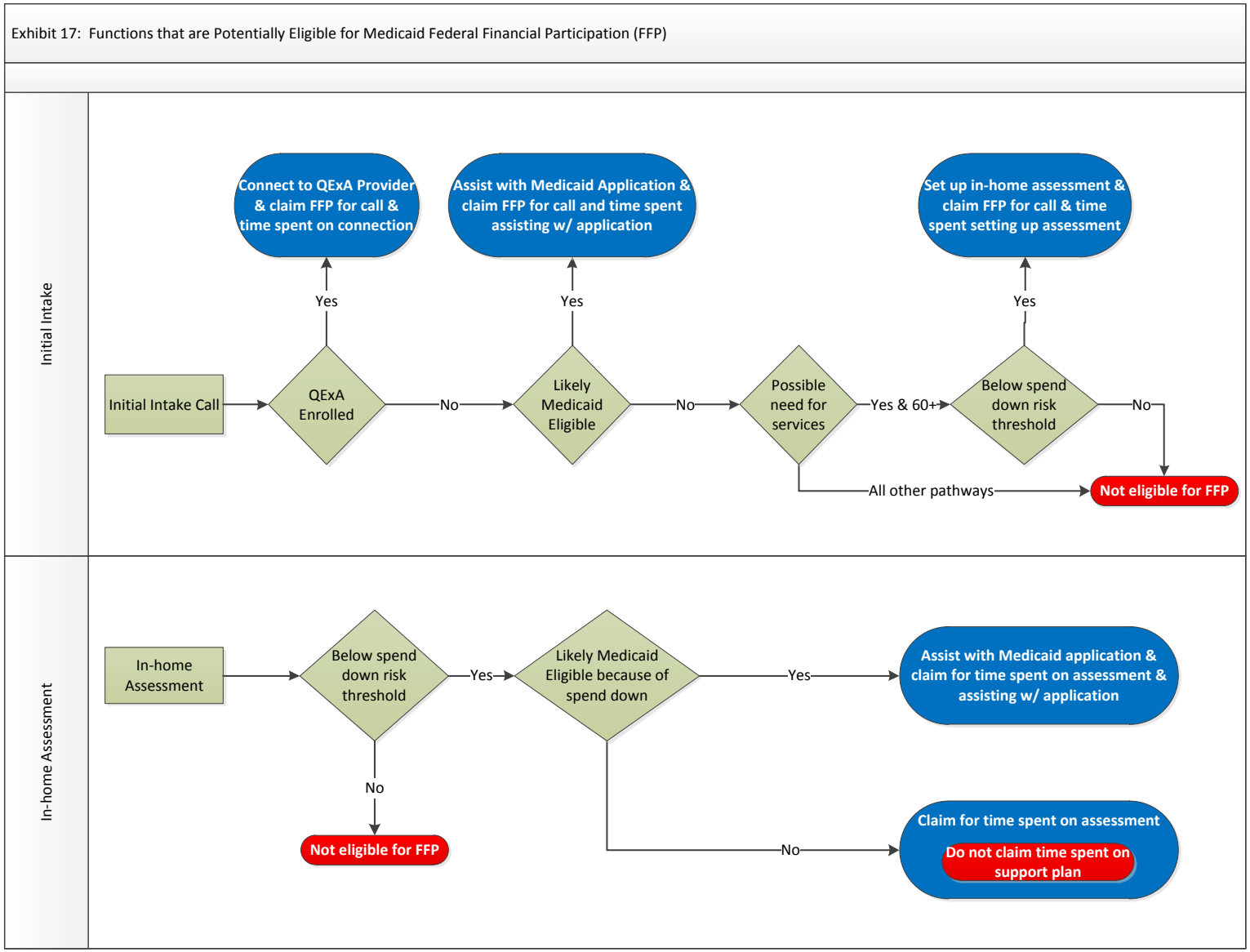


Exhibit 18: ADRC Functions by Potential for Medicaid Administrative Match

ADRC Staff Functions	Potential Ability to Receive Medicaid Administrative Match
Initial Intake	**Yes, if functions discuss Medicaid as potential service or if provided to someone who is Medicaid eligible**
Triage	**Only for individuals under Medicaid Spend Down Risk Threshold**
In-Home Assessment	**Only for individuals under Medicaid Spend Down Risk Threshold**
Case Management	**Only if providing short-term case management to help individuals connect with Medicaid services during crisis**
Other Activities	**If general support staff, could be included in overhead costs**

The AAAs will need to build infrastructure to comply with federal documentation requirements. The crux of this is having a methodology for documenting time spent on Medicaid reimbursable activities and attaching costs to these times. Hawaii's AAAs have a major advantage over other states in that they are already using a MIS system that will allow them to document staff time. This has been a major barrier for other states trying to draw down FFP for ADRC activities.

EOA, Med-QUEST and the AAAs will need to agree on a common format for reporting costs. We anticipate that this will involve making refinements to the current mechanisms by which the AAAs report costs to EOA.

Calculating a reliable estimate of the potential savings from drawing down administrative FFP would require an estimate of the number of contacts and individuals referred for assessment who fall below the threshold for risk of spend down to Medicaid. Unfortunately, the AAAs do not currently collect this data. Wisconsin, the state that developed the original ADRCs and has the most experience drawing down Medicaid administrative FFP, receives FFP for 56% of its activities (which at a 50% match rate covers 28% of the costs).

Chapter V: Implementation Plan

We developed a detailed implementation plan that lays out all of the tasks and corresponding timelines necessary to implement the components of the five-year plan. The complete Gantt chart for this effort, which is included as an ***Attachment B***, is nearly 600 task items long. This plan is meant to be a living document that will guide the work of EOA and the AAAs as all of the systems change efforts are implemented. We anticipate that as state and federal environments evolve and obstacles and opportunities arise, some dates and tasks will change. The implementation project plan will be tracked and managed using Microsoft Project. This will allow EOA to monitor and track the progress of the overall project management process.

Developing the plan required determining the relationship among key processes such as:

- The development of systems operations infrastructure;
- The timeline for phasing in county implementation;
- The state budgeting process; and
- The need for executive and/or legislative branch approvals at both the state and county levels.

The ***Exhibits 19 through 21*** show the relationship between each of these processes for the ADRC, participant direction, and hospital discharge planning efforts. These flowcharts depict the core activities and the relative order in which they will need to occur.

Exhibit 19: High Level Implementation Flow for Implementing ADRC Operations

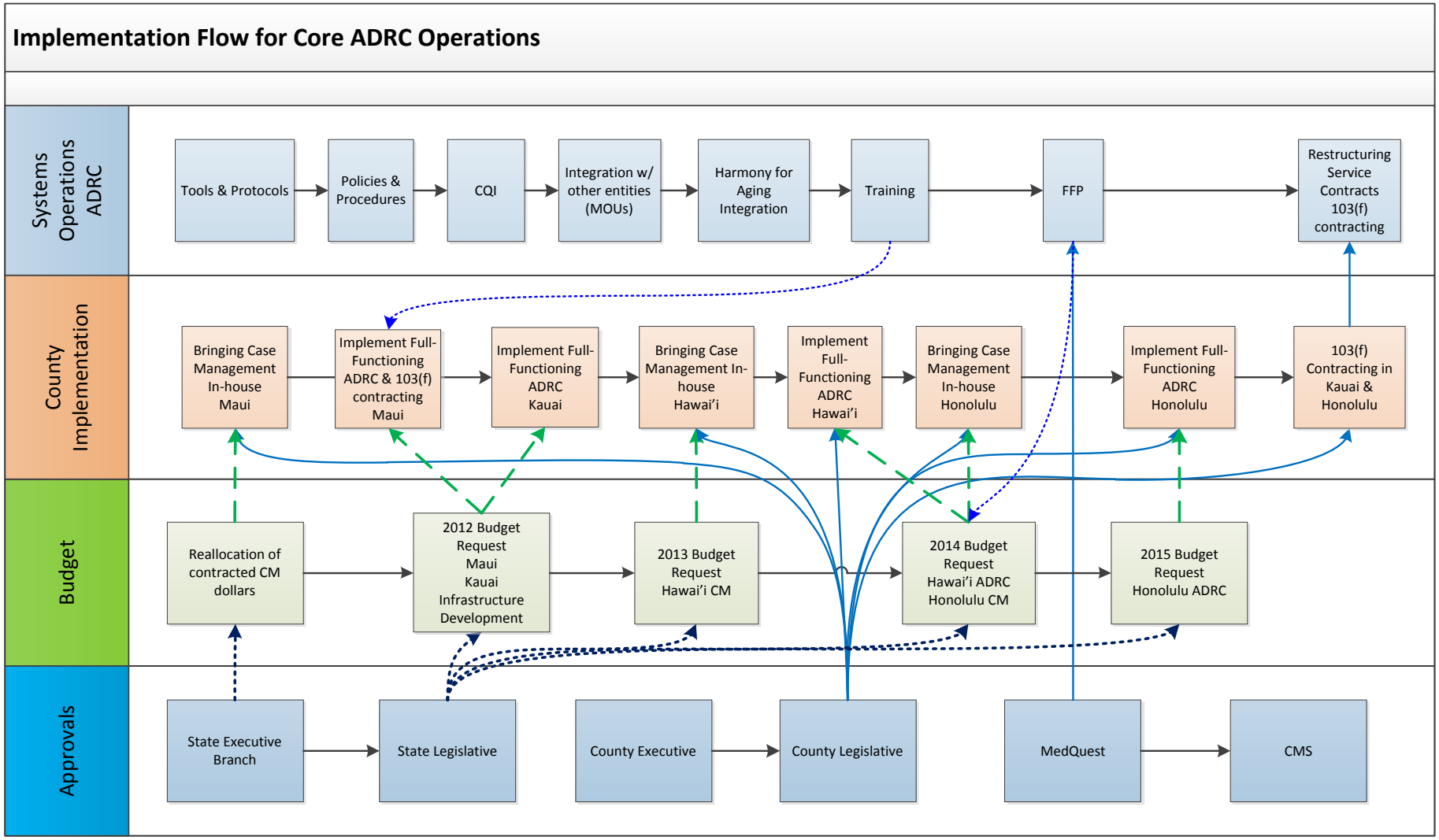


Exhibit 20: High Level Implementation Flow for Implementing the Participant Directed Option

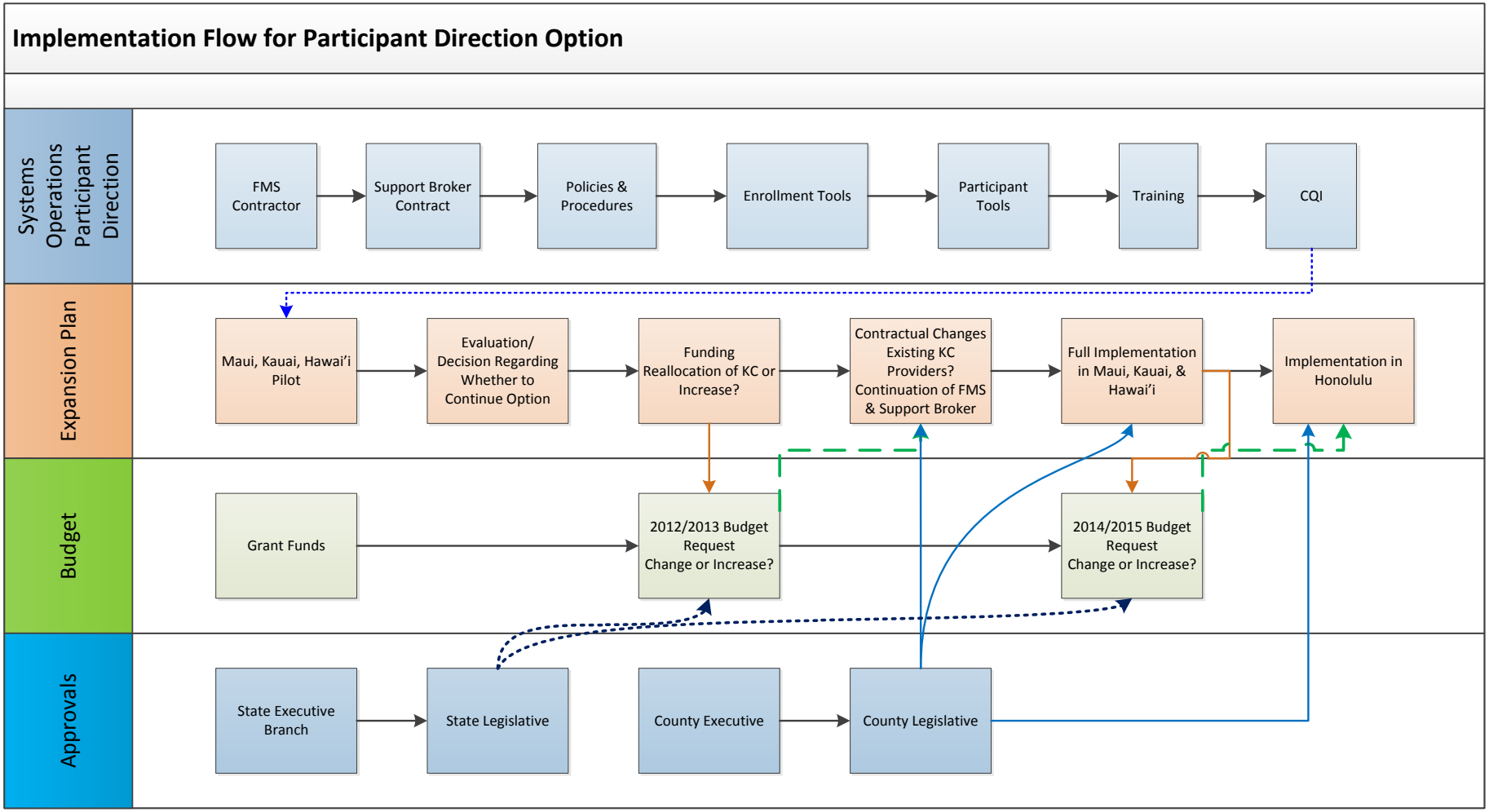
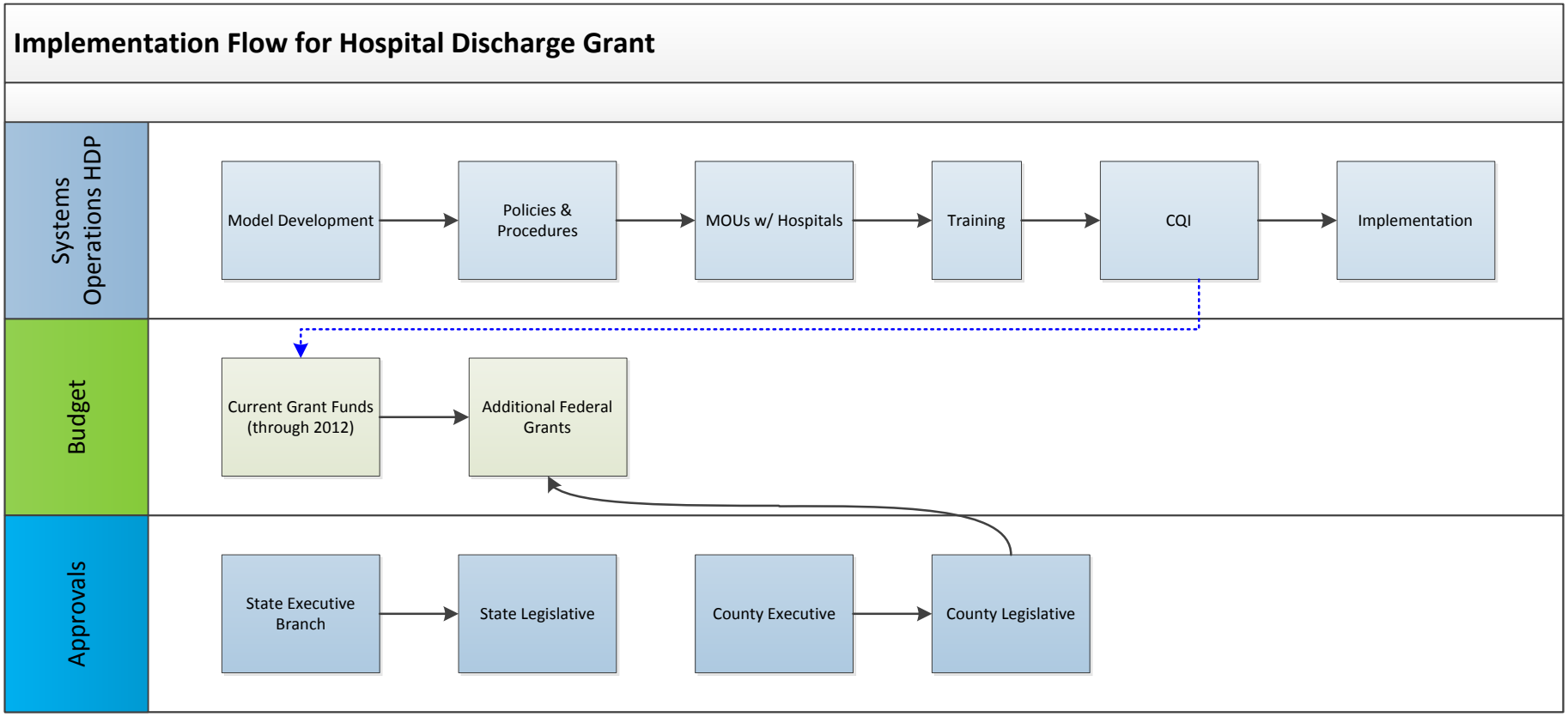


Exhibit 21: High Level Implementation Flow for Implementing the Hospital Discharge Planning Effort



Implementation Plan Legend

We color coded many of the rows in the implementation plan to highlight key aspects. The following is the key to the color coding:

Task is Related to MIS
Task is Related to Options Counseling Development
Task is Tied to Budget Process
Task Marks the Implementation of a Key Initiative

The detailed plan also identifies entities that will be working on each task. The following provides a crosswalk of the resource names to the resource initials included in ***Attachment B***:

Resource Name	Initials
Executive Office on Aging	EOA
Maui County	Mi
Kauai County	Ki
Honolulu County	Hu
Hawai'i County	Hi
Consultant	Cst
Harmony	Hmy
Med-QUEST	Mq
Core ADRC Workgroup	CAW
Participant Direction Workgroup	PDW
Hospital Discharge Workgroup	HDW
Executive Directors	ED
Finance & Sustainability Workgroup	FSW
Developmental Disabilities Division	DDD
Disability Organization	DO
Mental Health	MH
Options Counseling	OC
Information and Referral	I&R
Alliance of Information & Referral Systems	AIRS
Support Broker	SB
Fiscal Management Service	FMS
Veterans Administration Medical Center	VA

Key Implementation Dates

Exhibit 22 shows the current projected implementation dates for the key initiatives. It is important to note that these projected dates may change as circumstances evolve.

This exhibit shows that the first year will be spent developing key systems operations. The ADRC effort will be piloted in Maui before being rolled out to Kauai, Hawai'i and Honolulu Counties. The timeframe for the rollout in the other counties is significantly affected by the timing of budget appropriations and the administrative approval processes for hiring new staff at the county level.

Exhibit 22: Projected Implementation Dates for Key Initiatives

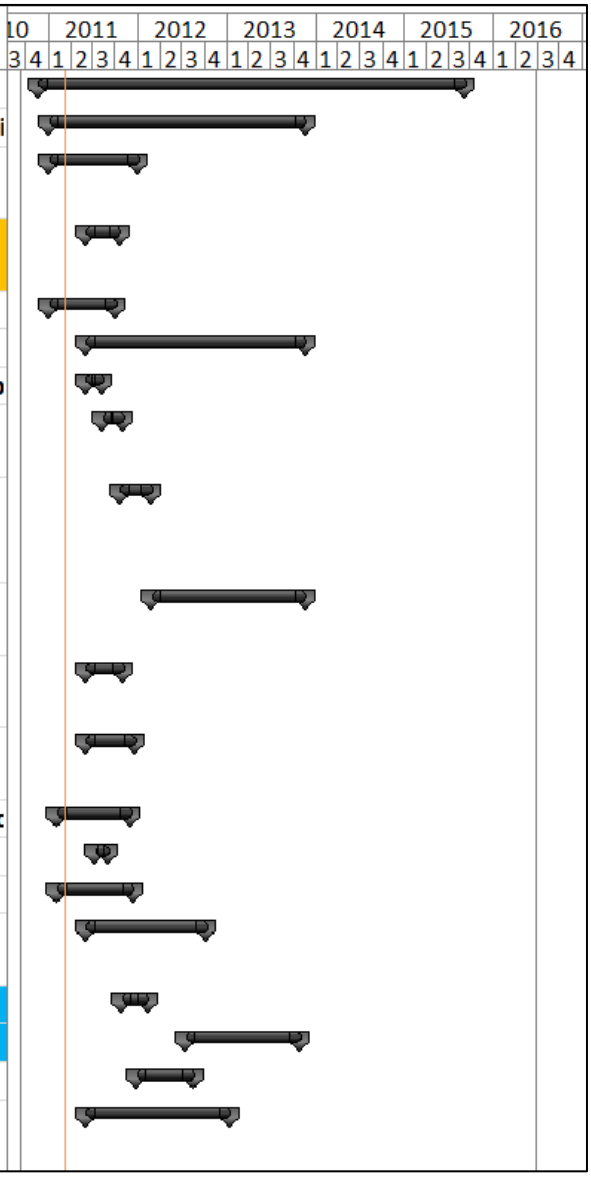
Initiative	Projected Implementation
Full-Functioning ADRC	**7/2015**
Full-Functioning ADRC - Maui Implementation	4/2012
Full-Functioning ADRC - Kauai Implementation	1/2013
Full-Functioning ADRC - Hawai'i County Implementation	3/2015
Full-Functioning ADRC - Honolulu Implementation	7/2015
In-House Case Management	**9/2013**
Maui implementation	12/2011
Hawai'i County implementation	3/2013
Honolulu Implementation	9/2013
Participant Direction	**9/2012**
Kauai, Hawai'i, and Maui pilot	8/2011
Kauai, Hawai'i and Maui full implementation	6/2012
Honolulu expansion plan	9/2012
Hospital Discharge Planning	**7/2011**
VA Option Implementation	**4/2012**
Service contracting changes	**6/2016**
Maui implementation	1/2012
Kauai and Honolulu implementation	6/2016

Implementing the Full-Functioning ADRC

Exhibit 23 provides the high-level timeframe for building the systems infrastructure for a full-functioning ADRC in Hawaii. The first several months involve a focus on finalizing tools and processes already identified in the implementation planning process. It is important to note that in all cases, EOA and the counties have reached a consensus regarding the framework and approach for each component; and in most cases, that consensus addresses the salient details, such as specific qualifications for staff, tools to be adapted and criteria to be used. Core new efforts during this initial implementation timeline will include incorporating these processes into the common MIS used across counties, Harmony for Aging, and into training materials.

Exhibit 23: High-Level Implementation Timeframe for Building Systems Infrastructure for the Full-Functioning ADRC Effort

ID	Task Name
1	Developing Full-Functioning ADRCs
2	Systems Infrastructure Development for Maui Pi
3	Develop mechanisms to streamline referrals to the ADRC
29	Develop comprehensive set of State-specific standards for OC
48	Develop common initial intake protocols
55	Refine I&R Database and Resources
56	Incorporate information about provider cap
61	Establish policy to incorporate AIRS taxonomy in I&R
66	Collect and integrate core information about programs supporting individuals with disabilities
72	Identify information on provider quality to be incorporated into I&R database
98	Develop protocol for assisting with Medicaid application
103	Develop protocols for linkages for other disability populations
121	Develop common in-home assessment protoc
142	Develop waitlist policy
146	Develop Support Plan
152	Develop Continuous Quality Improvement Infrastructure for ADRC Activities
198	Adapt Harmony for Maui Pilot
205	Longer term Harmony adaptations
210	Develop training infrastructure
233	Obtaining permission to draw down Medicaid Administrative Federal Financial Participation

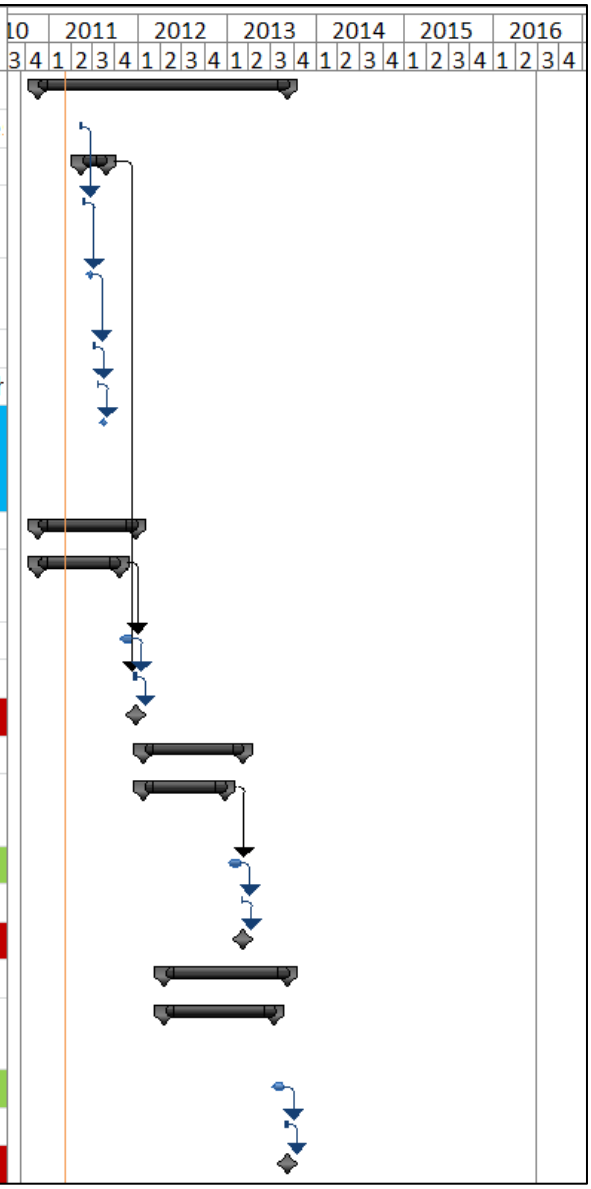


Implementing Changes to Case Management

As noted earlier, the three counties currently contracting for case management propose to bring these functions in-house. ***Exhibit 24*** provides a high-level timeframe for these efforts. Because Maui's proposed approach does not require any new state or county dollars, it has already begun preparing for this effort. The current timeframe has Honolulu County as the last county to roll out these changes.

Exhibit 24: Timeframe for Implementing Changes to Case Management

ID	Task Name
362	**Bring Case Management In-house**
363	Draft job descriptions and identification of serie
364	**Develop training infrastructure**
365	Decision whether to enroll in web-based training (e.g., U of MN or Boston College)
366	Develop training curricula and training approach (possibly adapting web-enabled
367	Core ADRC Workgroup input
368	Revise training curricula and training approach
369	Implement case management tools (case notes, case management supervision, performance/quality) in Harmony
370	**Maui County Rollout**
371	**Establishing Authority to Hire New Case Management Staff**
379	Hire staff
380	Train staff
381	Implementation
382	**Hawai'i County Rollout**
383	**Establishing Authority to Hire New Case Management Staff**
390	Hire staff
391	Train staff
392	Implementation
393	**Honolulu County Rollout**
394	**Establishing Authority to Hire New Case Management Staff**
401	Hire staff
402	Train staff
403	Implementation

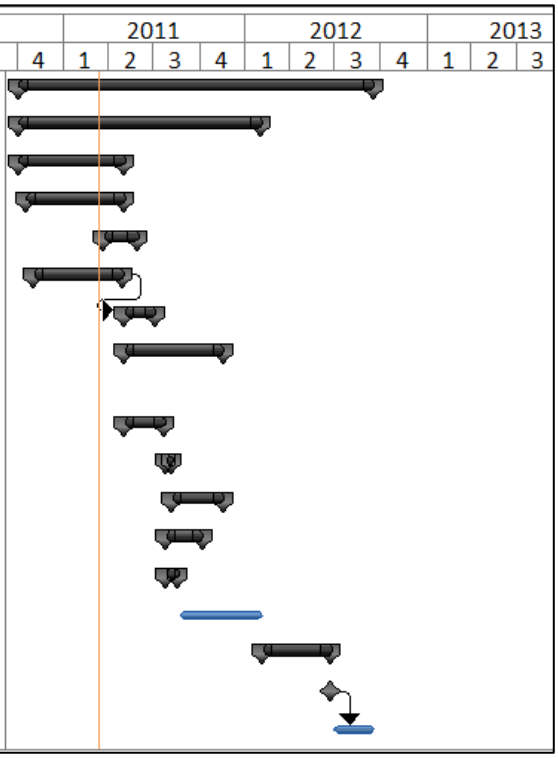


Implementing the Participant Directed Option

Exhibit 25 provides the high-level timeframe for implementing the participant directed option. EOA is already actively engaged in building this infrastructure, having recently issued RFPs for the FMS contractor and the support broker. This option will be piloted in Kauai, Maui, and Hawai'i Counties using federal grant funds. If the pilot is successful, the state will decide whether to expand the option in Kupuna Care and/or to request additional funding.

Exhibit 25: High-Level Implementation Timeframe for Building Systems Infrastructure for the Participant Directed Option

ID	Task Name
404	**Developing a Participant Direction Option**
405	**System Operations**
406	**FMS Contractor**
410	**Support Broker Contract**
414	**Policies & Procedures**
419	**Enrollment Process**
425	**Participant Tools**
430	**Develop Continuous Quality Improvement Infrastructure for Participant Direction**
431	**Finalize Performance Indicators**
435	**Develop data collection methods**
450	**Management Reports**
454	**Establish review and remediation processes**
463	**Training**
466	Maui, Kauai, Hawai'i Pilot
467	**Expansion Plan**
471	Full Implementation in Maui, Kauai, and Hawai'i
472	Develop expansion plan for Honolulu

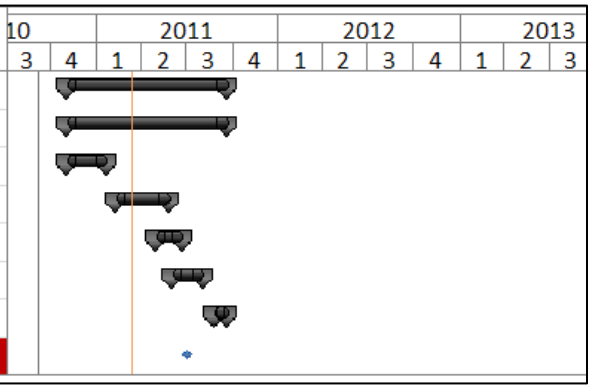


Implementing the Hospital Discharge Planning Effort

Exhibit 26 provides the timeframe for building infrastructure for the hospital discharge planning effort. It is important to note that all of the counties currently have staff working on this grant who are coordinating with local hospitals and assisting with hospital discharges. The tasks incorporated into the five-year plan would add greater structure and increased consistency across counties, something that is necessary in order to transform this pilot into an ongoing, statewide program.

Exhibit 26: High-Level Implementation Timeframe for Building Systems Infrastructure for the Hospital Discharge Planning Effort

ID	Task Name
473	**Providing Hospital Discharge Planning**
474	**System Operations**
475	**Model Development**
481	**Policies & Procedures**
486	**MOUs w/ Hospitals**
492	**Training**
494	**Continuous Quality Improvement**
496	Implementation

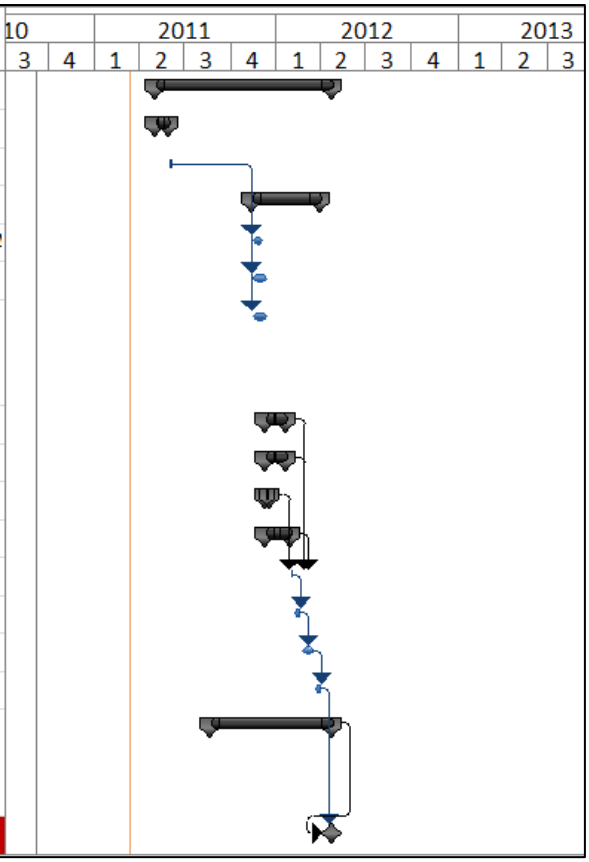


Implementation of the Veteran's Administration Option

Under the Community Living Program (CLP) grant, Hawaii has the option of establishing contracts with the local VA site so that veterans can access the participant directed option and the AAAs receive compensation for associated administrative costs. ***Exhibit 27*** provides an overview of the key steps for negotiating the major components of that contractual agreement.

Exhibit 27: High-Level Implementation Timeframe for Establishing a Veteran's Administration Option

ID	Task Name
497	**Build Veteran's Administration Program**
498	**EOA has initial meeting with VA**
503	Decision to proceed
504	**Provider Agreement with VAMC**
505	Parties to agreement (individual AAAs vs. EOA
506	Process for referrals from VA
507	Rate Determination (VAMC case-mix, VAMC sets rate for each Veteran, or AAA develops budget & VAMC approves)
508	**Rate Construction**
513	**VAMC Payment for VD-HCBS**
516	**Complying with VA Specific Requirements**
519	**Follow-up process**
523	AAA Decision to Proceed
524	County Executive Branch Approval
525	County Council Approvals
526	Signed Provider Agreement
527	**Operations that need to be in place prior to implementation (developed as part of participant-direction effort)**
534	Implementation



Chapter VI: Ongoing Planning Process

Given the five-year timeline and number of activities involved to implement a full functioning ADRC system, there must be a process to ensure the plan remains relevant and current. This document identifies a proposed structure to maintain, update and expand the work plan and its components to meet the goals of Hawaii's effort.

Exhibit 28 presents a proposed organizational structure for this process.

Exhibit 28: Proposed Framework for Ongoing Planning Process

A Leadership Team consisting of EOA representatives and Executive Directors from each county will oversee all implementation activities. Separate advisory groups will provide guidance to the Leadership Team. Finally, three workgroups provide effort on more detailed aspects of the implementation. The following describes the role and responsibilities for each.

Leadership Team

The Leadership Team oversees implementation of the plan and makes decisions regarding needed changes to the plan. Members include State EOA staff and the Executive Directors from each of the four county Area Agencies on Aging. The Leadership Team receives general administrative support from an EOA staff person.

The Leadership Team meets to review the progress of implementation at least every other month, but more often during critical times. The purpose of these meetings is:

- To monitor and review the progress of activities
- To identify, discuss, and seek solutions to challenges presented to overall plan or to individual county situations
- To assign tasks to workgroups
- To identify and take action on changes needed to the plan
- To make decisions and provide direction for implementation of the plan
- To enhance and facilitate continuance of a *statewide system*
- To facilitate sharing of resources and critical knowledge

EOA-AAA Continuous Quality Improvement Committee (CQI)

Shortly after the rollout of the full-functioning ADRC in Maui, a CQI committee will form to assist the Leadership Team to develop a Quality Management framework related to a full functioning ADRC system. The scope and process for this committee will be developed with input from the Core ADRC Workgroup. This committee will recommend a strategy and work plan to the Leadership Team covering:

- Reviewing management reports on performance indicators
- Identification of the range of potential remediation activities
- The identification and promotion of promising practices and excellence in performance

This committee membership will include representation from EOA and each of the AAAs. This group will also participate in the External Advisory and Interagency quality committees. In addition, it will receive reports from each AAA's internal CQI committee as these become active. EOA will provide administrative support to the committee.

Advisory Group

An ongoing advisory group provides input from individuals/entities critical to the efficient and effective implementation of the plan. This advisory group receives administrative support from state staff (e.g., arranging meetings and agendas, recording minutes and recommended actions).

The advisory group members include representatives from organizations or groups with key roles in a full functioning ADRC and other individuals with specific knowledge helpful to implementing a statewide ADRC system. Examples include representatives from state agency divisions (such as Med-QUEST and the state DD division), the Disability Communication Access Board, Veteran's Affairs, hospital discharge planners, provider organizations, disability organizations. The Policy Advisory Board on Elder Affairs convened by EOA provides a good basis for this ongoing group, with EOA inviting any missing memberships.

This advisory group will meet on at least a quarterly basis. The purpose of these meetings is:

- To provide advice and recommendations to the Leadership Team on specific topics
- To provide general input about the progress of activities

- To provide qualitative information regarding experiences with system
- To assist with community outreach or other efforts to improve the effectiveness of the *statewide system*
- To facilitate sharing of resources and critical knowledge

Workgroups

Workgroups provide focused effort and attention designed to implement details of the five-year plan. The workgroups involve key state and county staff. Staff includes individuals responsible to oversee and implement portions of the work plan at the local level.

State staff will provide support to the workgroups in two ways: 1) administrative support to arrange and maintain a calendar of meetings; and 2) EOA lead staff to facilitate the implementation of the plan, document recommendations and assignments made by the workgroup, and provide written reports to the Leadership Team.

A description of the role for each workgroup follows.

MIS Workgroup

The MIS workgroup responsibilities include implementation of the five-year plan concerning hardware and software to support the enhancement of the system to a statewide, fully functioning ADRC. The purpose of the workgroup includes

- To monitor, review, and report to the Leadership Team on the progress of activities
- To identify, discuss, and seek solutions to challenges presented to overall plan or to individual county situations
- To identify and organize the responsibilities for specific action steps related to plan implementation
- To identify and recommend action on changes needed to the plan
- To make other recommendations to the Leadership Team for implementation of the plan
- To enhance and facilitate continuance of a *statewide system*
- To facilitate sharing of resources and critical knowledge

Budget and Sustainability Workgroup

The Budget and Sustainability workgroup has the critical role of providing oversight for two related components of the implementation of the five-year plan.

Budget:

Budget oversight includes tracking the use and availability of financial resources to support the activities included in the five-year implementation plan. This includes resources from sources such as federal grants, state appropriations, and county funds. The purpose of budget meetings includes

- To track and report to the Leadership Team on the use and availability of financial resources to support the activities included in the five-year plan
- To identify, discuss, and seek solutions to any budget challenges that present barriers to the implementation of the plan
- To propose recommendations to the Leadership team regarding specific action steps to ensure continued progress of the five-year plan
- To provide fiscal analyses and cost effectiveness evaluation regarding implementation decisions, as directed by the Leadership Team
- To make other recommendations to the Leadership Team for implementation of the plan
- To enhance and facilitate continuance of a *statewide system*
- To facilitate sharing of resources and critical knowledge

Sustainable Infrastructure

The workgroup also maintains responsibility to evaluate and provide recommendations on infrastructure necessary to sustain progress of the five-year plan. This includes

- Evaluation of short and long term staffing to implement components of the five-year plan
- Recommending enhancements or changes of the initial sustainability plan to the Leadership Team
- Maintaining and tracking a consolidated plan for adequate infrastructure including acquisition, maintenance, repair, or replacement of equipment and supplies necessary to implement the five-year plan in each county

Program Design and Implementation Workgroup and Subgroups

The five-year plan includes a number of adjustments to current tools and practices in order to create a more standardized, reliable, and systematic resource for people using Hawaii's ADRC. The Program Design and Implementation Workgroup responsibilities include addressing the plan for standardizing many of the tools and approaches used by ADRC staff. For example, the five-year plan calls for standardization of assessment definitions and criteria used to determine service need and eligibility for programs.

The purpose of the main Program Design and Implementation workgroup meetings include

- To identify subgroup assignments and timelines
- To review and integrate the work and recommendations of subgroups into the overall program design and implementation
- To review and recommend to the Leadership Team specific programmatic tools and process for the standardization of ADRC activities across the four counties

- To review and recommend to the Leadership Team any other "best practices" from Hawaii's counties and nationwide that should be considered for incorporation into the plan
- To track and report to the Leadership Team on the development and implementation of the various programmatic action steps identified in the five-year plan
- To identify, discuss, and seek solutions to any programmatic challenges that present barriers to the implementation of the five-year plan
- To make recommendations to the Leadership Team about actions steps needed for continued progress on the five-year plan
- To enhance and facilitate continuance of a *statewide system*
- To facilitate sharing of resources and critical knowledge

Subgroups of the Program Design and Implementation Workgroup:

Three subgroups, reporting through the Program Design and Implementation Workgroup, will focus on specific issues and tools needed for 1) Hospital Discharge, 2) Participant Direction, and 3) Core ADRC. Subgroups provide a way to focus members on the details for efforts in these three areas. Funneling recommendations back through the overall Program Design and Implementation Workgroup helps to ensure consistency and overall integration within the ADRC design.

The responsibilities of the subgroups are similar to those described for the overall Program Design and Implementation workgroup, and include:

- To review and recommend to the Program Design and Implementation workgroup specific programmatic tools and process for the standardization of activities across the four counties
- To review and recommend to the Program Design and Implementation workgroup any other "best practices" from Hawaii's counties and nationwide that should be considered for incorporation into the plan
- To track and report to the Program Design and Implementation workgroup on the development and implementation of assigned programmatic activities
- To identify, discuss, and seek solutions to any programmatic challenges that present barriers to the implementation of the five-year plan
- To make recommendations to the Program Design and Implementation workgroup about actions steps needed for continued progress on the five-year plan
- To enhance and facilitate continuance of a *statewide system*
- To facilitate sharing of resources and critical knowledge

A short description of the subgroups follows.

A. Hospital Discharge

The Hospital Discharge workgroup will develop the infrastructure tools needed for addressing the goal of discharging individuals from acute inpatient hospitals back to the community. This work includes developing tools and protocols for identifying at risk individuals, providing timely assistance, and performing necessary follow up to help maintain the person in the community.

B. Participant Directed Services (Community Living Program)

The Participant Directed Services workgroup will develop the infrastructure tools needed to implement a consumer directed service option. This work includes developing tools and protocols for enrolling individuals, providing information and coaching about self-directed services, fiscal management, and quality oversight.

C. Core ADRC

The Core ADRC workgroup will develop the infrastructure tools needed to standardize many of the functions or components of the ADRC that relate to programmatic implementation. Examples of the work for this subgroup include development of common intake and assessment data and tools, common performance standards related to providing information and assistance, and the other programmatic components identified in the five year plan.

We anticipate that after the implementation of the full-functioning ADRC in Maui, there will no longer be a need for the subgroups. At that point, there work will be folded into the work of the larger committee.

Workgroup Composition

Each of the main workgroups (MIS, Budget and Sustainability, and Program Design and Implementation) will include one representative with knowledge specific to the subject matter from EOA and each of the four counties. These representatives will act as permanent members of the group. The group may also invite other state, county, and other partner representatives to participate on an ad hoc basis when beneficial to the efforts of the group. Members of subgroups or ad hoc committees needed to support the efforts of the main workgroups will be defined by the three workgroups.

The goals for this approach are to

- Ensure knowledgeable representation from each participating agency (EOA and county AAAs)
- Maintain a core group over the life of the five-year plan, facilitating in-depth knowledge and understanding of key components and rationales for decisions
- Ensure that each agency has input and influence into the way that the statewide system is implemented
- Identify and understand any variations in how the statewide system must be implemented in each county
- Help achieve the outcome of a *statewide system* for individuals and families to use

Workgroup Meetings and Supports

Each main workgroup will initially meet twice per month or at a frequency directed by the Leadership Team in order to complete work within the timelines of the five-year implementation plan.

Responsibilities for leading the meeting will rotate among the permanent members of the group on an every six-month basis, with EOA having responsibility for the first rotation. If the person responsible for leading the meeting is unable to attend and lead the meeting, the person having served the previous six months will assume the duty for that meeting. EOA support staff will take meeting notes and will distribute these to members of the workgroup after each meeting.

Workgroups do not need to meet in person and may use the established WebEx and other tools (e.g., blogs) to facilitate meetings. EOA support staff will assist each workgroup as needed to learn and use the tools available.

Attachment A: Acronym Glossary

AAA – Area Agency on Aging

ADLs – Activities of Daily Living

ADRC – Aging and Disability Resource Center

AIRS – Alliance of Information and Referral Systems

AoA – Administration on Aging

CIL – Center for Independent Living

CLP – Community Living Program

CMS – Centers for Medicare & Medicaid Services

DCAB – Disability and Communication Access Board

DHS – Department of Human Services

DOH – Department of Health

EAD –Elderly Affairs Division in the Department of Community Services of the City and County of Honolulu

EOA – Executive Office on Aging

FMS – Fiscal Management Service

HCIL – Hawaii Centers for Independent Living

HCOA – Hawai'i County Office of Aging

HDP – Hospital Discharge Planning

HIPAA – Health Insurance Portability and Accountability Act

I&R – Information and Referral

I&A – Information and Assistance

IADLs – Instrumental Activities of Daily Living

KAEA – Kauai County, Agency on Elderly Affairs

KC – Kupuna Care

MCOA – Maui County Office on Aging

MH – Mental Health

MOU – Memorandum of Understanding

OAA – Older Americans Act (Title III)

QExA – QUEST Expanded Access

SAMS – Social Assistance Management System, a product of Harmony Information Systems, Inc.

SCD – Systems Change Developer

SEP – Single Point of Entry

SHIP – Senior Health Insurance Program

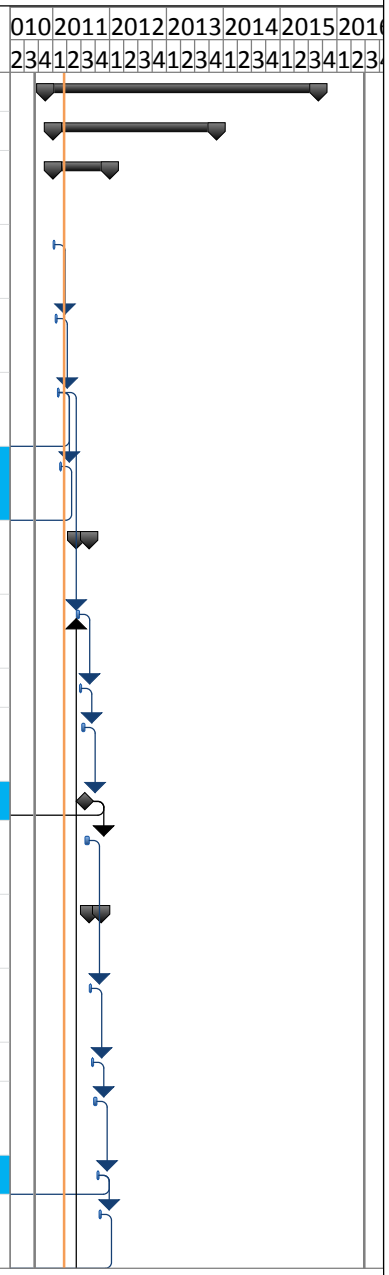
SNF/NF – Skilled Nursing Facility/Nursing Facility

Attachment B: Detailed Implementation Plan

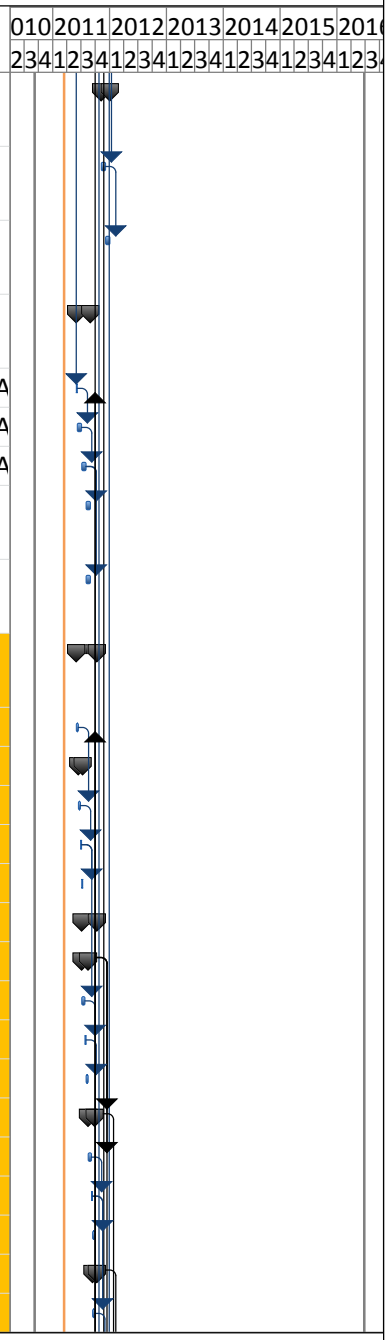
[***Attachment B*** on next page]

Hawaii SCD Implementation Plan

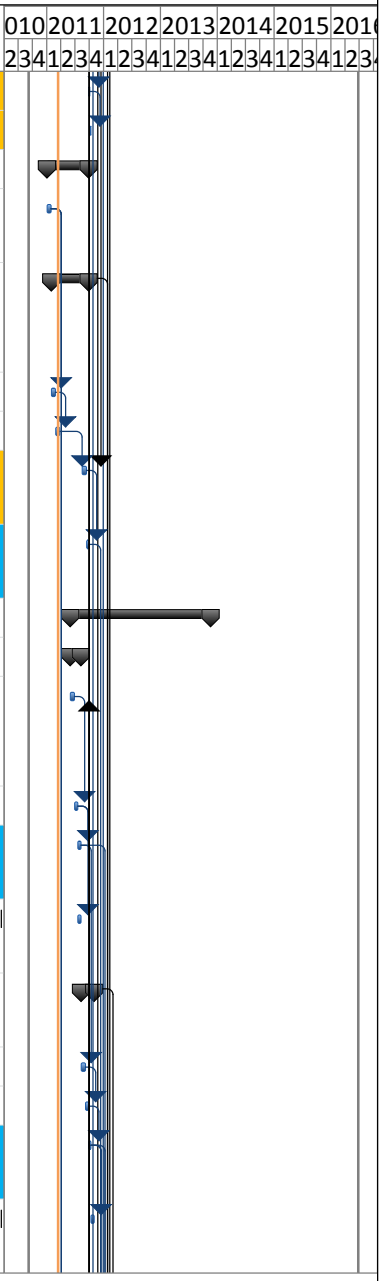
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
1	**1**	**Developing Full-Functioning ADRCs**		**1255 days**	**11/15/10**	**9/4/15**	
2	**1.1**	**Systems Infrastructure Development for Maui Pilot**		**752 days**	**1/3/11**	**11/19/13**	
3	**1.1.1**	**Develop mechanisms to streamline referrals to the ADRC**		**262 days**	**1/3/11**	**1/3/12**	
4	1.1.1.1	Protocol for HIPAA compliance for transmitting client information		10 days	1/3/11	1/14/11	H
5	1.1.1.2	Draft protocols for web-based, phone, email, and fax referrals	4	10 days	1/17/11	1/28/11	H
6	1.1.1.3	Core ADRC Workgroup review of draft protocols	5	10 days	1/31/11	2/11/11	CAW,H
7	1.1.1.4	Revised protocols ready for incorporation within Harmony	6	10 days	2/14/11	2/25/11	Hmy,H
8	**1.1.1.5**	**Establish state level MOUs for high volume referral sources to the AAA**		**60 days**	**6/1/11**	**8/23/11**	
9	1.1.1.5.1	EOA outreach to state level high volume agencies	6,588	15 days	6/1/11	6/21/11	EOA,Mi
10	1.1.1.5.2	Draft MOUs	9	10 days	6/22/11	7/5/11	EOA,Mi
11	1.1.1.5.3	Agreement/Sign on MOUs with respective agencies	10	15 days	7/6/11	7/26/11	EOA,Mi
12	1.1.1.5.4	Implement referral protocols	11	0 days	7/26/11	7/26/11	EOA,Mi
13	1.1.1.5.5	Provide outreach and training on referring to ADRC	12	20 days	7/27/11	8/23/11	EOA,Mi
14	**1.1.1.6**	**Establish local level MOUs for high volume referral sources to the AAA in Maui**		**55 days**	**8/24/11**	**11/8/11**	
15	1.1.1.6.1	AAAs outreach to respective county agencies with high volume referrals	13	10 days	8/24/11	9/6/11	Mi
16	1.1.1.6.2	Draft MOUs	15	10 days	9/7/11	9/20/11	Mi
17	1.1.1.6.3	Agreement/Sign MOUs with respective agencies	16	15 days	9/21/11	10/11/11	Mi
18	1.1.1.6.4	Implement referral protocols	17	10 days	10/12/11	10/25/11	Mi
19	1.1.1.6.5	Provide outreach and training on referring to ADRC	18	10 days	10/26/11	11/8/11	Mi



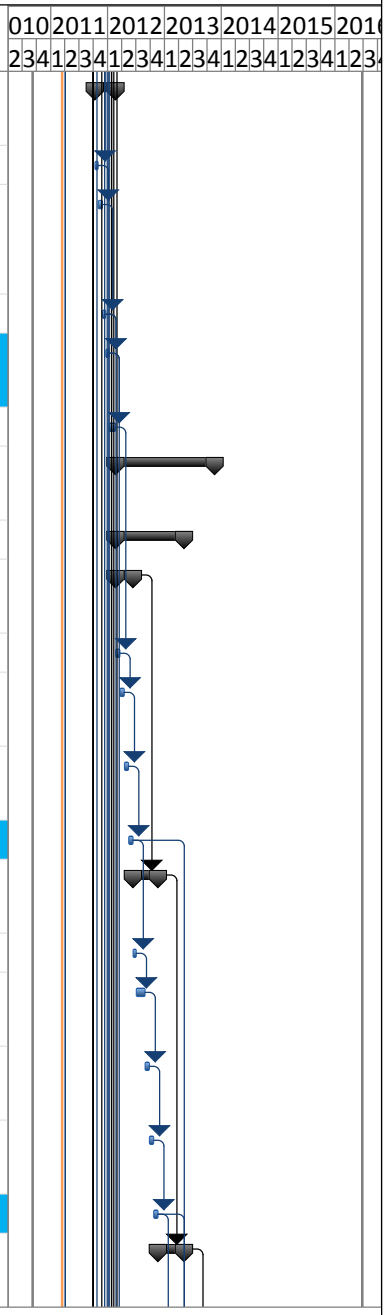
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
20	**1.1.1.7**	**Integration with Low Volume Referral Sources in Maui**		**40 days**	**11/9/11**	**1/3/12**	
21	1.1.1.7.1	AAAs/EOA outreach to low volume referral agencies	19	20 days	11/9/11	12/6/11	Mi
22	1.1.1.7.2	Provide outreach and training on referring to ADRC	21	20 days	12/7/11	1/3/12	Mi
23	**1.1.1.8**	**Establish MOU with Med-QUEST on referral to ADRC for all counties**		**65 days**	**6/1/11**	**8/30/11**	
24	1.1.1.8.1	Outreach to Med-QUEST	6,588	5 days	6/1/11	6/7/11	EOA,Mq,CA
25	1.1.1.8.2	Draft MOU Med-QUEST	24	20 days	6/8/11	7/5/11	EOA,Mq,CA
26	1.1.1.8.3	Agreement/Sign MOU with Med-QUEST	25	20 days	7/6/11	8/2/11	EOA,Mq,CA
27	1.1.1.8.4	Incorporate referral information with denial letters for individuals, ages 60 and older	26	20 days	8/3/11	8/30/11	EOA,Mq
28	1.1.1.8.5	Develop protocol for Med-QUEST to refer applicants to respective disability supports	26	20 days	8/3/11	8/30/11	EOA,Mq
29	**1.1.2**	**Develop comprehensive set of State-specific standards for OC**		**95 days**	**6/1/11**	**10/11/11**	
30	1.1.2.1	Background research	588	10 days	6/1/11	6/14/11	Cst
31	**1.1.2.2**	**Indentification of competencies**		**20 days**	**6/15/11**	**7/12/11**	CAW,Cst
32	1.1.2.2.1	Draft proposal	30	10 days	6/15/11	6/28/11	Cst
33	1.1.2.2.2	Core ADRC Workgroup review	32	5 days	6/29/11	7/5/11	CAW,Cst
34	1.1.2.2.3	Revised competencies	33	5 days	7/6/11	7/12/11	Cst
35	**1.1.2.3**	**Development of protocols**		**70 days**	**7/6/11**	**10/11/11**	
36	**1.1.2.3.1**	**Initial intake**		**30 days**	**7/6/11**	**8/16/11**	
37	1.1.2.3.1.1	Draft protocol	33	15 days	7/6/11	7/26/11	Cst
38	1.1.2.3.1.2	Core ADRC Workgroup review	37	5 days	7/27/11	8/2/11	CAW,Cst
39	1.1.2.3.1.3	Revised Protocol	38	10 days	8/3/11	8/16/11	Cst
40	**1.1.2.3.2**	**In-home assessment**	**36**	**30 days**	**8/17/11**	**9/27/11**	
41	1.1.2.3.2.1	Draft protocol	36	15 days	8/17/11	9/6/11	Cst
42	1.1.2.3.2.2	Core ADRC Workgroup review	41	5 days	9/7/11	9/13/11	CAW,Cst
43	1.1.2.3.2.3	Revised Protocol	42	10 days	9/14/11	9/27/11	Cst
44	**1.1.2.3.3**	**Support Plan**		**20 days**	**9/14/11**	**10/11/11**	
45	1.1.2.3.3.1	Draft protocol	42	10 days	9/14/11	9/27/11	Cst



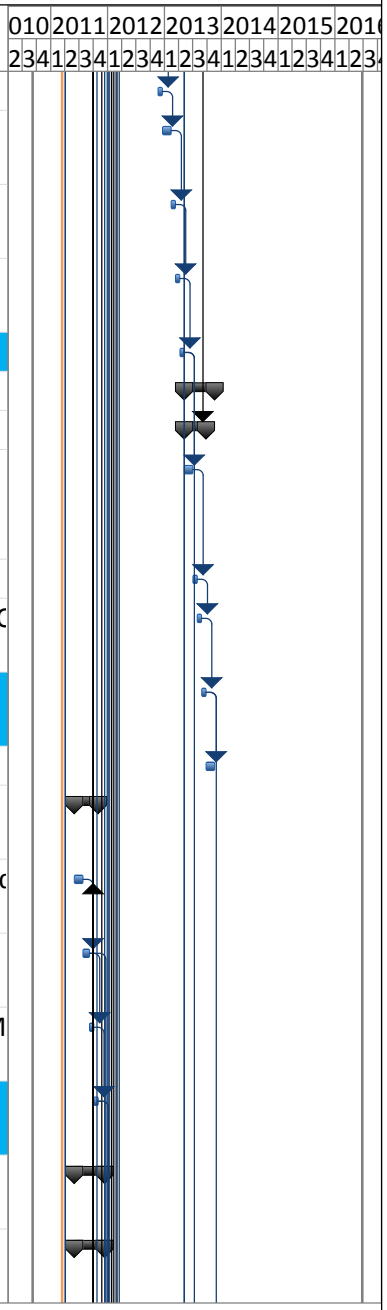
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
46	1.1.2.3.3.2	Core ADRC Workgroup review	45	5 days	9/28/11	10/4/11	CAW,Cst
47	1.1.2.3.3.3	Revised Protocol	46	5 days	10/5/11	10/11/11	Cst
48	**1.1.3**	**Develop common initial intake protocols**		**192 days**	**1/3/11**	**9/27/11**	
49	1.1.3.1	Review of interRAI screeners and associated algorithms		20 days	1/3/11	1/28/11	H
50	**1.1.3.2**	**Develop Intake Screens (LTC need, QExA enrolled, Likely Medicaid eligible, Need for Services, Case Complexity)**		**172 days**	**1/31/11**	**9/27/11**	
51	1.1.3.2.1	Draft Screens	49	20 days	1/31/11	2/25/11	H
52	1.1.3.2.2	Core ADRC Workgroup review	51	20 days	2/28/11	3/25/11	H,CAW
53	1.1.3.2.3	Incorporate protocols from LTC Options Counseling effort	52,36	20 days	8/17/11	9/13/11	Cst
54	1.1.3.2.4	Revised screens ready for incorporation within Harmony	53	10 days	9/14/11	9/27/11	Cst,Hmy
55	**1.1.4**	**Refine I&R Database and Resources**		**645 days**	**6/1/11**	**11/19/13**	
56	**1.1.4.1**	**Incorporate information about provider capac**		**50 days**	**6/1/11**	**8/9/11**	
57	1.1.4.1.1	Identify common data elements and procedure for providers to be notified to enter data and AAA review of data	588	20 days	6/1/11	6/28/11	Mi
58	1.1.4.1.2	Core ADRC Workgroup input	57	15 days	6/29/11	7/19/11	CAW,Mi
59	1.1.4.1.3	Revised fields ready for incorporation with Harmony	58	15 days	7/20/11	8/9/11	Hmy,Mi
60	1.1.4.1.4	Revised policies incorporated into AAA policies and procedures	58	15 days	7/20/11	8/9/11	EOA,Hi,Hu,I
61	**1.1.4.2**	**Establish policy to incorporate AIRS taxonomy in I&R**		**60 days**	**8/10/11**	**11/1/11**	
62	1.1.4.2.1	Develop draft proposal	59	20 days	8/10/11	9/6/11	Mi
63	1.1.4.2.2	Core ADRC Workgroup input	62	15 days	9/7/11	9/27/11	CAW,Mi
64	1.1.4.2.3	Revised policy ready for incorporation with Harmony	63	10 days	9/28/11	10/11/11	Hmy,Mi
65	1.1.4.2.4	Revised policies incorporated into AAA policies and procedures	64	15 days	10/12/11	11/1/11	EOA,Hi,Hu,I



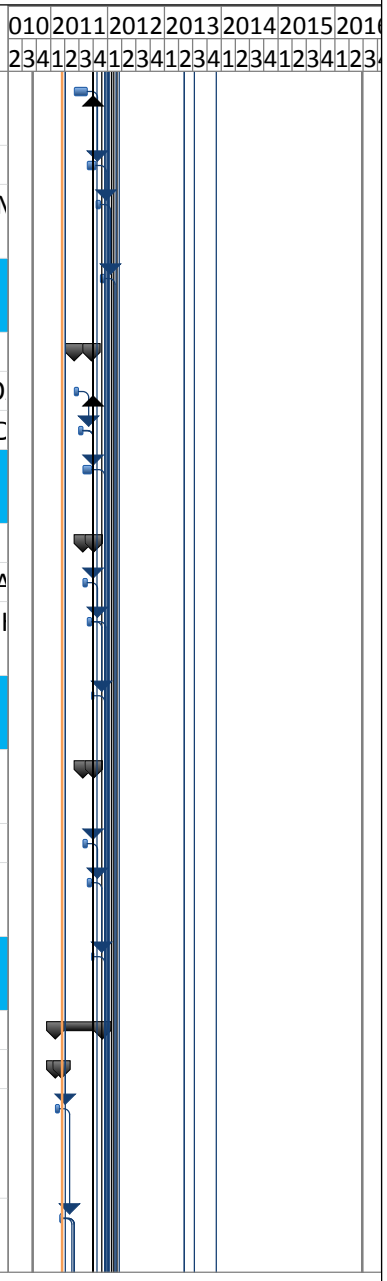
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
66	**1.1.4.3**	**Collect and integrate core information about programs supporting individuals with**		**95 days**	**10/12/11**	**2/21/12**	
67	1.1.4.3.1	Identify all relevant programs	64	15 days	10/12/11	11/1/11	Mi
68	1.1.4.3.2	Determine common program description data elements (e.g., eligibility criteria, point of access, etc.)	67	20 days	11/2/11	11/29/11	Mi
69	1.1.4.3.3	Core ADRC Workgroup review	68	15 days	11/30/11	12/20/11	CAW,Mi
70	1.1.4.3.4	Finalize data elements and incorporate within Harmony	69	15 days	12/21/11	1/10/12	Hmy,Mi
71	1.1.4.3.5	Populate database	70	30 days	1/11/12	2/21/12	EOA,Mi
72	**1.1.4.4**	**Identify information on provider quality to be incorporated into I&R database**		**455 days**	**2/22/12**	**11/19/13**	
73	**1.1.4.4.1**	**Mid-term enhancements**		**315 days**	**2/22/12**	**5/7/13**	
74	**1.1.4.4.1.1**	**Incorporate CMS/federal provider review data**		**80 days**	**2/22/12**	**6/12/12**	
75	1.1.4.4.1.1.1	Identify data to be incorporated	71	20 days	2/22/12	3/20/12	Mi
76	1.1.4.4.1.1.2	Determine way to upload federal review data into I & R database	75	20 days	3/21/12	4/17/12	Hmy,Mi
77	1.1.4.4.1.1.3	Core ADRC Workgroup input and decision to proceed	76	20 days	4/18/12	5/15/12	CAW,Mi
78	1.1.4.4.1.1.4	Establish uploading procedure	77	20 days	5/16/12	6/12/12	Hmy
79	**1.1.4.4.1.2**	**Incorporate residential care and nursing home information**	**74**	**115 days**	**6/13/12**	**11/20/12**	
80	1.1.4.4.1.2.1	Identify data to be incorporated	78	15 days	6/13/12	7/3/12	Mi
81	1.1.4.4.1.2.2	Obtain approval to access and publish data	80	40 days	7/4/12	8/28/12	EOA,Mi
82	1.1.4.4.1.2.3	Determine way to upload data into I & R database	81	20 days	8/29/12	9/25/12	Hmy,Mi
83	1.1.4.4.1.2.4	Core ADRC Workgroup input and decision to proceed	82	20 days	9/26/12	10/23/12	CAW,Mi
84	1.1.4.4.1.2.5	Establish uploading procedure	83	20 days	10/24/12	11/20/12	Hmy
85	**1.1.4.4.1.3**	**Incorporate Community Care Family Foster Homes**	**79**	**120 days**	**11/21/12**	**5/7/13**	



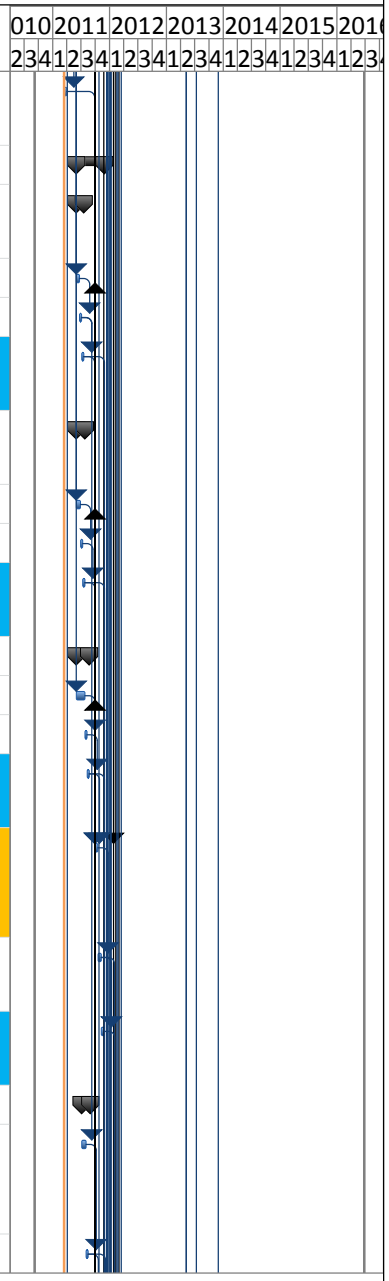
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
86	1.1.4.4.1.3.1	Identify data to be incorporated	84	20 days	11/21/12	12/18/12	Mi
87	1.1.4.4.1.3.2	Obtain approval to access and publish data	86	40 days	12/19/12	2/12/13	EOA,Mi
88	1.1.4.4.1.3.3	Determine way to upload data into I & R database	87	20 days	2/13/13	3/12/13	Hmy,Mi
89	1.1.4.4.1.3.4	Core ADRC Workgroup input and decision to proceed	88	20 days	3/13/13	4/9/13	CAW,Mi
90	1.1.4.4.1.3.5	Establish uploading procedure	89	20 days	4/10/13	5/7/13	Hmy
91	**1.1.4.4.2**	**Longer-term enhancements**		**140 days**	**5/8/13**	**11/19/13**	
92	**1.1.4.4.2.1**	**Incorporate AAA provider reviews**	**85**	**100 days**	**5/8/13**	**9/24/13**	
93	1.1.4.4.2.1.1	Develop draft common provider review tool and timeframes for conducting reviews	90	40 days	5/8/13	7/2/13	Cst
94	1.1.4.4.2.1.2	Core ADRC Workgroup input	93	20 days	7/3/13	7/30/13	Cst,CAW
95	1.1.4.4.2.1.3	Revise tool and obtain provider input	94	20 days	7/31/13	8/27/13	Cst,CAW,EC
96	1.1.4.4.2.1.4	Revised tool ready for incorporation within Harmony	95	20 days	8/28/13	9/24/13	Hmy,Cst
97	1.1.4.4.2.2	Explore consumer reviews	96	40 days	9/25/13	11/19/13	
98	**1.1.5**	**Develop protocol for assisting with Medicaid application**		**110 days**	**6/1/11**	**11/1/11**	
99	1.1.5.1	Discussion with Med-QUEST regarding requirements for a complete application	588	40 days	6/1/11	7/26/11	Cst,EOA,Mc
100	1.1.5.2	Draft protocol for completing package and tracking application status	99	30 days	7/27/11	9/6/11	Cst
101	1.1.5.3	Core ADRC Workgroup and Med-QUEST review	100	20 days	9/7/11	10/4/11	Cst,CAW,M
102	1.1.5.4	Revised protocol ready for incorporation within Harmony	101	20 days	10/5/11	11/1/11	Cst,Hmy
103	**1.1.6**	**Develop protocols for linkages for other disability populations**		**140 days**	**6/1/11**	**12/13/11**	
104	**1.1.6.1**	**Develop protocols for handoff for adults with physical disabilities**		**140 days**	**6/1/11**	**12/13/11**	



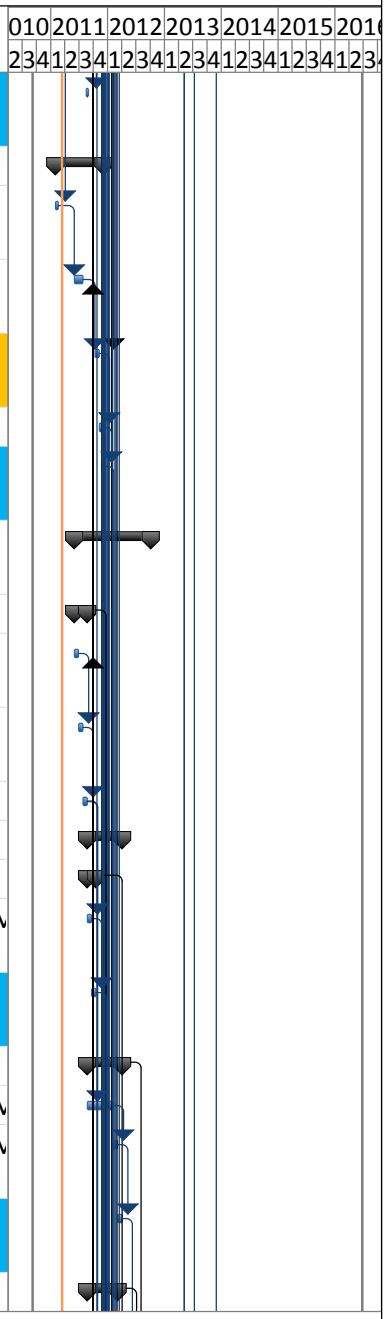
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
105	1.1.6.1.1	Identify organization that will receive referrals	588	60 days	6/1/11	8/23/11	EOA,Mi
106	1.1.6.1.2	Develop draft protocol for handoff	105	40 days	8/24/11	10/18/11	EOA,Mi
107	1.1.6.1.3	Core ADRC Workgroup and disability entity review	106	20 days	10/19/11	11/15/11	CAW,EOA,M
108	1.1.6.1.4	Revised protocol ready for incorporation within Harmony	107	20 days	11/16/11	12/13/11	Hmy,Mi
109	**1.1.6.2**	**Develop protocols for handoff to DDD**		**80 days**	**6/1/11**	**9/20/11**	
110	1.1.6.2.1	Develop draft protocol for handoff	588	20 days	6/1/11	6/28/11	Mi,DDD,EO
111	1.1.6.2.2	Core ADRC Workgroup and DDD review	110	20 days	6/29/11	7/26/11	CAW,Mi,DD
112	1.1.6.2.3	Revised protocol ready for incorporation within Harmony	111	40 days	7/27/11	9/20/11	Hmy,Mi
113	**1.1.6.3**	**Develop protocols for handoff to Mental Heal**		**50 days**	**7/27/11**	**10/4/11**	
114	1.1.6.3.1	Develop draft protocol for handoff	111	20 days	7/27/11	8/23/11	Mi,MH,EOA
115	1.1.6.3.2	Core ADRC Workgroup and Mental Health review	114	20 days	8/24/11	9/20/11	CAW,Mi,MI
116	1.1.6.3.3	Revised protocol ready for incorporation within Harmony	115	10 days	9/21/11	10/4/11	Hmy,Mi
117	**1.1.6.4**	**Develop protocols for handoff for children and youth**		**50 days**	**7/27/11**	**10/4/11**	
118	1.1.6.4.1	Develop draft protocol for handoff	111	20 days	7/27/11	8/23/11	EOA,Mi
119	1.1.6.4.2	Core ADRC Workgroup and agencies representing children and youth	118	20 days	8/24/11	9/20/11	Mi
120	1.1.6.4.3	Revised protocol ready for incorporation within Harmony	119	10 days	9/21/11	10/4/11	Hmy,Mi
121	**1.1.7**	**Develop common in-home assessment protocol**		**217 days**	**1/31/11**	**11/29/11**	
122	**1.1.7.1**	**Review and adapt interRAI-HC for Hawaii**		**30 days**	**1/31/11**	**3/11/11**	**Cst**
123	1.1.7.1.1	Identify necessary changes to items (e.g., descriptions of residential options, ethnicity categories, etc.)	49	20 days	1/31/11	2/25/11	H
124	1.1.7.1.2	Identify algorithms that can be used for risk status & assignment to case management	123	10 days	2/28/11	3/11/11	H



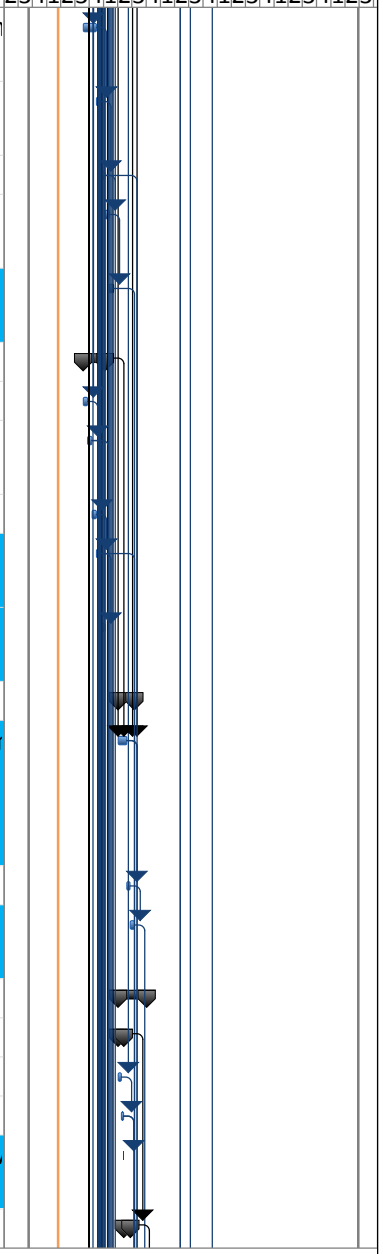
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
125	1.1.7.2	Review proposed changes with Core ADRC Workgroup and interRAI	124	15 days	3/14/11	4/1/11	H,CAW
126	**1.1.7.3**	**Develop assessment protocol**		**130 days**	**6/1/11**	**11/29/11**	
127	**1.1.7.3.1**	**Develop criteria to receive case management and assign to high risk status**		**35 days**	**6/1/11**	**7/19/11**	
128	1.1.7.3.1.1	Develop draft criteria	124,588	15 days	6/1/11	6/21/11	Cst
129	1.1.7.3.1.2	Obtain Core ADRC Workgroup input	128	10 days	6/22/11	7/5/11	Cst,CAW
130	1.1.7.3.1.3	Revised criteria ready for incorporation within Harmony	129	10 days	7/6/11	7/19/11	Cst
131	**1.1.7.3.2**	**Develop protocol for determining Medicaid spend down risk**		**40 days**	**6/1/11**	**7/26/11**	
132	1.1.7.3.2.1	Develop protocol criteria	124,588	20 days	6/1/11	6/28/11	Cst
133	1.1.7.3.2.2	Obtain Core ADRC Workgroup input	132	10 days	6/29/11	7/12/11	Cst,CAW
134	1.1.7.3.2.3	Revised protocol ready for incorporation within Harmony	133	10 days	7/13/11	7/26/11	Cst
135	**1.1.7.3.3**	**Incorporate person-centered planning**		**60 days**	**6/1/11**	**8/23/11**	
136	1.1.7.3.3.1	Develop draft modifications	124,588	40 days	6/1/11	7/26/11	Cst
137	1.1.7.3.3.2	Obtain Core ADRC Workgroup input	136	10 days	7/27/11	8/9/11	Cst,CAW
138	1.1.7.3.3.3	Revised protocols ready for incorporation within Harmony	137	10 days	8/10/11	8/23/11	Cst
139	1.1.7.3.4	Integrate revised interRAI-HC with other protocols and incorporate protocols developed as part of the Options	125,130,1	15 days	9/28/11	10/18/11	Cst
140	1.1.7.3.5	Review final assessment protocol with Core ADRC Workgroup	139	15 days	10/19/11	11/8/11	Cst,CAW
141	1.1.7.3.6	Revised protocol ready for incorporation within Harmony	140	15 days	11/9/11	11/29/11	Cst,Hmy
142	**1.1.8**	**Develop waitlist policy**		**40 days**	**7/6/11**	**8/30/11**	
143	1.1.8.1	Draft policy and protocol that identifies who goes on waitlist and procedure for handling wait list	129	20 days	7/6/11	8/2/11	Cst
144	1.1.8.2	Obtain Core ADRC Workgroup input	143	10 days	8/3/11	8/16/11	CAW,Cst



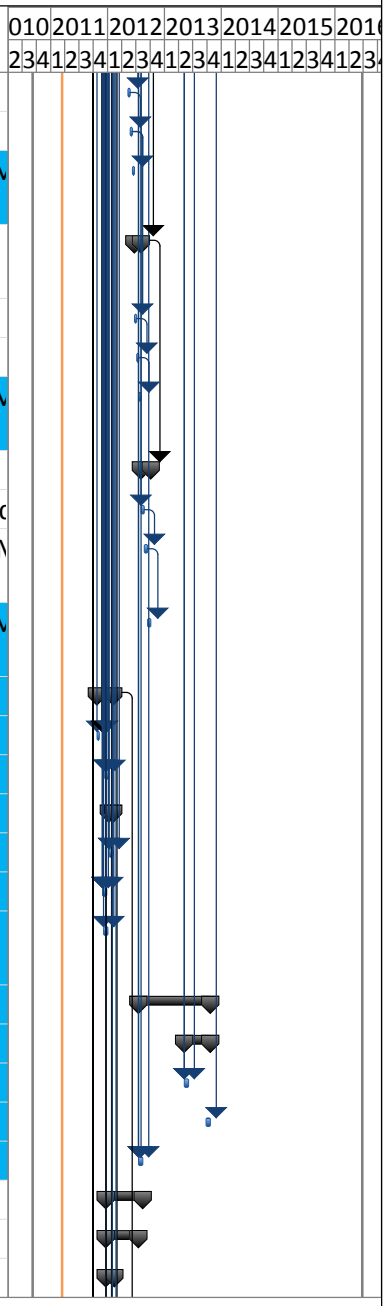
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
145	1.1.8.3	Revised protocols ready for incorporation within Harmony	144	10 days	8/17/11	8/30/11	Cst
146	**1.1.9**	**Develop Support Plan**		**222 days**	**1/31/11**	**12/6/11**	
147	1.1.9.1	Review interRAI capabilities, such as Clinical Action Plans (CAPS)	49	15 days	1/31/11	2/18/11	Cst
148	1.1.9.2	Develop draft Support Plan that includes goals and outcomes and CAPS	147,588	40 days	6/1/11	7/26/11	Cst
149	1.1.9.3	Incorporate protocols from Options Counseling Effort	148,44	20 days	10/12/11	11/8/11	Cst
150	1.1.9.4	Obtain Core ADRC Workgroup Input	149	10 days	11/9/11	11/22/11	CAW,Cst
151	1.1.9.5	Revise Support Plan and Prepare for Incorporation within Harmony	150	10 days	11/23/11	12/6/11	Cst
152	**1.1.10**	**Develop Continuous Quality Improvement Infrastructure for ADRC Activities**		**352.3 days**	**6/1/11**	**10/5/12**	
153	**1.1.10.1**	**Finalize Performance Indicators**		**60 days**	**6/1/11**	**8/23/11**	
154	1.1.10.1.1	Core ADRC Workgroup review of draft indicators	588	20 days	6/1/11	6/28/11	CAW,Cst
155	1.1.10.1.2	Core ADRC decision regarding threshold for when corrective action should occur	154	20 days	6/29/11	7/26/11	Cst,CAW
156	1.1.10.1.3	Finalization of performance indicators	155	20 days	7/27/11	8/23/11	Cst
157	**1.1.10.2**	**Develop data collection methods**		**160 days**	**8/24/11**	**4/3/12**	
158	**1.1.10.2.1**	**Timeliness of assessment**		**40 days**	**8/24/11**	**10/18/11**	
159	1.1.10.2.1.1	Ensure staff are documenting initial intake and assessments within Harmony	156	20 days	8/24/11	9/20/11	EOA,Hmy,M
160	1.1.10.2.1.2	Build query that tracks timeliness within Harmony	159	20 days	9/21/11	10/18/11	Hmy
161	**1.1.10.2.2**	**Timeliness of service delivery**		**160 days**	**8/24/11**	**4/3/12**	
162	1.1.10.2.2.1	Enroll all service providers in Provider Dir	156	6 mons	8/24/11	2/7/12	EOA,Hmy,M
163	1.1.10.2.2.2	Ensure that providers are documenting service delivery within Provider Direct	162	1 mon	2/8/12	3/6/12	EOA,Hmy,M
164	1.1.10.2.2.3	Build query that tracks timeliness within Harmony	163	20 days	3/7/12	4/3/12	Hmy
165	**1.1.10.2.3**	**Timeliness of QExA Approval**		**140 days**	**8/24/11**	**3/6/12**	



ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
166	1.1.10.2.3.1	Meet with Med-QUEST and obtain buy-in on indicator	156	60 days	8/24/11	11/15/11	Mi,EOA,Hm
167	1.1.10.2.3.2	Draft protocol for checking DMO for application status	166	20 days	11/16/11	12/13/11	Cst
168	1.1.10.2.3.3	Core ADRC Workgroup review	167	20 days	12/14/11	1/10/12	CAW,Cst
169	1.1.10.2.3.4	Revised protocol ready for incorporation within Harmony	168	20 days	1/11/12	2/7/12	Cst,Hmy
170	1.1.10.2.3.5	Build query that tracks timeliness within Harmony	169	20 days	2/8/12	3/6/12	Hmy
171	**1.1.10.2.4**	**Participant Experience**		**100 days**	**8/24/11**	**1/10/12**	
172	1.1.10.2.4.1	Core ADRC Workgroup selects tool	156	20 days	8/24/11	9/20/11	CAW,Cst
173	1.1.10.2.4.2	Draft protocol for use of tool (e.g., when it will be used and how)	172	20 days	9/21/11	10/18/11	Cst
174	1.1.10.2.4.3	Core ADRC Workgroup review	173	20 days	10/19/11	11/15/11	CAW,Cst
175	1.1.10.2.4.4	Revised protocol ready for incorporation within Harmony	174	20 days	11/16/11	12/13/11	Cst,Hmy
176	1.1.10.2.4.5	Build query that reports performance within Harmony	175	20 days	12/14/11	1/10/12	Hmy
177	**1.1.10.3**	**Management Reports**		**75 days**	**4/4/12**	**7/17/12**	
178	1.1.10.3.1	Incorporated queries into draft management reports targeting the following users: EOA, AAA management, AAA supervisors, AAA frontline staff (intake,	158,161,1	40 days	4/4/12	5/29/12	CAW,Cst,Hr
179	1.1.10.3.2	Core ADRC Workgroup review	178	15 days	5/30/12	6/19/12	CAW,Cst
180	1.1.10.3.3	Finalize management reports and prepare for incorporation within Harmony	179	20 days	6/20/12	7/17/12	Cst,Hmy
181	**1.1.10.4**	**Establish review and remediation processes**		**132.3 days**	**4/4/12**	**10/5/12**	
182	**1.1.10.4.1**	**Develop internal AAA review process**		**27.3 days**	**4/4/12**	**5/11/12**	
183	1.1.10.4.1.1	Develop draft process	164	15 days	4/4/12	4/24/12	Cst
184	1.1.10.4.1.2	Core ADRC Workgroup review	183	10 days	4/25/12	5/8/12	CAW
185	1.1.10.4.1.3	Revise process and incorporate into AAA policies and procedures	184	2.3 days	5/9/12	5/11/12	Hmy,EOA,M
186	**1.1.10.4.2**	**Develop EOA-AAA review process**	**182**	**30 days**	**5/11/12**	**6/22/12**	

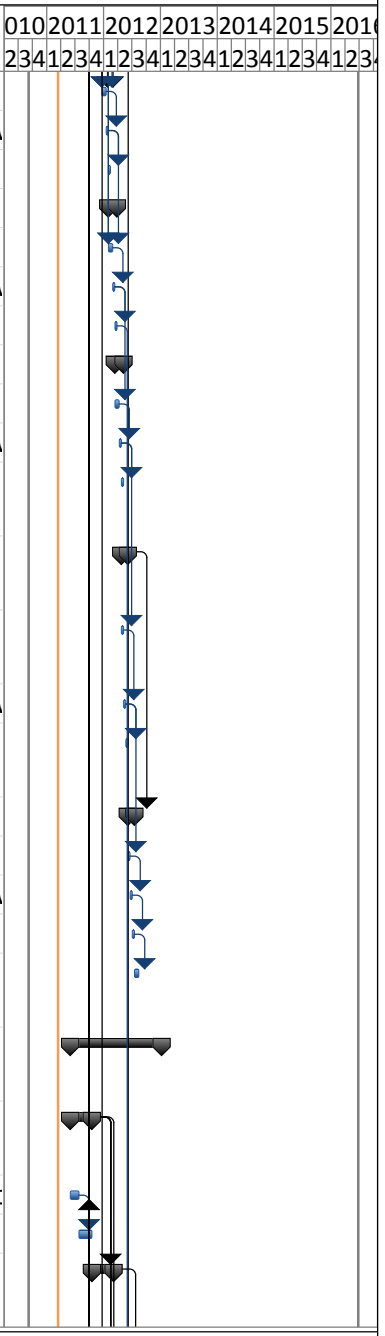


ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
187	1.1.10.4.2.1	Develop draft process	184	10 days	5/11/12	5/25/12	Cst
188	1.1.10.4.2.2	Core ADRC Workgroup review	187	10 days	5/25/12	6/8/12	CAW
189	1.1.10.4.2.3	Revise process and incorporate into AAA policies and procedures	188	10 days	6/8/12	6/22/12	Hmy,EOA,M
190	**1.1.10.4.3**	**Develop review process for external stakeholders**	**186**	**30 days**	**6/22/12**	**8/3/12**	
191	1.1.10.4.3.1	Develop draft process	188	10 days	6/22/12	7/6/12	Cst
192	1.1.10.4.3.2	Core ADRC Workgroup review	191	10 days	7/6/12	7/20/12	CAW
193	1.1.10.4.3.3	Revise process and incorporate into AAA policies and procedures	192	10 days	7/20/12	8/3/12	Hmy,EOA,M
194	**1.1.10.4.4**	**Develop interagency review process**	**190**	**45 days**	**8/3/12**	**10/5/12**	
195	1.1.10.4.4.1	Develop draft process	168	15 days	8/3/12	8/24/12	Cst,EOA,Mc
196	1.1.10.4.4.2	Core ADRC Workgroup and Med-QUEST review	195	15 days	8/24/12	9/14/12	CAW,EOA,M
197	1.1.10.4.4.3	Revise process and incorporate into AAA policies and procedures	196	15 days	9/14/12	10/5/12	Hmy,EOA,M
198	**1.2**	**Adapt Harmony for Maui Pilot**		**75 days**	**10/26/11**	**2/7/12**	
199	1.2.1	Incorporate referral protocols	12,18,7	10 days	10/26/11	11/8/11	Hmy
200	1.2.2	Incorporate initial intake protocols and algorithm	54,102,10	20 days	12/14/11	1/10/12	Hmy
201	**1.2.3**	**Incorporate changes to I & R database**		**20 days**	**1/11/12**	**2/7/12**	**Hmy**
202	1.2.3.1	Initial enhancement for Maui pilot	59,64,70	20 days	1/11/12	2/7/12	Hmy
203	1.2.4	Incorporate assessment protocols and algorithms	102,130,1	20 days	11/30/11	12/27/11	Hmy
204	1.2.5	Incorporate support plan and targeting protocols and algorithms	144,151	20 days	12/7/11	1/3/12	Hmy
205	**1.3**	**Longer term Harmony adaptations**		**330 days**	**7/18/12**	**10/22/13**	
206	**1.3.1**	**Incorporate changes to I & R database**		**120 days**	**5/8/13**	**10/22/13**	**Hmy**
207	1.3.1.1	Mid-term enhancements	78,84,90	20 days	5/8/13	6/4/13	Hmy
208	1.3.1.2	Longer term enhancements	96	20 days	9/25/13	10/22/13	Hmy
209	1.3.2	Longer term CQI enhancements	170,175,1	20 days	7/18/12	8/14/12	Hmy
210	**1.4**	**Develop training infrastructure**		**170 days**	**12/21/11**	**8/14/12**	
211	**1.4.1**	**Training specific to new ADRC operations**		**150 days**	**12/21/11**	**7/17/12**	
212	**1.4.1.1**	**Intake staff**		**40 days**	**12/21/11**	**2/14/12**	

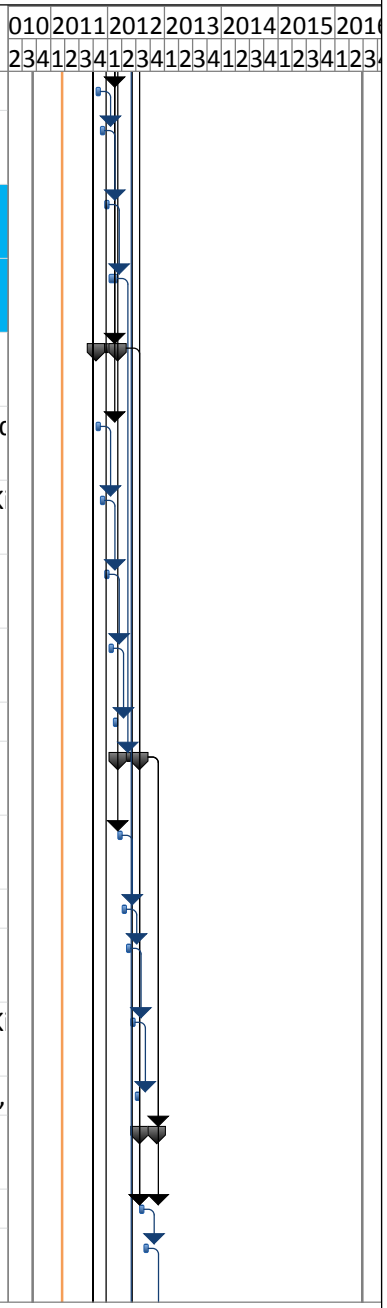


Hawaii SCD Implementation Plan

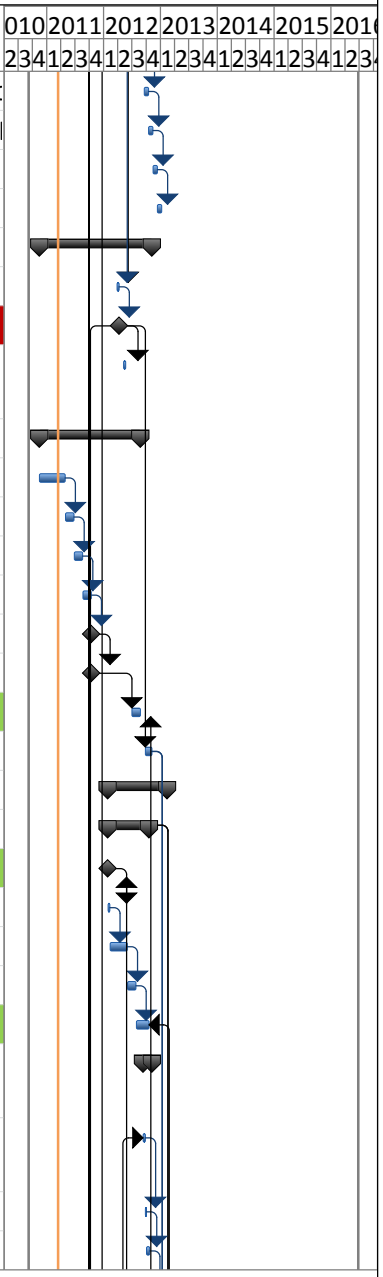
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
213	1.4.1.1.1	Develop training curricula and training appr	50,61,69,1	20 days	12/21/11	1/17/12	Cst,Mi
214	1.4.1.1.2	Core ADRC Workgroup input	213	10 days	1/18/12	1/31/12	Cst,Mi,CAW
215	1.4.1.1.3	Revise training curricula and training approa	214	10 days	2/1/12	2/14/12	Cst,Mi
216	**1.4.1.2**	**In-home assessment staff**		**40 days**	**2/1/12**	**3/27/12**	
217	1.4.1.2.1	Develop training curricula and training appr	214,140,1	20 days	2/1/12	2/28/12	Cst,Mi
218	1.4.1.2.2	Core ADRC Workgroup input	217	10 days	2/29/12	3/13/12	Cst,Mi,CAW
219	1.4.1.2.3	Revise training curricula and training approa	218	10 days	3/14/12	3/27/12	Cst,Mi
220	**1.4.1.3**	**AAA Management**		**40 days**	**3/14/12**	**5/8/12**	
221	1.4.1.3.1	Develop training curricula and training appr	218	20 days	3/14/12	4/10/12	Cst,Mi
222	1.4.1.3.2	Core ADRC Workgroup input	221	10 days	4/11/12	4/24/12	Cst,Mi,CAW
223	1.4.1.3.3	Revise training curricula and training approach	222	10 days	4/25/12	5/8/12	Cst,Mi
224	**1.4.1.4**	**Develop training for HCIL and other disability groups**		**30 days**	**4/25/12**	**6/5/12**	
225	1.4.1.4.1	Develop training curricula and training approach	222	10 days	4/25/12	5/8/12	Cst,Mi
226	1.4.1.4.2	Core ADRC Workgroup input	225	10 days	5/9/12	5/22/12	Cst,Mi,CAW
227	1.4.1.4.3	Revise training curricula and training approach	226	10 days	5/23/12	6/5/12	Cst,Mi
228	**1.4.1.5**	**Develop training for SHIP volunteers**	**224**	**30 days**	**6/6/12**	**7/17/12**	
229	1.4.1.5.1	Develop training curricula and training appr	226	10 days	6/6/12	6/19/12	Cst,Mi
230	1.4.1.5.2	Core ADRC Workgroup input	229	10 days	6/20/12	7/3/12	Cst,Mi,CAW
231	1.4.1.5.3	Revise training curricula and training approa	230	10 days	7/4/12	7/17/12	Cst,Mi
232	1.4.2	Decision whether to enroll in web-based training (e.g., U of MN or Boston College)	231	20 days	7/18/12	8/14/12	CAW
233	**1.5**	**Obtaining permission to draw down Medicaid Administrative Federal Financial Participation**		**420 days**	**6/1/11**	**1/8/13**	
234	**1.5.1**	**Obtain Med-QUEST Approval of Outlines of the Proposed Approach**		**100 days**	**6/1/11**	**10/18/11**	
235	1.5.1.1	Present Draft Approach to Med-QUEST	588	40 days	6/1/11	7/26/11	Cst,EOA,Mc
236	1.5.1.2	Revise Based Upon Med-QUEST input	235	60 days	7/27/11	10/18/11	Cst,EOA
237	**1.5.2**	**Develop approach for documenting time spent on Medicaid related activities**	**234**	**100 days**	**10/19/11**	**3/6/12**	



ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
238	1.5.2.1	Develop draft approach	234	20 days	10/19/11	11/15/11	Cst
239	1.5.2.2	Review by Finance and Sustainability Workgroup	238	20 days	11/16/11	12/13/11	Cst,FSW
240	1.5.2.3	Revised approach ready for MIS implementation	239	20 days	12/14/11	1/10/12	Cst,Hmy
241	1.5.2.4	Develop MIS to support 100% documentation of time	240	40 days	1/11/12	3/6/12	Cst,Hmy
242	**1.5.3**	**Develop accounting methodology to attach costs to Medicaid related time**	**234**	**100 days**	**10/19/11**	**3/6/12**	
243	1.5.3.1	Obtain Med-QUEST input regarding accounting requirements	234	20 days	10/19/11	11/15/11	Cst,EOA,Mc
244	1.5.3.2	County review and recommendations regarding how to comply with requirements	243	20 days	11/16/11	12/13/11	Cst,Hi,Hu,K
245	1.5.3.3	Creation of standardized reporting approach	244	20 days	12/14/11	1/10/12	Cst
246	1.5.3.4	Review by Finance and Sustainability Workgroup	245	20 days	1/11/12	2/7/12	Cst,FSW
247	1.5.3.5	Revise approach ready for implementation	246	20 days	2/8/12	3/6/12	Cst
248	**1.5.4**	**Develop accounting structures to ensure that FFP flows back to the AAAs**	**241**	**100 days**	**3/7/12**	**7/24/12**	
249	1.5.4.1	Obtain input from state CFO office to determine best approach	234	20 days	3/7/12	4/3/12	Cst,EOA
250	1.5.4.2	Draft transfer of funds plan	249	20 days	4/4/12	5/1/12	Cst,EOA
251	1.5.4.3	Review by Finance and Sustainability Workgroup	250	20 days	5/2/12	5/29/12	Cst,FSW
252	1.5.4.4	Determine what needs to occur at county to receive funds	251	20 days	5/30/12	6/26/12	Cst,Hi,Hu,K
253	1.5.4.5	Approach ready for implementation	252	20 days	6/27/12	7/24/12	Cst,EOA,Hi,
254	**1.5.5**	**Incorporate proposed approach in MOU with Med-QUEST**	**248**	**80 days**	**7/25/12**	**11/13/12**	
255	1.5.5.1	Draft MOU	237,242,2	20 days	7/25/12	8/21/12	Cst
256	1.5.5.2	Review by Finance and Sustainability Workgroup	255	20 days	8/22/12	9/18/12	Cst,FSW

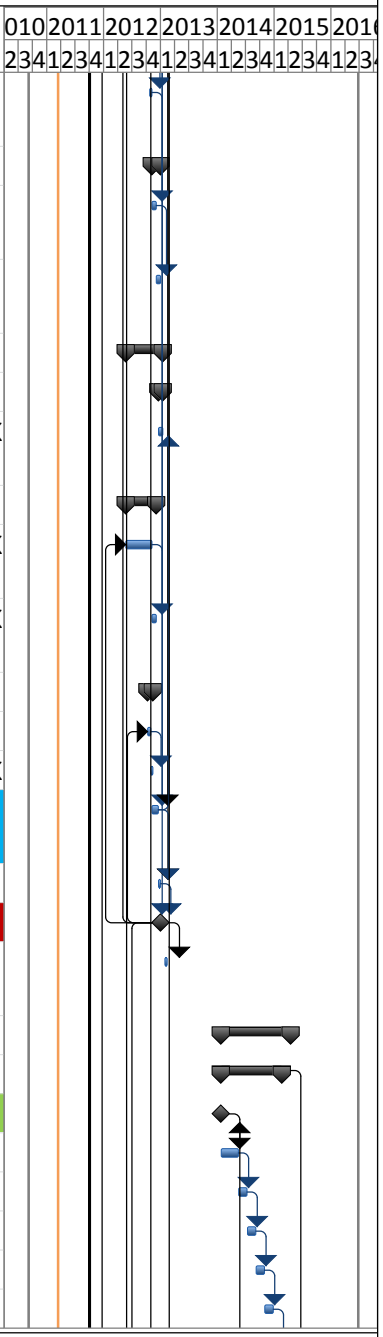


ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
257	1.5.5.3	Review by Med-QUEST	256	20 days	9/19/12	10/16/12	Cst,EOA,Mc
258	1.5.5.4	MOU Signed	257	20 days	10/17/12	11/13/12	EOA,Hi,Hu,I
259	1.5.6	Med-QUEST submits plan to CMS for approval	258	20 days	11/14/12	12/11/12	Mq
260	1.5.7	Proposed approach ready for implementation	259	20 days	12/12/12	1/8/13	Hi,Hu,Ki,Mi
261	**1.6**	**Maui County ADRC Rollout**		**517 days**	**11/15/10**	**11/6/12**	
262	1.6.1	Train staff	219,198	10 days	3/28/12	4/10/12	Cst,Mi
263	1.6.2	Implementation	262	0 days	4/10/12	4/10/12	Mi
264	1.6.3	Train management staff on CQI and implement procedures	263FS+1 mon	10 days	5/9/12	5/22/12	Cst,Mi
265	**1.6.4**	**Add supplemental staff**		**465 days**	**11/15/10**	**8/24/12**	
266	1.6.4.1	Creating series for type of position		6 mons	11/15/10	4/29/11	Mi
267	1.6.4.2	Creating job descriptions	266	2 mons	5/2/11	6/24/11	Mi
268	1.6.4.3	Assign SR rating	267	2 mons	6/27/11	8/19/11	Mi
269	1.6.4.4	Union approval if necessary	268	2 mons	8/22/11	10/14/11	Mi
270	1.6.4.5	Public Hearing	269	0 mons	10/14/11	10/14/11	Mi
271	1.6.4.6	County Council approval	270	0 mons	10/14/11	10/14/11	Mi
272	1.6.4.7	Hire new staff	271,563	2 mons	7/2/12	8/24/12	Mi
273	1.6.5	Evaluation and refinement	263FS+6 n	30 days	9/26/12	11/6/12	Mi
274	**1.7**	**Kauai County ADRC Rollout**		**272 days**	**1/27/12**	**2/12/13**	
275	**1.7.1**	**Add supplemental staff**		**190 days**	**1/27/12**	**10/19/12**	
276	1.7.1.1	Letter of Intent received from the State	561	0 days	1/27/12	1/27/12	EOA
277	1.7.1.2	Creating job descriptions and SR rating	276	10 days	1/30/12	2/10/12	Ki
278	1.7.1.3	Mayor, Finance, and Personnel Approval	277	4 mons	2/13/12	6/1/12	Ki
279	1.7.1.4	County Council approval	278	2 mons	6/4/12	7/27/12	Ki
280	1.7.1.5	Hire new staff	279,563SF	3 mons	7/30/12	10/19/12	Ki
281	**1.7.2**	**Establish local level MOUs for high volume referral sources to the AAA**		**40 days**	**9/12/12**	**11/6/12**	
282	1.7.2.1	Outreach to respective county agencies with high volume referrals	300SS-4 mons	10 days	9/12/12	9/25/12	Ki
283	1.7.2.2	Draft MOUs	282	5 days	9/26/12	10/2/12	Ki
284	1.7.2.3	Agreement/Sign MOUs with respective agencie	283	15 days	10/3/12	10/23/12	Ki



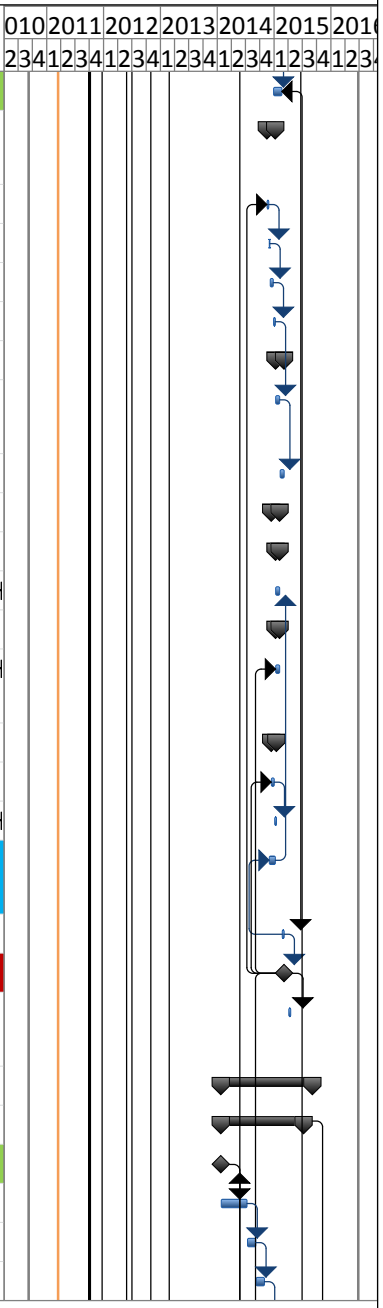
Hawaii SCD Implementation Plan

ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
285	1.7.2.4	Provide outreach and training on referring to ADRC	284	10 days	10/24/12	11/6/12	Ki
286	**1.7.3**	**Integration with Low Volume Referral Sources**		**40 days**	**11/7/12**	**1/1/13**	
287	1.7.3.1	Kauai/EOA outreach to low volume referral agencies	285	20 days	11/7/12	12/4/12	Ki
288	1.7.3.2	Provide outreach and training on referring to ADRC	287	20 days	12/5/12	1/1/13	Ki
289	**1.7.4**	**Kauai specific CQI changes**		**170 days**	**5/23/12**	**1/15/13**	
290	**1.7.4.1**	**Timeliness of assessment**		**20 days**	**12/19/12**	**1/15/13**	
291	1.7.4.1.1	Ensure staff are documenting initial intake and assessments within Harmony	298	20 days	12/19/12	1/15/13	EOA,Hmy,K
292	**1.7.4.2**	**Timeliness of service delivery**		**140 days**	**5/23/12**	**12/4/12**	
293	1.7.4.2.1	Enroll all service providers in Provider Direct	300SS-8 mons	6 mons	5/23/12	11/6/12	EOA,Hmy,K
294	1.7.4.2.2	Ensure that providers are documenting service delivery within Provider Direct	293	1 mon	11/7/12	12/4/12	EOA,Hmy,K
295	**1.7.4.3**	**Develop internal review process**		**25 days**	**10/10/12**	**11/13/12**	
296	1.7.4.3.1	Develop process based on Maui model	300SS-3 m	15 days	10/10/12	10/30/12	Ki
297	1.7.4.3.2	Incorporate into AAA policies and procedure	296	10 days	10/31/12	11/13/12	Hmy,EOA,K
298	1.7.5	Integrate Kauai data with Maui and add Kauai specific fields	273,275FS days	30 days	11/7/12	12/18/12	Ki
299	1.7.6	Train staff	298,275	10 days	12/19/12	1/1/13	EOA,Ki
300	1.7.7	Implementation	299,273	0 days	1/1/13	1/1/13	Ki
301	1.7.8	Train management staff on CQI and implement procedures	300FS+1 mon	10 days	1/30/13	2/12/13	EOA,Hi
302	**1.8**	**Hawai'i County ADRC Rollout**		**320 days**	**1/24/14**	**4/17/15**	
303	**1.8.1**	**Add supplemental staff**		**280 days**	**1/24/14**	**2/20/15**	
304	1.8.1.1	Letter of Intent from the State	566	0 days	1/24/14	1/24/14	EOA
305	1.8.1.2	Creating series for type of position	304	4 mons	1/27/14	5/16/14	Hi
306	1.8.1.3	Creating job descriptions	305	2 mons	5/19/14	7/11/14	Hi
307	1.8.1.4	Assign SR rating	306	2 mons	7/14/14	9/5/14	Hi
308	1.8.1.5	Union approval if necessary	307	2 mons	9/8/14	10/31/14	Hi
309	1.8.1.6	County Council approval	308	2 mons	11/3/14	12/26/14	Hi

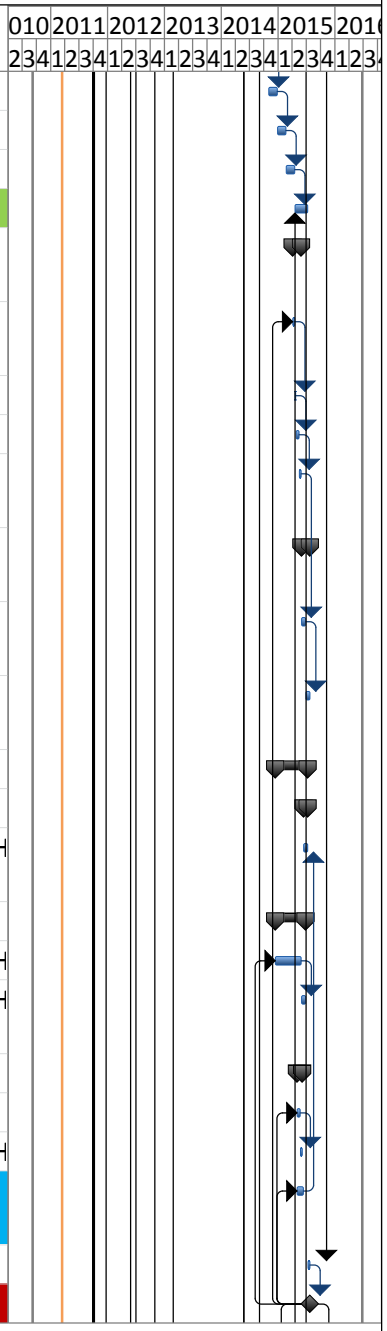


Hawaii SCD Implementation Plan

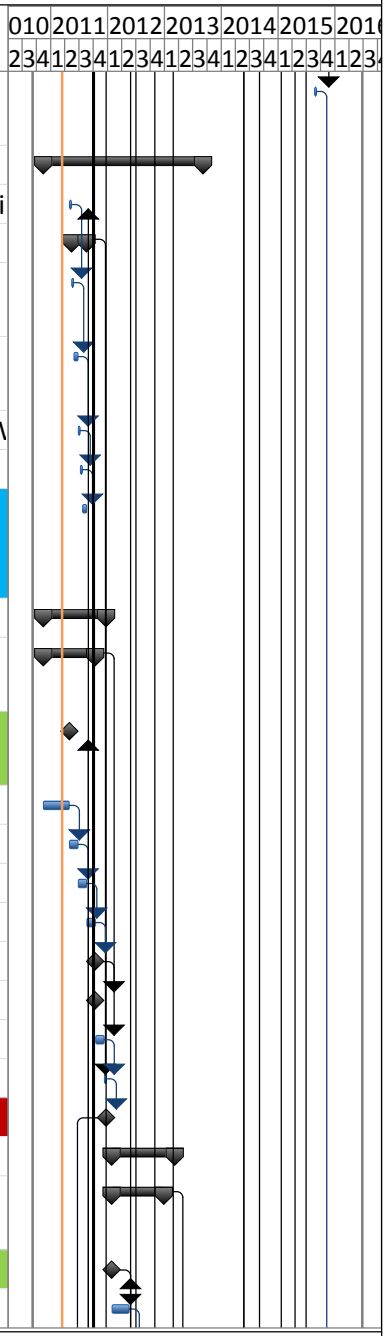
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
310	1.8.1.7	Hire new staff	309,568SF	2 mons	12/29/14	2/20/15	Hi
311	**1.8.2**	**Establish local level MOUs for high volume referral sources to the AAA**		**40 days**	**11/17/14**	**1/9/15**	
312	1.8.2.1	Outreach to respective county agencies with hi	329SS-4 m	10 days	11/17/14	11/28/14	Hi
313	1.8.2.2	Draft MOUs	312	5 days	12/1/14	12/5/14	Hi
314	1.8.2.3	Agreement/Sign MOUs with respective agencie	313	15 days	12/8/14	12/26/14	Hi
315	1.8.2.4	Provide outreach and training on referring to A	314	10 days	12/29/14	1/9/15	Hi
316	**1.8.3**	**Integration with Low Volume Referral Sources**		**40 days**	**1/12/15**	**3/6/15**	
317	1.8.3.1	Hawai'i County/EOA outreach to low volume referral agencies	315	20 days	1/12/15	2/6/15	Hi
318	1.8.3.2	Provide outreach and training on referring to A	317	20 days	2/9/15	3/6/15	Hi
319	**1.8.4**	**Hawai'i County specific CQI changes**		**40 days**	**12/15/14**	**2/6/15**	
320	**1.8.4.1**	**Timeliness of assessment**		**20 days**	**1/12/15**	**2/6/15**	
321	1.8.4.1.1	Ensure staff are documenting initial intake a	327	20 days	1/12/15	2/6/15	EOA,Hmy,H
322	**1.8.4.2**	**Timeliness of service delivery**		**20 days**	**1/12/15**	**2/6/15**	
323	1.8.4.2.1	Ensure that providers are documenting service delivery within Harmony	329SS-2 mons	1 mon	1/12/15	2/6/15	EOA,Hmy,H
324	**1.8.4.3**	**Develop internal review process**		**25 days**	**12/15/14**	**1/16/15**	
325	1.8.4.3.1	Develop process based on Maui model	329SS-3 m	15 days	12/15/14	1/2/15	Hi
326	1.8.4.3.2	Incorporate into AAA policies and procedure	325	10 days	1/5/15	1/16/15	Hmy,EOA,H
327	1.8.5	Integrate Hawai'i data with Maui/Kauai and add Hawai'i specific fields	328SS-3 mons	30 days	12/1/14	1/9/15	Hi
328	1.8.6	Train staff	303	10 days	2/23/15	3/6/15	EOA,Hi
329	1.8.7	Implementation	328	0 days	3/6/15	3/6/15	Hi
330	1.8.8	Train management staff on CQI and implement procedures	329FS+1 mon	10 days	4/6/15	4/17/15	EOA,Hi
331	**1.9**	**Honolulu County ADRC Rollout**		**420 days**	**1/24/14**	**9/4/15**	
332	**1.9.1**	**Add supplemental staff**		**380 days**	**1/24/14**	**7/10/15**	
333	1.9.1.1	Letter of Intent received from the State	566	0 days	1/24/14	1/24/14	EOA
334	1.9.1.2	Creating series for type of position	333	6 mons	1/27/14	7/11/14	Hu
335	1.9.1.3	Creating job descriptions	334	2 mons	7/14/14	9/5/14	Hu
336	1.9.1.4	Assign SR rating	335	2 mons	9/8/14	10/31/14	Hu



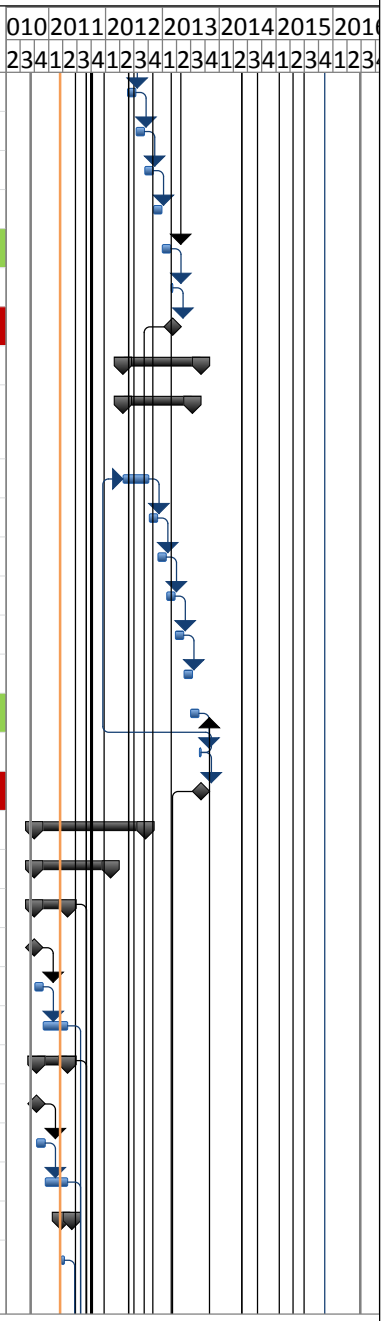
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
337	1.9.1.5	Union approval if necessary	336	2 mons	11/3/14	12/26/14	Hu
338	1.9.1.6	Public Hearing	337	2 mons	12/29/14	2/20/15	Hu
339	1.9.1.7	County Council approval	338	2 mons	2/23/15	4/17/15	Hu
340	1.9.1.8	Hire new staff	339,569FS	3 mons	4/20/15	7/10/15	
341	**1.9.2**	**Establish local level MOUs for high volume referral sources to the AAA**		**40 days**	**4/6/15**	**5/29/15**	
342	1.9.2.1	Outreach to respective county agencies with high volume referrals	360SS-4 mons	10 days	4/6/15	4/17/15	Hu
343	1.9.2.2	Draft MOUs	342	5 days	4/20/15	4/24/15	Hu
344	1.9.2.3	Agreement/Sign MOUs with respective agencie	343	15 days	4/27/15	5/15/15	Hu
345	1.9.2.4	Provide outreach and training on referring to ADRC	344	10 days	5/18/15	5/29/15	Hu
346	**1.9.3**	**Integration with Low Volume Referral Sources in Honlulu**		**40 days**	**6/1/15**	**7/24/15**	
347	1.9.3.1	Honolulu/EOA outreach to low volume referral agencies	345	20 days	6/1/15	6/26/15	Hu
348	1.9.3.2	Provide outreach and training on referring to ADRC	347	20 days	6/29/15	7/24/15	Hu
349	**1.9.4**	**Honolulu specific CQI changes**		**150 days**	**12/15/14**	**7/10/15**	
350	**1.9.4.1**	**Timeliness of assessment**		**20 days**	**6/15/15**	**7/10/15**	
351	1.9.4.1.1	Ensure staff are documenting initial intake and assessments within Harmony	358	20 days	6/15/15	7/10/15	EOA,Hmy,H
352	**1.9.4.2**	**Timeliness of service delivery**		**140 days**	**12/15/14**	**6/26/15**	
353	1.9.4.2.1	Enroll all service providers in Provider Direct	360SS-8 m	6 mons	12/15/14	5/29/15	EOA,Hmy,H
354	1.9.4.2.2	Ensure that providers are documenting service delivery within Provider Direct	353	1 mon	6/1/15	6/26/15	EOA,Hmy,H
355	**1.9.4.3**	**Develop internal review process**		**25 days**	**5/4/15**	**6/5/15**	
356	1.9.4.3.1	Develop process based on Maui model	360SS-3 m	15 days	5/4/15	5/22/15	Hu
357	1.9.4.3.2	Incorporate into AAA policies and procedure	356	10 days	5/25/15	6/5/15	Hmy,EOA,H
358	1.9.5	Integrate Honolulu data with other 3 counties and add Honolulu specific fields	360SS-3 mons	30 days	5/4/15	6/12/15	Hu
359	1.9.6	Train staff	332	10 days	7/13/15	7/24/15	EOA,Hu
360	1.9.7	Implementation	359	0 days	7/24/15	7/24/15	Hu



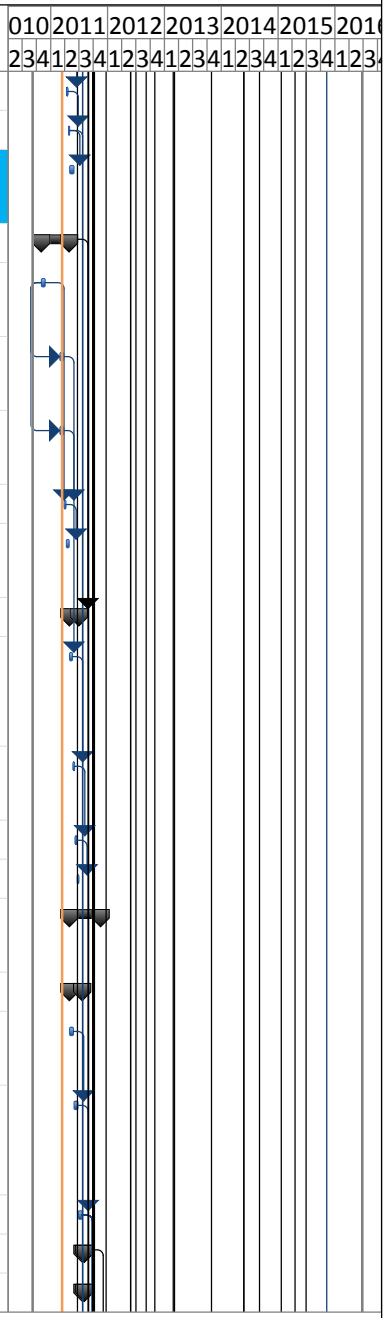
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
361	1.9.8	Train management staff on CQI and implement procedures	360FS+1 mon	10 days	8/24/15	9/4/15	EOA,Hu
362	**2**	**Bring Case Management In-house**		**735 days**	**11/15/10**	**9/6/13**	
363	2.1	Draft job descriptions and identification of series	558	10 days	5/2/11	5/13/11	Cst,EOA,Mi
364	**2.2**	**Develop training infrastructure**		**70 days**	**5/16/11**	**8/19/11**	
365	2.2.1	Decision whether to enroll in web-based training (e.g., U of MN or Boston College)	363	10 days	5/16/11	5/27/11	CAW,EOA
366	2.2.2	Develop training curricula and training approach (possibly adapting web-enabled system)	365	20 days	5/30/11	6/24/11	Cst,Mi
367	2.2.3	Core ADRC Workgroup input	366	10 days	6/27/11	7/8/11	Cst,Mi,CAW
368	2.2.4	Revise training curricula and training approach	367	10 days	7/11/11	7/22/11	Cst,Mi
369	2.2.5	Implement case management tools (case notes, case management supervision, performance/quality) in Harmony	368	20 days	7/25/11	8/19/11	Cst,Mi
370	**2.3**	**Maui County Rollout**		**290 days**	**11/15/10**	**12/23/11**	
371	**2.3.1**	**Establishing Authority to Hire New Case Management Staff**		**240 days**	**11/15/10**	**10/14/11**	
372	2.3.1.1	Letter notifying end of waiver requirement received by county	558	0 days	5/2/11	5/2/11	Mi
373	2.3.1.2	Creating series for type of position		6 mons	11/15/10	4/29/11	Mi
374	2.3.1.3	Creating job descriptions	373	2 mons	5/2/11	6/24/11	Mi
375	2.3.1.4	Assign SR rating	374	2 mons	6/27/11	8/19/11	Mi
376	2.3.1.5	Union approval if necessary	375	2 mons	8/22/11	10/14/11	Mi
377	2.3.1.6	Public Hearing	376	0 mons	10/14/11	10/14/11	Mi
378	2.3.1.7	County Council approval	377	0 mons	10/14/11	10/14/11	Mi
379	2.3.2	Hire staff	371	2 mons	10/17/11	12/9/11	Mi
380	2.3.3	Train staff	379,364	10 days	12/12/11	12/23/11	Mi
381	2.3.4	Implementation	380	0 days	12/23/11	12/23/11	Mi
382	**2.4**	**Hawai'i County Rollout**		**290 days**	**1/27/12**	**3/8/13**	
383	**2.4.1**	**Establishing Authority to Hire New Case Management Staff**		**240 days**	**1/27/12**	**12/28/12**	
384	2.4.1.1	Letter of Intent received from the State	561	0 days	1/27/12	1/27/12	Hi
385	2.4.1.2	Creating series for type of position	384	4 mons	1/30/12	5/18/12	Hi



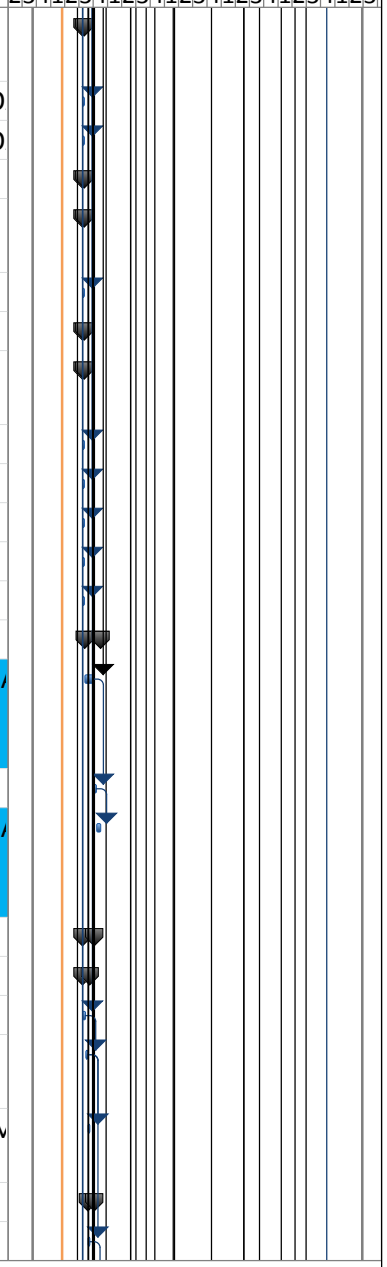
ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
386	2.4.1.3	Creating job descriptions	385	2 mons	5/21/12	7/13/12	Hi
387	2.4.1.4	Assign SR rating	386	2 mons	7/16/12	9/7/12	Hi
388	2.4.1.5	Union approval if necessary	387	2 mons	9/10/12	11/2/12	Hi
389	2.4.1.6	County Council approval	388	2 mons	11/5/12	12/28/12	Hi
390	2.4.2	Hire staff	383	2 mons	12/31/12	2/22/13	Hi
391	2.4.3	Train staff	390	10 days	2/25/13	3/8/13	Hi
392	2.4.4	Implementation	391	0 days	3/8/13	3/8/13	Hi
393	**2.5**	**Honolulu County Rollout**		**360 days**	**4/23/12**	**9/6/13**	
394	**2.5.1**	**Establishing Authority to Hire New Case Management Staff**		**320 days**	**4/23/12**	**7/12/13**	
395	2.5.1.1	Creating series for type of position	402FS-18 r	6 mons	4/23/12	10/5/12	Hu
396	2.5.1.2	Creating job descriptions	395	2 mons	10/8/12	11/30/12	Hu
397	2.5.1.3	Assign SR rating	396	2 mons	12/3/12	1/25/13	Hu
398	2.5.1.4	Union approval if necessary	397	2 mons	1/28/13	3/22/13	Hu
399	2.5.1.5	Public Hearing	398	2 mons	3/25/13	5/17/13	Hu
400	2.5.1.6	County Council approval	399	2 mons	5/20/13	7/12/13	Hu
401	2.5.2	Hire staff	568	2 mons	7/1/13	8/23/13	Hu
402	2.5.3	Train staff	401	10 days	8/26/13	9/6/13	Hu
403	2.5.4	Implementation	402	0 days	9/6/13	9/6/13	Hu
404	**3**	**Developing a Participant Direction Option**		**512 days**	**10/1/10**	**9/14/12**	
405	**3.1**	**System Operations**		**352 days**	**10/1/10**	**2/3/12**	
406	**3.1.1**	**FMS Contractor**		**153 days**	**10/1/10**	**5/2/11**	
407	3.1.1.1	RFP Issued		0 days	10/1/10	10/1/10	EOA
408	3.1.1.2	Contractor selected	407	40 days	10/4/10	11/25/10	EOA
409	3.1.1.3	Contractor ready to offer services	408	112 days	11/26/10	5/2/11	FMS
410	**3.1.2**	**Support Broker Contract**		**142 days**	**10/15/10**	**5/2/11**	
411	3.1.2.1	RFP Issued		0 days	10/15/10	10/15/10	EOA
412	3.1.2.2	Contractor selected	411	40 days	10/15/10	12/9/10	EOA
413	3.1.2.3	Contractor ready to offer services	412	102 days	12/10/10	5/2/11	SB
414	**3.1.3**	**Policies & Procedures**		**51 days**	**3/21/11**	**5/30/11**	
415	3.1.3.1	Translate workgroup decisions into draft policies and procedures document		16 days	3/21/11	4/11/11	EOA



ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
416	3.1.3.2	Participant Direction Workgroup Review	415	9 days	4/12/11	4/22/11	PDW
417	3.1.3.3	Finalize Policies and Procedures	416	6 days	4/25/11	5/2/11	EOA
418	3.1.3.4	Implement participant direction tracking in Harmony	417	20 days	5/3/11	5/30/11	Hmy
419	**3.1.4**	**Enrollment Process**		**130 days**	**11/1/10**	**4/29/11**	
420	3.1.4.1	Each AAA proposes process for enrolling individuals		20 days	11/1/10	11/26/10	Hi,Ki,Mi
421	3.1.4.2	Development of form that incorporates spend down and targeting criteria	420SS	19 days	3/1/11	3/25/11	EOA
422	3.1.4.3	Adapt MN Capacity for Self Direction tool for Hawaii	420SS	19 days	3/1/11	3/25/11	EOA
423	3.1.4.4	Participant Direction Workgroup Review	420,421	10 days	3/28/11	4/8/11	PDW
424	3.1.4.5	Finalization of county specific enrollment processes	423	15 days	4/11/11	4/29/11	Hi,Ki,Mi
425	**3.1.5**	**Participant Tools**	**419**	**45 days**	**5/2/11**	**7/1/11**	
426	3.1.5.1	Develop Draft Participant Information and Tools adapting work from other states (primarily forms and checklists)	422	15 days	5/2/11	5/20/11	EOA
427	3.1.5.2	Incorporate tools and policies and procedures into participant manual	426	10 days	5/23/11	6/3/11	EOA
428	3.1.5.3	Participant Direction Workgroup Review	427	10 days	6/6/11	6/17/11	PDW
429	3.1.5.4	Revise Tools	428	10 days	6/20/11	7/1/11	EOA
430	**3.1.6**	**Develop Continuous Quality Improvement Infrastructure for Participant Direction**		**145 days**	**5/2/11**	**11/18/11**	
431	**3.1.6.1**	**Finalize Performance Indicators**		**60 days**	**5/2/11**	**7/22/11**	
432	3.1.6.1.1	Participant Direction Workgroup review of draft indicators		20 days	5/2/11	5/27/11	PDW,EOA
433	3.1.6.1.2	Participant Direction Workgroup decision regarding threshold for when corrective action should occur	432	20 days	5/30/11	6/24/11	PDW,EOA
434	3.1.6.1.3	Finalization of performance indicators	433	20 days	6/27/11	7/22/11	PDW,EOA
435	**3.1.6.2**	**Develop data collection methods**		**10 days**	**7/25/11**	**8/5/11**	
436	**3.1.6.2.1**	**Data from AAAs**		**10 days**	**7/25/11**	**8/5/11**	

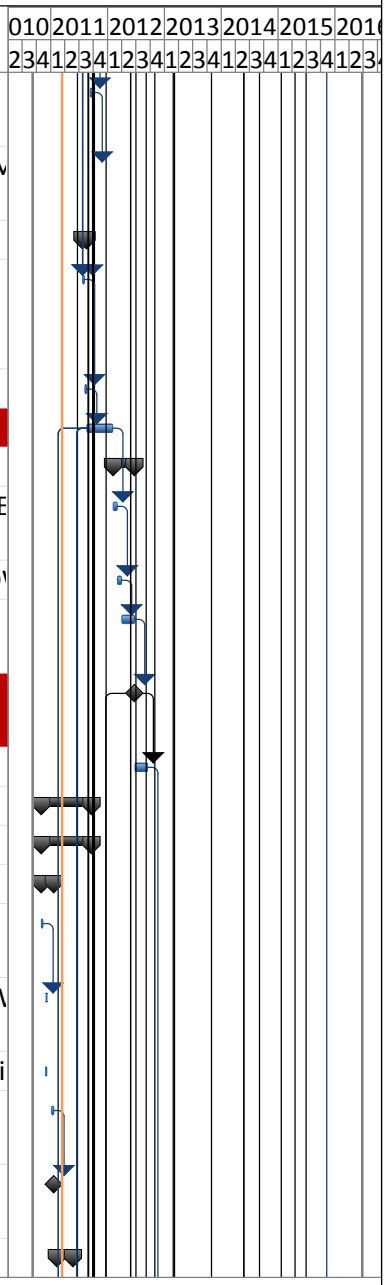


ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
437	**3.1.6.2.1.1**	**Establish data collection methods for the following areas:**		**10 days**	**7/25/11**	**8/5/11**	
438	3.1.6.2.1.1.1	Number enrolled	434	10 days	7/25/11	8/5/11	Hi,Ki,Mi,EO
439	3.1.6.2.1.1.2	Enrollees meet eligibility criteria	434	10 days	7/25/11	8/5/11	Hi,Ki,Mi,EO
440	**3.1.6.2.2**	**Data from FMS provider**		**10 days**	**7/25/11**	**8/5/11**	
441	**3.1.6.2.2.1**	**Establish data collection methods for the following areas:**		**10 days**	**7/25/11**	**8/5/11**	
442	3.1.6.2.2.1.1	Budget management	434	10 days	7/25/11	8/5/11	EOA,FMS
443	**3.1.6.2.3**	**Data from Support Broker(s)**		**10 days**	**7/25/11**	**8/5/11**	
444	**3.1.6.2.3.1**	**Establish data collection methods for the following areas:**		**10 days**	**7/25/11**	**8/5/11**	
445	3.1.6.2.3.1.1	Individual budget	434	10 days	7/25/11	8/5/11	EOA,SB
446	3.1.6.2.3.1.2	Support Planning	434	10 days	7/25/11	8/5/11	EOA,SB
447	3.1.6.2.3.1.3	Participant outcomes	434	10 days	7/25/11	8/5/11	SB,EOA
448	3.1.6.2.3.1.4	Support brokerage	434	10 days	7/25/11	8/5/11	SB,EOA
449	3.1.6.2.3.1.5	Health and safety	434	10 days	7/25/11	8/5/11	EOA,SB
450	**3.1.6.3**	**Management Reports**		**75 days**	**8/8/11**	**11/18/11**	
451	3.1.6.3.1	Incorporate data from AAAs, Support Brokers, and FMS Provider into management reports	435	40 days	8/8/11	9/30/11	FMS,SB,EO
452	3.1.6.3.2	Participant Direction Workgroup review	451	15 days	10/3/11	10/21/11	PDW
453	3.1.6.3.3	Finalize management reports and prepare for incorporation within Harmony	452	20 days	10/24/11	11/18/11	SB,FMS,EO
454	**3.1.6.4**	**Establish review and remediation processes**		**55 days**	**7/25/11**	**10/7/11**	
455	**3.1.6.4.1**	**Develop internal AAA review process**		**35 days**	**7/25/11**	**9/9/11**	
456	3.1.6.4.1.1	Develop draft process	434	15 days	7/25/11	8/12/11	EOA
457	3.1.6.4.1.2	Participant Direction Workgroup Review	456	10 days	8/15/11	8/26/11	PDW
458	3.1.6.4.1.3	Revise process and incorporate into AAA policies and procedures	457	10 days	8/29/11	9/9/11	Hi,EOA,Ki,M
459	**3.1.6.4.2**	**Develop EOA-AAA review process**		**30 days**	**8/29/11**	**10/7/11**	
460	3.1.6.4.2.1	Develop draft process	457	10 days	8/29/11	9/9/11	EOA

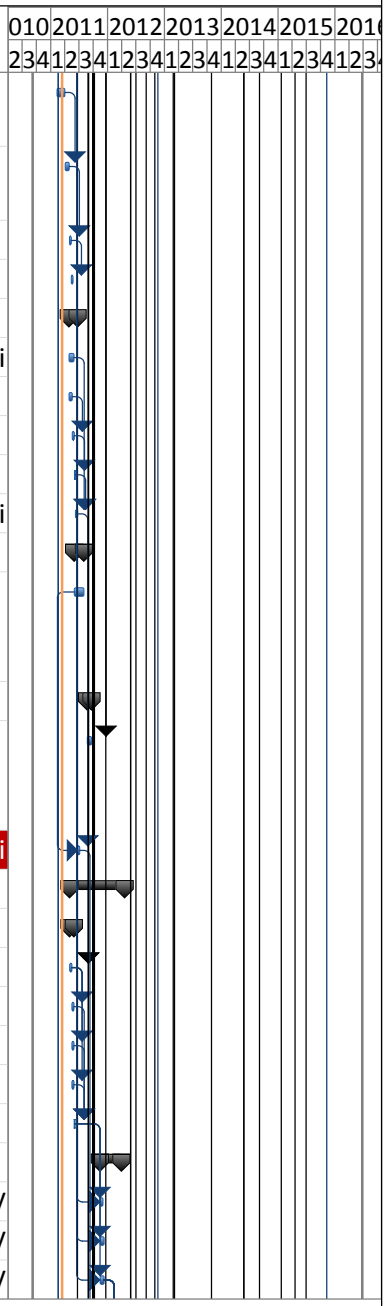


Hawaii SCD Implementation Plan

ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
461	3.1.6.4.2.2	Participant Direction Workgroup Review	460	10 days	9/12/11	9/23/11	PDW
462	3.1.6.4.2.3	Revise process and incorporate into AAA policies and procedures	461	10 days	9/26/11	10/7/11	Hi,EOA,Ki,M
463	**3.1.7**	**Training**		**20 days**	**7/25/11**	**8/19/11**	
464	3.1.7.1	Incorporate policies, FMS, and Support Broker information into staff training manual and curricula	417,413,4(	10 days	7/25/11	8/5/11	EOA,Cst
465	3.1.7.2	Train county staff	464	10 days	8/8/11	8/19/11	EOA
466	3.1.8	Maui, Kauai, Hawai'i Pilot	465	6 mons	8/22/11	2/3/12	Hi,Ki,Mi
467	**3.2**	**Expansion Plan**		**100 days**	**2/6/12**	**6/22/12**	
468	3.2.1	Evaluation Decision Whether to Continue Option	466	1 mon	2/6/12	3/2/12	EOA,PDW,E
469	3.2.2	Funding Reallocation of KC or Increase?	468	20 days	3/5/12	3/30/12	ED,EOA,PD
470	3.2.3	Contractual Changes w/ Existing KC Providers? Continuation of FMS and Support Broker	469	60 days	4/2/12	6/22/12	Hi,Ki,Mi
471	3.3	Full Implementation in Maui, Kauai, and Hawai'i	470	0 days	6/22/12	6/22/12	Hi,Ki,Mi
472	3.4	Develop expansion plan for Honolulu	471	3 mons	6/25/12	9/14/12	Hu
473	**4**	**Providing Hospital Discharge Planning**		**232 days**	**11/1/10**	**9/20/11**	
474	**4.1**	**System Operations**		**232 days**	**11/1/10**	**9/20/11**	
475	**4.1.1**	**Model Development**		**59 days**	**11/1/10**	**1/20/11**	
476	4.1.1.1	Select HDP models to review with Hospital Discharge Workgroup		9 days	11/1/10	11/11/10	EOA,Hi
477	4.1.1.2	Share Hospital Discharge Materials to share with HDPM group	476	4 days	12/2/10	12/7/10	EOA,Hi,HDV
478	4.1.1.3	Identify HDP representative for each AAA		1.2 wks	11/29/10	12/6/10	Hi,Hu,Ki,Mi
479	4.1.1.4	Review Hospital Discharge Materials/Models (2 HDP Models)		11 days	1/6/11	1/20/11	HDW
480	4.1.1.5	Determine Hospital Discharge Model of Choice	479	0 days	1/20/11	1/20/11	HDW
481	**4.1.2**	**Policies & Procedures**		**74 days**	**2/10/11**	**5/24/11**	

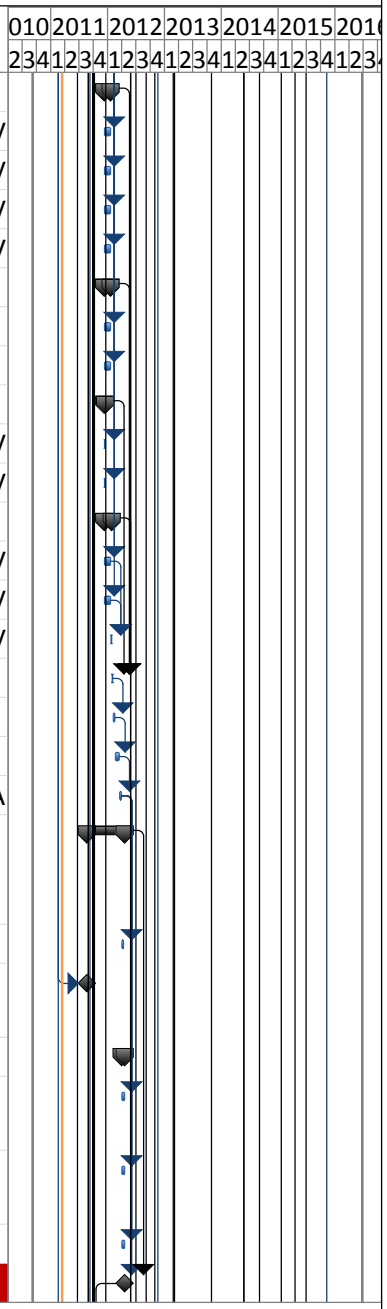


ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
482	4.1.2.1	Referral Protocol from Hospital Discharge Planners to AAA		37 days	2/10/11	4/1/11	EOA,Hi
483	4.1.2.2	Translate selected model and referral protocols into policies and procedures	482	20 days	4/4/11	4/29/11	EOA,Hi
484	4.1.2.3	Review by Hospital Discharge Workgroup	483	9 days	5/2/11	5/12/11	HDW
485	4.1.2.4	Revised policies and procedures	484	8 days	5/13/11	5/24/11	EOA,Hi
486	**4.1.3**	**MOUs w/ Hospitals**		**39 days**	**4/29/11**	**6/22/11**	
487	4.1.3.1	Outreach to Target Hospitals for HDP		22 days	4/29/11	5/30/11	Hi,Hu,Ki,Mi
488	4.1.3.2	Draft MOU For Participating Hospitals		14 days	4/29/11	5/18/11	EOA,Hi
489	4.1.3.3	Review by Hospital Discharge Workgroup	488	10 days	5/19/11	6/1/11	HDW
490	4.1.3.4	Revise MOU	489	5 days	6/2/11	6/8/11	EOA,Hi
491	4.1.3.5	Agreement/Sign MOU with Hospitals	487,490	10 days	6/9/11	6/22/11	Hi,Hu,Ki,Mi
492	**4.1.4**	**Training**		**44 days**	**6/1/11**	**8/1/11**	
493	4.1.4.1	Train HDP Staff on Selected HDP Model (e.g., Coleman, Transitional Care Model, etc..)		44 days	6/1/11	8/1/11	EOA,Hi
494	**4.1.5**	**Continuous Quality Improvement**		**20 days**	**8/24/11**	**9/20/11**	
495	4.1.5.1	Review and adapt Core ADRC performance indicators and data collection to reflect HDP effort	153	20 days	8/24/11	9/20/11	EOA,Hi
496	4.1.6	Implementation	493SS,491	10 days	6/23/11	7/6/11	Hi,Hu,Ki,Mi
497	**5**	**Build Veteran's Administration Program**		**254 days**	**5/3/11**	**4/20/12**	
498	**5.1**	**EOA has initial meeting with VA**		**20 days**	**5/3/11**	**5/30/11**	
499	5.1.1	Present Plan	406,410	10 days	5/3/11	5/16/11	EOA,VA
500	5.1.2	Agree on process for developing program	499	10 days	5/17/11	5/30/11	EOA,VA
501	5.1.3	Request to VAMC for information regarding distri	499	10 days	5/17/11	5/30/11	EOA,VA
502	5.1.4	Preliminary guidance from VAMC regarding prefe	499	10 days	5/17/11	5/30/11	EOA,VA
503	5.2	Decision to proceed	500,501,5(	5 days	5/31/11	6/6/11	Ki,Mi,Hi
504	**5.3**	**Provider Agreement with VAMC**		**100 days**	**11/14/11**	**3/30/12**	
505	5.3.1	Parties to agreement (individual AAAs vs. EOA)	503,466SS	15 days	11/14/11	12/2/11	EOA,FSW,V
506	5.3.2	Process for referrals from VA	503,466SS	20 days	11/14/11	12/9/11	EOA,FSW,V
507	5.3.3	Rate Determination (VAMC case-mix, VAMC sets	503,466SS	20 days	11/14/11	12/9/11	EOA,FSW,V

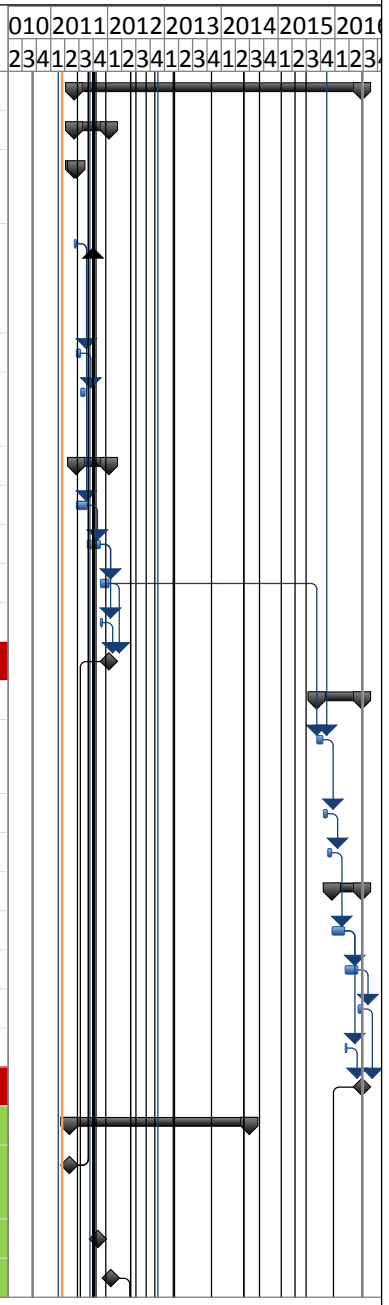


Hawaii SCD Implementation Plan

ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
508	**5.3.4**	**Rate Construction**		**30 days**	**12/12/11**	**1/20/12**	
509	5.3.4.1	Veteran Directed Budget	507	30 days	12/12/11	1/20/12	EOA,FSW,V
510	5.3.4.2	VD-HCBS Oversight	507	30 days	12/12/11	1/20/12	EOA,FSW,V
511	5.3.4.3	Assessment & related start-up costs	507	30 days	12/12/11	1/20/12	EOA,FSW,V
512	5.3.4.4	Veteran's "rainy day" fund	507	30 days	12/12/11	1/20/12	EOA,FSW,V
513	**5.3.5**	**VAMC Payment for VD-HCBS**		**30 days**	**12/12/11**	**1/20/12**	
514	5.3.5.1	AAA ability to submit monthly invoices	507	30 days	12/12/11	1/20/12	Hi,Ki,Mi
515	5.3.5.2	Cash flow	507	30 days	12/12/11	1/20/12	Mi,Ki,Hi
516	**5.3.6**	**Complying with VA Specific Requirements**		**5 days**	**12/12/11**	**12/16/11**	
517	5.3.6.1	Payments for non-professional workers may nc	507	5 days	12/12/11	12/16/11	EOA,FSW,V
518	5.3.6.2	Veteran Representatives cannot serve as paid \	507	5 days	12/12/11	12/16/11	EOA,FSW,V
519	**5.3.7**	**Follow-up process**		**35 days**	**12/12/11**	**1/27/12**	
520	5.3.7.1	Reassessments	507	30 days	12/12/11	1/20/12	EOA,FSW,V
521	5.3.7.2	At least quarterly face-to-face-visits	507	30 days	12/12/11	1/20/12	EOA,FSW,V
522	5.3.7.3	Reports to share with VAMC	520,521	5 days	1/23/12	1/27/12	EOA,FSW,V
523	5.3.8	AAA Decision to Proceed	508,513,5	5 days	1/30/12	2/3/12	Mi,Ki,Hi
524	5.3.9	County Executive Branch Approval	523	10 days	2/6/12	2/17/12	Mi,Ki,Hi
525	5.3.10	County Council Approvals	524	20 days	2/20/12	3/16/12	Mi,Ki,Hi
526	5.3.11	Signed Provider Agreement	525	10 days	3/19/12	3/30/12	Mi,Ki,Hi,VA
527	**5.4**	**Operations that need to be in place prior to implementation (developed as part of participant-direction effort)**		**175 days**	**8/22/11**	**4/20/12**	
528	5.4.1	Staff trained to accept referrals from VA	526	10 days	4/2/12	4/13/12	Mi,Ki,Hi
529	5.4.2	Participant Directed Pilot ready for implementation	466SS	0 days	8/22/11	8/22/11	
530	**5.4.3**	**Access to agency-provided services**		**15 days**	**4/2/12**	**4/20/12**	
531	5.4.3.1	Building in back-end ability to attribute costs to VA rather than KC	526	15 days	4/2/12	4/20/12	Mi,Ki,Hi
532	5.4.3.2	Contract amendment (if necessary) for additional units	526	15 days	4/2/12	4/20/12	Mi,Ki,Hi
533	5.4.4	Capacity to bill VA	526	15 days	4/2/12	4/20/12	Mi,Ki,Hi
534	5.5	Implementation	526,527	0 days	4/20/12	4/20/12	

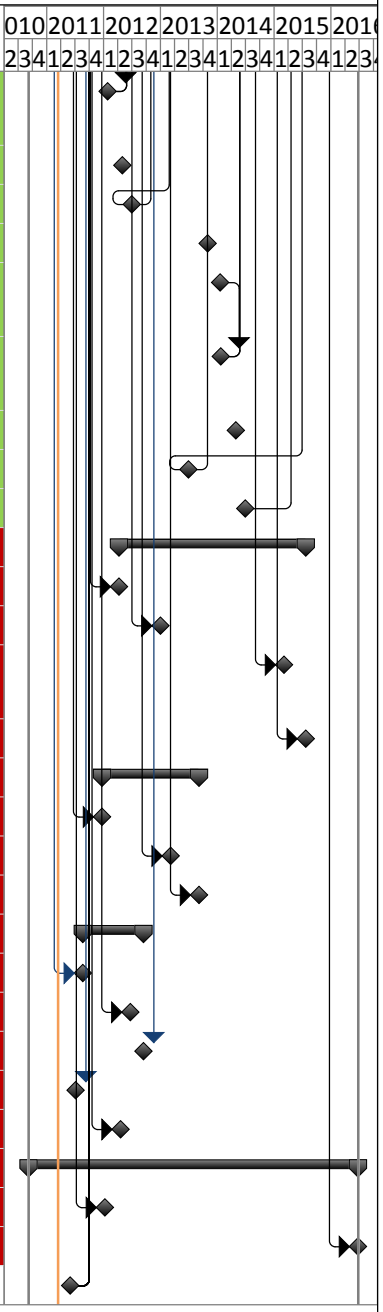


ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
535	**6**	**Restructuring Service Contracts**		**1323 days**	**6/1/11**	**6/24/16**	
536	**6.1**	**Maui Implementation**		**160 days**	**6/1/11**	**1/10/12**	**Mi**
537	**6.1.1**	**Develop process to utilize 103F purchasing authority for contracting services**		**10 days**	**6/1/11**	**6/14/11**	**Mi**
538	6.1.1.1	Explore how QExA health plans contract with Home Health/Home Care providers to do unit basis billing and payment	588	10 days	6/1/11	6/14/11	Mi
539	6.1.2	Train staff to understand procurement process	538	20 days	6/15/11	7/12/11	Mi
540	6.1.3	Outreach service providers on contracting changes	539	20 days	7/13/11	8/9/11	Mi
541	**6.1.4**	**RFP**		**150 days**	**6/15/11**	**1/10/12**	
542	6.1.4.1	Develop RFP	538	50 days	6/15/11	8/23/11	Mi
543	6.1.4.2	Release RFP and Review proposals	542	60 days	8/24/11	11/15/11	Mi
544	6.1.4.3	Signed contracts	543	2 mons	11/16/11	1/10/12	Mi
545	6.1.5	Train assessment and support plan staff	543	10 days	11/16/11	11/29/11	Mi
546	6.1.6	Implementation	544,545	0 days	1/10/12	1/10/12	
547	**6.2**	**Kauai and Honolulu implementation**		**210 days**	**9/7/15**	**6/24/16**	**Ki,Hu**
548	6.2.1	Develop process to utilize 103F purchasing authority for contracting services	544,361	30 days	9/7/15	10/16/15	**Ki,Hu**
549	6.2.2	Train staff to understand procurement process	548	20 days	10/19/15	11/13/15	**Ki,Hu**
550	6.2.3	Outreach service providers on contracting change	549	20 days	11/16/15	12/11/15	**Ki,Hu**
551	**6.2.4**	**RFP**		**140 days**	**12/14/15**	**6/24/16**	**Ki,Hu**
552	6.2.4.1	Develop RFP	550	60 days	12/14/15	3/4/16	**Ki,Hu**
553	6.2.4.2	Release RFP and Review proposals	552	60 days	3/7/16	5/27/16	**Ki,Hu**
554	6.2.4.3	Signed contracts	553	20 days	5/30/16	6/24/16	**Ki,Hu**
555	6.2.5	Train assessment and support plan staff	552	10 days	3/7/16	3/18/16	
556	6.2.6	Implementation	554,555	0 days	6/24/16	6/24/16	
557	**7**	**Budget**		**826 days**	**5/2/11**	**7/1/14**	
558	7.1	EOA issues letter informing counties that the waiver requirement has been removed for case		0 days	5/2/11	5/2/11	EOA
559	7.2	2013 Supplemental Budget Request Proposed by EC		0 days	11/1/11	11/1/11	EOA
560	7.3	2013 Budget Request Included in Governor's Budget		0 days	1/23/12	1/23/12	



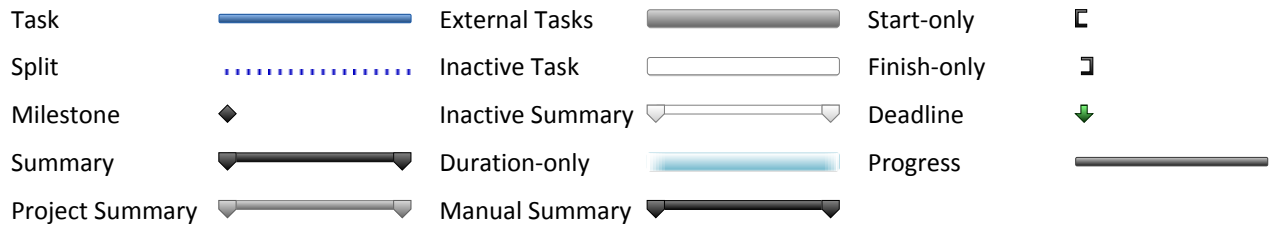
Hawaii SCD Implementation Plan

ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
561	7.4	Letter of Intent from the State sent to Maui, Kauai, & Hawai'i Counties	560FS+5 days	0 days	1/27/12	1/27/12	EOA
562	7.5	2013 Budget approved		0 days	5/2/12	5/2/12	
563	7.6	2013 Appropriations made to counties		0 days	7/2/12	7/2/12	
564	7.7	2014/2015 Budget Request Proposed by EOA		0 days	11/1/13	11/1/13	EOA
565	7.8	2014/15 Budget Request Included in Governor's Budget		0 days	1/20/14	1/20/14	
566	7.9	Letter of Intent from the State sent to Hawai'i and Honolulu Counties	565FS+5 days	0 days	1/24/14	1/24/14	EOA
567	7.10	2014/15 Budget approved		0 days	5/1/14	5/1/14	
568	7.11	2014 Appropriations made to counties		0 days	7/1/13	7/1/13	
569	7.12	2015 Appropriations made to counties		0 days	7/1/14	7/1/14	
570	**8**	**Full-Functioning ADRC**		**858 days**	**4/10/12**	**7/24/15**	
571	8.1	Full-Functioning ADRC - Maui Implementation	263SS	0 days	4/10/12	4/10/12	
572	8.2	Full-Functioning ADRC - Kauai Implementation	300SS	0 days	1/1/13	1/1/13	
573	8.3	Full-Functioning ADRC - Hawai'i County Implementation	329SS	0 days	3/6/15	3/6/15	
574	8.4	Full-Functioning ADRC - Honolulu Implementation	360SS	0 days	7/24/15	7/24/15	
575	**9**	**In-House Case Management**		**445 days**	**12/23/11**	**9/6/13**	
576	9.1	Maui implementation	381SS	0 days	12/23/11	12/23/11	
577	9.2	Hawai'i County implementation	392SS	0 days	3/8/13	3/8/13	
578	9.3	Honolulu Implementation	403SS	0 days	9/6/13	9/6/13	
579	**10**	**Participant Direction**		**280 days**	**8/22/11**	**9/14/12**	
580	10.1	Kauai, Hawai'i, and Maui pilot	466SS	0 days	8/22/11	8/22/11	
581	10.2	Kauai, Hawai'i and Maui full implementation	471SS	0 days	6/22/12	6/22/12	
582	10.3	Honolulu expansion plan	472	0 days	9/14/12	9/14/12	
583	**11**	**Hospital Discharge Planning**	**496**	**0 days?**	**7/6/11**	**7/6/11**	
584	**12**	**VA Option Implementation**	**534SS**	**0 days**	**4/20/12**	**4/20/12**	
585	**13**	**Service contracting changes**		**515 days?**	**9/7/10**	**6/24/16**	
586	13.1	Maui implementation	546SS	0 days	1/10/12	1/10/12	
587	13.2	Kauai and Honolulu implementation	556SS	0 days	6/24/16	6/24/16	
588	13.3	Implementation Contractor Procurred		0 days	6/1/11	6/1/11	



ID	Outline Number	Task Name	Predecesso	Duration	Start	Finish	Resource Initials
589	13.4	**Task is Related to MIS**					
590	13.5	**Task is Related to Options Counseling Developmen**					
591	13.6	**Task is Tied to Budget Process**					
592		**Task Marks the Implementation of a Key Initiative**					

Project: Hawaii SCD Operational P
Date: 3/15/11



Appendix C: 2009 Interagency Action Plan for the Emergency Preparedness of People with Disabilities and Special Health Needs.

2009
Interagency Action Plan

For the Emergency Preparedness Of People with Disabilities and Special Health Needs

State of Hawaii
August 2009

WORKING GROUP

State of Hawaii Departments or Agencies
(alpha)

Department of Education (DOE)
Department of Health (DOH)
Department of Human Services (DHS)
Disability and Communication Access Board (DCAB)
Executive Office on Aging (EOA)
State Civil Defense (SCD)
State Council on Developmental Disabilities (DDC)

County Departments or Agencies
(alpha)

City and County of Honolulu, Department of Emergency Management
County of Hawaii, Civil Defense Agency
County of Kauai, Civil Defense Agency
County of Maui, Civil Defense Agency

Community Agencies
(alpha)

American Red Cross (ARC)
Healthcare Association of Hawaii

Agencies Representing Individuals with Disabilities
(alpha)

County of Hawaii, Mayor's Committee on Persons with Disabilities
County of Kauai, Mayor's Advisory Committee for Equal Access
County of Maui, Mayor's Commission on Persons with Disabilities
Hawaii Centers for Independent Living
Hui Kupuna VIP
National Federation of the Blind
National Multiple Sclerosis Society, Hawaii Division

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Table of Contents

BACKGROUND

In the wake of the September 11th terrorist attacks and the subsequent disasters of Hurricanes Katrina, Rita and Wilma of 2005, the inability of the system to respond to the needs of persons with disabilities or other special health needs became more apparent as a major deficiency in our overall community emergency preparedness and response system. The State of Hawaii and its political jurisdictions would fare no better than mainland locations in meeting the needs of persons with disabilities were similar events to occur tomorrow. The disasters, coupled with the growing recognition that people with disabilities or special health needs are a more vulnerable population in an emergency or natural disaster when their daily survival mechanisms, coping skills, and support systems are interrupted, have emphasized the need to prepare a strategic plan which addresses the unique circumstances of persons with disabilities and special health needs in disaster preparedness planning.

A Harris Poll commissioned by the National Organization on Disability in November 2001 discovered that 58% of people with disabilities did not know whom to contact about emergency plans in their community. Some 61% of those surveyed had not made plans to quickly and safely evacuate their homes. And, among those individuals with disabilities who were employed, 50% said that no plans had been made to safely evacuate their workplace. All of these percentages were higher than the percentages for people without disabilities.

A Working Group convened in the Fall of 2005 and developed the original plan in February 2006 with six (6) goals. It was updated in February 2007 with the addition of a Goal 7 that focused on transportation needs of the target population. It was revised again in 2008 incorporating amendments to the existing goals and objectives along with additional information reflecting progress made and suggestions from the community statewide. It is the intent of the Working Group to review and revise the Plan on a biennial basis beginning in 2009.

On September 23, 2008, a small statewide forum was conducted in Honolulu as a follow up to the October 2007 forums previously conducted by DCAB and SCD in each county. Individuals with disabilities representing a variety of disability agencies were invited to attend. DCAB hosted the forum and sponsored airfares for representatives from the County Mayor's Committees on Persons with Disabilities and community to attend the meeting on Oahu. The purpose of the forum was to review 2008 accomplishments and identify objectives to address in 2009 for the population of people with disabilities and special health needs.

The forum was comprised of four (4) panels to review emergency shelters and sheltering-in-place, county civil defense agency activities, community education and training activities, and the development of community resources. Panelists presented activities that were conducted in each county and on a statewide basis. The audience was very active in soliciting and providing information that was instrumental in moving the Action Plan forward.

During the October 2007 forums counties developed their own invitation lists of key representatives from agencies, advocates, individuals with disabilities, family members and caregivers. Attendance at each forum was diverse, resulting in comments and suggestions that were creative and unique to each location. Representatives from Guam and American Samoa were invited to and included at the Oahu forum, along with two (2) representatives from each neighbor island forum. Using this methodology to obtain input resulted in development of this 2008 Plan that represents the needs of a broader base of Hawaii's community of people with disabilities. Both the 2007 and 2008 forums were funded by a grant from the Centers for Disease Control (CDC), U.S. Department of Health and Human Services through the Public Health Emergency Preparedness Cooperative Agreement.

This Action Plan is not an emergency preparedness document, nor is it a special health needs response plan. It is a roadmap to ensure that other legislative, administrative, or programmatic efforts are inclusive of the issues of people with disabilities or special health needs. This document does not propose an entirely separate set of emergency procedures or plans. The Plan is an acknowledgment that the interests of people with disabilities and special health needs must be made a part of overall community efforts. Everyone will benefit if the overall system is better prepared to respond to the entire community including people with disabilities or special health needs. Finally, the Plan is in recognition of the fact that people with disabilities and their caregivers have as much responsibility as any other citizen to prepare for surviving an emergency.

This Plan focuses on those individuals with disabilities (physical, mental, or health-related) that may compromise their ability to respond or respond as effectively as the general population. While many people will have unique needs in an emergency, such as those resulting from limited English speaking skills, homelessness, pet ownership, geographic isolation, cultural isolation, single parent status, criminal offender status, chemical dependency, or low income status, this Plan does not specifically address those circumstances at this time.

The Working Group has chosen to focus on emergency preparedness, notification, and sheltering in this Plan as the most pressing issues. The Working Group acknowledges the importance of other issues such as infrastructure, recovery and long-term support system. This Plan is an evolving document and other issues will be integrated into the Plan as the efforts of the Working Group continue.

TARGET POPULATION

POPULATION DESCRIBED

There is no absolute definition of the population of individuals with disabilities or special health needs for the purposes of this Plan. However, the population can be described, rather than defined, by its needs in the event of an emergency or disaster, and can be clustered by their level of independence and need for health or medical support acknowledging that even with the best of 'descriptions,' the population is not homogeneous and does not come together through a common service delivery system. For the purposes of this discussion the population can be very broadly described and clustered into the following categories as outlined by the American Red Cross (ARC) national guidelines:

Level I Care & Shelters:

Individuals going to a Level I shelter are people with disabilities who are independent and capable of self-care or care by those who are their daily caregivers (exclusive of the need for electrical power, generator, etc.). This includes the following persons, as a non-exhaustive list: those who use wheelchairs but are capable of transfer from their wheelchair; those with stable, controlled conditions such as arthritis; those with mild to moderate muscular conditions with a stable or assisted gait; colostomy patients; patients on special diets; those with artificial limbs or prosthesis; those with mechanical devices, such as pacemakers, implanted defibrillators, insulin pumps; those with visual, speech, or hearing impairments; those with managed, non-acute behavioral, cognitive or mental health illnesses; and those with tuberculosis controlled by medication.

Level I shelters are public evacuation shelters, often referred to as "mass care" or "general population" shelters.

Level II Care & Shelters:

Individuals who go to Level II shelters are people who have ongoing 'enhanced special health needs' and who, by the nature of their condition, need a heightened level of attention. This includes the following persons as a non-exhaustive list: those with attendant medical care and continuous health care support; those with special bed care and/or special toileting arrangements; those with life support equipment; those requiring significant supportive nursing care such as kidney dialysis; those with physician-ordered observation, assistance or maintenance or custodial care; those requiring skilled nursing care due to recent medical treatment; those whose disability prevents them from sleeping on a cot; those who require equipment normally found in a hospital or skilled nursing facility; and those who require assistance in performing activities of daily living or have health conditions whereby they cannot manage for themselves in a Level I general population evacuation shelter.

Level II shelters are not freestanding shelters. Rather, they are spaces within a Level I "mass care" or "general population" shelter for individuals needing Level II care.

Level III Care:

Individuals requiring Level III care are people who need acute medical care. This includes women giving birth, and individuals having a heart attack, individuals experiencing trauma or injury: people who would otherwise simply be a part of the general population. In the case of a disease outbreak or certain other disasters (such as a tsunami or hurricane), a significant portion of the population may immediately be included into this category. There are no Level III shelters. Individuals needing Level III care should be served in a hospital.

For the purposes of this document and disaster management and planning, the term "individuals with disabilities" will refer to individuals requiring both Level I and Level II care. "Individuals with special health needs" will refer only to people requiring Level II care. "Individuals with acute medical needs" are not the subject of this Plan.

The current Plan uses the terms "Level I," "Level II," and "Level III" to describe level of care and shelters or shelter spaces. The terminology change reflects the use of "people-first" language in lieu of labeling people. Also, the Plan references Level III care, instead of a Level III shelter. As such, a Level III shelter does not exist. Individuals requiring Level III care should be served in a hospital. During 2008, the Department of Health (DOH) convened a State Collaboration Workgroup to develop plans for Alternate Care Sites (ACS) to address needs that may arise during a pandemic influenza outbreak. As part of the planning process, DOH is considering the possibility of using ACS as Level II shelters because manpower to staff an ACS may be comparable to what is required in a Level II shelter. To date, the DOH State Collaboration Workgroup has not met with the Interagency Working Group to resolve the issue of staffing of ACS/Level II shelters. The purpose of an ACS is to supplement the healthcare system (whether it is a pandemic or hurricane) by providing basic care outside of hospitals. The planning process needs to be inclusive to attain the goal of supporting the healthcare system and of people with special health care needs during a disaster.

Another compelling reason to avoid categorizing people in levels is because the care required by an individual with a disability may change dramatically due to the emergency or the conditions surrounding an emergency. For example, a person who uses a wheelchair may be ordinarily able of independent living and self-care due to home accessibility modifications; however, the same individual may require Level II care because in a shelter the restrooms are not accessible with no grab bars or because there is no raised bed for the individuals to transfer onto and sleep.

POPULATION QUANTIFIED

The absence of a universal definition of the population of individuals with disabilities or special health needs makes it difficult to definitively quantify the population. While there are broad estimates of the number of people who have a variety of conditions, there is no single 'count' of people with disabilities or special health needs. The absence of this data is due to the fact that (1) 'disability status' or 'special health needs status' are often only

declared for the purpose of obtaining eligibility for a program, service, or benefit and (2) disability status is not necessarily a permanent characteristic of a person, such as age, race, or gender. Emergency preparedness and evacuation provides no incentive or reason for this population to self-identify without a demonstrable benefit to their disclosure. Therefore, for the purposes of planning we must rely on the best estimates based upon other community service data and figures.

The U.S. Census Bureau, 2000 Census of Population and Housing reflected a Hawaii population base of 1,211,537. The same census/survey identified 199,819 individuals, or approximately 16.5% of the non-institutionalized population over age 5 as having a disability or a "long lasting sensory, physical, or mental impairment." Recognizing that this excludes a significant portion of people with disabilities because they live in institutions or long-term care facilities, the actual figure will be higher.

Thus, the U.S. Census Bureau estimates that 54 million Americans, or about 20% of the U.S. population are individuals with disabilities. Extrapolation to the Hawaii 2007 estimated population base of 1,283,388 (Hawaii Data Book, 2007) people yields approximately 256,678 state residents with disabilities.

Some people with disabilities will not require special assistance during an emergency because they are able to take care of themselves. Therefore, while some 16.5 - 20% of the total population have a disability, the national planning average used by emergency management offices, according to an informal national survey conducted by the National Office on Disability, is notably lower at 10 – 13% (National Council on Disability, 2002). This figure encompasses only those who need help in an emergency, acknowledging that many people with disabilities are capable of self-support.

Based upon those figures of 10 – 13% extrapolated to Hawaii's population, the estimated number of people with disabilities for the purposes of emergency management planning is between 128,339 and 166,840 individuals. There is no further estimate as to what percentage of those individuals would require various levels of care.

In order to better quantify the 128,339 –166,840 population estimate, we must quantify the individuals we can identify through the service delivery system. We can locate concentrations of individuals without identifying individuals by name by counting the number of people in clustered group living arrangements. These clusters and groups may change over time, but the number usually will remain consistent. (Since the residential facilities are limited by occupancy and licensing regulations and most facilities are at or near capacity, the number of individuals will not change dramatically until new facilities are opened.)

For example:

Care Home A is licensed for 5 individuals. Care Home A is providing custodial care for 5 individuals and, unless it ceases to provide such services, we can expect 5 individuals living at a specific location to need 'extra help and attention' in the event of an emergency.

Appendix A lists clusters of individuals with disabilities or special health needs who can be identified by where they live. Such programs can be identified by the state agencies that either license or fund the residential programs. This includes: Adult Residential Care Homes, Expanded Adult Residential Care Homes, Assisted Living Facilities, Developmental Disabilities Domiciliary Homes, Adult Foster Homes, Child Foster Homes, Special Treatment Facilities, Therapeutic Care Facilities, Skilled Nursing Facilities, Intermediate Care Facilities, and Mental Health Group Homes. Attachment A reveals that there are approximately 12,300 people living in 1,842 identified clustered group living arrangements under some 'control' by the State of Hawaii. This is an unduplicated count.

Recognizing that most people with disabilities or special health needs do not live in a congregate group setting but rather are integrated into the community, often living semi-independently or in the care of their family, additional efforts must be taken to identify those individuals.

For example:

Individual A is frail, elderly, and has a disability. Individual A lives at home, but due to medical fragility, receives services from the Public Health Nursing Branch.

Individual B is elderly, in a wheelchair, and lives alone with rotating support of his children. He receives Meals on Wheels due to being homebound.

Individual C is similar to Individual B, but attends a day activity program instead of receiving Meals on Wheels.

Individual D is a person with a developmental disability, has a case manager through the Department of Health and receives a variety of personal care services to enable the family to keep him at home. Individual D receives SSI as well and does not attend any group program.

Currently, there is no comprehensive aggregate list to identify individuals with disabilities living independently in the community. No efforts are proposed to 'count' or identify such individuals. However, the Plan proposes, in its goals and objectives, to identify the array of social service, health, and education agencies or organizations that provide direct services and have customer-bases which include people with disabilities. This effort will help to assure that individuals with disabilities develop emergency readiness plans as an integral part of their individual service plans through community service agencies. For individuals with disabilities and special health needs who do not use community service agencies, individual emergency readiness is a personal responsibility that may be enhanced through a coordinated community media outreach campaign.

BASIC PREMISES AND ASSUMPTIONS

(A) Although the circumstances of individuals with disabilities or special health needs may be different from the general population at-large, with the assumption that their needs are 'greater,' the means to address those needs must be integrated into the overall, general plans for emergency readiness and evacuation for the general population. A 'separate' emergency management plan for individuals with disabilities or special health needs is not appropriate. We cannot plan for 'special health needs populations' in isolation. If the general infrastructure of emergency preparedness, evacuation, and response is not increased for the population as a whole, planning for this population alone will be an exercise in frustration.

(B) Emergency readiness is foremost an individual's personal responsibility, or, if the person is in the care of another person, the caregiver's responsibility. Increased personal readiness for a person with a disability or special health need is even more important to ensure that the person's unique challenges or needs are met.

(C) While some other states have started to create registries of persons with disabilities, we do not recommend this as the state or county levels of government do not have the capability to keep the registry up-to-date nor to meet the possible expectation of those on the registry that they will be 'rescued,' thereby creating a false sense of security.

(D) All Level I shelters available to the population at-large should be physically accessible for individuals with disabilities who have the capability of self-care or have a personal attendant or caregiver to assist them.

(E) A selected number of locations within Level I shelters should be designated for more intensive health support as noted above for Level II care.

(F) Hospitals should be reserved for individuals who are acutely ill needing Level III care. The role of a hospital is to respond first to its inpatient population and secondly, as a back up to other hospitals.

(G) The population of individuals who have disabilities or special health needs may include people who have become disabled as a result of the disaster. It may also include non-resident tourists whose location and personal medical needs will vary at any given time. While the immediate response of the community will need to accommodate all individuals, this Plan focuses on the resident population whose disabilities are known prior to the emergency.

(H) People with disabilities or special health needs should remain as a unit with their family or caregivers and should not be separated from their families due to their requirements for additional care.

GOALS AND OBJECTIVES

This Plan sets forth seven (7) Goals as listed below:

Goal 1: Level I public emergency evacuation shelters shall meet minimum requirements for facility access to enter/exit and use toilet facilities.

Goal 2: The capacity of the community to “shelter-in-place” shall be increased.

Goal 3: The number and dispersion of public emergency evacuation shelters able to provide augmented health support with Level II shelter spaces shall be increased, with the long-term goal of having ALL public emergency evacuation shelters contain Level II shelter spaces.

Goal 4: Individuals with disabilities or special health needs shall have an emergency evacuation plan in place developed by themselves or by their caregivers to implement in the event of a notification of evacuation.

Goal 5: Education shall be provided to all licensed health care providers in order that appropriate emergency guidelines for health care facilities and/or residential settings are in place.

Goal 6: All notification of pending emergencies and evacuation shall be accessible to persons with disabilities using multiple methods of delivery.

Goal 7: Individuals with disabilities or special health needs shall have an emergency evacuation transportation plan developed by themselves or their caregivers to implement in the event of notification for evacuation.

Each Goal, with its corresponding Objectives and relevant background information, is described in detail in subsequent pages. The agencies listed after each objective are responsible for implementing the objective, with the lead agency or agencies noted with an asterisk (*). The lead agency or agencies are responsible for convening the identified players (and any others not identified in the Plan) to achieve the stated objective, including the development of strategies and actions to implement the objective.

Many other initiatives to enhance and strengthen the overall emergency management system will benefit people with disabilities. Only goals specifically targeting or directly impacting people with disabilities or special health needs are listed.

GOAL 1: LEVEL I PUBLIC EMERGENCY EVACUATION SHELTERS SHALL MEET MINIMUM REQUIREMENTS FOR FACILITY ACCESS TO ENTER/EXIT AND USE TOILET FACILITIES.

Objective 1.1: Retrofit/harden all public emergency evacuation shelters, with priority to those schools already identified as ADA Transition Plan or Architectural Barrier Removal schools of the Department of Education (DOE), to meet already developed baseline facility requirements for hardening and accessibility. ***(State Civil Defense*, Department of Education*, County Civil Defense Agencies)***

Objective 1.2: Obtain State Capital Improvement Projects (CIP) funds and upgrade current public emergency evacuation shelters to ensure that those sites meet the minimum facility requirements for accessibility and sheltering. ***(State Civil Defense*, all Working Group partners)***

Objective 1.3: Amend Hawaii Revised Statutes (HRS) to require all newly constructed state buildings and facilities, as appropriate, to have the capability to serve as a public emergency evacuation shelter for up to 130% of occupancy. (Note: All new buildings and facilities are required by law to be physically accessible per HRS §103-50.) ***(State Civil Defense*, all Working Group partners)***

Objective 1.4: Provide approved American Red Cross (ARC) training to all Level I shelter workers to respond to the needs of persons with disabilities or special health needs (e.g., how to respond to service animals, how to handle mobility devices, etc.). ***(American Red Cross*, Department of Health, Disability and Communication Access Board, State Council on Developmental Disabilities)***

Objective 1.5: Increase the pool of trained shelter workers, including persons with disabilities, so that public emergency evacuation shelters can be more responsive to the needs of persons with disabilities and special health needs. ***(American Red Cross*, all Working Group partners)***

Objective 1.6: Amend Hawaii Revised Statutes (HRS) to allow public funds to be used for privately-owned and approved public emergency evacuation shelters open to the public. ***(State Civil Defense*, and all Working Group partners)***

For progress to-date on Goal 1 see Appendix B.

GOAL 2: THE CAPACITY OF THE COMMUNITY TO "SHELTER-IN-PLACE" SHALL BE INCREASED.

Objective 2.1: Amend Hawaii Revised Statutes (HRS) to provide grants to offset costs incurred for the plan, design, construction, and equipment for a qualified facility (to include private facilities) that retrofits, updates, or hardens its existing structure to permit sheltering-in-place, as established by State Civil Defense. ***(State Civil Defense*, all Working Group partners)***

Objective 2.2: Assist owners or proprietors of licensed health care settings or day facilities, including retirement homes, through site consultation to assess their facility for hardening to shelter-in-place, develop evacuation plans to ensure compliance/conformance with County Civil Defense procedures and guidelines, and use the financial incentives provided in Objective 2.1 to retrofit their facilities. ***(State Civil Defense*, Department of Health, Department of Human Services)***

Objective 2.3: Create tax incentives for private owners, builders, developers and care facilities to provide shelter-in-place options in new construction. ***(State Civil Defense*, all Working Group partners)***

For progress to-date on Goal 2 see Appendix C.

GOAL 3: THE NUMBER AND DISPERSION OF PUBLIC EMERGENCY EVACUATION SHELTERS ABLE TO PROVIDE AUGMENTED HEALTH SUPPORT WITH LEVEL II SHELTER SPACES SHALL BE INCREASED, WITH THE LONG-TERM GOAL OF HAVING ALL PUBLIC EMERGENCY EVACUATION SHELTERS CONTAIN LEVEL II SHELTER SPACES.

Objective 3.1: Establish minimum facility and space requirements for Level II special health needs shelter spaces to include, but not be limited to, the availability of back-up electricity (generator), refrigeration, accessible toilet facilities and water, and hardening criteria applicable to all shelters. ***(State Civil Defense*, Department of Health, American Red Cross)***

Objective 3.2: Establish a minimum staffing pattern (quantity and type of staff) for staff oversight and operations and secure commitments to activate staff of a Level II shelter in the event of an emergency. ***(Department of Health*, Healthcare Association of Hawaii, American Red Cross, Medical Reserve Corps)***

Objective 3.3: Implement the needed retrofit of identified special health needs Level II shelters, either existing or new, in each of the counties and ensure that those shelters meet the minimum requirements set forth in Objective 3.1. **(State Civil Defense*, County Civil Defense Agencies)**

For progress to-date on Goal 3 see Appendix D.

GOAL 4: INDIVIDUALS WITH DISABILITIES OR SPECIAL HEALTH NEEDS SHALL HAVE AN EMERGENCY EVACUATION PLAN IN PLACE DEVELOPED BY THEMSELVES OR BY THEIR CAREGIVERS TO IMPLEMENT IN THE EVENT OF A NOTIFICATION OF EVACUATION.

Objective 4.1: Develop a comprehensive list of organizations serving persons with disabilities and/or the elderly population with estimates of their direct client caseloads or membership, to form the foundation of a statewide public education program as well as agency readiness and shelter-in-place survey. ***(Executive Office on Aging*, Disability and Communication Access Board*, Department of Health, Department of Human Services)***

Objective 4.2: Conduct a comprehensive statewide public and professional education outreach program using a standardized statewide 'Individual Emergency Readiness' message to agencies providing services to people with disabilities and special health needs. The public education and outreach program shall be multilingual based upon state ethnic needs and integrated with a community-wide public education effort for all. ***(State Civil Defense*, Department of Health*, Department of Human Services*, Department of Education, County Civil Defense Agencies, American Red Cross, Disability and Communication Access Board, State Council on Developmental Disabilities, Executive Office on Aging)***

Objective 4.3: Integrate emergency evacuation planning into the plans of clients who have a case manager in the Department of Health, Department of Human Services or their contracted agencies. ***(Department of Health*, Department of Human Services*)***

Objective 4.4: Integrate the emergency evacuation planning of students with disabilities in the school-wide evacuation plans of public schools, private schools, and early intervention programs. ***(Department of Education*)***

For progress to-date on Goal 4 see Appendix E.

GOAL 5: EDUCATION SHALL BE PROVIDED TO ALL LICENSED HEALTH CARE PROVIDERS IN ORDER THAT APPROPRIATE EMERGENCY GUIDELINES FOR HEALTH CARE FACILITIES AND/OR RESIDENTIAL SETTINGS ARE IN PLACE.

Objective 5.1: Ensure the administrative oversight of licensing of all health care facilities includes the review of emergency guidelines of the facility to comply with County Civil Defense procedures and guidelines. ***(Department of Health-OHCA*, State Civil Defense*, County Civil Defense Agencies*, Department of Human Services)***

Objective 5.2: Assist community-based health care facilities to develop emergency plans. Provide continued planning support including review of plans for appropriateness. ***(Department of Health-OCHA*, State Civil Defense*, County Civil Defense Agencies*, Department of Human Services)***

Objective 5.3: Develop a means to assess privately-owned residential settings for senior citizens, other than assisted living facilities, to determine whether the resident should shelter-in-place or go to a public emergency evacuation shelter during a disaster. ***(Executive Office on Aging*, County Area Agencies on Aging)***

For progress to-date see Appendix F.

GOAL 6: ALL NOTIFICATIONS OF PENDING EMERGENCIES AND EVACUATION SHALL BE ACCESSIBLE TO PERSONS WITH DISABILITIES USING MULTIPLE METHODS OF DELIVERY.

Objective 6.1: Secure agreements with visual broadcast media to (1) provide open captioning on all television announcements of pending or current disasters, (2) ensure that crawl messages across a television screen do not run in any area reserved for closed captioning, as this will make both sets of messages unintelligible for deaf and hearing viewers, (3) coordinate with sign language or other language interpreters to be available to work with local television stations during emergencies and include the interpreter in all messages broadcasted, and (4) provide an aural description of emergency information in the main audio. If the emergency information is being provided in the video portion of a program that is not a regularly scheduled newscast does not interrupt regular programming (e.g., "crawling" or "scrolling" during regular programming), this information must be accompanied by an aural tone. ***(State Civil Defense*, Disability and Communication Access Board)***

Objective 6.2: Obtain a TTY at all key emergency information lines (including, but not limited to, State Civil Defense, County Civil Defense Agencies, National Weather Service, and the American Red Cross) and ensure that all staff at the agencies are trained on TTY use. ***(State Civil Defense*, Disability and Communication Access Board)***

Objective 6.3: Provide information in an accessible format[1] on the web sites of the following agencies providing information on disasters: FEMA, State Civil Defense, County Civil Defense Agencies, National Weather Service, and the American Red Cross (i.e., "Bobby-approved" or the equivalent). ***(Oahu Department of Emergency Management*, State Civil Defense, Other County Civil Defense Agencies, Disability and Communication Access Board, National Weather Service, American Red Cross)***

Objective 6.4: Research alternatives (to include pictograms or graphics) for the provision of an alert paging system to warn individuals who do not hear, understand, or comprehend the conventional siren of a possible emergency to include, but not be limited to, wireless services, and develop agreements to implement a system. Research should include an analysis of the feasibility of new technology to initiate messages to individuals with disabilities in an emergency. ***(State Civil Defense*, Disability and Communication Access Board)***

For progress to-date see Appendix G.

[1] "Accessible format" means that information provided to the general public about an emergency must also be simultaneously and effectively communicated to people with disabilities (captions provided for people who are deaf and spoken for people who are blind, and simple graphics for people with cognitive disabilities).

GOAL 7: INDIVIDUALS WITH DISABILITIES OR SPECIAL HEALTH NEEDS SHALL HAVE AN EMERGENCY EVACUATION TRANSPORTATION PLAN DEVELOPED BY THEMSELVES OR THEIR CAREGIVERS TO IMPLEMENT IN THE EVENT OF NOTIFICATION FOR EVACUATION.

Objective 7.1: Develop an operational service plan at the county level for transportation in the event of an emergency and publicize the information to county residents. ***(County Transportation Agencies*, County Civil Defense Agencies*, Department of Transportation)***

Objective 7.2: Incorporate transportation options developed into the comprehensive statewide public and professional personal readiness outreach programs under Objective 4.3. ***(State Civil Defense*, Department of Health*, Department of Human Services*, Department of Education, County Civil Defense Agencies, American Red Cross, Disability and Communication Access Board, State Council on Developmental Disabilities, Executive Office on Aging)***

For progress to-date on Goal 7 see Appendix H.

APPENDICES

Appendix A

Listed below are clusters of individuals with disabilities or special needs who can be identified by where they live in a clustered group living arrangement. Such programs can be usually be identified by the licensing process of the State of Hawaii.

Type of Facility	# Hawaii		Kauai		Maui		Molokai		Lanai		Oahu		Total	
	#fac	#beds	#fac	#beds	#fac	#beds	#fac	#beds	#fac	#beds	#fac	#beds	#fac	beds
Adult Residential Care Homes (ARCH) Arch I & II	48	211	16	73	13	61	4	31	0	0	413	2232	**494**	**2608**
Expanded ARCH	14	28	1	2	1	2	1	3	0	0	160	347	**177**	**382**
Therapeutic Living Programs (TLP)	2	12	2	12	2	23	0	0	0	0	9	60	**15**	**107**
Special Treatment Facility (STF)	4	49	0	0	4	75	0	0	0	0	30	577	**38**	**701**
Developmental Disabilities Domiciliary Homes (DD Dom Homes)	1	5	0	0	1	5	0	0	0	0	30	133	**32**	**143**
Assisted Living Facility (ALF)	1	220	1	100	1	144	0	0	0	0	7	1280	**10**	**1744**
Intermediate Care Facility– Mentally Retarded in the Community (ICF-MR-C)	0	0	0	0	4	24	0	0	0	0	14	67	**18**	**91**
Residential Alternatives for Care in the Community (RACC)	44	88	4	8	19	38	1	2	0	0	574	1158	**642**	**1294**
Intermediate Care Facility-Skilled Nursing Facility (ICF/SNF)	8	720	5	318	4	498	1	3	1	10	31	2547	**50**	**4096**
Mental Health– Adult Group Living Sites	15	97	7	33	9	60	0	0	0	0	62	429	**93**	**619**
Developmental Disabilities Foster Homes (DD Foster Homes)	4	6	9	16	8	13	0	0	0	0	252	494	**273**	**529**
Total	**141**	**1436**	**45**	**562**	**66**	**943**	**7**	**39**	**1**	**10**	**1582**	**9324**	**1842**	**12314**

Appendix B

Goal 1: Level I public emergency evacuation shelters shall meet minimum requirements for facility access to enter/exit and use toilet facilities.

All public emergency evacuation shelters may not have the capability of serving individuals who have specialized medical or health needs. However, many individuals with mobility impairments, individuals with chronic but not serious medical or health conditions, and individuals with mental impairments without other medical or health needs should be able to go to the nearest public emergency evacuation shelter closest to their home and be with their family if they have the ability to self-care or bring an individual with them who can attend to their unique needs. Public emergency evacuation shelters provide basic protection from the current disaster with minimum services and such locations provide 'only a roof over one's head' to protect individuals from the immediate harm of the disaster. To satisfy requirements for 'program access' for people with disabilities, sites must minimally include parking, accessible routes, enter/exit, and restrooms.

In addition, training is needed to accommodate individuals with disabilities who can use a Level I shelter. Sensitivity to the needs of individuals with disabilities and special health needs, as well as to the elderly, will help maintain a person with his or her family in the shelter. Training of volunteers who staff shelters will include such training. Training also needs to be expanded to include recruiting individuals with disabilities to staff shelters. Because someone has a disability, does not preclude the person from being able to assist others during a disaster. Anyone trained by the American Red Cross (ARC), as a shelter worker, including people with disabilities, will provide a valuable service as a shelter volunteer during a crisis.

Progress regarding retrofitting existing shelters:

- SCD identified spaces to use as emergency evacuation shelters, with the list subject to change. Retrofitting requires funding, thus progress is dependent on monies appropriated by the Legislature. SCD initiated legislation for funding to upgrade currently designated shelters each year since 2006. To date, the Hawaii State Legislature has not appropriated funds for this purpose. Legislation will be introduced again at the 2010 Legislative session. (2006 and ongoing)
- SCD and DCAB cross-referenced and identified the majority of community shelters to be located in DOE facilities using DCAB's database of schools that underwent Transition Plan or Architectural Barrier Removal renovations for disability access under HRS §103-50. This allowed SCD to target the selection of sites for hardening from a baseline of sites already known to be accessible. (2007)

Progress regarding increasing new shelters spaces:

- DCAB served as the Investigative Subcommittee on Accessibility to the State Building Code Council. This Subcommittee provided feedback to items that impact accessibility to persons with disabilities in new construction. When the State Building Code goes to public hearing, DCAB will submit comments. (2008, 2009)

- SCD initiated a bill at the Legislature to require new State buildings to be evaluated for suitability as an emergency shelter and to require qualifying new State buildings to be modified to serve as emergency shelters. However the bill was not passed by the Legislature. (2009)

- A Governor's Administrative Directive was drafted requiring plans for all newly constructed State buildings be reviewed by SCD to ensure that they have the capability to serve as public shelters in addition to the purpose for which they are primarily constructed. The directive is still pending finalization. (2006)

Progress regarding training Level I shelter workers:

- Pacific EMPRINTS sponsored a Conference January 22-23, 2009 that included a session conducted by Hawaii American Red Cross (ARC) staff entitled "Serving People with Disabilities Following a Disaster." The course was intended for individuals planning to be Red Cross volunteers in shelters to increase their capacity to work with people with disabilities. DCAB will collaborate with Hawaii ARC to train Red Cross volunteers with disabilities to work in shelters. (2009)

- ARC initiated a national, eight-hour course to train all shelter workers, including volunteers, on ways to best serve people with disabilities in the mass care or general population (Level I) shelter environment. The course is divided into a four-hour classroom setting and a four-hour individual self-study, online format. The online portion is open to anyone, while the classroom setting is limited to individuals considered part of an ARC "shelter team." Training involves many subject matter topics, of which disability awareness and sensitivity are just one component. Team members, registered with the ARC, are trained in advance of an actual emergency as the ARC recognized that conducting on-site training for people to work with individuals with disabilities or special health needs after an emergency starts is not practical. Training is limited, as ARC has only two (2) instructors available. (2008 and ongoing)

- ARC and SCD initiated and conducted statewide public emergency evacuation simulations and education fairs. The shelter simulations included both Level II and pet shelters spaces on the same campus where Level I shelters are located. DCAB assisted by contacting people with disabilities to volunteer at the simulations. (2007 and ongoing)

Progress regarding including people with disabilities in shelter awareness:

- DCAB identified the value of using volunteers with disabilities to work in shelters. Individuals with disabilities already understand some of the ramifications of having a disability, thus they may have more rapport working with individuals with disabilities arriving at the shelters. Individuals with disabilities wanting to volunteer as shelter workers must participate in training conducted by ARC. Trainings for individuals with disabilities to become shelter workers are planned for 2009. Trainings specifically for people with disabilities require a minimum enrollment of five (5) people to conduct the course. (2008 and ongoing)

Appendix C

Goal 2: The capacity of the community to "shelter-in-place" shall be increased.

The number of shelter spaces in the community is inadequate for the general population, let alone the additional requirements for individuals with disabilities or special health needs who may require additional assistance at less than the acute care level. Encouraging adult residential care homes, assisted living facilities, nursing facilities, other similar health care settings, community centers, and senior housing to shelter-in-place will allow individuals in such settings to continue to receive appropriate levels of care during disasters and other emergencies. Also, by increasing the capacity of the community to shelter-in-place, people will be made safe without the need to be transported (thus freeing up the transportation arteries) while providing more spaces in the public emergency evacuation shelters.

Sheltering-in-place serves several purposes: alleviation of traffic during an emergency, release of space in emergency evacuation shelters that are already inadequate to serve the general public, and provision of a safer, accessible home location and with more amenities familiar for individuals with disabilities.

The ARC defines "shelter-in-place" as a precaution aimed to keep a person safe while remaining indoors. When one shelters-in-place it may mean using a small, interior room, with no or few windows to take refuge. It does not necessarily mean sealing off the entire home or office building. Depending on the type of emergency situation that has been declared, instructions will be provided if people are told to shelter-in-place. Instructions on sheltering-in-place are provided on the ARC web site at http://www.redcross.org/services/disaster/beprepared/shelterinplace.html. Different instructions are provided if a person is at home, school, work, or in a vehicle. If there are any chemical, biological or radiological contaminants released into the environment, there may be a need for sheltering-in-place. If this type of emergency occurs, local authorities would provide information over the television or radio about how to protect oneself and family.

Progress regarding private shelter-in-place options:

- SCD intends to initiate legislation at the 2010 Legislature to provide money to offset costs for the planning, design, construction, and equipment for hardening a facility to shelter-in-place. (2009)

- SCD initiated a bill in the 2009 Legislature that supported shelter-in-place initiatives by exempting civil liability for care homes and schools, in addition to hotels, during an officially designated emergency. This measure was part of the Governor's package, but did not pass. (2009)

- SCD developed a site survey for use at care facilities, hotels and condominiums. Utilizing this survey, SCD conducted site surveys of care facilities, hotels, and

condominiums to determine what types of costs would be incurred for planning, design, construction and equipment for retrofits updates or hardening to permit sheltering-in-place. (2007 and ongoing)

- SCD identified the need to educate staff of long-term care facilities about the option of sheltering-in-place, recognizing that health care facilities house many of the community's most disabled residents. SCD and DOH-Office of Health Care Assurance (OHCA) coordinated efforts, utilizing U.S. Department of Homeland Security funding, to outreach to licensed group living facilities to focus on surveying the location for capacity to shelter-in-place and assisted managers in emergency readiness efforts. (2006, 2007, 2008) (Note: See Goal 5 for more information.)

Progress regarding shelter-in-place tax incentives:

- SCD plans to initiate legislation to support a tax credit for private owners, builders, developers, and care facilities to provide shelter-in-place options with new construction. The consensus of the Working Group was that any legislation involving tax credits for hardening facilities should be 10% of the cost incurred for renovations (instead of 4% as originally proposed) to offer a greater incentive to harden facilities for sheltering-in-place. (2008, 2009)

- SCD identified the need to make sheltering-in-place an incentive to health care providers by offering a tax credit for costs incurred to plan, design, construct or equip a facility to shelter-in-place. (2006)

Appendix D

Goal 3: The number and dispersion of public emergency evacuation shelters able to provide augmented health support with Level II shelter spaces shall be increased, with the long-term goal of having ALL public emergency evacuation shelters contain Level II shelter spaces.

Although facilities should not exclude people with mobility impairments due to architectural barriers, the nature and selection of sites, the lack of electricity and refrigeration at all sites, and the lack of adequate medical personnel make it unrealistic to expect every public emergency evacuation shelter site to be capable of rendering medical support with Level II shelter spaces in the immediate future. Hospitals are not the appropriate location, as their first priority must be caring for the acute medical patients in their facilities; secondly, supporting other acute care hospitals; and third, supporting the mission of public health.

Many individuals with disabilities or special health needs may be accommodated in a Level I shelter. Enhanced health/medical needs of individuals too ill/disabled to go to a Level I shelter, but not ill/incapacitated enough to go to a Level III shelter or hospital must be addressed in a Level II shelter. ARC volunteers at Level I shelters plan to do the initial triage and determine who may need the services of a Level II shelter. Individuals with disabilities will be allowed to have a caregiver stay with them at a Level II shelter to provide caregiving that will free staff to care for other patients. Therefore, a selected number of shelters should be designated to fulfill those needs. These spaces are Level II shelter spaces where Level II care can be provided. At the present time, all Level II shelter spaces planned are portions of Level I shelters, although in the long run, a freestanding shelter with only Level II spaces is an option. The long-term goal is to have all Level I shelters contain Level II shelter spaces.

Occupancy by an individual with a disability is likely to require more space than a person without a disability due to the possible presence of additional equipment, service animals, or a companion caregiver. Thus, determining an appropriate square footage minimum requirement is necessary for planning purposes. Currently ten (10) sq. ft. per person is used for the general population (for a Level II space) and approximately twenty (20) to forty (40) sq. ft. per person is used for a special needs Level II space to allow for auxiliary aids, equipment, and possibly a caregiver. These figures are for planning purposes only to calculate overall need and capacity.

The average occupancy rate of public evacuation shelters takes into account employees in the facility and individuals who may be visiting the building. During a disaster it may become necessary to go beyond the 100% occupancy rate. For employees' peace of mind, it is desirable to allow family members to be included in the number sheltered at a particular site. The figure was increased to 130% to address the inclusion of family members who may need to shelter at the site.

Progress regarding establishing and readying Level II shelter spaces:

- DOE and SCD collaborated on the Readiness and Emergency Management in Schools (REMS) grant. DOE was awarded money under the REMS grant that contains funding to purchase equipment. Purchase of generators are planned for hub shelters that include Level II shelters that may need electricity for refrigerating medication and/or food items for people with disabilities. (2008, 2009)

- SCD applied for funding from the Department of Homeland Security to outfit Level II shelters and is awaiting the status of funding. Prior year funding was not granted. (2008, 2009)

- SCD and DOE coordinated and identified hub shelters that will consist of Levels I, II and pet shelters. SCD provided a tentative list to DOE for the review and approval by school principals. A current list with notations for "Special Needs Shelters" and pet shelters is posted on the SCD web site. (2008, 2009)

- SCD designated DOE campuses with special education classrooms that included ADA compliant restrooms, showers and kitchens (which included refrigeration) as "special needs" shelter spaces. These spaces may accommodate Level I clients who need an accessible facility, or may be augmented with staff and supplies to serve as Level II shelters. (2007)

- SCD inspected and identified thirty (30) pre-designated public emergency evacuation shelters that could be used as Level II shelters. SCD selected initial Level II shelter spaces based on the physical characteristics of the schools and their geographic location (to ensure dispersion of sites island-wide and statewide). (2006, 2007)

- SCD initiated bills at the Legislature requesting funding ($6 - $10 million) for architectural barrier removal projects and transition plan alterations in DOE facilities. (2007, 2008)

- DOH was awarded a grant to develop the capacity to operate Alternate Care Sites (ACS). In the event of a disaster, DOH will co-locate ACSs with Level I shelters at selected "hub" sites to serve as Level II shelters. These sites will provide a low level of medical care. Supply caches have been purchased and are being positioned around the state. Training plans are being developed and implemented for DOH Public Health Nurses and volunteer Medical Reserve Corps. The initial total capacity of ACSs will be 1000 clients total. Future development is dependent on funding, but plans include expansion of identified staff, training, exercises, and purchase of additional supplies. During a disease pandemic, ACSs will be activated and may then be located at sites other than those designated as "special needs shelters." (2008 and ongoing)

- DOH and DHS collaborated and mapped the location of all facilities under their licensing jurisdiction on a GIS system recognizing that proximity to where people with Level II needs reside should be one factor to select shelter spaces. While the clientele may change, the facilities and their locations will be relatively stable for planning purposes. This information will be used to prepare public emergency evacuation shelters for the possible on-site impact during an emergency. Although mapped in 2007, there has been no consistent updating. (2007)

Progress regarding staffing Level II shelter spaces:

- DOH ACS staff developed a Disaster Alternate Care Site (DACS) and Pandemic Alternate Care Site (PACS) Plan and conducted an ACS tabletop exercise, using the recent H1N1 virus as discussion point. (2009)

- DOH PHNs, Oahu MRC, and Maui County Health Volunteers received training on the DACS and PACS plans. All counties are developing addenda to the DACS and PACS plans with county-specific information, including sites. (2008, 2009)

Appendix E

Goal 4: Individuals with disabilities or special health needs shall have an emergency evacuation plan in place developed by themselves or by their caregivers to implement in the event of a notification of evacuation.

Emergency readiness is first and foremost an individual responsibility or, in the case of those without the capacity to self-care, the responsibility of their caregivers. Communication is the lifeline of emergency management and is even more critical for persons with disabilities. Many are unemployed (and thus do not receive information from the workplace), socially isolated, homebound, or unable to benefit from customary means of communication because of sensory or cognitive limitations of their disability. A heightened outreach program using materials already developed by organizations including the ARC, through support groups and social service agencies such as Meals on Wheels, and community health nurses may be the best way to encourage individual readiness. Awareness and readiness messages and materials for persons with disabilities must be similar to those provided to the population at-large but also must be customized for specific groups based upon acknowledged limitations and likely problems to be encountered as a result of those limitations. A public and professional education campaign will increase the ability of these individuals with disabilities to plan and survive in the event of an emergency or disaster.

Progress regarding emergency planning efforts:

- Governor Lingle held a press conference (July 2009) to announce that SCD has developed "special needs" shelters and pet shelters as a part of the selected general population evacuation shelters. In her remarks she indicated that SCD has designated 158 "special needs" shelters and 55 pet shelters statewide. (2009)
- The Executive Office on Aging (EOA) will compile a database of agencies serving people who are elderly and conduct a survey of agencies to determine what type of emergency preparedness information is being provided to individuals who are elderly. (2009)
- DCAB updated a statewide database of agencies providing services to individuals with disabilities, and conducted a survey of these agencies to determine what emergency readiness information is being provided to consumers with disabilities or special needs on a regular basis. Collaborated with a consultant to compile a report titled "Emergency Planning for People with Disabilities 2008 Agency Readiness Survey." (2007, 2008)
- DCAB was awarded a grant from the Centers for Disease Control to conduct public forums with representatives from service agencies and individuals with disabilities statewide to obtain information about emergency preparedness and planning priorities in local communities. Collaborating agencies in this effort were SCD, ARC, Pacific Rehabilitation Research and Training Center, and the State Council on Developmental Disabilities. (2007, 2008)

Progress regarding community outreach and education efforts to develop individual emergency readiness plans:

- DOH-Adult Mental Health Division plans to work with the Developmental Disabilities Division (DDD) to develop and conduct training of clients on emergency preparedness and establish a GIS map to locate clients. (2009)

- DCAB began collaboration with the DOE under their REMS grant to educate teachers, families, and students with disabilities about emergency preparedness at home and in schools. Began planning to conduct a panel presentation at the Special Parent Information Network's April 2009 Conference and statewide conference for educational professionals in the fall of 2009. (2008, 2009)

- DCAB was awarded a grant and contracted with a vendor to produce two (2) videos to educate individuals with disabilities about how to prepare an emergency evacuation kit and shelter-in-place. DCAB consulted with DOH-DDD, SCD, ARC and individuals with disabilities to produce these videos. Completion date is estimated for fall 2009. (2008, 2009)

- The County of Maui continues to conduct public education on emergency preparedness to the community, as well as develop and identify resources for individuals who are not native English speakers. (2008 and ongoing)

- DHS and DOH collaborated by creating a working group with divisions from both Departments. Staff efforts were focused on client training through the development of tools or instruments to assist with readiness planning. (2007)

- DOH-DDD and DHS, ACCSB case managers met with pre-identified individuals, living alone or living with elderly parents or caregivers, unable to prepare their own emergency supplies. Education was provided to the individual, family and caregiver, as well as information about the closest evacuation shelter(s). Backpacks were purchased from ARC, as needed, and labeled to assist individuals with limited communication skills who plan to go to an evacuation shelter or may require medical care at the hospital post-disaster. A database with this information was also developed. (2007, 2008)

- The County of Hawaii's DHS office developed a presentation and conducted it for one hundred twenty (120) Senior Companions. The presentation emphasized helping elderly people have a realistic plan for their sheltering needs based on the availability of Level II shelters. (2007)

- DHS conducted a presentation for forty (40) Senior Companions on Oahu. It emphasized that elderly people should have a realistic plan for their sheltering needs based on the availability of Level II shelters. (2007)

- DOH-DDD conducted monthly classes on emergency preparedness for adult foster home caregivers. A more intense curriculum was conducted between April and December 2007 for adult foster home caregivers. Classes included a presentation, sample of "go-kits" from ARC, and a 20-minute film on hurricanes in Hawaii. (2007)

- DCAB and Hawaii Services on Deafness collaborated and co-sponsored a two (2) day training titled "Emergency Responders and the Deaf and Hard of Hearing Community: Taking the First Steps to Disaster Preparedness." The training was developed by Telecommunications for the Deaf and Hard of Hearing and conducted by a trainer from the Community Emergency Preparedness Information Network (CEPIN). Day one focused on emergency responders and the deaf and hard of hearing community taking the first steps to disaster preparedness. Day two was a trainer session to develop a pool of trainers (first responders and persons who are deaf) to conduct similar trainings in Hawaii. (2006)

Appendix F

Goal 5: Education shall be provided to all health care providers in order that appropriate emergency guidelines for health care facilities and/or residential settings are in place.

The Working Group identified group living arrangements categorized in Attachment A that are licensed by the State of Hawaii where a significant number of individuals with disabilities or special health needs reside. By definition, these individuals are not able to live independently in the community and thus reside in a setting where they are dependent, due to their disability or age, on the care of a paid provider. These providers are reimbursed for their caregiving services and are regulated by administrative rules and regulations, either federal or state or a combination of both, concerning health, safety, and other factors, as appropriate.

Concerns have arisen relative to the adequacy and appropriateness of the evacuation plans of these facilities and the care providers. The plans are developed as a condition of licensure but are not approved by the respective licensing authorities. Thus, incorrect assumptions or understanding of the function of community shelters and hospitals may result in inappropriate responses in an evacuation. Additionally, facility caregivers may face competing interests of protecting their own families while continuing to provide for those individuals with disabilities or special health needs in their custodial care. Efforts to ensure that the legal obligations to provide care are continued during a disaster or emergency whether sheltering-in-place or at a community shelter, should be increased.

Progress regarding education of health care providers and evacuation procedures:

- The County of Hawaii encourages new residential facilities (including health care facilities) to submit an all-hazards response plan through the Planning Department on a continual basis. Although the County does not review plans, facilities are encouraged to update them annually each spring. (2009)

- DOH recommended requirements to facilities regarding nutrition/food safety standards, and incorporated them into trainings. DOH continued ongoing efforts to ensure compliance. (2007)

- The City and County of Honolulu's Department of Emergency Management assisted health care providers by providing guidance and templates for them to develop necessary evacuation procedures. This assistance is made available to all levels of health care providers from individual care homes to large-scale clinical facilities. (2007)

- SCD reviewed the respective county guidelines and developed standardized statewide guidelines for distribution by DOH to all providers to use in the development of effective and appropriate disaster/evacuation plans. At the time of initial licensure, DOH reviews all policies and procedures and plans for compliance

guidelines, and annually during inspections/surveys reviews evacuation plans, observes the ability of the facility to execute effective drills. The focus is currently on fire safety. (2007)

- DOH and DHS collaborated to ensure that guidelines are shared with DHS certified/licensed settings/agencies in order to develop consistency between both Departments. (2007)

Progress related to inspection of facilities and sheltering-in-place:

- DCAB plans to invite representatives from the Condominium Association Institute, Area Agencies on Aging (AAA), and Catholic Charities to attend future Working Group meetings to begin working on plans to develop a means to assess privately-owned residential settings for senior citizens to determine whether it is appropriate to shelter-in-place. (2009)

- DOH, OCHA trained more than thirty-six (36) sites in emergency readiness and sheltering-in-place. Sites included assisted living facilities, adult residential care homes, Community Care Foster Family Homes, Developmental Disabilities Domiciliary Homes, Adult Foster Homes for the DD/MR, Therapeutic Living Programs and Special Treatment Facilities. After being informed of the criteria for sheltering-in-place, ten (10) facilities (including nursing homes) indicated a willingness and were referred to an engineer for follow up. The contractor provided attendees with documents and a CD to train their staff, residents and family members to ensure awareness about the need for emergency preparedness. (2008, 2009)

- SCD representatives made unannounced visits to a sampling of the providers to ensure that disaster plans have been developed and assessed those facilities that have indicated an interest in sheltering-in-place. (2008)

- DCAB was awarded funds from the Centers for Disease Control and selected a vendor to produce a video regarding sheltering-in-place. The video will be completed in the fall of 2009 and will be available on YouTube. Copies of the DVD will be distributed to agencies serving people with disabilities. (2008, 2009)

- SCD, DHS, DOH, and OCHA are collaborating to complete annual site visits to assist facilities in determining if it is safe to shelter-in-place. DOH entered into a memorandum of agreement with SCD to train community-based providers (also resident of these settings and family members) and simultaneously gathered data related to sheltering-in-place. (2007 and ongoing)

- SCD provided education and training, as well as assessments for sheltering-in-place. These efforts enhanced community awareness about being prepared to address disasters and the care of their residents/consumers, etc., during any disaster. (2006 and ongoing)

Appendix G

Goal 6: All notifications of pending emergencies and evacuation shall be accessible to persons with disabilities using multiple methods of delivery.

Notification of an impending disaster, time permitting, and the call to evacuate is initiated by the counties. People with disabilities or special health needs and their caregivers should expect to receive information through the same notification system as the population at-large, not through the social service or health systems, whose workers will be preparing for staffing the emergency as needed. However, the Working Group recognized that many people with cognitive or developmental disabilities may not understand the content of an announcement. For such individuals, dependence upon a caregiver, family, friend or social service/health agency is critical.

The Plan recognizes that no single means of notification will be sufficient, nor reach all disability groups. Therefore, redundancy of effort is critical to successful notification of the target population. The fact that "no one system will meet the needs of all, but many systems will meet the needs of a majority" must be emphasized to reach many groups with diverse needs and abilities to receive and comprehend a message.

The Working Group raised a concern that people with disabilities and special health needs do not all have access to computers or wireless technologies being addressed in the objectives. If the person, the family member or caregiver does not have access to a radio, television or computer/wireless technology (due to finances or geography), then personal planning becomes more important. This re-emphasizes the point that individuals with disabilities and special health needs, their families and caregivers are ultimately responsible to make plans for their own safety and well being for emergencies and disasters that may necessitate evacuation or sheltering-in-place. This may need to include developing a local network system with neighbors or a natural support group.

Planning and preparing on a statewide level includes research and investigation of alternatives, even though everyone may not have access to all options. Responsible planning efforts need to involve as many viable alternatives as possible, and through the repetition using various methods; the message will hopefully reach as many individuals in the public as possible.

Progress regarding agreements with broadcast media and agencies obtaining TTYs:

- DCAB plans to contact and arrange agreements with American Sign Language (ASL) interpreters to provide services through the Hawaii Registry of Interpreters for the Deaf and link them with television broadcasters. (2009)

- ARC e-mailed an online survey to ASL interpreters to obtain information about availability to interpret during a hurricane. (2009)

- SCD has agreements in place and has coordinated with television broadcasters as part of the Emergency Alert System (EAS). All EAS messages transmitted will be both as audio messages and video "crawlers." (2008)

- Not clear if a change in the law to require how emergency information is provided must be made at a local or national level. DCAB plans to contact the Federal Communications Commission to determine if a change is needed at the federal level to ensure all persons with disabilities are able to obtain such information in a manner similar to that provided to the general public. (2008)

- Agencies are responsible for purchase, installation and training of use on the TTY. SCD purchased and installed a TTY on a dedicated line. Currently, SCD is determining placement of the TTY possibly with the State Warning Point. DCAB conducted training for SCD on proper use of the TTY. Training needs to be ongoing due to staff turnover. DCAB will follow up with all County Civil Defense agencies regarding progress, installation and training on the use of a TTY. (2007 and ongoing)

Progress regarding accessible formats on web sites and alternatives to traditional notification systems:

- Follow up is needed with the City and County of Honolulu's Department of Emergency Management regarding accessible formats for web sites providing information on disasters. (2009)

- DCAB obtained an emergency preparedness kit from California that used graphics to make it easier to understand. DCAB plans to research ways to duplicate it for use in Hawaii. Materials developed for use by persons with developmental disabilities, would also be effective for people with limited English proficiency. (2009)

- The County of Kauai registered residents requesting service to a mass notification system called Connect-CTY, a free mass notification service allowing the County to inform residents about emergencies through a single phone call. Service also allows officials to send text messages to cell phones, PDAs e-mail accounts and TTYs. (2009)

- The County of Hawaii announced a new mass emergency notification system called City Watch. The system notifies residents about evacuations or other emergencies via the phone or e-mail. A pilot project uses maps with registered residents and targets specific communities on the island. Residents with disabilities or special health needs must voluntarily register for the system to contact them. (2008, 2009)

- The October 2007 statewide forums included feedback that focused on people with cognitive disabilities and notification. Messages need to include simple graphics or pictograms to make information understandable regardless of the individual's

reading ability. Warnings and emergency notification with graphics would also makes the message understandable to visitors with limited English proficiency, thus improving the understanding of warnings for everyone. (2007)

- The County of Hawaii initiated a demonstration project, Project Lifesaver, to track persons with Alzheimer's, Down's Syndrome, Autism or mental health issues or who tend to wander if unattended. Project Lifesaver used a bracelet with an electronic tracking system that uses an FM signal to locate the wearer. The tracking range is only within a few miles of the device. An active tracking device assists in locating the person quickly and can make the difference in saving a life. Project Lifesaver began with ten (10) bracelets, and eight (8) bracelets have been assigned to individuals. If the person wanders off it is easier for the person to be located if they were wearing a Project Lifesaver bracelet. The results of this demonstration project may have implications for how similar devices can be used during an emergency. (2007)

- The County of Maui has elected not to use the phone system for emergency notification because it is usually overloaded during an emergency even though the public is asked not to use the phone. (2007)

- SCD was awarded a grant from the Department of Homeland Security for a pilot project that continued through 2008. The pilot project initially was for first responders, and included slots for 500 people (300 for first responders and 200 for persons with disabilities). Once registered, a person with a disability is registered permanently. Exercises or practice drills were conducted in-house at SCD to refine the messaging system. Monthly tests conducted with registered users with predetermined dates given to users to know when to expect messages. Notification can be done through e-mail with special software to produce a pop-up on screen, cellular phone message, or TTY or pager message. If the message is not received, the user will know something is wrong and inform SCD to make the correction. (2006, 2007, 2008)

Appendix H

Goal 7: Individuals with disabilities or special health needs shall have an emergency evacuation transportation plan developed by themselves or their caregivers to implement in the event of notification for evacuation.

Past experience has revealed that any "emergency" will likely result in a massive transportation gridlock making travel very congested even with the availability of a personal vehicle or, in the case of Oahu, an operating public transit system. Therefore, it is necessary for all individuals, with and without disabilities or special health needs, to include transportation to a shelter or safe haven as an integral part of a personal emergency readiness plan.

Community input continued to emphasize that transportation for persons with disabilities living independently, but not able to drive or transport to a shelter, is as important an issue to address as developing accessible shelters. If individuals with disabilities or special health needs are unable to get to a shelter they may be left vulnerable in an unsafe community location. It was also emphasized that the development of a personal emergency evacuation plan (including transportation to and from the shelter) is an individual responsibility for a person with or without a disability. In an emergency the county transportation agency would take direction from the County Civil Defense or Department of Emergency Management agency. All county transportation systems will revert under the control of the county emergency management departments. Many emergencies (e.g., flood, earthquake) will not offer significant information to provide advanced notice.

Transportation system officials have also emphasized the need to protect vehicles from damage (due to a hurricane) to ensure their operability post-emergency. This may result in the shutdown of any public transit system earlier than the public realizes. For persons with disabilities and special health needs who may stay in their homes as long as possible with their own supports, the lack of transportation at the "12th hour" will be a huge problem.

County transportation agencies, especially on the Neighbor Islands where the population is smaller and more manageable compared to the City and County of Honolulu, may choose to establish working relationships with various health and human service agencies that maintain database(s) of client caseloads. Such information will assist in emergency transportation response, but should not be construed to be a registry maintained by the county either within the transportation agency or civil defense agency. Transportation options will vary and their effectiveness in response will depend on the type of emergency and the amount of lead-time that Civil Defense has to notify the community. It is also dependant on whether or not the transportation system is able to function during an emergency (i.e., in a tsunami, transportation may continue in non-inundation zones). Developing this type of cooperative arrangements with county service providing agencies would serve individuals with disabilities or special health needs if a situation exists that the person has no transportation to a shelter. In these situations, government may be the only option as a transportation provider.

To address this critical need at a statewide level, any transportation planning effort must be county specific, because regular, consistent, and accessible public transportation, either fixed-route or paratransit, is not available in every county in non-emergency situations as it is on Oahu. However, it was apparent during the October 2007 statewide forums that no transportation plans were being developed by government agencies for implementation during an emergency for either the general population or specifically for individuals with disabilities. When advanced notice is available (e.g., hurricane) transportation systems may operate until it becomes unsafe for both the drivers and the vehicles. Vehicles will most likely be prioritized to transport stranded groups or areas and will not be able to respond to individual requests. During such times, the general public, including individuals with disabilities and people with special health needs, will have to be vigilant about including transportation in their plan for emergencies and listen for announcements about what to do if they depend on someone else for transportation when a disaster occurs. The State and the counties also need to share the responsibility for safety of people in the community by collaborating, planning, and informing the public of any available accessible transportation options during an emergency.

Progress regarding development of county transportation operational service plans and community education:

- The City and County of Honolulu's emergency transportation plan during an emergency necessitating evacuation is for a person to be able to flag down a City bus. The bus will pick up the person and take them to the closest shelter. Enunciators on the bus will make announcements inside and outside the bus to inform the public of the emergency. The City plans to implement a public education campaign to inform residents and tourists of the transportation plan in case of an emergency. (2007, 2009)

- The County of Maui has not developed an operational transportation plan, because it is the individual's responsibility to develop a personal evacuation plan whether the person has a disability or special health need or not. An individual's plan should include transportation to and from the shelter, and public transportation should not be included as an option. (2008, 2009)

- The County of Kauai plans to practice the emergency evacuation transportation plan to assess whether or not it can be effectively executed. Following the practice, if the plan is not workable, it will be amended. (2009)

- The County of Hawaii will rewrite the County Emergency Operating Plan to include the use of mass transit system for evacuation of individuals with disabilities. (2009)

Progress regarding integrating transportation options into personal emergency readiness plans:

- The County of Maui proposed a new objective related to case managers of clients with disabilities known to DOH and DHS will review current personal emergency plans to ensure it contains a transportation component. Any new plan developed by case managers should include transportation to and from a shelter. (2009)

Appendix I

Acronyms

ACRONYM	MEANING	DESCRIPTION
AAA	Area Agency on Aging	County agencies focusing on the needs of people who are elderly
ABR	Architectural Barrier Removal	Removal of physical barriers in an existing building that restricts access to the building for a person with a disability.
ACS	Alternate Care Site	A temporary facility to provide care for individuals with minor medical or special health needs in the event of a displacement due to a disaster or an emergency. Not a substitute for a hospital, but provides ancillary care to decrease the volume of patients going to a hospital for minor problems. Depending on the disaster, may be considered a level II shelter because of level of care and staff.
ADA	Americans with Disabilities Act	Civil rights law passed in 1990 to protect people with disabilities from discrimination in employment, state and county government services, transportation, services from private businesses, and telecommunication.
ARC	American Red Cross	Organization that was chartered to help relieve the suffering caused by disasters. Provides health and safety training to disaster volunteers who respond regularly to house and apartment fires, and are prepared for larger disasters like hurricanes, tsunamis, and floods.
ARCH	Adult Residential Care Home	Residences licensed by the State of Hawaii's Department of Health, Office of Health Care Assurance. Licensed homes can accept and care for adults with special needs.
CDC	Centers for Disease Control and Prevention	An agency of the U.S. Department of Health and Human Services that provided funds through their Public Health Emergency Preparedness Cooperative Agreement to support the statewide Emergency Preparedness Forums for persons with disabilities and special health needs. The CDC works to protect public health and the safety of people, by providing information to enhance health decisions, and promotes health through partnerships with state health departments and other organizations.

ACRONYM	MEANING	DESCRIPTION
CIL	Centers for Independent Living	A consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities; and provides an array of independent living services.
CMISB	Case Management and Information Services Branch	Provides outreach to the community, including community education and information to identify and provide necessary supports to individuals with developmental disabilities. Provides Home and Community-Based Services for individuals with developmental disabilities and mental retardation.
DDD	Developmental Disabilities Division	An agency within the State of Hawaii's Department of Health.
DHS	Department of Human Services	Provides programs, services and benefits, to empowering people who are the most vulnerable in Hawaii.
DOH	Department of Health	Protects and improves the health and environment for all people in Hawaii.
DOT	Department of Transportation	A State department in the Executive Branch of government that is responsible to plan, design, construct, operate, and maintain State facilities in all modes of transportation, including air, water, and land.
FEMA	Federal Emergency Management Agency	A federal agency that is part of the U.S. Department of Homeland Security responsible for the reduction of the loss of life and property and protect the Nation from all hazards, including an established location/facility in which local and State staff and officials can receive information pertaining to an incident and from which they can provide direction, coordination, and support to emergency operations, natural disasters, acts of terrorism, and other man-made disasters, by leading and supporting the Nation in a risk-based, comprehensive emergency management system of preparedness, protection, response, recovery, and mitigation.

ACRONYM	MEANING	DESCRIPTION
GIS	Geographic Information Systems	An information system used to input, store, retrieve, manipulate, analyze and map geographically referenced data or geospatial data. Can be used in planning and decision making for scientific investigation, resource management, and development planning.
HRS	Hawaii Revised Statutes	Codified permanent State laws in Hawaii passed by the State Legislature.
MOA	Memorandum of Agreement	A cooperative agreement in the form of a written document between parties to cooperatively work together on an agreed upon project or meet an agreed upon objective. May include money payment from one party to another.
MRC	Medical Reserve Corps	Statewide volunteer program housed in the Department of Health
SHN	Special Health Needs	For the purpose of this Plan, it is an individual who may have special health needs that require medical care or assistance beyond what the person can do for him or herself during an emergency.
SCD	State Civil Defense	The State agency responsible for preparation for and the carrying out of all functions, other than functions for which military forces are primarily responsible, to prevent, minimize, and repair injury and damage resulting, or which would result, from natural disasters or others caused by an attack.
TTY	TeleTYpewriter	Device that allows people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate. Allows the user to type text messages. A TTY is required at both ends of the conversation in order to communicate. Like a traditional modem for land-lines, a traditional TTY will only work on analog mobile phone networks, not digital. Therefore a special digital TTY mode must be used with digital mobile phones.

Appendix J

Glossary of Terminology

TERM/PHRASE	SCOPE	DEFINITION
Access or Accessibility	During readiness and notification of a disaster or emergency.	People with various types of disabilities are included (instructed when needed), in planning for an emergency or disaster, and responsible agencies are familiar with and provide accessible alerts to the public, in order to ensure everyone is aware of the situation. Planning also includes ensuring that people with disabilities can enter, exit and receive services at designated public emergency evacuation shelters.
Accommodation	During readiness and notification of a disaster or emergency.	In terms of emergencies and disaster, agencies responsible to assist people with disabilities in personal preparedness and notification are also responsible to ensure effective communication (i.e., provision of interpreters, print materials in alternate format, etc.) is occurring. Notifications on television stations should be captioned (and interpreted, if possible), and any crawl messages should be narrated. Making public emergency evacuation shelters accessible is also a government responsibility, and plans are being made and implemented. Accommodations for individuals to have equal access to services available at a public shelter are also being made, but are not yet operational. County transportation providers are currently working on plans regarding getting people with disabilities to and from public emergency evacuation shelters.
Action Plan	Interagency Action Plan for the Emergency Preparedness of People with Disabilities and Special Health Needs	A coalition of State, county and private agency representatives that convened to draft the “2006 Interagency Action Plan” to acknowledge the interests of people with disabilities or special health needs, and make it part of overall community efforts in planning, developing and responding to the entire community during an emergency or a disaster. The Plan is updated annually.

TERM/PHRASE	SCOPE	DEFINITION
Harden	"To harden a facility"	To reinforce a home or facility to protect it against hurricane force winds.
Notification	Systems used to alert the public of impending disasters or emergencies such as, sirens, television and radio announcements, text messages, pagers, digital signage, and the Internet.	Systems used to rapidly disseminate accurate emergency information before, during and after a disaster to protect life, to prevent or limit casualties and minimize chaos.
Pet	Pets provide companionship to many people, and are dependent on their owners for safety and wellbeing. Recent disasters have shown that many pet owners will not seek proper shelter if it means abandoning their pets.	Any domesticated animal (i.e., cat, dog, etc.) that is kept as a companion.
Pet friendly shelter	Act 117 from the 2006 Hawaii State Legislature requires the Director of State Civil Defense to operate and maintain emergency shelters during disasters to make suitable arrangements and accommodations for pets.	Administrative rules shall be promulgated, pursuant to Section 128-27, HRS, to establish criteria, requirements, conditions, and limitations for providing suitable arrangements and accommodations for the sheltering of pets in public shelters.
Preparedness	Actions taken to save lives before and during a natural disaster. It ensures people are ready for a disaster and respond to it effectively.	Requires figuring out what to do if essential services break down, developing a disaster plan, and practicing the plan. Preparedness activities include forecasting and warning systems, stocking an emergency preparedness kit with supplies, and knowing where the nearest emergency shelter is.
Readiness	Personal preparedness including actions that individuals take before a disaster or emergency strikes.	Actions taken by an individual to minimize the damage from a disaster or emergency to possessions and improves chances of survival.
Redundancy	Repeating, doing, or providing the same information to the public in various formats.	Providing information through various modes of communication allows the majority of the public to receive emergency warnings in a manner that is accessible to the specific individual.
Retrofit	To add or change a facility or home to make it able to withstand a specific kind of wind force (Level III, IV or V hurricane).	To furnish with parts or equipment after the time of original manufacture.

TERM/PHRASE	SCOPE	DEFINITION
Reverse 911	Automated warning system from 911 to wired telephone numbers in a specific jurisdiction.	A company who purchased the software can purchase a database of telephone numbers from the phone company, overlay mapping on it, and set up the capability to call a lot of people at once on their home phone with a short voice message about the emergency and a warning to evacuate.
Service animal	An animal, in Hawaii it's usually a dog, individually trained to provide services for a person with a disability.	The ADA defines a service animal as any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. Certification about the animal's training may not be requested as proof that the animal is a service animal. A service animal is not a pet, and per the ADA, a person with a disability who uses a service animal has the right to have the animal accompany them to most public places.
Shelter-in-place	When a person, family or group of individuals decide to stay at home through a disaster, instead of going to a designated shelter.	When sheltering-in-place, it is better to have a safe room installed for protection. If the facility is not certified as a shelter, it may be unsafe to stay in place.
Simulation	Planned activity to allow volunteers and the community to practice evacuating to an emergency shelter.	Emergency shelter simulations for Level I (general) shelters, pet shelters and Level II shelters were conducted by State and County Civil Defense agencies in conjunction with American Red Cross this year. Practicing evacuating to an emergency shelter in the community provides everyone involved the opportunity to practice what is planned (similar to a fire drill). It allows the volunteers to interact with people with disabilities and special health needs coming into a shelter, as well as people with disabilities to know what to expect at an emergency shelter and what types of information to bring with them. It also provided the American Red Cross and State Civil Defense to better plan staffing ratios needed in similar shelters.

Appendix D: Intrastate Funding Formula (IFF)

The Executive Office on Aging is the designated State Agency responsible for developing an Intrastate Funding Formula (IFF) to distribute Older Americans Act(OAA) Title III funds to its Planning and Service Areas (PSAs). The IFF reflects the best available data on the geographic distribution of the characteristics of individuals aged 60 and older in the State of Hawaii.

Under the OAA, older adults with the "greatest economic need" and "greatest social need" are given preference. The "greatest economic need" is defined as the need resulting from an income at or below the poverty line as defined by the Office of Management and Budget and adjusted by the Secretary for the U.S. Department of Health and Human Services (DHHS). The "greatest social need" is defined as the need caused by non-economic factors which include: physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently.

I. Goals for Hawaii's IFF

The following goals were developed for Hawaii's IFF:

1. Follow OAA provisions and program instructions concerning intrastate funding formula development.

2. Distribute funds in a fair and equitable manner.

3. Consider the following distribution among planning and service areas (PSAs):
    a) Adults age 60 and older
    b) Adults age 60 and older with greatest economic need
    c) Adults age 60 and older with greatest social need
    d) Adults age 60 and older who are low income minorities
    e) Adults age 60 and older living in rural areas

4. Ensure open, adequate, and inclusive discussion on factors and their definitions, base amounts, and weights.

II. Assumptions for Hawaii's IFF

In selecting factors for the IFF, the EOA made the following assumptions:

Low Income: Older persons with income at or below poverty will have difficulty meeting the costs of daily life and health care.
Low Income Minority: Many low income minority persons disproportionately experience social and economic hardship or challenges.

Disabilities: Older persons with physical and mental disabilities, whatever the causes, require a variety of support services to remain independent in their own home or in the community.

Language Barriers: Many older persons who are unable to speak English or speak English "not well" may have limited access to information and services and may require additional support services.

Geographic Isolation: Many older persons who live in rural areas are often isolated from family and friends and formal support services. In addition, isolated areas may not have the service infrastructure to provide needed support services.

III. IFF Factors and Their Definitions

Section 305(a)(2)(c) of the Older Americans Act (as amended in 2006) stipulates that the state agency (EOA) shall use "best available data" in developing the IFF. The IFF factors and their definitions are shown below.

IFF Factors and Their Definitions

Factor	Definition and source
Age 60 years and over	American Community Survey, (ACS) Three Year Estimates (2005-2007)
Greatest Economic Need (125% FPL)	Defined as Age 65 and over, and income below 125% FPL. Source: American Community Survey, Three year estimates (2005-2007)
Low income minority (100% FPL)	Defined as 65 yrs and over and non-white (total minus whites only), and income below FPL. Source: American Community Survey, Three Year Estimates (2005-2007)
Unable to perform 2 ADL; using census data 65 or older	Defined as: 65 yrs and over, and having "two or more types of disabilities". Source: American Community Survey, Three years Estimate (2005-2007), Table: B18001
Speak English not well and not at all; 65 or older from census data	U.S. Census Bureau, Census 2000 Special Tabulation, updated with 2002 60+ estimates.
Older population in rural areas	U.S. Census Bureau, Census 2000 Special Tabulation, updated with 2002 60+ estimates.
Density of older population in the PSA	American Community Survey, Three Year Estimates (2005-2007)
Living alone in Poverty	Aged 60 years and over, below poverty level, and living alone. Source: Census 2000

Based on the data definitions, the following data was used in deriving Hawaii's IFF:

A Listing of Population, Economic, and Social Data Used

		PSA 1	PSA 2	PSA 3	PSA 4	
		KAEA Kauai	EAD Honolulu	MCOA Maui	HCOA Hawaii	Total
Factors						
Older adults (OA) /1		12159	175197	24299	31623	243278
Greatest Economic Need (GEN)/2		1007	14660	1752	3128	20547
Low-Income Minority /3		633	9784	695	1327	12439
Disabilities (DA) /4		1711	28237	3165	5333	38446
Language barrier (LB) /5		934	19414	2355	1765	24468
Geographic Isolation (GI) /5, 6		10992	5920	16227	18363	51502
IPD						
	Total older population/1	12159	175197	24299	31623	243278
	Land area (square mile)	622.44	599.77	1172.41	4028.02	6422.64
	Population density	19.53441	292.107	20.72568	7.8507555	37.87819
	Inverse ranking	0.401894	0.026876	0.378794	1	0.207263
Living Alone in Poverty/7		275	4110	580	980	5945

/1 American Community Survey, Three Year Estimates (2005-2007), Table B01001
/2 Defined as Age 65 and over, and income below 125% FPL. Source: American Community Survey, Three year estimates (2005-2007), Table B17024
/3 Defined as: 65 yrs and over, non-white (includes Hispanic), income below FPL. Source: American Community Survey, Three Year Estimates (2005-2007), Table B17001
/4 Defined as: 65 yrs and over, and having "two or more types of disabilities". Source: American Community Survey, Three years Estimate (2005-2007), Table: B18001

/5 U.S. Census Bureau, Census 2000 Special Tabulation, updated with 2002 60+ estimates.
/6 A rural area is: any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.
/7 Census 2000 Special Tabulation on Aging (STA), 2004. Table P087_HI.

IV. Numerical Statement of Hawaii's IFF

The detailed IFF formula for each category is shown below.

	Part B	Part C1	Part C2	Part D	Part E
Base Amount	$128,758	$75,600	$12,375	--	--
Factors					
Older adults (OA)	0.25	0.25	0.25		0.25
Greatest Economic Need (GEN)	0.20	0.20	0.20	0.40	0.20
Low-Income Minority (LIM)	0.10	0.10	0.10	0.20	0.10
Disabilities (DA)	0.19	0.19	0.19	0.10	0.19
Language barrier (LB)	0.07	0.07	0.07	0.08	0.07
Geographic Isolation (GI)	0.10	0.10	0.10	0.14	0.10
Living alone in poverty (LAP)	0.03	0.03	0.03	0.08	0.03
Inverse Population Density (IPD)	0.06	0.06	0.06		0.06

Weighted Proportions Formulas

After the base amounts are granted, the following formula is used to calculate the proportion of the remaining funds each PSA will receive.

Formula #1: Part B, C1, C2, E:

.25(***p***OA) + .20(***p***GEN) + .10(***p***LIM) + .19 (***p***DA) + .07(***p***LB) + .10 (***p***GI) + .03(***p***LAP) + .06(***p***IPD)

Formula #2: Part D

.40(***p***GEN) + .20(***p***LIM) + .10(***p***DA) + .08(***p***LB) + .14(***p***GI) + .08(***p***LAP)

p *is the proportion a PSA has of a specific factor.*

Based on the weights and the data above, the summary weighted proportions of each is shown below:

		PSA 1 **KAEA** Kauai	**PSA 2** **EAD** Honolulu	**PSA 3** **MCOA** Maui	**PSA 4** **HCOA** Hawaii
Part B	Supportive Services	7.458%	62.961%	11.700%	17.881%
Part C1	Congregate Meals	7.458%	62.961%	11.700%	17.881%
Part C2	Home-Delivered Meals	7.458%	62.961%	11.700%	17.881%
Part D	Preventive Health	7.087%	65.103%	11.313%	16.498%
Part E	Family Caregiver Support	7.458%	62.961%	11.700%	17.881%

V. Descriptive Statement of Hawaii's IFF

Part B
Each PSA will receive a base amount of $128,758. The remainder of the funds will be distributed using the weighted proportion formula #1.

Part C1
Each PSA will receive a base amount of $75,600. The remainder of the funds will be distributed using the weighted proportion formula #1.

Part C2
Each PSA will receive a base amount of $12,375. The remainder of the funds will be distributed using the weighted proportion formula #1.

Part D
No base amount. Funds will be distributed using the weighted proportion formula #2.

Part E
No base amount. Funds will be distributed using the weighted proportion formula #1.

VI. Demonstration of Allocations of Title III Funds to PSAs

Based on the weighted proportions formulas and assuming funding at 2010 level, the allocations for the PSAs are as follows (FFY 2011 projected allotment):

	PSA 1	PSA 2	PSA 3	PSA 4
	KAEA (Kauai)	EAD (Honolulu)	MCOA (Maui)	HCOA (Hawaii)
Part B	$222,974	$924,138	$276,563	$354,647
Part C1	$178,481	$944,131	$236,999	$322,264
Part C2	$89,044	$659,611	$132,651	$196,190
Part D	$7,678	$66,727	$13,925	$16,800
Part E	$56,934	$480,637	$89,317	$136,502
Total	**$555,111**	**$3,075,244**	**$749,455**	**$1,026,403**

VII. Additional Notes

State Administrative and Title VII Allocations

The amount available for IFF allocation is calculated by subtracting from the State's total Title III grant $500,000 for the State to carry out the purposes of Title III (OAA Section 308(b)) and $45,000 to conduct an effective Ombudsman program under OAA Section 703(a)(9) and OAA Section 304(d)(1)(B)). Administrative funds for EOA will be taken from Part C1. Ombudsman funds will be taken from the Part B.

Services for older adults residing in rural areas

Pursuant to OAA Section 307(a)(3)(B)(i), with respect to the services for older individuals residing in rural areas, the State will spend, for each fiscal year, not less than the amount expended for such services for fiscal year 2000.

Appendix E: Glossary

1. Programs, Services, and Activities:

Adult Day Care/Adult Day Health: Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day.

Assisted Transportation: Assistance and transportation, including escort, to a person who has difficulties using regular vehicular transportation.

Attendant Care: The service provides primarily stand-by assistance, supervision or cues, and may include other activities to help maintain the independence of older adults.

Case Management: Assistance either in the form of access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers or family caregivers.

Chore: Assistance such as heavy housework, yard work, or sidewalk maintenance for a person.

Congregate Meal: A meal provided to a qualified individual in a congregate or group setting. The meal meets all of the requirements of the OAA and State/Local laws.

Home Delivered Meal: A meal provided to a qualified individual i his/her place of residence. The meal is served in a program administered by State Units on Aging and/or AAAs and meets all the requirements of the OAA and State/Local laws.

Homemaker: Assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.

Information and Assistance: A service that: a) provides individuals with information on services available within the communities; b) links individuals to the services and opportunities that are available within the communities; c) to the extent practical, establishes adequate follow-up procedures.

Legal Assistance: Legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.

Outreach: Intervention with individuals initiated by an agency or organization for the purpose of identifying potential clients or their caregivers, and encouraging their use of existing services and benefits.

Nutrition Counseling: Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers.

Nutrition Education: A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.

Personal Care: Personal assistance, stand-by assistance, supervision or cues.

Respite: Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers.

Transportation: Transportation from one location to another. Does not include any other activity.

2. Other Definitions

Aging and Disability Resource Center (ADRC): An entity established by a state as part of the state system of long-term care, to provide a coordinated system for providing: a) comprehensive information on the full range of available public and private long-term care programs, options, service providers, and resources within a community, including information on the availability of integrated long-term care; b) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; c) consumers access to the range of publicly-supported long-term care programs for which consumers may be eligible, by serving as a convenient point of entry for such programs.

Aging Network: The network of State agencies, Area Agencies on Aging, Title VI grantees, and the administration and organizations that are providers of direct services to older individuals or are institutions of higher education, and receive funding under the OAA.

Older Americans Act: An Act to provide assistance in the development of new or improved programs to help older persons through grants to the states for community planning and services and for training, through research, development, or training project grants, and to establish within the Department of Health, Education, and Welfare, and operating agency to be designed as the "Administration on Aging".

Title III: The purpose of Title III is to encourage and assist State agencies and Area Agencies on Aging to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated systems to serve older individuals by entering into new cooperative arrangements in each State with the persons in State agencies and Area Agencies on Aging; other State agencies, including agencies that administer home and community care programs; Indian tribes, tribal organizations, and Native Hawaiian organizations; the providers, including voluntary organizations or other private sector organizations, of supportive services, nutrition services, and multipurpose senior centers; and organizations representing or employing older individuals or their families, for the planning, and for the provision of supportive services and multipurpose senior centers, in order to secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive services; remove individual and social barriers to economic and personal independence for older individual; provide a continuum of care for vulnerable older individual; and secure the opportunity for older individuals to receive managed in-home and community-based long-term care services.