NEW HAMPSHIRE
SYSTEMS TRANSFORMATION

FINAL EVALUATION REPORT

UNIVERSITY OF NEW HAMPSHIRE
NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OCTOBER 2010
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New Hampshire’s Systems Transformation Grant project implemented a comprehensive strategy to rebalance the system of supports for older adults and for adults with disabilities from a primarily provider-driven, medical model of care to a consumer-directed, person-centered system of supports. The State has accomplished many of the goals established in the comprehensive strategy. Systems change is not a quick or easy process and the five years of systems transformation funding, 2005-2010, has provided the initial impetus and support necessary to stimulate this change. But, these five years are only the beginning and the New Hampshire Department of Health and Human Services (NH DHHS) must continue the work begun through this initiative.

The Bureau of Elderly and Adult Services (BEAS) within NH DHHS was awarded the Systems Transformation Grant in 2005 with funding ending in 2010. Leadership and staffing for the project was led by BEAS. A contract was established between BEAS and the Institute on Disability (IOD) at the University of New Hampshire to provide project management, technical assistance and evaluation for the project. Subsequently, the University of New Hampshire Survey Center and New Hampshire Institute for Health Policy and Practice were retained for the evaluation portion of the grant.

The evaluation results on this project paint a mixed picture of accomplishment towards system rebalancing. The majority of the objectives and strategies identified with Goal 1, access, and Goal 2, choice and control, have been accomplished. The experiences of the Goal 4, IT, have been mixed. However, the activities and program outcomes achieved under the System’s Transformation Grant were externally successful in bringing stakeholders together to inform system change, implementing a highly successful person-centered training across the state, streamlining the eligibility process, expanding access to community based programs for frail adults to needed areas of the state, and leveraging the broad range of CMS Real Choice grants to move New Hampshire closer to a consumer-directed, person-centered system of supports.
CHAPTER II
DATA SOURCES – BRIEF DESCRIPTION

*A complete technical report can be found in Appendix A.

GRANITE STATE POLL (GSP)

Data about public awareness of long-term supports generally, and ServiceLink specifically were collected using the Granite State Poll, a quarterly survey of New Hampshire adults conducted by the UNH Survey Center.

REFER7 DATABASE

The State of New Hampshire Department of Health and Human Services (DHHS), Bureau of Elderly and Adult Services (BEAS) maintains, and has full administrative management of the Refer7 license and contract with RTM Designs.

The data within the database is populated and maintained in partnership with the 10 ServiceLink Resource Center (SLRC) contracts and their staff. Contact, client, referral, follow up, and unmet need data are all recorded by staff of the SLRCs statewide. Each Center Manager has the authority along with BEAS to pull data reports as needed.

SERVICELINK CONSUMER SATISFACTION SURVEY

The University of New Hampshire (UNH) Survey Center in partnership with the 10 statewide ServiceLink Resource Centers (SLRC) conducts an ongoing consumer satisfaction survey.

MEDICAID DECISION SUPPORT SYSTEM (MDSS)

The Medicaid Decision Support System (MDSS) utilizes the Advantage Suite application from Thomson Medstat Corporation to report and analyze paid claim information from the New Hampshire’s Advanced Information Management (NHAIM) system. The NHAIM system is a fee for service claims processing and payment system, which supports provider management, prior authorization, and service history maintenance.

NH DHHS-BEAS OPTIONS SYSTEM

Elderly & Adult Services (EAS) Options is an information system application used to:

- Manage BEAS social worker caseload,
- Manage the adult protection program and State Registry,
- Manage service authorizations, and provider payments related to the Social Services Block Grant (SSBG) and the Older Americans Act (OAA) services, and
- Manage medical eligibility, case information, and service authorizations for the Medicaid Home and Community Based Care for the Elderly and
Chronically Ill (HCBC-ECI) waiver, Money Follows the Person and Nursing Facility programs.

**NH PARTICIPANT EXPERIENCE SURVEY**

The Participant Experience Survey (PES) project interviewed a representative sample of Home and Community Based Care Services Elderly and Chronically Ill waiver participants about the services and supports they receive. The Home and Community Based Care Services Elderly and Chronically Ill waiver program, formerly known as HCBC-ECI, has been renamed the Choices for Independence (CFI) program.
CHAPTER III
SYSTEMS TRANSFORMATION OVERVIEW

MISSION STATEMENT:
To create a dynamic and enduring community-based system of long-term supports so all New Hampshire citizens may live and age with respect, dignity, choice and control until the end of life.

VISION STATEMENT:
All New Hampshire citizens have access to the full array of long-term supports and services. This allows them to exercise personal choice and control and affords them dignity and respect throughout their lives. To the greatest extent possible, each of us is able to make informed decisions about our aging, health, and care needs. There is a high level of quality and accountability in everything offered and in everything provided. Over time, New Hampshire truly becomes an extended community of people who care about, value, and help one another.

Why is long-term care systems transformation important in New Hampshire

For decades New Hampshire has led the country in community services and supports for people with developmental disabilities and mental illness. Its long-term care (LTC) system for elders has lagged behind and was disjointed and highly dependent on nursing homes. The most significant areas of weakness identified in 2005, the year the Centers for Medicare and Medicaid Services (CMS) Systems Transformation Grant (STG) was awarded to New Hampshire, were barriers accessing home and community-based services, choice and control over those services, and lack of information and technology for people who are aging and/or have disabilities. Transforming the long-term care system is important to address these weaknesses; therefore activities aimed at balancing the money spent between institutional care and home-based care and creating a person-centered service delivery system were the major focus of the five year grant.

In 2005, New Hampshire spent $237,000,000 on nursing homes compared to $29,000,000 on home and community-based services for the elderly and chronically ill. At that time, New Hampshire Department of Health and Human Services (NH DHHS) had projected that LTC costs would grow from $183.6 million in 2000 to $279.5 million in 2005, to $390.1 million in 2010 and to $557.7 million in 2015. These projections did not
include the financial implications associated with Medicare Part D and “dual eligibles”. Clearly, the state could not sustain this level of growth within the LTC system and changes were needed to rebalance the system and control costs.

The cost of LTC was a major driver of the need for a comprehensive approach to systems change; however, in 2005 there was also a significant need to bolster the development of access, choice and control projects across the LTC system. In essence, to support the work of moving from a provider-driven system to a person-centered system. The focus of a person-centered system is on the individual, their assets, and their network of family and community supports in developing a flexible and cost effective plan to allow maximum choice and control over the supports necessary to live in the community. Within a person-centered system, individuals and providers work in full partnership to guarantee that each person’s values, experiences and knowledge drive the creation of an individualized plan as well as the delivery of services and supports. Person Centered Planning (PCP) is recognized as an important vehicle for empowering individuals to have a voice in the planning process and actively shape their futures.

The NH DHHS started the culture and paradigm shift in 1997, with the enactment of Senate Bill 409, which recognized that that LTC is a continuum and people have the right to choose the kind of care they want to receive and to have control over how that care is provided. Building on this statement of legislative intent, Senate Bill 324 was enacted in 2001 and established a consumer-directed personal care model for Medicaid recipients. This model was extended to those individuals paying privately in 2003. While these legislative efforts certainly provided a foundation for a person-centered system, participants in stakeholder meetings held in New Hampshire to discern the current status of the system identified many barriers to fulfilling this vision. Barriers such as an ingrained medical model of service delivery; workforce shortages in home and community-based programs; lack of funding and consensus on who should pay for LTC services; and competing rules, laws, and regulations across the spectrum of programs dealing with LTC.

Both balancing the cost of the system and shifting to a person-centered model of service delivery could only be achieved by the third major area identified in 2005, improving the information and technology system. Several factors have led to a fragmented information and technology system: the provider-driven system, the decentralization of programs through the implementation of the Aging and Disability Resource Center (ADRC) project, the increasing number of programs and departments which touch LTC, and the fragmented and insufficient funding streams for technology. New Hampshire recognized the need to streamline the information technology system which serves all LTC programs in order to achieve all other system transformation goals.
Where New Hampshire started

In 2005, New Hampshire stakeholders spanning the private and public LTC system completed a “systems readiness assessment.” Through a series of key stakeholder meetings, an assessment of the state’s current LTC system was completed and areas for focus identified. Eight areas were summarized in the 2005 application for Systems Transformation Grant funding; however, only seven are presented in this report. The area of housing was not a focused goal of New Hampshire’s STG or any subsequent activities. Please refer to the original grant application for more information.

One area of assessment was examining the extent to which the system has a shared vision. In the fall of 2001, NH DHHS, Bureau of Elderly and Adult Services (BEAS) embarked upon a public process to develop a vision and mission statement through statewide community meetings. The vision developed read: “The NH long-term support system is person-centered, promoting the right and ability of individuals, families, and caregivers in need of supports to exercise choice and direction, thus maximizing the independence, dignity, and quality of life of the individuals receiving care.” While the vision statement was not officially adopted by BEAS prior to 2005, it was used as a starting point for the STG project in the development of a shared vision statement (the statement is included on page 4).

The second area of assessment occurred in relation to the ease of access to LTC services. Prior to 2005, there was no single statewide coordination point, except for the state Medicaid agency, nor was there a single system that delivered uniform, non-duplicative programs and supports. Established in 2000, ServiceLink attempted to respond to the lack of coordinated care for seniors. It was a statewide network of locally-administered, community-based resources for seniors, adults with disabilities and their families. It primarily offered information and supported referral and did not have a formal service function. Building on the ServiceLink effort, in 2003, the State received an ADRC Grant that became the vehicle for advancing a single point of entry concept for older adults and adults with disabilities. In 2005, the ADRC model was field-tested in Belknap and Strafford Counties, and with two more pilots implemented in 2006. Statewide roll-out was anticipated by 2007. The model is known as ServiceLink Resource Centers (SLRC) in New Hampshire.

When fully implemented statewide, the SLRC model’s vision was to ensure that all older adults and individuals with disabilities in New Hampshire will have a single, inviting, accessible, culturally competent, and trusted place in their communities that will provide effective delivery of information and referral, counseling, education, and case management support related to LTC. The SLRCs will promote informed choice and self-direction, as well as support family caregivers.
Consumer-directed services was the third assessment area. Since the early 1990’s, the developmental disabilities and independent living communities have led the transformation to a self-directed system. Both long-term care and mental health have lagged behind. In 2005, BEAS had only two programs which incorporated significant features of consumer-directed care programs. They were the Personal Care Services Program (PCSP) provided under the HCBC-ECI waiver program and the state plan Personal Care Attendant (PCA) program. The remaining programs were delivered under the more traditional, provider-managed model.

An assessment of the quality management system was also completed in 2005. New Hampshire’s efforts on quality improvement at that time were taking place under the CMS Real Choice Systems Change Quality Assurance Quality Improvement (QA/QI) Grant awarded in October of 2004. The grant provided the structure needed for management of the HCBC-ECI waiver and was producing a replicable template that could be modified and adopted for use in all state waiver programs. An area of focus for the quality assurance grant was risk management. A process looking at both administrative and clinical processes was put in place. In addition, BEAS was focusing on developing a standardized clinical assessment tool and had established a quality workgroup. The workgroup included both internal and external stakeholders. The Participant Experience Survey was being adopted under QA/QI for use in evaluating the experience of participants within the HCBC-ECI waiver program.

The fifth area of assessment was information technology. In 2005, a variety of stand-alone, separate automated systems was in place under the larger umbrella of the LTC system. There was no common platform, standards, or architecture. The systems included the NewHEIGHTS benefit financial eligibility determination system for public assistance programs. NewHEIGHTS was the primary system for daily Medicaid recipient eligibility data to the State’s Medicaid Management Information System (MMIS). MMIS is the Medicaid claims processing and information retrieval system that supports administration of the State’s Title XIX and Medicaid-related programs. New Hampshire has a ‘modular’ MMIS comprised of distinct primary system components that interface with each other, including the New Hampshire Advanced Information Management (NHAIM) claims processing and payment system which supports provider management, prior authorization, and service history maintenance; the Pharmacy Benefits Management (PBM) system for processing of pharmacy claims, payment, and drug rebate management; and the Medicaid Decision Support System (MDSS) which is a Medicaid data repository.

Rebalancing of funding efforts between institutions and community-based services was a major assessment area. Prior to 2005, efforts to rebalance funding streams were active. Senate Bill 409 enacted revisions to the Medicaid matching share formula for LTC. The bill resulted in County and State governments equally sharing matching requirements for nursing home care, related medical services to Medicaid
nursing home recipients, and HCBC-ECI program services and related medical services provided to HCBC-ECI recipients. Increases in enrollments in home and community-based care versus nursing home placement since the enactment of Senate Bill 409 had been made. In 1998 the average monthly caseloads in home care was 1,282 while nursing homes were at 5,106; a difference of 3,824. By 2004, home care average monthly caseloads were 1,940 and nursing home 4,808; a difference of 2,920. While spending under Medicaid-funded nursing home expenditures had been controlled between 1999-2001, the funding allocation between institutional care (64%) and home and community-based care (36%) was out of balance, especially when comparisons to other states’ funding balance and consumer preferences to remain in home and community-based settings are taken into account (Coleman, Fox-Grage & Folkemer, 2002).

Lastly, an assessment of New Hampshire’s interagency and intra-agency collaboration was completed. A planning meeting with a broad range of LTC stakeholders met to plan for the submission of the Systems Transformation grant proposal. A sub-group discussed interagency and intra-agency collaboration and identified areas of collaboration and remaining challenges. Areas of current collaboration can be found in the original application. Areas where challenges to true collaboration still existed in 2005 were identified as:

1) Lack of a stable, collaborative cross-disability vision or strategy;
2) Collaborative efforts tend to be funding dependent, issue specific, and/or agency specific as inter/intra agency collaboration is not a core value “built into” or practiced by the system;
3) Increasing needs of people who are aging and acquiring disabilities and people with disabilities who are aging create greater competition for available resources;
4) Many stakeholders such as those representing minority and low-income communities are left out of collaborative processes due to lack of appropriate supports to participate;
5) Lack of strong collaboration across state departments; and
6) Lack of institutionalized processes to feed information about barriers at the community level to the state.

OVERVIEW OF NEW HAMPSHIRE’S SYSTEMS TRANSFORMATION GRANT ACTIVITIES AND ACHIEVEMENTS

The New Hampshire Department of Health and Human Services (NH DHHS) commitment to enhancing access to home and community-based services to prevent unnecessary institutionalization led to the STG application. The activities outlined were
intended to implement a comprehensive strategy to rebalance the system of supports for older adults and adults with disabilities from a primarily provider driven, medical model of care to a participant-directed, person-centered system of supports. In many respects, the State has accomplished this goal. The majority of the objectives and strategies identified with Goal 1, access, and Goal 2, choice and control, has been accomplished. The experiences of the Goal 4, IT, have been mixed. The State’s strategy was to utilize the activities identified as part of Goal 4 as means to accomplish Goals 1 and 2. While specific activities were planned to support these goals, many were dependent upon the implementation of the State’s new MMIS, which has been delayed for a variety of reasons.

The BEAS was awarded the STG in 2005 with funding ending in 2010. Leadership and staffing for the project were led by BEAS. A contract was established between BEAS and the Institute on Disability (IOD) at the University of New Hampshire to provide project management, technical assistance and evaluation for the project. Subsequently, the University of New Hampshire Survey Center and New Hampshire Institute for Health Policy and Practice were retained for the evaluation.

Significant progress has been made by BEAS in creating the culture change necessary to move from a medical model, provider driven system to a more person-centered/consumer driven model. There are significant challenges ahead and much work to be done, but the framework has been put in place to continue this forward movement. Key accomplishments include:

- Community Listening sessions were held in 17 communities and comments from over 355 people who attended these sessions were compiled and used to inform systems change efforts.
- Person centered planning has been embraced throughout the service delivery system.
- A participant directed model, including individualized budgeting, has been implemented.
- The Seniors Count model of community partnerships has been replicated in two communities.
- Quality assurance mechanisms now include the Participant Experience Survey in order to fully listen to the voice of program participants.
- A Coalition has been formed to address issues related to the direct care workforce.
- Sustainability of system transformation initiatives and accomplishments through programmatic changes, cultural shifts, and new funding sources to support continued change efforts.
NH has been successful in obtaining various Real Choice grants, funded by CMS, that have supported systems change throughout the long-term services and supports system. STG activities across the five-year project were diverse yet integrated and built on initiatives developed through previous Real Choice Systems Change grants.

Principles of a person-centered system were developed by a committee comprised of consumers, advocates, community providers, and state agency staff. The work of the STG around implementing Person-Centered Planning is integrated across many aspects of systems change. Community and state staff working in the Community Passport (New Hampshire's Money Follows the Person initiative), for all six independent case management agencies, in Transitions in Care giving (the AoA Nursing Home Diversion project), at several Service Link Resource Centers, as well as at numerous other community agencies, have been trained in person-centered planning. Trainings in person-centered planning are conducted four times a year throughout the state and have been very well received. A training manual is being completed and will be published in the fall of 2010. The New Hampshire legislature passed a law in 2007 mandating person-centered planning in long-term care services. This solidifies New Hampshire's commitment to person-centered planning for all persons regardless of age, disability or residential setting.

A participant directed service model with in the HCBC-ECI has been designed and enrollment in this service began in July, 2010. Participant directed services were first piloted through Transitions in Caregiving, an AoA funded caregiver support program.

New Hampshire's application for renewal of its HCBC-ECI was submitted in the spring of 2007. This filing was timely in that efforts underway within the Real Choice grants were able to be included in this waiver renewal. Additional amendments are forthcoming with new services available under consumer direction and Money Follows the Person.

Quality assurance mechanisms that support a person-centered system have been designed and implemented. A core component of the quality assurance system is the Participant Experience Survey, which has been conducted twice, 2008 and again in 2010.

The Service Link Resource Centers (SLRC), New Hampshire’s ADRC project, assures that people receive information about resources in a clear and effective manner; that eligibility for services is determined in an efficient and responsive manner; and that communities are engaged to support all people. The STG project supported the development of competencies for the Long Term Support Counselor position which is a key position in each SLRC. The development of these competencies is a step closer to assuring the quality delivery of information about resources related to options counseling. The SLRC’s touch all of the system change initiatives providing the
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community connection for state initiatives. For example, the Transitions in Caregiving project is implemented through the SLRC network.

The STG leveraged other federal and state funding opportunities to advance its work. Examples include:

- The STG strategic plan informed the development of New Hampshire’s MFP Operational Protocols;
- The state was able to expand the availability of consumer directed service models to both the Medicaid and non-Medicaid populations; and
- The MFP project was the pilot for a quality assurance/risk management tool.

The role of the community in LTC has been strengthened through the replication of the Seniors Count model in 2 communities, along with the implementation of a project designed to prevent institutionalizations and hospitalizations by building on the social capital in the Lakes region. Legislation was passed to enable communities to establish community care and services planning boards and training has begun to help communities establish such boards.

The STG project supported the establishment of the New Hampshire Coalition for the Direct Care Workforce (CDCW) to address the critical shortages within the direct care workforce. The CDCW has conducted a survey of workers and completed a white paper outlining a number of policy issues (appendix C). The annual Real Choice conference in 2009 focused on the direct care workforce and the coalition presented the results of the survey and white paper. The coalition has also done a significant amount of work with the legislature. A LTC Caucus was established during the 2008/2009 legislative session and coalition representatives provided information and assistance to them. In the fall of 2009 a legislative briefing was conducted to share the results of the workforce survey and white paper. The white paper was the basis for New Hampshire’s application to the Department of Labor and subsequent grant award to develop trainings and increase the direct care workforce labor market. The project, now known in New Hampshire as DirectConnect, utilizes the CDCW as its advisory board.

In addition to understanding the formal supports needed for home and community-based services, the STG allowed New Hampshire to begin to understand the informal supports. Not only through the parallel work under the Transitions in Caregiving grant, but through the collection of data through the 2009 and 2010 Behavioral Risk Factor Surveillance Survey (BRFSS) Caregiver module.

All STG activities and subsequent successes took place with the guidance of stakeholders and supports across the LTC system. Of significance, is that the mission, vision, and values statements developed by the STG planning group have been adopted by the Department of Health and Human Services and several other groups related to
Long Term Care. They were recently adopted by the Long Term Care Caucus, established through the Legislative Committee on Elderly Affairs.

The State attempted to fulfill the work promised under Goal 4 by using other information technology applications; e.g., the use of Lotus eForms and web-enabled ADRC resource data base, to enhance and increase access to services and to promote choice and control for consumers.

Information technology improvements have been utilized across all of these efforts to improve the efficiency and effectiveness of service delivery. Laptops and electronic signature pads have been purchased for all nurses who do medical eligibility determinations for the HCBC-ECI waiver, which has greatly decreased the amount of time to complete assessments and determine eligibility. The utilization of technology to connect parts of the long-term care service delivery system that are related but have previously functioned independent of one another is another promising practice. Two examples are expanding the use of the OPTIONS system, an internal tool, to independent case managers and ADRC staff, and automating the Medical Eligibility Determination form. Including external partners in the use of these IT-related tools improves the efficiency and effectiveness of our business practices, which will result in better access to services for our consumers.

New Hampshire has been able to effectively coordinate the work across all Real Choice grants and other systems change initiatives to leverage resources to promote systems transformation. Support for transforming New Hampshire’s system of community-based long-term care is widespread, including the Governor's office, legislators, Department of Health and Human Services, community providers, families, and individuals. Efforts have been coordinated across all Real Choice grants, but specifically with the ADRC, the QA/QI, the Person-Centered Planning, and the Home Care Connections grants. New Hampshire is also a recipient of a Money Follows the Person award and this work has been closely integrated into the overall systems transformation effort. The Operational Protocols for the Money Follows the Person Project are informed by the Systems Transformation Grant strategic plan.

This summary of activities spanning the five-year grant period demonstrates the diverse yet integrated work in New Hampshire. The experiences of the State were definitely affected by its financial shortfall; however, despite a 25% vacancy rate and cutbacks in services, New Hampshire was able to use its Systems Transformation Grant to create an environment that is supportive of systems change that will used as the state moves toward the implementation of the Health Care Reform legislation.
**Looking forward**

New Hampshire’s STG project was intended to implement a comprehensive strategy to rebalance the system of supports for older adults and for adults with disabilities from a primarily provider-driven, medical model of care to a consumer-directed, person-centered system of supports. In many respects, the State has accomplished this goal. Systems change is not a quick or easy process and the five years of systems transformation funding has provided the initial impetus and support necessary to stimulate this change. But, these five years are only the beginning and the NH DHHS is committed to continuing the work begun through this initiative.

The STG implementation has demonstrated the necessity and value of unifying the long-term care eligibility application process. Having separate processes for medical eligibility and financial eligibility was identified as the biggest barrier affecting access timely to services and consumer-centered services. The New Hampshire DHHS plans to combine the two eligibility processes beginning January 2011.

Trainings in person-centered planning will continue to be held throughout the state to further disseminate knowledge and expertise in person-centered thinking. BEAS will continue to roll out individual budgeting through the participant-directed HCBC-ECI waiver program and through the New Hampshire Caregiver Support program. The Service Link Resource Centers continue to be developed as the one-stop resource for information, referral, and options counseling in New Hampshire. Most importantly, a culture of person-centered thinking is beginning to take root and is influencing policy and programmatic decisions at every level of the Long Term Care system.

The work of the STG has also informed the ADRC project in New Hampshire. Under the 2009 ADRC Enhancement Grant, a person-centered approach to hospital discharge planning is being developed, ongoing streamlining of processes under the long term care system is being evaluated, and a comprehensive evaluation of the long term care system is being designed.

Lastly, the NH DHHS is reviewing the opportunities under The Patient Protection and Affordable Care Act to enhance the states’ long-term care systems. New Hampshire is reviewing the provisions and considering opportunities to further enhance access to person-centered, home and community-based care options.
CHAPTER IV
GOAL 1: IMPROVED ACCESS TO LONG TERM CARE SUPPORT SERVICES

OVERALL GOAL ACTIVITIES:

To achieve Goal 1: Improved Access to Long Term Care Support Services, a structure was established for collaboration, participation, and oversight. Key participating organizations include the ServiceLink Resource Centers, independent case management agencies, community home health agencies, community action programs, AARP, developmental services agencies, community mental health centers, local hospitals, Home Health Agencies, the Aging Network, legislators, advocates, Granite State Independent Living, Seniors Count in Manchester, and other community-based providers. The Real Choice Advisory Council, the statewide consumer advisory group established in 2001 to guide the work of the Real Choice grants in NH, assumed oversight responsibility for the Systems Transformation Grant implementation. Consumer participation on this council, as well as advocates and long term care professionals, actively provided meaningful feedback to the Project Team.

Community listening sessions were held throughout the state of New Hampshire in 2008. Over 350 community members attended these forums, over 250 of whom were consumers/consumer representatives. The State Committee on Aging collaborated with BEAS and the IOD to organize and host these forums. The forums elicited feedback on the current status of community services, ideas for improvement, and issues of concern. A report on the Community Listening Sessions (appendix E) documents the involvement of consumers and consumer representatives in achieving Goal 1. The findings are used by NH DHHS to inform long term care policy and make changes to processes to improve access to service.

New Hampshire’s ADRC model, the ServiceLink Resource Centers, achieved statewide implementation by the end of 2007. SLRCs cover the entire state, with offices located in each of New Hampshire’s ten counties; three counties support additional satellite offices. According to a March 2008 assessment from The Lewin Group (New Hampshire: Progress towards a Fully Functioning Single Entry Point System/ADRC), the major ADRC strengths in New Hampshire are: 1) Integrated/centralized ADRC, achieved through co-location of eligibility staff; 2) State has achieved statewide ADRC coverage; and 3) ADRCs represent true single entry point in terms of maintaining a comprehensive database of resources and services, providing options counseling, required referral to ADRC for pre-admission screening, uniformity and consistency across multiple sites, and training and professional development of staff. This achievement provides the infrastructure necessary to implement several STG goals.
In concert with the expansion of the ADRC model to improve access, the Seniors Count model, which originated in Manchester, NH, was expanded to two additional communities. Seniors Count is a partnership working to ensure that frail seniors can live and age in their communities. This model has been effective as a catalyst to convene community partners to effect systems change at the community level. Through the STG, this model has been replicated in the Seacoast region and in the city of Nashua. A community project to mobilize volunteer resources was also implemented in the Lakes Region of NH to build social capital to support local seniors.

The collaboration, participation, and oversight established above were a key to achieving Goal 1. In addition, The Participant Experience Survey (PES) conducted in 2008 and 2010 documents the experiences of HCBC-ECI participants in accessing long term-care services and was a key to evaluating systems change. Other keys to system evaluation for Goal 1 included a survey of the direct care workforce (which led to the completion of an issue brief and white paper) and the addition of the Behavioral Risk Factor Surveillance Survey (BRFSS) Caregiver Module to the Granite State Poll in 2009 and New Hampshire’s state BRFSS in 2010. These evaluation activities are utilized in understanding the success of New Hampshire’s long-term care systems transformation and will provide guidance for moving forward.
Objectives

Objective 1: Provide awareness, information, and assistance

1) Increased rate of public awareness of home and community long-term care supports. (p.18)
2) Increase in rate of ADRC consumer contacts. (p.23)
3) Analysis of gaps between service need and service availability. (p.24)
4) Increase in number of community partnerships. (p.25)

Objective 2: Target individuals who are at imminent risk for admission to an institution

1) Decrease in rate of nursing home admissions of HCBC-ECI consumers. (p.27)

Objective 3: Streamline multiple eligibility processes

1) 80% of data required for eligibility determination for HCBC-ECI serves is collected at the consumer’s first encounter with the process. (p.31)
2) Length of time (days) between initial application for service and medical determination of eligibility for HCBC-ECI services. (p.31)

Objective 4: Reduce the imbalance between increased demand and capacity to deliver home and community-based services

1) Wait time for initiation of home and community-based services decreases (p. 36)
2) 90% of participants report that their needs are being met. (p.41)
ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 1; OBJECTIVE 1

ACTIVITIES FOR OBJECTIVE 1: PROVIDE AWARENESS, INFORMATION, AND ASSISTANCE

Goal 1, objective 1 has four metrics of measurement to assess public awareness, utilization and availability of services, and community partnerships across the LTC system in New Hampshire. The activities to achieve these objectivities span outreach, education, and technical assistance. Transformation of the long-term care system in the state is based in the culture change necessary to move from a medical model, provider driven system to a more person-centered, consumer driven model. Training in person-centered thinking is a critical first step in achieving this type of systems change. Initial trainings were held with all BEAS staff on person-centered services as well as the array of initiatives underway within BEAS that support person-centered services. This training was then expanded to include all community providers and key stakeholders.

Under outreach, three legislative educational sessions were held in January and February, 2007 to educate legislators about the need for LTC reform and the initiatives currently underway and proposed. STG project staff also gave presentations at numerous forums and agency meetings across the state. Annual Real Choice conferences continued to be held in 2006, 2007, 2008, 2009, and 2010. Each year the themes, keynotes, and breakout sessions have provided long-term care system change information and opportunities for feedback from professionals and consumers.

BEAS held 18 community listening sessions for consumers, families, and providers. The State Committee on Aging, the advisory group for BEAS, was an active partner in developing and hosting these sessions. Over 350 people attended forums and provided input. The findings of the 18 consumer listening sessions have been published (appendix E) and DHHS made presentations on the findings to key legislative policy committees. The results are guiding policy and programs throughout the department.

Technical assistance was provided to expand community partnerships through the expansion of the Seniors Count, a community collaboration designed to support frail seniors to remain in the community, in two other communities- Nashua and Portsmouth. STG program staff also provided technical assistance in the development of New Hampshire House Bill 717. This bill enables communities to establish Community Care and Service Boards to assess and plan for the needs of all residents.

Technical assistance was also provided to the QA/QI grant in developing a brochure to inform families and recipients about the availability and scope of HCBC-ECI waiver services and to explain the program more clearly for families and participants.
The name of the waiver program was changed to Choices for Independence to reflect the shift to a more person centered focus within the program.

Several key public policy changes have been enacted to support these systems transformation efforts. The following laws have been passed by the New Hampshire General Court since 2007:

- Person-centered planning is required in all long-term care services;
- Presumptive eligibility in the 1915 (c) Waiver for the Elderly and Chronically Ill has been implemented;
- Municipalities have been given the authority to establish community care and service board; and
- A statewide person-centered caregiver support system has been established.

**OUTCOMES FOR OBJECTIVE 1: PROVIDE AWARENESS, INFORMATION, AND ASSISTANCE**

**Objective 1.1.1**

*Increased rate of public awareness of home and community long-term care supports*

The primary gateway that has been established for the general public to access long-term care supports has been the ServiceLink Resource Centers which have been established in each New Hampshire County. We anticipate that general public awareness of SLRCs would proceed slowly as most New Hampshire residents are not in immediate need of these services. Public opinion research has long shown that public awareness of most issues, and especially those that do not impact the public directly, is typically low.
There has been a slow but steady increase in public awareness of New Hampshire’s SLRCs since they were first instituted in 2005 (Figure 1). Currently, 28% of New Hampshire adults express some level of familiarity with SLRC, up from 19% in 2005. This increase is statistically significant ($\chi^2=13.204$, df=1, p<0.001). However, there has been only a slight increase in the percentage who say they are very or somewhat familiar, from 10% in 2005 to 15% in 2010.

**Figure 1**

Familiarity with information service called ServiceLink Resource Center

*Source: Granite State Poll*
There is higher awareness of SLRCs among those most likely to need its services (those 50 and older, Figure 2). The increase in awareness of SLRCs among this population is statistically significant from 2005 to 2010 ($X^2=9.696$, df=1, p=0.002). This increase is also evident in those who say the are very or somewhat familiar from 9% in 2005 to 19% in 2010 ($X^2=9.911$, df=1, p=0.002).

**Figure 2**

Familiarity with information service called ServiceLink Resource Center
Respondents 50 or older

*Source: Granite State Poll*

New Hampshire adults are confident they can find out about how to get long-term support services if someone in their household needed them (Figure 3). There has not been a significant increase in the percentage who are confident they can find out about services in their community. There has also been no change in confidence among respondents 50 or older who would be most likely to need these services (Figure 4).
Figure 3
Confidence to find out about how to get long-term support services in community if you or someone in your household needed them

*Source: Granite State Poll

Figure 4
Confidence to find out about how to get long-term support services in community if you or someone in your household needed them: Respondents 50 or older

*Source: Granite State Poll
When asked who they would contact to find out more about long-term support services most people mentioned they would contact a health care provider, followed by government agencies, home care agencies, word-of-mouth, media and other sources (Figure 5). Most recently, approximately one-tenth report they would not know who to contact. There are significant increases from 2005 to 2010 in those who mention they would contact a medical provider or a state or local social service agency. The pattern of information sources has remained largely unchanged for the years 2005 and 2010.

**Figure 5**

*Who would you contact to find more info on long-term support services? (Multiple responses possible. Percentages may add to more than 100%)*

*Source: Granite State Poll*

Overall, objective 1.1.1 has been met, but there is room for additional growth in awareness of services and sources of referral for services.
Objective 1.1.2
Increase in rate of ADRC consumer contacts

There has been a steady increase in the number of people who have accessed SLRCs in New Hampshire as they have expanded to encompass the entire state in 2007. Better awareness of SLRC also seems to have resulted in greater usage. The Medicare Part D implementation in 2006 resulted in a large increase in the volume of calls to SLRCs.

The increase between 2008 and 2010 is largely due to SLRCs in the two largest New Hampshire counties, Hillsborough and Rockingham, transitioning to fully-functional ADRC models (Figure 7). Since 2008, usage in most counties has stabilized, indicating that SLRCs have either reached their maximum capacity or are reaching most of the people who need the information and referral they provide. Objective 1.1.2 has been met.

Figure 6
Total Number of SLRC Contacts

*Source: Refer7 Database*
Objective 1.1.3
Analysis of gaps between service need and service availability

In order to determine if there are significant unmet needs, a question was added to the SLRC Customer Satisfaction Survey in 2009 that asked if a SLRC customer’s needs were met when they received a referral from SLRC. Approximately 95% of SLRC customers say that their needs were met (Figure 8) and approximately 85% strongly agree with this assessment. There was no significant change in this measure between 2009 and 2010, although the initial results were high.

While this indicator may not fully measure the unmet needs of the entire population of older adult and adults with disabilities, it does indicate that the SLRC’s do an excellent job in how they refer customers. The state continues to work to find appropriate tracking and measurement of gaps in service need and availability.
Objective 1.1.4  
*Increase in number of community partnerships*

The Seniors Count model of community collaboration was replicated in the city of Nashua and the Seacoast area. Both communities have established strong partnerships which will continue beyond the grant period. Both communities are pursuing further funding opportunities, but are committed to continuing to work together, regardless of funding. The Lakes Region Partnership for Public Health, Inc. was also funded to develop a community partnership. The theme of their campaign is “Neighbors Helping Neighbors” and the intent is to engage, educate and empower citizens to work together to ensure that unmet needs are met.

In addition to the community models, the collaborative nature of the project’s early planning period has been a factor in developing and sustaining other community
partnerships with nursing homes, case management agencies, hospital discharge planners, home health and other community agencies. Registered nurses from these agencies have assisted the State in securing the information necessary to establish an individual’s clinical eligibility for long-term care, thus decreasing the time it takes to process a long-term care application. The relationships established through these collaborative activities have had other good outcomes for consumers’ access to services; for example, inter-disciplinary teams are convened at the local level to problem-solve difficult situations that present barriers to service access.

**ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 1; OBJECTIVE 2**

**ACTIVITIES FOR OBJECTIVE 2: TARGET INDIVIDUALS WHO ARE AT IMMINENT RISK FOR ADMISSION TO AN INSTITUTION**

Goal 1; Objective 2 has one metric to assess the success of New Hampshire’s effort to rebalance the long-term care system from one heavily weighted towards institutional care. Activities required addressing the systems biases toward nursing home admissions for persons seeking long-term care services.

Individuals who are at imminent risk for admission to an institution have become a critical focus of State policy formulation and budget development, from the perspective of both consumer choice and a cost containment strategy. With this emphasis, the project’s activities related to Objective 1.2 are viewed as strengthening legislative and departmental priorities. The project has been involved with outreach and training efforts with hospital discharge planners, nursing homes, case managers, service providers, and caregiving families to identify and utilize community supports to maintain vulnerable individuals in the community.

Early in the grant period a community forum was held to design a rapid response team model. Based on the input received, it was determined that this model would not meet the identified needs. A follow up meeting with community stakeholders was held to talk about respite and caregiver needs at the community level. It was determined to develop community pilots to address caregiver needs and discharge planning instead of the Rapid Response Team. A pilot project was implemented in the Laconia region. In addition, the STG informed the current work related to person-centered hospital discharge planning under the ADRC 2009 Enhancement Grant.

Systems transformation efforts have influenced initiatives throughout the long-term care system, supporting NH’s work at rebalancing. These include: 1) The establishment of Elder Wrap teams in most local communities that focus on the needs
of persons in challenging and complex situations; 2) Changes in ECI Waiver processing that transferred the responsibility for care plan development from the nursing staff to case managers, which have streamlined service access; 3) Long Term Support Counselors at the ADRCs conduct the Instrumental Activities of Daily Living (IADL) assessment, which frees up the nursing staff's time to focus on the clinical assessment (both the IADL and clinical assessment are used to determine the service plan under the HCBC-ECI waiver); 4) Clinical determinations of level of care for some programs are now handled at the community level instead of centrally, which reduces the time between application and the initiation of service; 5) Presumptive eligibility for the HCBC-ECI Waiver has been implemented; 6) Changes in the Family Caregiver Support Program, which has implemented a consumer-directed model managed at the community level, have been implemented statewide; 7) Continued program development has occurred in the Adult Family Care alternatives; 8) The SLRC have better coordinated linkages with hospital discharge planners; 9) An informed decision-making protocol for long-term care has been developed by an inter-disciplinary work group that includes nursing homes and hospitals; 10) There has been increased outreach and utilization by the Community Passport Program, NH's Money Follows the Person Program; and 11) BEAS received an AoA-funded Alzheimer’s Supportive Services Grant that is providing training to family caregivers, primary care physicians, case managers, and other service providers on effective ways of serving this population in the community.

**OUTCOMES FOR OBJECTIVE 2: TARGET INDIVIDUALS WHO ARE AT IMMINENT RISK FOR ADMISSION TO AN INSTITUTION**

**Objective 1.2.1**

*Decrease in rate of nursing home admissions of HCBC-ECI consumers*

State budget shortfalls have resulted in rate reductions for long-term care providers and reductions in the number of service units for consumers, both in the Medicaid-funded programs as well as the Social Service Block Grants and Title III programs. These latter programs have traditionally served as the safety net for those low-income frail and disabled individuals who do not qualify for Medicaid but who lack the resources to pay for their own care. While it is too soon to determine if these reductions have been factors in driving institutional utilization, BEAS is experiencing an increase in the number of home health agencies who are no longer willing to accept Medicaid rates.
Figure 9 displays the percentage of HCBC-ECI eligible clients who have entered nursing facilities or who have enrolled in the HCBC-ECI waiver program (Choices for Independence) between 2005 and 2010 (this does not include hospitalized HCBC-ECI eligible participants). The percentage of persons who participate in the HCBC-ECI waiver has increased from 29.4% to 37.7% during this time frame while the percentage of eligible persons who enter nursing facilities declined 12% during this time (from 70.6% to 62.3%).

*SOURCE: NH DHHS – Medicaid Decision Support System (MDSS)*
While the cost of providing care has increased for both participants receiving care in nursing facilities and those on the HCBC-ECI waiver, the per capita costs of the HCBC-ECI waiver continue to be significantly less expensive than providing care in a nursing facility (Figure 10). Expenditures for persons receiving the waiver cost approximately half as much as those for persons receiving care in nursing facilities. Increasing the number of participants receiving care at home should result in significant cost savings to the state in future years.

*SOURCE: NH DHHS – Medicaid Decision Support System (MDSS)*
ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 1; OBJECTIVE 3

ACTIVITIES FOR OBJECTIVE 3: STREAMLINE MULTIPLE ELIGIBILITY PROCESSES

The evaluation metrics for Goal 1; Objective 3 assess another barrier to access of long-term care services, i.e., the multiple eligibility processes. Considerable work has been done on both the financial as well as the medical eligibility determination processes for long-term care; however, the two processes are still distinct and are administered by two different organizational entities within DHHS. The Division of Family Assistance, which oversees financial eligibility, has completed an analysis of the eligibility processes using a LEAN process improvement model. One of the recommendations of the analysis was to establish a unit specifically dedicated to processing financial eligibility for long-term care. At present, this function is performed by the same staff who process financial eligibility for Temporary Assistance for Needy Families, Supplemental Nutrition Benefits, State Supplement payments, and Medicaid State Plan services.

The STG project has collaborated with the ServiceLink Resource Centers to streamline the multiple eligibility processes. Competencies for long-term support counselors (SLRC staff) were recently developed and address the ability for the counselors to understand and communicate the eligibility process to prospective consumers.

Activities also included the purchase of electronic signature pads, the establishment of SLRC staff’s access and use of Refer7 system and OPTIONS systems, publication of a consumer’s guide to the eligibility process which outlines requirements and time frames for each step of the eligibility process, and implementation of presumptive eligibility for some Waiver applicants. The Medical Eligibility Determination (MED) process was revised to include multiple community providers in the process.
OUTCOMES FOR OBJECTIVE 3: STREAMLINE MULTIPLE ELIGIBILITY PROCESSES

Objective 1.3.1
80% of data required for eligibility determination for HCBC-ECI serves is collected at the consumer’s first encounter with the process

The original metric was changed. The metric for measuring the streamlining of eligibility processes is now reflected in objective 1.3.2.

Objective 1.3.2
Length of time (days) between initial application for service and medical determination of eligibility for HCBC-ECI services

In 2009, as a result of staffing shortages in its nursing staff, which adversely impacted the ability to process long-term care applications in a timely way, BEAS authorized nursing facility nurses who were trained in the clinical eligibility process to complete the MED form for new admissions. The MEDs were then transmitted to the State Office where they were reviewed and eligibility determined by the State Nurse. At the same time, a similar change was occurring in the HCBC-ECI Program. State nurses who were formerly assigned to the State’s ADRC sites were reassigned to the State Office, and trained community provider nursing staff completed the MED form for HCBC-ECI applicants. These were also transmitted to the State Office for review and eligibility determination by a State nurse. In 2010, findings by a legislative audit indicated that the eligibility process for long-term care is often delayed, particularly when resources must be verified as part of a four-year look back period.
There has not been a decrease in the length of time between a client’s application for the HCBC-ECI waiver and the determination of eligibility for services over the past 3 years; in fact, there has been a slight increase in the time it takes to achieve a determination (Figure 11). There had been a decrease until budget and staff cuts within BEAS occurred in October 2009; since that time, delays have increased. The effect of those cuts has moved this metric in the wrong direction.

**Figure 11**

*Length of time (days) between initial application for service and medical determination of eligibility for HCBC-ECI services*

*SOURCE: NH DHHS – BEAS Options system*
The single largest source of this delay comes from the time between the completion of the application and when a nurse visit is completed (Figure 12). This appears to have been impacted by staff changes at BEAS as timeliness had been improving until fall 2009.

**Figure 12**  
Length of time for determination of eligibility for HCBC-ECI services by step in process

```
Activity   | Median Days
-----------|-------------
Application Received to Application Completed | 20
Application Complete to RN Visit | 15
RN Visit to NewHeights Eligibility Entered | 10
NewHeights Eligibility Entered to Outcome | 5
```

*SOURCE: NH DHHS – BEAS Options system*

**ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 1; OBJECTIVE 4**

**ACTIVITIES FOR OBJECTIVE 4: REDUCE THE IMBALANCE BETWEEN INCREASED DEMAND AND CAPACITY TO DELIVER HOME AND COMMUNITY-BASED SERVICES**

System rebalancing also needed to address the gap between the increasing demand for home and community-based services and the lack of capacity – Goal 1; Objective 4. To address this issue, New Hampshire received assistance through the CMS-sponsored Direct Service Work Force Resource Center to develop a strategy for focusing legislative and public attention on long-term care workforce shortages. While workforce concerns are but a single facet of the larger long-term care infrastructure issue, they nevertheless are a significant part. Early in the grant project, a training and planning session was held with Robyn I. Stone, Dr.P.H., a noted researcher on health
care and aging policy, and executive director of the Institute for the Future of Aging Services, housed within the American Association of Homes and Services for the Aging. Dr. Stone worked with NH stakeholders to develop strategies for New Hampshire to address direct care workforce shortages. The group identified two areas to begin work on: collecting data to exemplify the need and developing training for direct care workers’ supervisors. Two priority areas were also identified: to improve wages and benefits and to improve supervision of direct care workers.

In order to achieve the planning group’s goal, a coalition was established, designated as the New Hampshire Coalition on the Direct Care Workforce (CDCW). The coalition accomplished much through the volunteer efforts of inter-agency representatives charged with focusing legislative attention on the challenges of recruiting and retaining direct care workers, technical support from the National Direct Service Workforce Resource Center (DSWRC), a Centers for Medicare and Medicaid Services funded and supported center), and staff support from the UNH Institute for Health Policy and Practice. The CDCW conducted a survey in 2008 of direct care workers and published a white paper, with the assistance of the DSWRC, outlining the findings and strategies for investing in this workforce. In addition, the coalition held a legislative event in September of 2009 to release the results of the direct care workers’ survey and the white paper. A sub group of the CDCW helped to plan the conference agenda for the 2009 Real Choice conference, the theme of which was the New Hampshire direct care workforce. The conference highlighted several workshops related to the work of the CDCW, including a presentation on the survey findings and a workshop presented by PHI National (PHI National is an organization which works to strengthen the nation’s long-term care directcare workforce) on the Coaching Supervision model. The complete findings of the survey are compiled in two documents: “Strategies to Invest in the Future of the Direct Care Workforce” and “Home Care Workers: Keeping Granite Staters in Their Homes as They Age”. These documents are located in (appendix C).

Utilizing the information gathered through the workforce survey, NH was able to apply for a Department of Labor (DOL) grant to focus on this workforce. The grant was awarded to the University of New Hampshire in March 2010 and is intended to help recruit, train and retain home and community-based direct care workers.

New Hampshire also sought to understand and quantify the work of informal caregivers in the state to improve the state’s capacity to provide appropriate supports. In 2009, the Behavioral Risk Factor Surveillance Survey (BRFSS) Caregiver Module questions were added to the Granite State Poll (GSP). NH chose to add these questions to the GSP, because the questions could not be added to the NH BRFSS in 2009 (but could in 2010). Rather than wait until 2010, NH chose to add the module to the 2009 GSP to provide initial quantitative information about caregiving in NH, and to provide an opportunity to identify any modifications NH would want to the module prior to it being
included on the 2010 NH BRFSS. The module was successfully added to the 2010 NH BRFSS survey.

Several initiatives have been implemented that have the potential to expand the range of options available to consumers and to enhance the community-based services infrastructure. These initiatives include: Implementation of Adult Family Care through the HCBC-ECI Waiver; Development of supplemental services through the Money Follows the Person Project, subject to CMS approval; and Implementation of individual budgeting through the HCBC-ECI Waiver.
OUTCOMES FOR OBJECTIVE 4: REDUCE THE IMBALANCE BETWEEN INCREASED DEMAND AND CAPACITY TO DELIVER HOME AND COMMUNITY-BASED SERVICES

Objective 1.4.1

Wait time for initiation of home and community-based services from date applied to date services were initiated

A reduction in time between determination of eligibility for services and actually receiving services is an important indicator of a system’s ability to meet demand. Despite an increase in the time it takes to determine eligibility for services (see objective 1.3.2), there has been a 44% decrease in the length of waiting time between when home and community-based services are applied for and when they are initiated (Figure 13). Much of this decrease occurred between 2005 and 2007 when wait times decreased from 32 to 23 days. Since 2007, wait times have declined 22%, from 23 days to 18 days. The capacity to deliver home and community-based services has improved during the period of the grant.

Figure 13

Wait time for initiation of home and community-based services from date applied to date services were initiated

*SOURCE: NH DHHS – Medicaid Decision Support System (MDSS)
A second indicator of New Hampshire’s ability to meet service demand can be seen in responses to SLRC client satisfaction surveys (Figure 14). When the number of clients who did not leave a message is excluded, more than 90% of SLRC clients who left a message were called back within 24 hours. (There was no significant difference between 2006 and 2009, $\chi^2=8.743$, df=4, p=0.068.)

**Figure 14**
(If you left a message) The SLRC representative called me back within 24 hours

*SOURCE: SLRC Customer Satisfaction Survey*
In New Hampshire’s original STG application a chart was included spanning SFY2000-2005 showing an increase in funding for services provided by BEAS. The table displayed below was created to show that funding for home and community-based services has continued to increase. Between State Fiscal Year (SFY) 2006 and 2010 actual expenditure’s for HCBC-ECI increased by about $20,000,000. Although Nursing Facility Actual Expenditures also increased during this time frame, Nursing Facility average enrollment decreased while HCBC-ECI average enrollment increased.

**Figure 15**
Funding for services provided by BEAS through grant period

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<th>SFY 2006</th>
<th>SFY 2007</th>
<th>SFY 2008</th>
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<td>Average Enrollment</td>
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*Source: NH DHHS – BEAS Medicaid Decision Support System (MDSS)
Figure 16, Long Term Care Average Monthly Caseloads 2000-2010, also demonstrates the rise in participation in the HCBC-ECI waiver and decrease in Nursing Facility caseloads.

**Figure 16**

*Long Term Care Avg Monthly Caseloads 2000 - 2010*

*SOURCE: NH DHHS – BEAS Medicaid Decision Support System (MDSS)*

Over the course of the STG project, considerable work was conducted to evaluate and address the future demands on home and community-based direct care workforce. The following two metrics have been added to this evaluation report based on the workforce focus under STG. New Hampshire found that the projected growth in demand for workers is not matched by a commensurate growth in the supply of workers. PHI National provided calculations based on the New Hampshire Employment Security occupational projections, U.S. Census Bureau demographic projections data, and Bureau of Labor Statistics (BLS) labor force participation data. The results show that growth in demand for direct care workers is expected to outpace the growth in the supply of available workers, women aged 25-54, who are the core labor pool for this workforce. Figure 17 shows that from 2006-2016, the state will need an estimated 6,230 additional direct care workers, while the net number of new women, aged 25-54, entering the New Hampshire labor force is expected to be only 4,198 (PHI Analysis, 2009).
In addition, demand for new direct care workers in New Hampshire is outpacing growth in the core labor pool in part because wages for these services are quite low, even for workers without families to support (Figure 18).

A 2008 report published by the Carsey Institute at the University of New Hampshire indicates that of the forty occupations projected to grow the fastest from 2006 to 2016, only two occupations paid a median hourly wage below the state’s 2007 livable wage: Home Health Aides and Personal Care Aides (Kenyan and Churilla, 2008) both of which are direct care workforce categories.

Objective 1.4.2

90% of participants report that their needs are being met

RESULTS

Data to measure this objective come from the Participant Experience Survey, conducted in 2008 and 2010 with clients who are participating in the HCBC-ECI waiver.

Nearly all waiver participants (85%) felt that their plan addresses all their service needs and concerns, and they report they are receiving all services described in their plan for services (Figure 19). However, this did not reach the goal of 90% and there has been no change between 2008 and 2010 ($\chi^2 = 0.006$, df=2, p=0.940).

While most participants felt their needs were met, some indicated that the programs do not always have the flexibility to meet their needs. Some participants felt they would like more time with the caregiver or more hours of service than their benefit may allow. Responses included, “I am very happy when my care worker is here but I
need more time.” In addition, a number of participants indicated that transportation is problematic, including for outings or events not medically related. Several participants mentioned issues with obtaining durable medical equipment, such as forearm crutches or a particular wheelchair. Remarks included, “if we could get the equipment we need it would be better” and “I needed a ramp and railing I never got” and “good except for transportation and ramping.” One participant commented that the day program should offer more activities.

**Figure 19**

Does your plan address all your service needs and concerns?

*SOURCE: NH Participant Experience Survey*
Similarly, Figure 20 shows that most waiver recipients (more than 80%) are receiving all of the services listed in their plan for services. However, this has also not reached the 90% target and there has also been no significant change in this indicator between 2008 and 2010 ($\chi^2 = 0.504$, df = 2, $p = 0.478$).

**Figure 20**
*Are you receiving all the services listed in your plan for services?*

*SOURCE: NH Participant Experience Survey*
CHAPTER V
GOAL 2: CHOICE AND CONTROL
DEVELOPMENT/ENHANCEMENT OF SELF-DIRECTED SERVICE DELIVERY SYSTEM

OVERALL GOAL ACTIVITIES:

To achieve Goal 2: Development/Enhancement of a self-directed service delivery system, the same structure for collaboration, participation, and oversight used in implementing Goal 1 was utilized.

Activities for Goal 2 fell under two main foci, person-centered planning and consumer directed services. Workgroups were established, which included strong consumer membership, to work on these focus areas. The Person Centered Planning (PCP) workgroup developed principles for PCP and assisted in the development and implementation of a PCP training curriculum. The self-directed services workgroup assisted in developing a concept paper, work flow diagram, and implementation of individualized budgeting.

OBJECTIVES

OBJECTIVE 1: DEVELOP OR ENHANCE PERSON-CENTERED PLANNING

(1) Membership of advisory committee reflects diverse representation. (p.46)

(2) Input into the design and implementation of person-centered planning obtained from at least 100 participants, families, and providers. (p.46)

(3) 80% of participants surveyed are satisfied with the amount of choice provided in accessing services. (p.47)

(4) Persons enrolled in the HCBC-ECI Program are offered the opportunity to choose person-centered planning, increasing over the course of the grant to 100% of enrollees. (p.49)

OBJECTIVE 2: DEVELOP OR ENHANCE INDIVIDUAL BUDGETING

(1) Individualized budgeting workgroup membership is diverse and included 25% participant and family membership (p.51)

(2) 95% of participants who direct their own care will express high satisfaction with services and report unmet needs. (p.52)

(3) Average costs of HCBC services for persons directing their own care will be 10% less than the average cost of persons in traditional service models. (p.55)

(4) 10% of participants eligible for HCBC-ECI services choose a participant-directed model (p.55)
ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 2; OBJECTIVE 1

ACTIVITIES FOR OBJECTIVE 1: DEVELOP OR ENHANCE PERSON-CENTERED PLANNING

Goal 2; Objective 1 focused on person-centered planning to advance choice and control throughout the LTC system. With guidance from a workgroup of key stakeholders a set of PCP principles was developed followed by the drafting of a training curriculum which was then field tested, and implemented. The workgroup was comprised of a variety of key stakeholders representing state agencies, consumers, community advocates, independent case management agencies, NH’s Center for Independent Living, home health care agencies, community service agencies, University of New Hampshire, and Franklin Pierce Law Center.

Four PCP trainings are held at various locations throughout the state each year and each session has been filled to capacity. This has resulted in over 300 people trained to date. A specific focus area of training has been the caregiver specialists under the Transitions in Care Giving program (New Hampshire's nursing home diversion project funded by AoA). All caregiver specialists have attended the full five-day PCP training program. The interest and involvement of independent case management agencies, community social workers, hospital discharge planners, long-term care specialists, caregiver specialists, and others involved in planning has been overwhelmingly positive. This work led to the embracement of PCP principles throughout the long term care system; however, there continues to be varying interpretations of PCP.

New Hampshire’s success in the development of person-centered planning across the long-term care systems is evident by the request for and subsequent delivery of presentations at national conferences and in other states (Louisiana, Vermont, Ohio, and Massachusetts). Another measure of success occurred in 2007 when legislation was passed mandating that all services be planned utilizing person-centered planning regardless of the participant’s age, disability or residential setting.

In addition to PCP, New Hampshire also focused on improving its consumer directed services under the long-term care system. A proposal for the development of a consumer-directed service package within the HCBC-ECI waiver was developed with the guidance of a multi-stakeholder work group. The proposal was presented to the Department of Health and Human Services. Based on this proposal, the decision was made to amend the existing 1915c HCBC-ECI waiver to include consumer directed goods and services. The workgroup designed a flow chart describing how the service will be
implemented and managed. The first participant was enrolled in this new consumer-directed option in July of 2010.

**OUTCOMES FOR OBJECTIVE 1: DEVELOP OR ENHANCE PERSON-CENTERED PLANNING**

**Objective 2.1.1**

*Membership of advisory committee reflects diverse representation*

The Real Choice Advisory Council served as the advisory committee for the STG project. The committee consists of 30 members representing consumers, community service agencies, state agencies, independent living centers, and universities. The complete membership list is included in appendix D. All meeting minutes and public forum results are posted on the public website link: [http://www.realchoicenh.org/](http://www.realchoicenh.org/).

**Objective 2.1.2**

*Input into the design and implementation of person-centered planning obtained from at least 100 participants, families, and providers*

A workgroup was formed to advise the design and implementation of person-centered planning for older adults. The workgroup was comprised of consumers (2), community advocates (2), case management agency (1), state agency staff (2), and University of New Hampshire staff (2). (See appendix D for full workgroup membership list) The group developed a set of principles for person-centered planning, advised the development of the training curriculum, and provided ongoing feedback on training implementation. Evaluations are completed at the end of each PCP training session and the curriculum is being continuously updated.

Community listening sessions were held and additional feedback was obtained on the design and implementation of person-centered planning. A copy of this report can be found at [http://realchoicenh.org/CommunityListeningSessions%20Final%20Report.pdf](http://realchoicenh.org/CommunityListeningSessions%20Final%20Report.pdf). To date, over 500 people have provided some level of input, through the venues outlined above, into the design and implementation of person-centered planning for older adults and adults with disabilities in New Hampshire.
Objective 2.1.3

80% of participants surveyed are satisfied with the amount of choice provided in accessing services

In order to determine patient control of the services they receive, HCBC-ECI waiver participants were asked if they believe they have enough say in developing their plan for services. The 80% goal for this measure was not quite reached, but by 2010, 78% said they have enough say in developing their plan for services (Figure 21). There was no significant change between 2008 and 2010 ($\chi^2 = 1.186$, df = 2, $p = 0.276$). Comments from participants surveyed included “I have the entire say!”, “I just told them what I like and what I don’t like” and “someone came in the beginning and explained the entire thing.”

Figure 21

Did you have enough say in developing your plan for services?

*SOURCE: NH Participant Experience Survey*
Most HCBC-ECI waiver participants are satisfied with the services they receive under the program – 91% report they are satisfied (62% say they are “very satisfied” and another 29% report they are “satisfied”, Figure 22). There was no significant change between 2008 and 2010 ($\chi^2 = 3.818$, df = 5, p = 0.576).

Comments from participants surveyed included: “I couldn’t be happier” and “I give them a 10!”, “100% satisfied” or “A+++!” One participant said, “I love it, I never want to leave this place, it’s my home for good.” However, some participants indicated that the provider agencies seem understaffed, and they were happiest when they had their regular caregivers; “some of them do better than others”, “if the regular worker is out, I don’t get any services” and “with the new company and (name of case management agency), it’s great; in the past I had to trouble shoot.”

Figure 22
Overall how satisfied are you with the services you receive from this program?

*SOURCE: NH Participant Experience Survey*
Objective 2.1.4

Persons enrolled in the HCBC-ECI Program are offered the opportunity to choose person-centered planning, increasing over the course of the grant to 100%

While HCBC-ECI waiver participants may be offered the opportunity to choose person-centered planning, more than half say they are either not able to pick the people who help them, or that they are unaware if they are able to (Figure 23). This objective has not been met, but there has been significant improvement since 2008 ($\chi^2 = 12.014$, df = 2, $p < 0.001$). Individual responses from participants surveyed who indicated they picked the people to help them included, “when I don’t like one I tell them to send me another one” and “I can hire or fire, if I don’t like someone. I can just say I don’t want them anymore, but so far I haven’t had a problem with that.”

Figure 23
Do you help pick the people who are paid to help you?

*SOURCE: NH Participant Experience Survey*
But while the goal is to offer all program participants the chance to choose their own care, most of those who report that they were not given the chance say they would not like to pick the people who care for them (Figure 24). In 2010, nearly two-thirds (65%) of HCBC-ECI participants who said they are not able to pick the people who help them said they would not like to help pick these caregivers. There has been a significant change on this measure since 2008 ($\chi^2 = 17.603$, df = 2, $p < 0.001$). Individual responses ranged from, “I don’t know anybody anyways”, “I don’t really have a need to help pick them, I’ve been pretty happy so far” and “I think sometimes. We can fire whoever we have technically because they are working for us.”

**Figure 24**

*Would you like to help pick the people who are paid to help you?*

*Asked of those who did not help pick the people who are paid to help*

2008 N = 174, 2010 N = 161

*SOURCE: NH Participant Experience Survey*
ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 2; OBJECTIVE 2

ACTIVITIES FOR OBJECTIVE 2: DEVELOP OR ENHANCE INDIVIDUAL BUDGETING

Activities which fell under this objective, i.e., to develop or enhance individual budgeting, were built off those in Goal 2; Objective 1. The multi-stakeholder consumer-directed workgroup has been key in guiding the advancement of consumer-directed, individual budgeting. In addition, the success of a consumer-directed model in the New Hampshire Family Caregiver Support program has facilitated the replication of this model to this Medicaid waiver. The first step New Hampshire took towards individual budgeting in the long-term care systems was in 2007 with the development of a concept paper outlining how a consumer-directed model could be implemented in the HCBC-ECI waiver. The workgroup continued to participate in the development of work flow processes, and finally, in the implementation of a consumer-directed option within the HCBC-ECI waiver program.

New Hampshire’s AoA nursing home diversion and CMS Money Follows the Person grants also utilized consumer-directed services. By 2008, the consumer-directed, individual budgeting model was adopted and fully implemented within Transitions in Caregiving, NH’s AoA funded community living project. By 2009, a process for developing individual budgets and implementing a consumer-directed option within the HCBC-ECI waiver had been developed and a contractor had been secured to provide financial management services. Enrollment in this service began in 2010.

OUTCOMES FOR OBJECTIVE 2: DEVELOP OR ENHANCE INDIVIDUAL BUDGETING

Objective 2.2.1

*Individualized budgeting workgroup membership is diverse and included 25% participant and family membership*

A work group was formed to advise on the design and implementation of a participant-directed, individual budgeting process within the HCBC-ECI waiver program. The workgroup was comprised of consumers (1), community advocates (3), case management agency (1), state agency staff (2), community service providers (3), financial management service provider (1), and University staff (1). (See appendix D full workgroup membership list) The group developed a concept paper and met for over four years to advise the design and implementation of the program.
Community listening sessions were held and additional feedback was obtained on the design and implementation of participant directed services. A copy of this report can be found at [http://realchoicenh.org/CommunityListeningSessions%20Final%20Report.pdf](http://realchoicenh.org/CommunityListeningSessions%20Final%20Report.pdf).

The membership of the individualized budgeting workgroup was diverse and included 25% participant and family membership. In addition, input was obtained from a broad range of community members through the community listening sessions.

**Objective 2.2.2**

*95% of participants who direct their own care will express high satisfaction with services and report on unmet needs*

In 2008, a fully consumer-directed service package had been designed but had not yet been implemented in the HCBC-ECI waiver. This objective has not yet been met as only 87% of waiver participants who are currently directing their own care say their plans address all of their service needs and concerns (Figure 25). There has been no significant change 2008 to 2010 among those who are directing their own care ($\chi^2 = 2.444$, df = 2, p = 0.118).

Some participants were not sure of the complete scope of services that might be offered to them in their particular situation, but most felt their needs were being met. For specific information, please refer to the text on p.40 (Objective 1.4.2).
Similarly, most waiver participants who are directing their own care (83%) say they are receiving all of the services listed in their plan of services, but this does not reach the 95% goal (Figure 26). There was no significant change from 2008 to 2010 among those who are directing their own care ($\chi^2 = 0.967, df = 2, p = 0.325$). Comments from participants included, “if I don’t get what I want I scream loudly” and “they take very good care of me, I can’t say enough good about them. They are the top of the top and they know that I’m very outspoken and I’ll tell them if I’m not happy.”

However, in 2010, 15% cited they did not know if they were receiving all the services listed in their plan. Qualitative responses supported this, with a number of participants indicating they don’t know all of the services available, that for a number of reasons they do not use all the services that may be available to them, or that they are unsure of what is in their plan. Responses included, “I don’t remember what’s in my plan” and “I haven’t read the plan in a long time”. One participant commented, “I can’t answer that one because I don’t know what was in the plan. If it wasn’t for the A team, my life would be nonexistent. That’s been a worry of mine with the coming up changes. I really don’t have a family.”
Overall, HCBC-ECI waiver participants who are directing their own care report high satisfaction with the services they receive from the program – 92% report being satisfied with the services they receive (66% say they are very satisfied and 26% say they are satisfied, Figure 27).

There was no significant change between 2008 to 2010 among those who are directing their own care ($X^2 = 5.089, df = 5, p = 0.405$) nor in the overall sample ($X^2 = 3.818, df = 5, p = 0.576$).
Overall how satisfied are you with the services you receive from this program?
All HCBC-ECI Waiver Participants and those Directing Own Care


**Objective 2.2.3**

Average costs of HCBC-ECI services for persons directing their own care will be 10% less than the average cost of persons in traditional service models

New Hampshire fully implemented a comprehensive consumer-directed model of services, including individualized budgeting, under the HCBC-ECI waiver in the summer of 2010. Therefore, we are not yet able to compare costs based on this more comprehensive model of consumer-directed care.

**Objective 2.2.4**

10% of participants eligible for HCBC-ECI services choose a participant-directed model

By 2010, 37% of eligible waiver participants received consumer-directed care, exceeding the 10% goal (Figure 28). This objective has been met. An additional 3% receive a combination of agency and consumer-directed care, bringing the total percentage for whom care is driven by the consumer to 40%.
Figure 28 depicts the utilization of both agency managed and consumer directed personal care services. The percentage of participants who choose consumer-directed personal care services includes both those who receive only consumer-directed services (yellow bar) and those who receive both consumer-directed as well as agency managed personal care services (green bar). The percentage of participants who choose consumer-directed services has increased from 19% in SFY 05 to 40% in SFY10. Considering only those participants who choose to receive consumer-directed personal care services only, the increase is from 9% in SFY 05 to 37% in SFY10. Both analyses indicate a statistically significant increase in the number of participants choosing a participant directed model and well exceed the original goal of 10% ($X^2 = 780.205$, df = 5, P=.0000).

*SOURCE: NH DHHS – BEAS Medicaid Decision Support System (MDSS)*
CHAPTER VI

GOAL 4: INFORMATION TECHNOLOGY – TRANSFORMATION OF INFORMATION TECHNOLOGY TO SUPPORT SYSTEMS CHANGE

OVERALL GOAL ACTIVITIES:

Activities which occurred in 2006 through 2008 focused on automating the LTC eligibility, case tracking and service authorization processes in the OPTIONS System, while setting up a secure environment to allow access through the Internet by independent case managers (HCBC-ECI) and SLRC staff. In addition, quality measures for HCBC-ECI were finalized, SLRC data collection related to service gaps and unmet needs were standardized, and the Participant Experience Survey was expanded to include questions related to consumer directed service models and person-centered planning.

However, MMIS delays were a major impediment to progress on Goal 4. The systems integration being planned under this project were dependent upon the implementation of the new MMIS. Lack of staff resources to commit to this phase of the project on both the program and the technical sides also contributed to lack of activity under this goal.

In 2008 it was determined that while the IT goal and objectives remain unchanged, the focus of this phase of the project would concentrate on bringing the STG activities within the overarching DHHS goal of automating eligibility forms using IBM eForms products. The long-term care medical eligibility determination process, which is a key area of STG interventions from both Goal I and 2 perspectives, was selected as the first pilot project. Three phases have been identified: Phase 1--set up development, test and production environments and pilot an automated production version of the MED tool; Phase 2--integrate Lotus eForms with other State applications to share data and eliminate duplicate data entry; Phase 3--deploy additional forms throughout DHHS. Phase 1 was successfully completed in December 2008 but with the significant change in process to allow trained nursing home and community provider nursing staff to complete the MED form, the IBM eForms software did not work in this model. The project is on hold and a request has been submitted to fund phase 2 and 3, including an upgrade to the web-enabled version of IBM eForms software, in the State of NH 2012-2013 budget.
OBJECTIVES

OBJECTIVE 1: DESIGN IT APPLICATIONS THAT WILL SUPPORT PROGRAM PRACTICES AND PROCESSES THAT ARE INDIVIDUAL-CENTERED AND ENABLE PERSONS TO DIRECT THEIR OWN SERVICES.

(1) 90% of state program managers and community providers are highly satisfied with the ability of the IT system to support person-centered planning, individualized budgets, and consumer-directed services. (p.60)

OBJECTIVE 2: IMPROVE CLIENT ACCESS TO LONG-TERM CARE SERVICES THROUGH THE USE OF INTEGRATED IT SYSTEMS(S).

(1) 90% of individuals residing in underserved areas and from minority communities report that they are highly satisfied with the overall system access features. (p.61)

OBJECTIVE 3: USE INTEGRATED SYSTEMS TO MONITOR THE QUALITY OF SERVICES RENDERED

(1) 90% of program managers and service providers are highly satisfied with the ability of the IT system to support person-centered planning, individualized budgets, and consumer-directed services. (p.62)

(2) 90% of program managers and service providers are highly satisfied with the integration of quality improvement systems into the IT system. (p.63)

(3) 90% of program managers and service providers are highly satisfied with the IT system’s ability to track program quality based on individual outcomes. (p.63)

(4) 90% of program managers and service providers are highly satisfied with the IT system’s capacity to foster collaboration across programs. (p.63)
Activities, Objectives, and Outcomes for Goal 4; Objective 1

ACTIVITIES FOR OBJECTIVE 1: DESIGN IT APPLICATIONS THAT WILL SUPPORT PROGRAM PRACTICES AND PROCESSES THAT ARE INDIVIDUAL-CENTERED AND ENABLE PERSONS TO DIRECT THEIR OWN SERVICES.

Activities in this area have concentrated on linking STG activities and goals with reducing fragmentation and streamlining business processes between the long-term care medical eligibility process and the financial eligibility process. Staff participated in the LEAN analysis of the financial eligibility process, and an inter-departmental task force was charged with simplifying the integration of both processes. Focus groups met to analyze the process flow for the medical eligibility determination and to recommend changes in the form used to determine the eligibility. Program specifications for the self-directed budgeting initiatives were finalized, and prospective participants are coming forward.

Activities and progress under this objective have been the result of the systems development work that has occurred as part of the AoA-funded Community Living Program (CLP) demonstration grant, which uses a consumer-directed model. The financial management services process developed for the CLP is being used in the HCBC-ECI consumer-directed model. Funding was obtained to enhance the referral database for the ServiceLink Resource Centers (SLRC) and to customize the reporting functions of the Refer7 system, the case management system used by the SLRCs.

Lack of staff resources, especially programmers needed to work on systems development and changes, was a major barrier to performing activities under this goal. BEAS is currently operating at a 25% vacancy rate yet long-term care caseloads continue to increase. Ongoing management needs of the Medicaid long-term care program compete with resources needed for systems transformation.
OUTCOMES FOR OBJECTIVE 1: DESIGN IT APPLICATIONS THAT WILL SUPPORT PROGRAM PRACTICES AND PROCESSES THAT ARE INDIVIDUAL-CENTERED AND ENABLE PERSONS TO DIRECT THEIR OWN SERVICES.

Objective 4.1.1
90% of state program managers and community providers are highly satisfied with the ability of the IT system to support person-centered planning, individualized budgets, and consumer-directed services

As IT activities were changed mid-grant period, we were not able to gauge achievement of this measure.

ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 4; OBJECTIVE 2

ACTIVITIES FOR OBJECTIVE 2: IMPROVE CLIENT ACCESS TO LONG-TERM CARE SERVICES THROUGH THE USE OF INTEGRATED IT SYSTEMS(S).

Early activities under this objective match objective 4.1.

In 2009, this objective did not change; however, the focus of this phase of the project was to bring the STG activities within the overarching DHHS goal of automating the eligibility process for all DHHS programs. DHHS implemented Project ACCESS, Achieving Community Centered Excellence in Services, which focuses on the financial eligibility process for public assistance, medical assistance and food stamps. Activities accomplished under this objective were the automation of a combined Financial/Medical Eligibility Determination process due to be implemented by January 2011, the accessibility of the ServiceLink Resource Center database through the internet, and the business processes developed for a consumer-directed service model. BEAS was also able to leverage the Same-Page eStudio web-base software used by DHHS as a secure means of transmitting clinical data about consumers relative to medical eligibility.
OUTCOMES FOR OBJECTIVE 2: IMPROVE CLIENT ACCESS TO LONG-TERM CARE SERVICES THROUGH THE USE OF INTEGRATED IT SYSTEMS.

Objective 4.2.1

90% of individuals residing in underserved areas and from minority communities report that they are highly satisfied with the overall system access features.

As IT activities were changed mid-grant period, we were not able to gauge achievement of this measure.

ACTIVITIES, OBJECTIVES, AND OUTCOMES FOR GOAL 4; OBJECTIVE 3

ACTIVITIES FOR OBJECTIVE 3: USE INTEGRATED SYSTEMS TO MONITOR THE QUALITY OF SERVICES RENDERED

The change in focus on forms and workflow automation described in the two previous objectives also impacted the quality monitoring objective. Plans and recommendations have not been implemented because of delays in MMIS development and implementation. The functionality of the new MMIS is critical to implementing quality monitoring through IT.

However, the successful completion of the Quality Assurance/Quality Improvement (QA/QI) Grant resulted in the identification of key quality issues in the HCBC-ECI Waiver and development of the groundwork for a division-wide Quality Management system across three of the bureaus in the Department's Division of Community Based Care. The automation of the medical eligibility process as previously described improves the timeliness and accuracy of the process. A sentinel event reporting protocol has been developed and implemented across all three HCBC Waivers as well as a program evaluation protocol for case managers.

BEAS adopted a structured decision making® model for adult protective services, and a risk management/informed decision making protocol was developed for Waiver consumers. A comprehensive training plan for QM was drafted. Quality management is also being addressed within the context of the newly implemented consumer-directed option in the HCBC-ECI waiver program.

The QA/QI grant has provided an effective structure for aligning and implementing the activities related to this objective. While progress was initially delayed, the collaboration between the STG and the QA/QI grant has facilitated the
purchase of laptops and electronic signature pads for eligibility and program review staff and supported the implementation of the first Participant Experience Survey to monitor quality.

In accordance with the Division of Community Services' quality management plan, the five independent case management agencies working under the HCBC-ECI Waiver were evaluated in 2009. The agencies finalized their corrective action plans in response to the recommendations in their specific program evaluation reports. The sentinel event protocol, introduced throughout the DCBCS bureaus, and the structured decision making® model developed for the Adult Protective Services program are ongoing. Work on a risk management protocol for Waiver consumers is also underway.

In 2010, progress on this objective focused on reviewing and revising Section H of the HCBC-ECI Waiver. Work that was done on analyzing the eligibility processes for both the financial and medical aspects is also being utilized in the development of the Section H revision. The State is consulting with a national long-term care quality expert to develop Section H, which will take into account the previous work that the project had done on utilizing IT systems to monitor service quality.

**OUTCOMES FOR OBJECTIVE 3: USE INTEGRATED SYSTEMS TO MONITOR THE QUALITY OF SERVICES RENDERED**

**Objective 4.3.1**

*90% of program managers and service providers are highly satisfied with the ability of the IT system to support person-centered planning, individualized budgets, and consumer-directed services*

As IT activities were changed mid-grant period, we were not able to gauge achievement of this measure.
Objective 4.3.2

90% of program managers and service providers are highly satisfied with the integration of quality improvement systems into the IT system

As IT activities were changed mid-grant period, we were not able to gauge achievement of this measure.

Objective 4.3.3

90% of program managers and service providers are highly satisfied with the IT system’s ability to track program quality based on individual outcomes

As IT activities were changed mid-grant period, we were not able to gauge achievement of this measure.

Objective 4.3.4

90% of program managers and service providers are highly satisfied with the IT system’s capacity to foster collaboration across programs

As IT activities were changed mid-grant period, we were not able to gauge achievement of this measure.
Appendix A: Technical Report
GRANITE STATE POLL (GSP)

Each of the Granite State Polls is a survey of randomly selected adults in the state of New Hampshire. These surveys were conducted using a procedure called Random Digit Dialing (RDD) which is described below.

A sample of households in the area was selected by a procedure known as random digit dialing. The way this works is as follows. First, with the aid of the computer, one of the three-digit telephone exchanges that are currently used in the area (e.g., 772) is randomly selected. The computer then randomly selects one of the "working blocks"--the first two of the last four numbers in a telephone number (e.g., 64)--and attaches it to the randomly selected exchange. Finally, the computer program then generates a two-digit random number between 00 and 99 (e.g., 57) which is attached to the previously selected prefix (772), and the previously selected working block (64) resulting in a complete telephone number -- i.e., 772-6457. This procedure is then repeated numerous times by the computer to generate more random numbers, so that we have a sufficient quantity to conduct the survey. The end result is that each household in the area in which there is a telephone has an equally likely chance of being selected into the sample.

The random samples used in the Granite State Poll were purchased from Scientific Telephones Samples (STS), Foothill Ranch, California. STS screens each selected telephone number to eliminate non-working numbers, disconnected numbers, and business numbers to improve the efficiency of the sample, reducing the amount of time interviewers spend calling non-usable numbers.

Each of these randomly generated telephone numbers is called by one of our interviewers from a centrally supervised facility at the UNH Survey Center. If the number called is found not to be a residential one, it is discarded and another random number is called. (Approximately 45% of the numbers were discarded because they are found to be businesses, institutions, or not assigned.) If it is a residential number, the interviewer then randomly selects a member of the household by asking to speak with the adult currently living in the household who has had the most recent birthday. This selection process ensures that every adult (18 years of age or older) in the household has an equally likely chance of being included in the survey. No substitutions are allowed. If, for example, the randomly selected adult is not at home when the household is first contacted, the interviewer cannot substitute by selecting someone else who just happens to be there at the time. Instead, he or she must make an appointment to call back when the randomly selected adult is at home. In this way, respondent selection bias is minimized.
When the Interviewing Was Done

Each selected respondent was called by a professional UNH Survey Center interviewer from a centrally supervised facility at the UNH Survey Center. Telephone calls during the field period were made between 9:00 AM and 9:00 PM.

Response Rates

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<th>Telephone Numbers used</th>
<th>Number of Interviews</th>
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<td>5068</td>
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*The Winter 2005 Granite State Poll included an oversample of the two Pilot counties, Belknap and Strafford; however, all statewide data presented in this report represents only the statewide data and does not include the over-sampled counties.

The formula to calculate the standard American Association for Public Opinion Research (AAPOR) response rate #4 is:

\[
\frac{I}{(I+P) + (R+NC+O) + e(UH+UO)}
\]

I = Complete Interviews, P = Partial Interviews, R = Refusal and break off, NC = Non Contact, O = Other, e = estimated portion of cases of unknown eligibility that are eligible, UH = Unknown household, UO = Unknown other.

Weighting of Data

The data have been weighted to account for known biases of telephone surveys. The data in the Granite State Poll are weighted by the number of adults and telephone lines within households to equalize the chances that any one adult would be selected for inclusion. The data are also weighted by respondent sex, and region of the state.
Sampling Error

The Granite State Poll, like all surveys, is subject to sampling error due to the fact that all residents in the area were not interviewed. For those questions asked of five hundred (500) or so respondents, the error is +/-4.4%. For those questions where fewer than 500 persons responded, the sampling error can be calculated as follows:

\[
\text{Sampling error} = \frac{\pm (1.96) \sqrt{P(1-P)}}{\sqrt{N}}
\]

Where \( P \) is the percentage of responses in the answer category being evaluated and \( N \) is the total number of persons answering the particular question.

For example, suppose you had the following distribution of answers to the question, "Should the state spend more money on road repair even if that means higher taxes?" Assume 1,000 respondents answered the question as follows:

- YES - 47%
- NO - 48%
- DON'T KNOW - 5%

The sampling error for the "YES" percentage of 47% would be

\[
\frac{\pm (1.96) \sqrt{(47)(53)}}{\sqrt{1,000}} = \pm 3.1%;
\]

for the "NO" percentage of 48% it would be

\[
\frac{\pm (1.96) \sqrt{(48)(52)}}{\sqrt{1,000}} = \pm 3.1%;
\]

and for the "DON'T KNOW" percentage of 5% it would be

\[
\frac{\pm (1.96) \sqrt{(5)(95)}}{\sqrt{1,000}} = \pm 1.4%;
\]

In this case we would expect the true population figures to be within the following ranges:

- YES 43.9% - 50.1% (i.e., 47% +/-3.1%)
- NO 44.9% - 51.1% (i.e., 48% +/-3.1%)
- DON'T KNOW 3.6% - 6.4% (i.e., 5% +/-1.4%)
REFER7 DATABASE

The state of New Hampshire Department of Health and Human Services (DHHS), Bureau of Elderly and Adult Services (BEAS) maintains, and has full administrative management of, the Refer7 license and Contract with RTM Designs.

The data within the database is populated and maintained in partnership with the 10 ServiceLink Resource Center (SLRC) contracts and their staff. Contact, client, referral, follow up, and unmet need data are all recorded by staff of the SLRCs statewide. Each Center Manager has the authority along with BEAS to pull data reports as needed.

The SLRC program Manager at BEAS and two Center Managers are designated as the system administrators. In addition to the above, these staff can add or inactivate staff and manage staff rights, can troubleshoot systems issues, maintain the agency and site databases statewide, and assist as a liaison between staff and RTM designs as needed.

There are currently 11 staff trained (this amounts to 5 sites plus BEAS) to maintain agency, site, and service data for the state. This currently covers half of the sites and the other half will be trained to maintain their own local resources during SFY 2011.

SERVICELINK CONSUMER SATISFACTION SURVEY

The University of New Hampshire (UNH) Survey Center in partnership with the 10 statewide ServiceLink Resource Centers (SLRC) conducts an ongoing consumer satisfaction survey.

Each center, through Refer7 database, records each contact with their agency. Each month, the centers randomly select 30% who have valid addresses and have contacted the SLRC during that month. Those individuals are mailed a letter inviting the consumer to participate in a survey about their most recent contact with the SLRC, included in the packet is a short one page survey and a prepaid return envelope addressed to the UNH Survey Center.

The UNH Survey Center staff enters the data from the survey into database for use in analysis. Quarterly reports are provided on statewide and center level data to the program evaluators and program managers at the New Hampshire Department of Health and Human Services (DHHS), Bureau of Elderly and Adult Services (BEAS).
**MEDICAID DECISION SUPPORT SYSTEM (MDSS)**

The Medicaid Decision Support System (MDSS) utilizes the Advantage Suite application from Thomson Medstat Corporation to report and analyze paid claim information from the New Hampshire’s Advanced Information Management (NHAIM) system. The NHAIM system is a fee for service claims processing and payment system, which supports provider management, prior authorization, and service history maintenance.

Figures 9 and 10: Client Counts and Net Payment

The information was generated from the Medicaid Decision Support System (MDSS) and based on paid Medicaid claims. Each claim is assigned a fund code to designate the payment type. The report was run for clients 18 or older.

a. General Medicaid = All Fund Codes  
b. Nursing Facility = Fund Codes B, C and E  
c. Choices For Independence = Fund Code N

Fund Code Descriptions:

<table>
<thead>
<tr>
<th>Source Code</th>
<th>Description</th>
<th>Source Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GENERAL PROVIDER - MEDICAID</td>
<td>N</td>
<td>HCBC - ECI PAYMENTS - MEDICAID</td>
</tr>
<tr>
<td>B</td>
<td>NURSING HOMES - MEDICAID</td>
<td>O</td>
<td>SPECIAL EDUCATION</td>
</tr>
<tr>
<td>C</td>
<td>OTHER NURSING HOMES – MEDICAID</td>
<td>P</td>
<td>NH HOSPITAL - PHILBROOK CTR</td>
</tr>
<tr>
<td>D</td>
<td>LACONIA DEVELOP SVCS</td>
<td>Q</td>
<td>NH HOSPITAL - APS UNDER 22</td>
</tr>
<tr>
<td>E</td>
<td>GLENCOLL MORTAL FOR ELDERLY</td>
<td>R</td>
<td>DCYF MEDICAID</td>
</tr>
<tr>
<td>F</td>
<td>NH HOSPITAL-TH-DS</td>
<td>S</td>
<td>HCTF POVERTY LEVEL/170-185</td>
</tr>
<tr>
<td>G</td>
<td>TRANSITIONAL HOUSING SVCS-MI</td>
<td>T</td>
<td>ACQUIRED BRAIN DISORDER WAIVER</td>
</tr>
<tr>
<td>H</td>
<td>COMMUNITY MENTAL HEALTH</td>
<td>U</td>
<td>DCYF OUT OF HOME SERVICES</td>
</tr>
<tr>
<td>I</td>
<td>DS-CASE MANAGEMENT</td>
<td>V</td>
<td>DMHDS EARLY INTERVENTION</td>
</tr>
<tr>
<td>J</td>
<td>PROVIDER PAYMENTS-LTC</td>
<td>W</td>
<td>DCYF IN HOME SERVICES</td>
</tr>
<tr>
<td>K</td>
<td>DS-COMMUNITY CARE - WAIVER</td>
<td>X</td>
<td>MEDICAID EXPANSION-CHIP</td>
</tr>
<tr>
<td>L</td>
<td>NH HOSPITAL - ICF/IMD</td>
<td>Y</td>
<td>DISABILITY DETERM - PAYMENTS</td>
</tr>
<tr>
<td>M</td>
<td>IHS WAIVER PAYMENTS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For each state fiscal year, clients with a HCBC-ECI program start date during that year were identified from the Options system.

This list of clients was used to pull their Fund Code N (HCBC-ECI) Claims from MDSS with dates of service during that year.

Using Microsoft Access, the list of clients with their HCBC-ECI program start date was combined with the claims list. For Case Management, each client’s HCBC-ECI program start date was compared to the earliest start date for claims with a procedure code of T1016. For other HCBC-ECI services, each client’s HCBC-ECI program start date was compared to the earliest start date for claims with all other fund code N services.

An expression was added to the Access query to compute the date difference between the HCBC-ECI start date and the earliest service date. This field was used to calculate the median number of days, from when the client was eligible to when case management or other HCBC-ECI services started, for each state fiscal year.

In some cases this number was negative because claims had a start date before the HCBC-ECI start date. This is possible because a client might have more than one ECI start date. Their program eligibility can start and stop during and across the fiscal years. Because of this, the negative rows were excluded from the median calculation.

NH DHHS-BEAS OPTIONS SYSTEM

The Bureau of Elderly and Adult Services (BEAS) Options is an information system application used to:

- Manage BEAS social worker caseload,
- Manage the adult protection program and State Registry,
- Manage service authorizations, and provider payments related to the Social Services Block Grant (SSBG) and the Older Americans Act (OAA) services, and
- Manage medical eligibility, case information, and service authorizations for the Medicaid Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI) waiver, Money Follows the Person and Nursing Facility programs.

Figures 11 & 12: Application to Eligibility Determination

This information is run monthly from the Options system and is based on Long Term Care applications submitted for medical eligibility determination.
NH PARTICIPANT EXPERIENCE SURVEY

The Participant Experience Survey (PES) project is based on a random sample of Home and Community Based Care Services Elderly and Chronically Ill waiver participants about the services and supports they receive. The Home and Community Based Care Services Elderly and Chronically Ill waiver program, formerly known as HCBC-ECI, has been named the Choices for Independence (CFI) program.

A February 2010 report of CFI participant cases that were open for at least six months reflected 2520 cases and further calculation indicated that a randomized and representative sample of 183 would yield a 5% confidence interval at the 95% confidence level, for a statewide sample.

Notification letters were sent to all HCBC-ECI waiver participants (N=2520) notifying them that they may be randomly selected to participate in the Participant Experience survey. Ultimately, 316 interviews were actually completed. All Participant Experience Surveys (PES) were completed as face-to-face interviews in CFI participants’ homes and/or residences based on appointments arranged by the trained surveyors. Surveyors reported that, on average, interviews took 30 minutes.

The initial survey team consisted of eight interviewers with past experience working with the older adult and disabled population. The PES survey team received training and technical assistance from the PES developer, the Healthcare business of Thomson Reuters, which developed the survey under contract with the Centers for Medicare and Medicaid Services (CMS) and the University of New Hampshire Survey Center who coordinated the 2010 implementation of the PES survey.

Not all CFI participants in the sample were available or interested in participating in the PES. The surveyors recorded the reason a selected CFI participant did not complete a PES based on the following list of non-survey reasons.

1. participant does not wish to participate
2. unable to participate per provider, guardian or family member/advocate
3. unable to contact
   a. 3 attempts made
   b. check telephone number with support staff; if different try again
4. unable to arrange for interpreter or adequate proxy
5. unsafe for surveyor (as determined by the surveyor)
6. surveyors not to survey people known to them; will transfer to another surveyor
7. other, e.g., participant who schedules multiple times and cancels multiple times
8. death
A particular challenge was undelivered notification letters at a return rate of at least 8%. Letters that were returned undeliverable were re-mailed with new contact information. In addition, a significant number of participants’ telephone numbers were incorrect making it necessary to check other resources and, if contact information was not available, those CFI participants were crossed off the list and other participants were selected from the randomized sample list.

The response rate for the 2010 Participant Experience Survey can be found below:

<table>
<thead>
<tr>
<th>Completed Interviews</th>
<th>316</th>
<th>31.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant does not wish to participate</td>
<td>155</td>
<td>15.5%</td>
</tr>
<tr>
<td>Unable to arrange for interpreter or adequate proxy</td>
<td>2</td>
<td>0.2%</td>
</tr>
<tr>
<td>Surveyors not to survey people known to them; name will be transferred to other interviewer</td>
<td>3</td>
<td>0.3%</td>
</tr>
<tr>
<td>Participant was unable to participate per provider, guardian or family member/advocate</td>
<td>72</td>
<td>7.2%</td>
</tr>
<tr>
<td>Participant was unable to be reached after 3 attempts were made including having the participant’s telephone number checked with BEAS</td>
<td>74</td>
<td>7.4%</td>
</tr>
<tr>
<td>Answering Machine</td>
<td>46</td>
<td>4.6%</td>
</tr>
<tr>
<td>Missed Appointment</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Busy</td>
<td>4</td>
<td>0.4%</td>
</tr>
<tr>
<td>No Answer</td>
<td>25</td>
<td>2.5%</td>
</tr>
<tr>
<td>Changed Number</td>
<td>14</td>
<td>1.4%</td>
</tr>
<tr>
<td>Disconnected</td>
<td>43</td>
<td>4.3%</td>
</tr>
<tr>
<td>No Contact Information / No Contact Made</td>
<td>185</td>
<td>18.5%</td>
</tr>
<tr>
<td>Deceased</td>
<td>15</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>3.9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>8</td>
<td>0.8%</td>
</tr>
<tr>
<td><strong>Total Records Selected</strong></td>
<td>1002</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix B: Survey Instruments (GSP, ADRC, PES)
“Now let’s talk about a different topic ... Suppose you or someone else in your household had a condition or illness that required long-term supports, such as help with bathing or dressing, preparing meals, helping with medications, help with chores, or help with transportation. How confident are you that you could find out about how to get long-term support services in your community if you or someone in your household needed them ... very confident ... somewhat confident ... not very confident ... not confident at all?”

1  VERY CONFIDENT
2  SOMEWHAT CONFIDENT
3  NOT VERY CONFIDENT
4  NOT CONFIDENT AT ALL

98  DK / NOT SURE – DO NOT PROBE
99  NA / REFUSED

“Who would you contact to find out more about long-term support services and top arrange to receive them?”

(DO NOT READ RESPONSES. RECORD ALL MENTIONED)

1  FAMILY MEMBER
2  FRIEND
3  DOCTOR
4  CLERGY
5  WEB SITE
6  PHONE BOOK
7  NEWSPAPER
8  BROCHURE/FLYER
9  POSTER OR BILLBOARD
10 LOCAL SOCIAL SERVICE AGENCY
11 VISITING NURSE ASSOCIATION (VNA)
12 HOME CARE AGENCY
13 SENIOR CENTER
14 HOSPITAL / CLINIC
15 MENTAL HEALTH CENTER
16 GOVERNMENT OFFICE

1 The Granite State Poll is a quarterly omnibus survey of New Hampshire adults.
17  AREA AGENCY ON DISABILITY
18  DISABILITY RIGHTS CENTER
19  GRANITE STATE INDEPENDENT LIVING
20  OTHER (SPECIFY)
21  DON’T KNOW / NOT SURE
22  NA / REFUSED

SLRC3
"How familiar are you with an information and referral service called the ServiceLink Resource Center ... very familiar... somewhat familiar ... not very familiar ... or not familiar at all?"

1  VERY FAMILIAR
2  SOMEWHAT FAMILIAR
3  NOT VERY FAMILIAR
4  NOT FAMILIAR AT ALL

98  DON’T KNOW/NOT SURE
99  NA/REFUSED

SLRC4
"As you may know, the ServiceLink Resource Center is a free service that provides information about programs and services that are available to elderly adults and persons with disabilities. Have you or anyone in your household, ever called the ServiceLink Resource Center for information about services available for elderly adults and persons with disabilities?"

IF YES: "How recently did you LAST call the ServiceLink Resource Center ... within the last 6 months ... between 6 months and one year ago ... or more than one year ago?"

1  WITHIN LAST 6 MONTHS
2  6 MONTHS TO 1 YEAR AGO
3  MORE THAN 1 YEAR AGO
4  NEVER CALLED SERVICELINK → SKIPTO SLRC7

98  DON’T KNOW/NOT SURE → SKIPTO SLRC7
99  NA/REFUSED
SLRC5

"How satisfied were you with the information provided by the ServiceLink Resource Center ... very satisfied... somewhat satisfied ... not very satisfied ... or not satisfied at all?"

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VERY SATISFIED</td>
<td>SOMEWHAT SATISFIED</td>
<td>NOT VERY SATISFIED</td>
<td>NOT SATISFIED AT ALL</td>
</tr>
</tbody>
</table>

98 DON'T KNOW/NOT SURE
99 NA/REFUSED

ASK SLRC6 IF SLRC3 = 1, 2 OR 3

SLRC6

“How did you hear of the ServiceLink Resource Center?” “Anywhere else?” (DO NOT READ RESPONSES. RECORD ALL MENTIONED)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FAMILY MEMBER</td>
<td>FRIEND</td>
<td>DOCTOR</td>
<td>CLERGY</td>
<td>WEB SITE</td>
<td>PHONE BOOK</td>
<td>NEWSPAPER</td>
<td>BROCHURE/FLYER</td>
<td>POSTER OR BILLBOARD</td>
<td>LOCAL SOCIAL SERVICE AGENCY</td>
<td>VISITING NURSE ASSOCIATION (VNA)</td>
<td>HOME CARE AGENCY</td>
<td>SENIOR CENTER</td>
<td>HOSPITAL / CLINIC</td>
<td>MENTAL HEALTH CENTER</td>
<td>GOVERNMENT OFFICE</td>
<td>AREA AGENCY ON DISABILITY</td>
<td>DISABILITY RIGHTS CENTER</td>
<td>GRANITE STATE INDEPENDENT LIVING</td>
<td>OTHER (SPECIFY)</td>
<td>DON'T KNOW / NOT SURE</td>
<td>NA / REFUSED</td>
</tr>
</tbody>
</table>
"If you or someone else in your household, needed information about services for elderly adults or persons with disabilities in your community, how likely would you be to call the ServiceLink Resource Center ... very likely ... somewhat likely ... not very likely ... or not likely at all?"

1   VERY LIKELY
2   SOMewhat LIKELY
3   NOT VERY LIKELY
4   NOT LIKELY AT ALL

98   DON'T KNOW/NOT SURE
99   NA/REFUSED
ServiceLink Resource Center (SLRC) of Belknap County
Consumer Satisfaction Survey

At the ServiceLink Resource Center, we want to continually improve the quality of the assistance we provide to our valued clients. Please tell us about your most recent experience with SLRC by taking a few minutes to complete this survey. Just circle the number of the response that best represents your opinion. If the question does not apply to you, circle the “5”. When you’re finished, place the survey in the return envelope provided, and drop it in the mail. You do NOT have to put a stamp on the envelope.

1. What is the primary reason you most recently contacted ServiceLink?
   - Medicare
   - Medicaid
   - Long Term Care Planning
   - General Information
   - Help Finding Services
   - Caregiver Support
   - Other ________

2. Who did you contact SLRC for help about?
   - Myself
   - My spouse / partner
   - Parent
   - Other _______________

<table>
<thead>
<tr>
<th>Your Most Recent Contact</th>
<th>Strongly Agree</th>
<th>Agree Somewhat</th>
<th>Disagree Somewhat</th>
<th>Strongly Disagree</th>
<th>Doesn't Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. (If you left a message) The SLRC representative called me back within 24 hours.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The SLRC representative understood my needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The SLRC representative answered all my questions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. The SLRC representative referred me to the appropriate agency/agencies for service.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. The SLRC representative was courteous and friendly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I understand how SLRC can assist me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I trust the information provided by SLRC.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I would use the SLRC again.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I would recommend SLRC to a friend or relative.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Overall, I am satisfied with my experiences with the SLRC.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

13. During this most recent contact, was there a staff member that was very helpful? If yes, please tell us about your experience? ____________________________

14. Did the assistance you received from SLRC help you make more informed decisions about care and services?
   - Yes
   - No → What could we do better? ____________________________

<table>
<thead>
<tr>
<th>Contact Results</th>
<th>Strongly Agree</th>
<th>Agree Somewhat</th>
<th>Disagree Somewhat</th>
<th>Strongly Disagree</th>
<th>Doesn't Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. If needed, my SLRC representative followed-up within a reasonable time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. My contact with SLRC led to an appropriate follow-up / referral(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. The referral(s) I received resulted in my needs being met</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Optional: Please sign and print your name here if you agree to allow us to use your comments for public awareness of SLRC.

Sign _____________________________________    Print ______________________________

1-866-634-9412
www.ServiceLink.org
Rev. Belknap 3/20/09
PARTICIPANT EXPERIENCE SURVEY

ELDERLY/DISABLED (E/D) VERSION

Version 1.0
August 1, 2003

A Technical Assistance Tool for States

DEVELOPED BY
The MEDSTAT Group, Inc.
FOR THE
Centers for Medicare & Medicaid Services
AN AGENCY OF
The Department of Health & Human Services
CONTRACT #500-96-0006 T.O. #2
Survey Instructions

- Make sure you have the respondent’s face sheet available when conducting the interview, since you are directed to refer to it at various points during the interview.
- Text read to the respondent is in mixed case. Text just for you is in all CAPS (with the exception of the Interviewer Comments Section).
- Please answer every question by checking one box, unless instructed to "Check all that apply," in which case multiple boxes may be checked.
- Do not leave any questions blank. If the respondent does not answer an item, check the box for "No Response."
- Record only responses provided by the respondent.
- Some questions require you to write in the respondent's answer, like the example below. Please record the respondent's verbatim response as best you can.

66. What kind of work do you do? (SPECIFY)

- Some questions are skipped over in this survey. When this is necessary, an arrow directs you to the next question to be asked, like the example below.

1  YES
2  NO  → Skip to Q.15
7  UNSURE  → Skip to Q.17
8  UNCLEAR RESPONSE  → Skip to Q.17
9  NO RESPONSE  → Skip to Q.17

- If there is no arrow next to a response category, like the "YES" response above, please continue with the very next item in the sequence.
- Some items have instruction boxes, like the example below. These boxes are intended to provide you with additional information or instructions. Do not read these to the respondent.

Refer to the face sheet for the case manager's or support coordinator's name.

1  YES
2  NO  → Skip to Q.15
7  UNSURE  → Skip to Q.17
8  UNCLEAR RESPONSE  → Skip to Q.17
9  NO RESPONSE  → Skip to Q.17

Refer to the face sheet for the case manager's or support coordinator's name.

1  NAMES CASE MANAGER/SUPPORT COORDINATOR
2  DOES NOT NAME CASE MANAGER/SUPPORT COORDINATOR
8  UNCLEAR RESPONSE
9  NO RESPONSE
Hello, my name is _______ and I am from ________. How are you today? Thank you again for letting me come talk with you. I am very interested in hearing about your life and how satisfied you are with the assistance you get from the people paid to help you. If you have any questions, please stop me and ask me. Also, please let me know if you do not understand a question or if you would like me to repeat it. Are you ready to begin?
A. Access to Care

The first set of questions I am going to ask you have to do with some everyday activities, like getting dressed and taking a bath. Some people have no problem doing these things by themselves. Other people need somebody to help them.

1. Is there any special help that you need to take a bath or shower?

   REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

   1  □  NEEDS HELP FROM ANOTHER PERSON
   2  □  DOES NOT NEED HELP FROM ANOTHER PERSON → Skip to Q.4
   8  □  UNCLEAR RESPONSE → Skip to Q.4
   9  □  NO RESPONSE → Skip to Q.4

2. Do you ever go without a bath or shower when you need one?

   1  □  YES
   2  □  NO → Skip to Q.4
   7  □  UNSURE → Skip to Q.4
   8  □  UNCLEAR RESPONSE → Skip to Q.4
   9  □  NO RESPONSE → Skip to Q.4

3. Is this because there is no one there to help you?

   1  □  YES
   2  □  NO
   7  □  UNSURE
   8  □  UNCLEAR RESPONSE
   9  □  NO RESPONSE
4. Is there any special help that you need to get dressed? *(SPECIFY)*

If respondent indicates any help is received from another person, including cueing or standby assistance, check "Needs Help."

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1  □  NEEDS HELP FROM ANOTHER PERSON
2  □  DOES NOT NEED HELP FROM ANOTHER PERSON → Skip to Q.7
8  □  UNCLEAR RESPONSE → Skip to Q.7
9  □  NO RESPONSE → Skip to Q.7

5. Do you ever go without getting dressed when you need to?

1  □  YES
2  □  NO → Skip to Q.7
7  □  UNSURE → Skip to Q.7
8  □  UNCLEAR RESPONSE → Skip to Q.7
9  □  NO RESPONSE → Skip to Q.7

6. Is this because there is no one there to help you?

1  □  YES
2  □  NO
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
7. Is there any special help that you need to get out of bed?

If respondent indicates any help is received from another person, including cueing or standby assistance, check "Needs Help."

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1  NEEDS HELP FROM ANOTHER PERSON
2  DOES NOT NEED HELP FROM ANOTHER PERSON → Skip to Q.10
8  UNCLEAR RESPONSE → Skip to Q.10
9  NO RESPONSE → Skip to Q.10

8. Do you ever go without getting out of bed when you need to?

1  YES
2  NO → Skip to Q.10
7  UNSURE → Skip to Q.10
8  UNCLEAR RESPONSE → Skip to Q.10
9  NO RESPONSE → Skip to Q.10

9. Is this because there is no one there to help you?

1  YES
2  NO
7  UNSURE
8  UNCLEAR RESPONSE
9  NO RESPONSE
10. Is there any special help that you need to eat?

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1  □  NEEDS HELP FROM ANOTHER PERSON
2  □  DOES NOT NEED HELP FROM ANOTHER PERSON  ➔ Skip to Q.13
8  □  UNCLEAR RESPONSE  ➔ Skip to Q.13
9  □  NO RESPONSE  ➔ Skip to Q.13

11. Do you ever go without eating when you need to?

1  □  YES
2  □  NO  ➔ Skip to Q.13
7  □  UNSURE  ➔ Skip to Q.13
8  □  UNCLEAR RESPONSE  ➔ Skip to Q.13
9  □  NO RESPONSE  ➔ Skip to Q.13

12. Is this because there is no one there to help you?

1  □  YES
2  □  NO
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
13. Is there any special help that you need to make your meals?

If respondent indicates any help is received from another person, including cueing or standby assistance, check “Needs Help.”

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1 □ NEEDS HELP FROM ANOTHER PERSON
2 □ DOES NOT NEED HELP FROM ANOTHER PERSON → Skip to Q.16
8 □ UNCLEAR RESPONSE → Skip to Q.16
9 □ NO RESPONSE → Skip to Q.16
95 □ NOT APPLICABLE , TUBE FED → Skip to Q.19

14. Do you ever go without a meal when you need one?

1 □ YES
2 □ NO → Skip to Q.16
7 □ UNSURE → Skip to Q.16
8 □ UNCLEAR RESPONSE → Skip to Q.16
9 □ NO RESPONSE → Skip to Q.16

15. Is this because there is no one there to help you?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE
16. Is there any special help that you need to get groceries?  

If respondent indicates any help is received from another person, including cueing or standby assistance, check "Needs Help."

- Needs Help from another person
- Does not need help from another person → Skip to Q.19
- Unclear response → Skip to Q.19
- No response → Skip to Q.19
- Not applicable, tube fed → Skip to Q.19

17. Are you sometimes unable to get groceries when you need them?  

- Yes
- No → Skip to Q.19
- Unsure → Skip to Q.19
- Unclear response → Skip to Q.19
- No response → Skip to Q.19

18. Is this because there is no one there to help you?  

- Yes
- No
- Unsure
- Unclear response
- No response
19. Is there any special help that you need to do housework – things like straightening up or doing dishes?

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1  □  NEEDS HELP FROM ANOTHER PERSON
2  □  DOES NOT NEED HELP FROM ANOTHER PERSON  →  Skip to Q.22
8  □  UNCLEAR RESPONSE  →  Skip to Q.22
9  □  NO RESPONSE  →  Skip to Q.22

20. Does the housework not get done sometimes?

1  □  YES
2  □  NO  →  Skip to Q.22
7  □  UNSURE  →  Skip to Q.22
8  □  UNCLEAR RESPONSE  →  Skip to Q.22
9  □  NO RESPONSE  →  Skip to Q.22

21. Is this because there is no one there to help you?

1  □  YES
2  □  NO
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
22. Is there any special help that you need to do laundry?

If respondent indicates any help is received from another person, including cueing or standby assistance, check "Needs Help."

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1 □ NEEDS HELP FROM ANOTHER PERSON
2 □ DOES NOT NEED HELP FROM ANOTHER PERSON → Skip to Q.25
8 □ UNCLEAR RESPONSE → Skip to Q.25
9 □ NO RESPONSE → Skip to Q.25

23. Does the laundry not get done sometimes?

1 □ YES
2 □ NO → Skip to Q.25
7 □ UNSURE → Skip to Q.25
8 □ UNCLEAR RESPONSE → Skip to Q.25
9 □ NO RESPONSE → Skip to Q.25

24. Is this because there is no one there to help you?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE

25. Can you always get to the places you need to go, like work, shopping, the doctor's office, or a friend's house?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE
26. Is there any special help that you need to take medicine, such as someone to pour it or set up your pills?

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REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

27. Do you ever go without taking your medicine when you need it?

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28. Is this because there is no one there to help you?

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29. Is there any special help that you need to get to or use the bathroom?

If respondent indicates any help is received from another person, including cueing or standby assistance, check "Needs Help."

REVIEW RESPONSE ABOVE AND THEN CODE AS APPROPRIATE BELOW.

1 ☐ NEEDS HELP FROM ANOTHER PERSON
2 ☐ DOES NOT NEED HELP FROM ANOTHER PERSON → Skip to Q.32
8 ☐ UNCLEAR RESPONSE → Skip to Q.32
9 ☐ NO RESPONSE → Skip to Q.32

30. Are you ever unable to get to or use the bathroom when you need to?

1 ☐ YES
2 ☐ NO → Skip to Q.32
7 ☐ UNSURE → Skip to Q.32
8 ☐ UNCLEAR RESPONSE → Skip to Q.32
9 ☐ NO RESPONSE → Skip to Q.32

31. Is this because there is no one there to help you?

1 ☐ YES
2 ☐ NO
7 ☐ UNSURE
8 ☐ UNCLEAR RESPONSE
9 ☐ NO RESPONSE
32. Think about the people who are paid to help you with the everyday activities we have been discussing. Do they spend all the time with you that they are supposed to?

1  □  YES
2  □  NO
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
95 □  NO HOME SUPPORT STAFF

33. Have you ever talked with your case manager or support coordinator about any special equipment, or changes to your home, that might make your life easier?

1  □  YES
2  □  NO  → Skip to Q.36
7  □  UNSURE  → Skip to Q.36
8  □  UNCLEAR RESPONSE  → Skip to Q.36
9  □  NO RESPONSE  → Skip to Q.36

34. What equipment or changes did you talk about? (SPECIFY)

________________________________________________________________________
________________________________________________________________________

35. Did you get the equipment or make the changes you needed?

1  □  YES
2  □  NO
3  □  IN PROCESS
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
B. Choice and Control

These next few questions are about how much choice you have in the help you get, and the assistance you receive from your case manager or support coordinator.

36. Do you help pick the people who are paid to help you?

1 □ YES → Skip to Q.38
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE → Skip to Q.38
9 □ NO RESPONSE → Skip to Q.38
95 □ NO PERSONAL CARE STAFF → Skip to Q.41

37. Would you like to help pick the people who are paid to help you?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE

38. Did you know you can change the people who are paid to help you if you want to?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE
39. Thinking again about the people who are paid to help you, do you tell them what to help you with?

1  □  YES  \(\rightarrow\) Skip to Q.41
2  □  NO
3  □  SOMETIMES  \(\rightarrow\) Skip to Q.41
7  □  UNSURE
8  □  UNCLEAR RESPONSE  \(\rightarrow\) Skip to Q.41
9  □  NO RESPONSE  \(\rightarrow\) Skip to Q.41

40. Would you like to tell them the things you want help with?

1  □  YES
2  □  NO
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE

41. If there is something wrong with the help you are getting, who do you talk with to get the problem fixed? (CHECK ALL THAT APPLY)

1  □  NO ONE
2  □  FAMILY/FRIEND
3  □  CASE MANAGER/SUPPORT COORDINATOR/OTHER STAFF
4  □  OTHER (SPECIFY)___________________
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
42. Who is your case manager or support coordinator?

Refer to the face sheet for the case manager’s or support coordinator’s name.

1  □  NAMES CASE MANAGER/SUPPORT COORDINATOR
2  □  DOES NOT NAME CASE MANAGER/SUPPORT COORDINATOR
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE

43. Can you talk to your case manager or support coordinator when you need to?

1  □  YES
2  □  NO
3  □  SOMETIMES
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
95 □  NOT APPLICABLE – HAVE NOT TRIED

44. Does your case manager or support coordinator help you when you ask for something?

1  □  YES
2  □  NO
3  □  SOMETIMES
7  □  UNSURE
8  □  UNCLEAR RESPONSE
9  □  NO RESPONSE
95 □  NOT APPLICABLE – HAVE NOT ASKED
C. Respect/Dignity

Now I would like to ask you about how you are treated by the people who are paid to help you. The next two questions are about people who come to your home.

45. Do the people paid to help you treat you respectfully in your home?

1 □ YES
2 □ NO
3 □ SOMETIMES
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE
95 □ NO STAFF IN HOME → Skip to Q.47

46. Do the people paid to help you listen carefully to what you ask them to do in your home?

1 □ YES
2 □ NO
3 □ SOMETIMES
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE

47. Have you ever been injured by any of the people paid to help you now?

Reminder:
Refer to your state's policy on reporting for any suspected incidents of abuse or neglect. Record only reports of current abuse.

1 □ YES
2 □ NO → Skip to Q.49
7 □ UNSURE → Skip to Q.49
8 □ UNCLEAR RESPONSE → Skip to Q.49
9 □ NO RESPONSE → Skip to Q.49
95 □ NOT APPLICABLE (DOES NOT INTERACT WITH ANY PAID STAFF) → Skip to Q.59
48. What happened? When? Would you like any help with this problem?

________________________________________________________________________________

49. Are any of the people paid to help you now mean to you, or do they yell at you?

Reminder:
Refer to your state's policy on reporting for any suspected incidents of abuse or neglect. Record only reports of current abuse.

1 □ YES
2 □ NO → Skip to Q.51
3 □ SOMETIMES
7 □ UNSURE → Skip to Q.51
8 □ UNCLEAR RESPONSE → Skip to Q.51
9 □ NO RESPONSE → Skip to Q.51

50. What happens? Would you like any help with this problem?

________________________________________________________________________________

51. Have any of the people paid to help you now ever taken your things without asking?

Reminder:
Refer to your state's policy on reporting for any suspected incidents of abuse or neglect. Record only reports of current abuse.

1 □ YES
2 □ NO → Skip to Q.53
7 □ UNSURE → Skip to Q.53
8 □ UNCLEAR RESPONSE → Skip to Q.53
9 □ NO RESPONSE → Skip to Q.53
52. What happened? When? Would you like any help with this problem?


53. Do you go to a day program outside your home?

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54. Do the people paid to help you at a day program outside your home treat you respectfully?

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55. Do the people paid to help you at a day program outside your home listen carefully to what you ask them to do?

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56. Do you ride a van or use other transportation services?

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57. Do the people paid to help you on the van or with other transportation treat you respectfully?

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58. Do the people paid to help you on the van or with other transportation listen carefully to what you ask them to do?

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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>☐</td>
<td>UNCLEAR RESPONSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>☐</td>
<td>NO RESPONSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
D. **Community Integration/Inclusion**

The last few questions I’d like to ask you are about things you do in your community and the help you get to do these things.

59. **Is there anything you want to do outside your home that you don’t do now?**

1. [ ] YES
2. [ ] NO → Skip to Q.61
3. [ ] UNSURE → Skip to Q.61
4. [ ] UNCLAR RESPONSE → Skip to Q.61
5. [ ] NO RESPONSE → Skip to Q.61

60. **What would you like to do? What do you need to make this happen? (SPECIFY)**

_________________________________________________________________________________

_________________________________________________________________________________

61. **Is there anything else you want to talk to me about?**

_________________________________________________________________________________

_________________________________________________________________________________
The last few questions I'd like to ask you have to do with your work experiences.

62. Are you working right now?

1. YES
2. NO → Skip to Q.66
7. UNSURE → End of interview
8. UNCLEAR RESPONSE → End of interview
9. NO RESPONSE → End of interview

63. What kind of work do you do? (SPECIFY)

64. Did you help pick the job you have now?

1. YES
2. NO
7. UNSURE
8. UNCLEAR RESPONSE
9. NO RESPONSE
65. Do you like your job?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE

→ End of interview

66. Do you want to work?

1 □ YES
2 □ NO
7 □ UNSURE
8 □ UNCLEAR RESPONSE
9 □ NO RESPONSE

Thank you for talking with me today. I really appreciate all your help. If you have other questions, here is information on how you can contact me. INFORMAL PARTING OF YOUR CHOICE – GOOD-BYE, TAKE CARE, HANDSHAKE, ETC.
E. Interviewer Comments and Observations

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

What amount of the questions did the program participant answer by him/herself?

☐ ALL
☐ MOST
☐ ABOUT HALF
☐ SOME
☐ A FEW
☐ NONE

Who else provided responses? (If applicable) ___________________________________________________________
New Hampshire Specific Questions

“These last few questions relate to your plan for services. This is the document that lists all the services you will/are receiving from the Medicaid Home and Community-Based Care Services Waiver Programs, and who will be/are providing them.”

71. Have you been provided with a copy of your plan for services?
   1. Yes
   2. No
   3. Unsure/Can’t remember
   4. I don’t know what this is
   5. Unclear Response
   6. No Response

72. Does your plan address all your service needs and concerns?
   1. Yes
   2. No
   3. Unsure/can’t remember
   4. Unclear Response
   5. No Response

73. Has anyone ever explained to you your role in developing your plan for services?
   1. Yes
   2. No
   3. Unsure/Can’t remember
   4. Unclear Response
   5. No Response

74. Did you have enough say in developing your plan for services?
   1. Yes
   2. No
   3. Unsure/can’t remember
   4. Unclear Response
   5. No Response

75. Are you receiving all the services listed in your plan for services?
   1. Yes
   2. No
   3. Unsure/can’t remember
   4. Unclear Response
   5. No Response
76. Overall, how satisfied are you with the services you receive from this program? Would you say very satisfied, satisfied, neither satisfied or dissatisfied, dissatisfied, or very dissatisfied?
   1. Very satisfied
   2. Satisfied
   3. Neither satisfied or dissatisfied (neutral)
   4. Dissatisfied
   5. Very dissatisfied
   6. Unsure
   7. Unclear response
   8. No Response

77. Would you like to be contacted by someone from the Medicaid program to discuss any concerns or questions you have about your services?
   1. Yes
   2. No

Note: These questions will follow the new items added in 2008 regarding service planning, and appear at the end of the survey.

*Item for all participants*

78. Did you know you can change case management agencies if you want?
   1. Yes
   2. No
   3. I don’t know/not sure
   4. Unclear response
   5. No response

*79. Items for participants who have been on the waiver 6-12 months only*

80. When you submitted your application for long term care services and supports, were you given information about how long it would take to process it?
   1. Yes
   2. No
   3. I don’t know/not sure
   4. Unclear response
   5. No response

81. Were you given information about the steps in the application process?
   1. Yes
   2. No
   3. I don’t know/not sure
   4. Unclear response
   5. No response
82. Was this information (about the application process) helpful to you?
   1 Yes
   2 No
   3 I don’t know/not sure
   4 N/A – did not receive any information
   5 Unclear response
   6 No response

83. Did you receive any information about the status of your application for long term care services and supports while you were waiting to learn if you were eligible?
   1 Yes
   2 No
   3 I don’t know/not sure
   4 Unclear response
   5 No response

84. If you had a question about the status of your application, were you able to get the information you needed?
   1 Yes
   2 No
   3 I don’t know/not sure
   4 Unclear response
   5 No response

85. When you were applying for long term care services and supports, were you given a choice between receiving services in a nursing home and receiving them in your community?
   6 Yes
   7 No
   8 I don’t know/not sure
   9 Unclear response
   10 No response

86. Were you able to choose which case management agency to use?
   1 Yes
   2 No
   3 I don’t know/not sure
   4 Unclear response
   5 No response
Appendix C: Direct Care Workforce Reports
Strategies to Invest in the Future of the Direct Care Workforce

September 2009
The Coalition for the Direct Care Workforce is thankful to the following funders for their support:

Aging and Disability Resource Center Grant sponsored by the Administration on Aging and Centers for Medicare and Medicaid Services
Charles Stewart Mott Foundation
Endowment for Health
Money Follows the Person Grant sponsored by the Centers for Medicare and Medicaid Services
National Direct Service Workforce Resource Center
Systems Transformation Grant sponsored by the Centers for Medicare and Medicaid Services

Acknowledgements:

The New Hampshire Coalition for the Direct Care Workforce is grateful for the time and effort by many people to prepare this document.

Thanks go to Terry Lochhead (NH Community Loan Fund), Kimberly Persson and Laura Davie (Institute for Health Policy and Practice, University of New Hampshire), Susan Fox (Institute on Disability, University of New Hampshire), Alex Olins and Rhada Biswas (PHI), Kristin Smith (Carsey Institute, University of New Hampshire), Tracy Fowler (Survey Center, University of New Hampshire) and Susan Covert (Consultant).
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Robin Carlson, Direct Support Professional
Mary Ann Cooney, Deputy Commissioner; NH Department of Health and Human Services
Susan Covert, Facilitator; Consultant
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Ellen Edgerly; Brain Injury Association
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Danielle Fuller, Director, Human Resources; Gateways Community Services
Dottie Gove, Home Care Program Director; Child and Family Services of New Hampshire, Inc.
Laurie Harding; NH House/Armistead Caregiver Services
Rebecca Crosby-Hutchinson, Director; LSS In-Home Care Lutheran Social Services
Terry Lochhead, Consultant; Alliance for Retired Americans
Mary Maggioncalda, Administrator for Program and Policy Development; Bureau of Elderly and Adult Services, NH Department of Health and Human Services
Liz McConnell; Alzheimer's Association, MA/NH Chapter
Doug McNutt, Associate State Director for Advocacy; AARP NH
Alex Olins, Paraprofessional Health Institute
Kathleen F. Otte, Bureau Administrator; Bureau of Elderly and Adult Services, NH Department of Health and Human Services
David L. Ouellette; Council on Developmental Disabilities
Kimberly Persson, Research Associate; Institute for Health Policy and Practice, University of New Hampshire
Sally Varney, Quality Management Program Manager; Division of Community Based Care, NH Department of Health and Human Services
Margaret Walker; NH Board of Nursing
Susan M. Young, Executive Director; Home Care Association of New Hampshire
KEY MESSAGES

With a population that is aging at a faster rate than the national average, New Hampshire needs a qualified direct care workforce capable of supporting our state’s older citizens and those with disabilities to continue living in their homes and communities. The capacity of the state’s direct care workforce currently is not adequate to meet this increasing demand for home-based supports and services. The following are among the New Hampshire Coalition for the Direct Care Workforce’s recommendations to address this issue:

- The New Hampshire Department of Health and Human Services should establish a rational rate setting and reimbursement process that will enable home care agencies to pay a livable wage to their direct care workers.
- New Hampshire stakeholders should work with its Congressional delegation to create federal reimbursement for the training of home and community-based workers. (Nursing facilities receive federal reimbursement for training their direct care workers.)
- New Hampshire home care agencies should implement a steady work week, create loan repayment programs for their direct care workers, and improve the quality of staff supervision.

INTRODUCTION

With a population that is aging faster than the national average, New Hampshire can anticipate an increasing demand for healthcare and support services. Research shows that many Americans prefer home and community-based care facility-based services (HCBS). Further, providing care in home and community-based settings may be more cost-effective than institutional care. However, there is a real concern that resources for home and community-based care will be insufficient to meet demand in the coming years. This white paper explores the policy implications for New Hampshire as it confronts the challenge of how to attract and retain a direct care workforce capable of meeting the state’s need for HCBS. It examines the state’s current direct care workforce shortage and presents strategies for workforce retention. While direct care workers staff nursing facilities and other institutions, this paper focuses only on the direct care workforce employed in home and community-based settings.

Direct care workers provide essential HCBS for older adults and those who are chronically ill or have disabilities. The availability of this quality direct care is a critical factor in supporting people so they are able to continue to reside in their own homes as their needs increase, rather than in residential facilities, such as nursing homes. In New Hampshire, the number of residents 65 and older is growing at twice the rate of the total population (Gittell, 2006). As the population ages, New Hampshire is expected to rely more heavily on HCBS for long-term care, as opposed to placements in nursing facilities and other residential settings (PHI, 2001). In order to ensure that quality home and community-based services will be available to those who need them, the direct care workforce shortage must be addressed.

BACKGROUND

New Hampshire has made concerted efforts to increase the accessibility of HCBS. It was one of the first states in the nation to establish a statewide “single-point of entry” system for long-term care. This system provides information, counseling, and referrals to older adults and those who are chronically ill or have disabilities, helping them to access long-term care services, including HCBS. New Hampshire has been awarded federal grants to support the development of more flexible services and to improve accessibility to HCBS.
2002, the State spent 9% ($24 million) of its Medicaid funding on HCBS. Following the expansion of HCBS, 2007 figures show that HCBS spending increased to 13% ($46 million) of the Medicaid long-term care budget, an increase of 44%. During this same time period, long-term care funding for nursing facilities decreased by 4% (Houser et al, 2009).

The shift in funding from institutional settings to home and community-based care represents a paradigm shift in how long-term care is delivered. The increasing demand for HCBS has resulted in a shortage of direct care workers. New Hampshire employers have experienced difficulty in recruiting and retaining direct care workers to provide HCBS, a problem that is expected to continue unless changes are made to address the quality of direct care jobs. Without an adequate and stable workforce, the State will not be able to meet the demands of the growing number of residents who need home and community-based services.

In 2007, the New Hampshire Community Loan Fund, as a state partner of the Paraprofessional Healthcare Institute’s (PHI) LEADS Institute (Leadership, Education and Advocacy for Direct Care and Support), convened representatives from the American Association of Retired Persons (AARP), the Home Care Association of New Hampshire, the Institute on Disability (IOD), and the New Hampshire Bureau of Elderly and Adult Services (BEAS) to discuss potential strategies for addressing the direct care workforce shortage.

Later that year, through a grant from the Centers for Medicare and Medicaid Services (CMS), BEAS invited Robyn Stone, DPH, an expert in healthcare and aging policy, to help launch a statewide effort to address the direct care workforce shortage. As a result, the New Hampshire Coalition for the Direct Care Workforce (NHCDCW) was formed. The Coalition, which meets bimonthly, is focused on understanding the demographics of the direct care workforce, educating legislators and policy makers regarding the needs of this workforce, and providing training and education on best practices in the recruitment, training, and retention of direct care workers.

**TYPES OF LONG-TERM CARE**

Older adults and those with disabilities may require supports to meet their healthcare needs and assistance with personal care and activities of daily living (ADLs) (Super, 2002). Long-term care describes the range of healthcare and support services for people with disabilities or chronic illnesses. Long-term care encompasses both formal and informal supports and services and may be either medical or non-medical in nature. Most long-term care provides consumers with assistance in completing ADLs, such as dressing, bathing, and using the bathroom. Long-term can be provided in home and community-based settings, as well as in nursing homes and assisted living facilities (Medicare, 2009). Table 1 provides definitions of each type of care, based on criteria from the New Hampshire Department of Health and Human Services (NHDHHS).

**Table 1: Types of Long Term Care**

<table>
<thead>
<tr>
<th>Type of Long Term Care</th>
<th>Description of Long Term Care Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home Facility</td>
<td>Provides residency, meals, skilled nursing and rehabilitative care, medical services and protective supervision for eligible individuals who are ill, frail and need 24-hour supervision (NHDHHS, 2009).</td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td>Provides care for adults who qualify for nursing home care and can no longer manage independent living in their own homes. Assisted living facilities provide support services based on the specific needs of the resident, and can include nursing care, personal care, homemaker services and medication management (NHDHHS, 2009).</td>
</tr>
<tr>
<td>Home and Community Based Services: Formal</td>
<td>Provides in-home nursing care, homemaker services, and respite care performed by an employee working for an HCBS agency (NHDHHS, 2009).</td>
</tr>
<tr>
<td>Home and Community Based Services: Informal</td>
<td>Provides in-home nursing care, homemaker services, and respite care performed by a close friend or family member, who is not paid to perform care (NHDHHS, 2009).</td>
</tr>
</tbody>
</table>
THE HCBS DIRECT CARE WORKFORCE

Across all long term care settings nationally, direct care workers provide an estimated 70 to 80% of the paid hands-on long-term care and personal assistance received by Americans who are over the age of 65 or who have disabilities or other chronic conditions. The direct care workforce is comprised of approximately 80-90% women. The majority of direct care workers is in the 25-54 age range (Harris-Kojetin et al, 2004).

Table 2: Types of Direct Care Workers

<table>
<thead>
<tr>
<th>Type of Direct Care Workers</th>
<th>Job Description</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNAs</td>
<td>Must complete 100 hours of training and attain a license. Operate under the supervision of a nurse and provide assistance with ADLs such as eating, dressing, bathing, and toileting. Perform clinical tasks such as range-of-motion exercises and blood pressure readings. In some states, may also assist in administering oral medications (which requires additional training in NH) (NHDDHHS, 2009).</td>
<td>Medicaid, Medicare, Private Insurance.</td>
</tr>
<tr>
<td>PCSPs/PCAs</td>
<td>Must complete 10 hours of training to work for agency-directed programs or licensed home health agencies. Provide non-medical assistance with ADLs and often help with housekeeping chores, meal preparation, and medication management. Help individuals go to work and remain engaged in their communities (PHI, Facts 3, 2009).</td>
<td>Medicaid.</td>
</tr>
<tr>
<td>Homemakers/Companions</td>
<td>Provide services which do not involve physical contact with the individual, such as light housekeeping and meal preparation (PHI, Facts 3, 2009).</td>
<td>Social Services Block Grant (Title XX), Older Americans Act (Title III), or Medicaid HCBS, known in New Hampshire as Choices for Independence.</td>
</tr>
</tbody>
</table>

In 2003, the AARP conducted a survey of 805 randomly selected New Hampshire AARP members to inquire about their beliefs regarding long-term care options. Of the 805 respondents, 81% of those surveyed said that it was “very important” that people were provided with services that enabled them to remain in their homes (as compared to somewhat important, not important, or not sure). When asked about preferences for their own long-term care options, 70% reported that they would rather receive services at home than reside in a nursing home (6%) or in an assisted living facility (20%) (AARP, 2003).

Based on a multi-state analysis of Medicaid spending from 1995-2005, AARP found that states with established HCBS programs reduced their Medicaid spending over time (Mollica et al, 2009). These states were able to manage the growth in demand for long-term care services while maintaining control over their expenditures. Vermont’s experience with HCBS expansion is worth considering. In 2005, Vermont implemented “Choices for Care,” a long-term care Medicaid waiver. Under Choices for Care, older Vermonters and adults with physical disabilities who qualify for the waiver, are given an “allowance” of Medicaid dollars and may choose whether to receive services at home, in an assisted living facility, or in a nursing home. This program decreased the number of nursing home residents by 9% and increased HCBS caseloads by 155%. This included expanding HCBS services to 1,183 Vermonters in moderate-need of assistance. Choices for Care helped Vermont reduce long-term care spending growth by more than half of what was projected (State of Vermont, 2009).

Because direct care workers are generally paid lower wages than their nursing home counterparts, HCBS programs often save money. Additional savings take place as the number of HCBS hours required by individuals is significantly less than the 24 hour, 7 day per week care provided to patients in nursing facilities.
For the purpose of this paper, New Hampshire’s direct care workforce is comprised of three primary groups: Licensed Nursing Assistants (LNA), Personal Care Service Providers (PCSP)/Personal Care Attendants (PCA), and Homemaker/Companions. Information about each category is provided in Table 2.

As previously discussed, demand for direct care workers in home and community settings is expected to increase significantly in the coming years. Although future demand cannot be predicted with complete certainty, demographic trends indicate a growing gap between the number of people who are likely to need care and the number of people who will be able to provide it. Finding qualified workers to fill these job openings will be challenging.

DIRECT CARE WORKFORCE SHORTAGE IN NEW HAMPSHIRE

New Hampshire is a rapidly aging state. In 2000, New Hampshire was nationally ranked 42nd for the percentage of the population aged 65 and older. By 2030, it is estimated that New Hampshire will rank 17th in this category (U.S. Census, 2008). The number of New Hampshire residents 65 and older will have increased 138% in 30 years (U.S. Census, 2005). The group relying most heavily on the direct care workforce, those who are 85 and older, will have increased by 146% (U.S. Census, 2005).

According to 2007 estimates, there were approximately 26,000 working-age adults (ages 21-64) in New Hampshire who are living with a self-care disability. A self-care disability is defined as any disability—physical, mental, or emotional—that causes difficulty in dressing, bathing, or navigating the home (Erickson & Lee, 2008).

Employment security forecasters anticipate an increase in the need for direct care workers.

Occupational growth projections1 from the New Hampshire Department of Employment Security (NHDES) for 2006-2016 show that direct care occupations—Personal Care Aides, Home Health Aides, and Nursing Aides/LNAs, Orderlies and Attendants—are expected to add over 6,000 jobs by 2016. This is a 50% growth rate over a decade (PHI Analysis, 2009), as shown in Figure 1.

Figure 1: Direct care Workforce Growth in NH, 2006-2016

Employment security forecasters anticipate an increase in the need for direct care workers.

---

1 PHI’s employment projections analysis takes into consideration both new job openings and openings arising from replacements (retirements, and/or people leaving the profession). 2016 projections on the NHDES website do not factor in job growth due to replacements.
Personal Care Aides and Home Health Aides are also among the fastest-growing occupations in New Hampshire. Among occupations expected to generate over 1,000 jobs by 2016, Personal Care Aides rank third, growing by 75%, and Home Health Aides rank fifth, growing by 68% (PHI Analysis, 2009). Table 3 provides more detail about this growth.

**Table 3: Projected Job Growth in New Hampshire**

<table>
<thead>
<tr>
<th>Table 3: Projected Rank</th>
<th>Occupation Title</th>
<th>Estimated 2006 employment</th>
<th>Projected 2016 employment</th>
<th>Total openings: 2006-2016</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Counter Attendants, Cafeteria, Food Concession, and Coffee Shop</td>
<td>2,906</td>
<td>5,406</td>
<td>2,500</td>
<td>86%</td>
</tr>
<tr>
<td>2</td>
<td>Hosts and Hostesses, Restaurant, Lounge, and Coffee Shop</td>
<td>1,859</td>
<td>3,429</td>
<td>1,570</td>
<td>84%</td>
</tr>
<tr>
<td>3</td>
<td>Personal and Home Care Aides</td>
<td>2,691</td>
<td>4,721</td>
<td>2,030</td>
<td>75%</td>
</tr>
<tr>
<td>4</td>
<td>Waiters and Waitresses</td>
<td>12,170</td>
<td>20,780</td>
<td>8,610</td>
<td>71%</td>
</tr>
<tr>
<td>5</td>
<td>Home Health Aides</td>
<td>2,247</td>
<td>3,777</td>
<td>1,530</td>
<td>68%</td>
</tr>
</tbody>
</table>

The projected growth in demand for workers, however, is not matched by a commensurate growth in the supply of workers. PHI’s calculations, based on the New Hampshire Employment Security occupational projections, U.S. Census Bureau demographic projections data, and Bureau of Labor Statistics (BLS) labor force participation data, show that growth in demand for direct care workers is expected to outpace the growth in the supply of available workers, women aged 25-54, who are the core labor pool for this workforce.

**Figure 2: New Hampshire’s Projected Direct Care Workforce Shortage**

- **Demand for New Direct-Care Workers in New Hampshire** is Outpacing Growth in Core Labor Pool
- **Net new women aged 25-54 entering workforce, 2006-2016**
- **Demand for direct-care worker positions, 2006-2016**
Figure 2 shows that from 2006-2016, the state will need an estimated 6,230 additional direct care workers, while the net number of new women, aged 25-54, entering the New Hampshire labor force is expected to be only 4,198 (PHI Analysis, 2009).

Fewer new workers are entering the long-term care workforce due to increased opportunities in other fields. As compared to 40 years ago, women in particular now are able to select from careers that pay far better and are less physically strenuous than direct care employment (Super, 2002).

PHI’s calculations based on wage data from the BLS Occupational Employment Survey show that median hourly wages for New Hampshire’s HCBS workers are lower than the state’s livable wage, which is the estimated hourly wage that a New Hampshire resident needs to earn in order to meet basic needs such as housing, food, transportation, child care and healthcare (PHI Analysis, 2009). In 2008, the median hourly wage for Home Health Aides and Personal and Home Care Aides was $10, while the state’s hourly livable wage for a single person was $11.55. These figures indicate that direct care wages are not adequate to meet the workers’ basic needs. Low wages pose a major challenge in the recruitment and retention of this critical workforce.

A 2008 report published by the Carsey Institute at the University of New Hampshire indicates that of the forty occupations projected to grow the fastest from 2006 to 2016, only two occupations paid a median hourly wage below the state’s 2007 livable wage: Home Health Aides and Personal Care Aides (Kenyan and Churilla, 2008).

Figure 3: New Hampshire HCBS Worker Wage Compared to State’s Livable Wage, 2008

ISSUES IMPACTING THE NEW HAMPSHIRE HCBS DIRECT CARE WORKFORCE

A 2008 survey developed by the NHCDCW, New Hampshire Institute for Health Policy and Practice and Carsey Institute at the University of New Hampshire, and implemented by the University of New Hampshire Survey Center, provides detailed information about the issues impacting the State’s direct care workforce. The purpose of the survey was to quantify the current workforce demographics, capture wage and benefit ranges, and identify recruitment and retention issues for home and community-based direct care workers.
It is expected that survey results will help to guide the NHCDCW and state policy makers in addressing New Hampshire’s HCBS direct care workforce shortage.

The New Hampshire direct care workforce survey was conducted in two parts: an employer component and a separate employee component.²

**Employer Perspective**
The Survey Center contacted all 60 New Hampshire agencies that employ HCBS direct care workers and 38 agencies responded. All three types of direct care workers were represented in this sample. A summary of the types of agencies is provided in Table 4.

<table>
<thead>
<tr>
<th>Type of Agency</th>
<th>Number of Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private, non-profit</td>
<td>22</td>
</tr>
<tr>
<td>Publicly owned and operated</td>
<td>3</td>
</tr>
<tr>
<td>Private, for profit</td>
<td>9</td>
</tr>
<tr>
<td>Associated with health system or hospital</td>
<td>5</td>
</tr>
</tbody>
</table>

According to the survey results:

- Almost three-quarters of employers reported offering health insurance benefits to employees. Most stipulated eligibility criteria, such as tenure at the agency and minimum hours worked per week, to qualify for health insurance benefits. Employers reported that the average monthly health insurance premium paid by employees for individual coverage is $91.

- 87% of employers surveyed reported that job retention was an issue.
- 81% reported a current need to hire direct care workers in order to meet service demands.
- Eight in ten employers reported reimbursing for mileage. Of the agencies providing mileage reimbursement, the average reimbursement rate was $.49 per mile with a range of $.25 to $.585 per mile.³
- When driving between consumer homes, some direct care workers were paid a wage below their usual hourly rate and sometimes as little as minimum wage.⁴

**Employee Perspective**
The second component of the survey focused on HCBS direct care workers. The total number of respondents was 579. Table 5 displays the demographics of the survey respondents.

**Factors Influencing Job Satisfaction**
When direct care workers were asked what would improve their jobs, the greatest number identified increased pay, increased access to benefits, and more paid leave. Over three-quarters of the group identified the desire for higher pay, almost half expressed a need for increased access to benefits, and almost one-third reported a desire for more time off.

**Hours & Wages**
Less than one-third of direct care workers were employed by one employer on a full-time basis (35 or more hours per week). Over 15% reported working multiple jobs to achieve full-time work. This approach was effective in regards to increasing one’s income, however, it did not increase benefits as full-time hours were not met at one company.

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² For more information about the NH Direct Care Workforce Survey, see Smith, 2009.

³ In June 2008, the federal mileage reimbursement rate was $.505 per mile. This figure jumped to $.585 per mile in July 2008.

⁴ Federal law requires employers to pay their employees for time spent on work-related travel.
Over 46% of direct care workers had more than one job. On average, direct care workers worked 33 hours per week with 24 of the hours associated with direct care work.

**Table 5: Demographics of Respondents to the Direct Care Worker Survey**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>90% female</td>
</tr>
<tr>
<td>Average Age</td>
<td>48 years old</td>
</tr>
<tr>
<td>Married</td>
<td>58%</td>
</tr>
<tr>
<td>Minor children living in-home</td>
<td>33%</td>
</tr>
<tr>
<td>Single mothers</td>
<td>11%</td>
</tr>
<tr>
<td>Education:</td>
<td></td>
</tr>
<tr>
<td>High School Diploma or less</td>
<td>47%</td>
</tr>
<tr>
<td>Some college experience</td>
<td>40%</td>
</tr>
<tr>
<td>Associate’s or bachelor’s</td>
<td>13%</td>
</tr>
<tr>
<td>Family income less than $30,000</td>
<td>52%</td>
</tr>
</tbody>
</table>

The median hourly wage for HCBS workers was $10 for part-time workers and $10.25 for full-time workers. Among the categories of direct care workers, LNAs earned the highest median hourly wage at $11.77. PCSPs/PCAs earned a median hourly wage of $10.00 and homemaker/companions earned a median hourly wage of $8.98. These wages were not dependent on educational level. A direct care worker without a high school diploma earned the same wage as a worker with a college degree. Assuming that a full-time direct care worker worked 40 hours per week for 50 weeks per year, at the median hourly full-time rate of $10.25, she earns $20,500 per year. In comparison, the median annual salary in New Hampshire (in all job categories) is currently $40,000 (Smith, 2009).

**Health Insurance**

Over one-third of direct care workers did not have health insurance. Survey responses from direct care workers indicate that the primary reason for this was that the premiums on employer sponsored plans were too expensive. Other primary responses indicated that employers did not offer insurance or that employees were ineligible to qualify for employer sponsored insurance plans.

Less than one-fifth of direct care workers participated in employer sponsored health insurance. Using the monthly health insurance premium of $91 for an individual, over the course of a year, an employee earning $20,500 spends more than 5% of her income on health insurance.

**Paid Leave**

Only one-third of HCBS workers report receiving one or more types of paid leave. Employees who receive paid time off benefits, as with the health insurance benefit, must meet eligibility criteria such as tenure at agency and minimum hours worked per week.

**IMPROVING DIRECT CARE JOBS: WORKFORCE RETENTION STRATEGIES**

There is evidence demonstrating direct care needs will increase in the near future and that demand will outpace supply. The increased demand is due to the rapidly aging population in New Hampshire. The decreased supply of direct care workers is caused by a combination of factors: the aging of the current workforce, wages that are below the State’s determined livable wage, and unaffordable or unavailable benefits. The strategies below outline initiatives that speak to the three systems needing change in order to address this multi-faceted problem— state government, federal government, and local agencies.
**Identified Problem:** The State of New Hampshire Medicaid reimbursement structure does not compensate agencies to adequately provide direct care workers with a livable wage and access to sufficient benefits.

The Coalition suggests the following initiatives to address this problem:

**Change the reimbursement structure.** Explore the establishment of a reimbursement incentive structure that pays agencies according to the level of wage and benefits that they provide to their direct care employees. Possible solutions include developing a tiered approach or a pay-for-performance model that would increase agency reimbursement as agencies improve employee wages and benefits. This restructuring could include such benchmarks as providing: a salary that meets the livable wage, access to affordable health insurance, paid leave, mileage reimbursement at the federal rate, and increasing travel pay to meet base rate of pay.

**Establish a rational rate-setting process.** Explore the establishment of a rational rate-setting process under New Hampshire Medicaid that examines the true cost of providing quality direct care. In developing rates, agency overhead - wages, benefits, administrative costs - should all be considered. Current reimbursement rates are inadequate, leaving employers unable to offer livable wages or provide adequate benefits. Provider agencies are forced to supplement direct care positions through other funding streams. Rhode Island has utilized a rational rate setting strategy for several years. Rhode Island provides a base rate of reimbursement for each 15 minute unit of time that an employee spends providing care. It increases the base rate of reimbursement when specific performance measures are provided. Measures utilized in Rhode Island include client satisfaction, continuity of care, worker satisfaction, accreditation, patient acuity, staff education and training, and shift differential. Rate increases can range from $.50 to $1.50 per hour (PHI, 2008).

**Identified Problem:** Federal reimbursement rates for agencies providing education, training benefits, and career advancement opportunities for direct care workers are biased towards institutional settings.

The Coalition suggests the following initiatives to address this problem:

**Provide tuition support.** Currently, the Centers for Medicare and Medicaid provide reimbursement to agencies that train direct care workers for employment in institutional settings. Agencies providing training to direct care staff who work in home and community-based settings are not reimbursed for the cost of training. Federally funded reimbursement should be available to home and community-based service agencies for training direct care workers. Opportunities to improve skills and increase career advancement will aid in retention of this workforce. Changes at the federal level will be needed to address this issue.

**Fund peer mentor training programs.** Research has shown that direct care workers who are trained as peer mentors provide effective support to new workers and decrease employee turnover rates. Due to the strenuous nature of direct care and the social isolation of home-based care, many workers leave their jobs during the initial weeks or months of work. By sharing their knowledge and skills, mentors can answer questions, acclimate workers to the job, and help new employees discover the rewards of providing quality direct care. A federally funded reimbursement program aimed at training veteran direct care workers to become peer mentors should be developed. Agencies have already begun implementing this strategy. Those providing a higher rate of pay to peer mentors have been most successful in implementing the program (PHI, 2009, Building Skills).
**Identified Problem:** New Hampshire’s home care agencies have difficulty supporting and retaining their direct care workers.

The Coalition suggests the following initiatives to address this problem:

**Implement a steady work program.** A steady work program is designed to stabilize the fluctuating work-week experienced by direct care workers when the individual they are supporting enters the hospital or passes away. A steady work program replaces an employee’s lost wages for up to two months in situations when her hours are decreased by at least 20%. The employee could be asked to perform tasks other than those of direct care work and might work outside of her normal schedule. If no work can be found, she will still paid. This program was successfully piloted at Quality Care Partners (QCP), a home care agency, in Manchester, New Hampshire. The expansion of a steady work program across the state could be a winning retention strategy for the home and community-based workforce (PHI, 2001).

**Establish an employee loan program.** An employee loan program offers access to immediate, interest-free loans. QCP provides this service to their employees and the program has been popular with its direct care workers. Utilizing the agency’s reserves, employees can access loans of up to $250 after being employed by the agency for 90 days and are in good standing with the company. Loans are paid back in $25 or $50 installments via automatic withdrawal from the employee’s paycheck. If the employee leaves QCP prior to paying the balance, the remainder is obtained from their last pay check. In the ten years the program has been in place, QCP has lost less than $500. In 2007 and 2008, they loaned $11,215 without any loss. While employee loan programs do not increase employee income, they do provide a no-interest alternative to other lenders. In addition, these programs can be offered at hardly any cost to the agency.

**Incorporate a coaching supervision training program.** Training in Coaching Supervision for facility managers has been found to improve the work environment for direct care workers in institutional settings (PHI Supervision, 2007). Given the similarities of the workforce, it is likely that expanding this initiative for supervisors in HCBS would be beneficial. Licensed nurses and other supervisors learn to support direct care staff while still holding them accountable. By building constructive, positive relationships, managers and supervisors show respect for staff, while at the same time helping them to become better communicators and more effective at problem solving (PHI Supervision, 2007). New Hampshire can build on the PHI Coaching Supervision program, which is currently being implemented at a few long-term care agencies in New Hampshire.

**CONCLUSION**

In order for New Hampshire to provide quality home and community-based services the state must be able to attract and retain an adequate direct care workforce. Projections show New Hampshire’s population is rapidly aging at the same time that the pool of direct care workers is not adequate to meet the demand. The implication of this projected workforce shortage could mean that older adults and those who are chronically ill or have disabilities will have significantly fewer options for where and how they receive the care that they need. The State must act. The New Hampshire Coalition on the Direct Care Workforce will work with stakeholders to develop and implement the strategies proposed in this paper to improve the recruitment, training, and retention for this critical workforce. The Coalition welcomes the opportunity to collaborate with the Department of Health and Human Services, the State Legislature, direct care employees and employers, and other key stakeholders to address this crucial issue.
References


Paraprofessional Healthcare Institute. (2008) State Efforts to Incentivize Job Quality in Home and Community-based Care Settings


**Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July 1 2004 to 2030.** Available at: http://www.census.gov/population/www/projections/projectionsagesex.html.


**Home healthcare worker wage data** is from New Hampshire Coalition for the Direct Care Workforce, NH Direct Care Workforce Survey, 2008.


Home Care Workers: Keeping Granite Staters in Their Homes as They Age

The question of how to provide necessary health care and personal services to a growing population over age 65 is an urgent policy problem facing New Hampshire and the nation. With the aging baby boom generation, the New Hampshire population over the age of 65 is growing twice as fast as the total population, and today 13 percent of the state’s population is age 65 or older, up from 11 percent in 1990. Research shows that the population over 65 in New Hampshire prefers to remain in their own homes and receive home-based care rather than reside in a nursing home or an assisted living facility. There is evidence suggesting that home-based care may be more cost effective than institutional care, as states with established home and community-based services (HCBS) experienced cost savings in Medicaid spending over time. In response to the preference for home-based care among older adults and people with disabilities and the potential for cost savings, the state of New Hampshire has supported the expansion of the HCBS system and increased Medicaid funding for home-based services.

The growing older population and their desire to remain in their homes coupled with increased funding for home-based services translates into increased demand for the services the home care workforce provide. In fact, the New Hampshire Department of Employment Security projects that between 2006 and 2016, “home health aide” will be the fastest growing occupation, highlighting the demand and preference for home-based care. Yet, despite the growth of the home care workforce in New Hampshire, the demand for home care workers outpaces the supply. New Hampshire is just not keeping up with the rising demand.

High turnover rates are common among the home care workforce. The majority of direct care employers in New Hampshire agree that turnover is a problem and state that they need to hire one or more home care workers to meet current service demands. High turnover in this workforce contributes to lower-quality care. Furthermore, research

Key Findings:

- The median hourly wage for home care workers in New Hampshire is $10.00, whereas the median hourly wage for all New Hampshire workers is $16.48. LNAs earn the highest median hourly wage, at $11.77 per hour, almost $2.00 more per hour than PCSPs and almost $3.00 more per hour than homemakers.
- Twenty-nine percent of home care workers in New Hampshire typically work full-time hours for their home care agency. By cobbling together part-time jobs, 46 percent attain full-time hours, but they lack benefits and face a wage disadvantage compared with those who have full-time hours at their home care agency.
- One-third of home care workers in New Hampshire lack health insurance, primarily because it is too expensive for the employees.
- More than half of home care workers are covered by health insurance through a private sector provider; fewer than one in five home care workers are covered by health insurance through their direct care employer.
- Very few home care workers receive paid time off; in fact, 67 percent have no paid leave of any kind. Full-time workers are twice as likely to have paid leave as part-time workers.
- Home care workers were asked to name all the features that would make their job better. Higher wages was the leading factor, followed by better access to benefits, such as health insurance, more paid time off, and more opportunities for advancement.
using national data shows that those who work in direct care occupations face a wage penalty; that is, they earn less than expected given their job characteristics and qualifications.\(^7\) Low wages, unstable work hours, and limited benefits contribute to high turnover among this workforce.\(^8\)

Many in the Granite State are considering strategies to address the shortage of home care workers. To inform these discussions, the Carsey Institute at the University of New Hampshire was asked by the New Hampshire Institute for Health Policy and Practice to assist with the development, administration, and analyses of a survey of the home care workforce and their employers in order to profile the workforce and examine wages, benefits, and retention. The results from this New Hampshire Direct Care Workforce Survey are presented in this brief (see the Data section at the end of this brief for more information about the data collection effort).

This policy brief provides a demographic and economic profile of the current home care workforce in New Hampshire, which includes licensed nursing assistants (LNA), personal care service providers (PCSP), personal care assistants (PCA), and homemakers and companions. The profile includes home care workers who work for agencies that provide home- and community-based services and receive reimbursement from Medicaid, Medicare, and other federal and state-funded programs. The final section of the brief discusses the potential implications of low pay and high turnover for long-term care among older adults and people with disabilities in New Hampshire.

**Types of Home Care Workers**

Direct care workers (of which home care workers are one type) provide the majority of paid, hands-on care, supervision, and emotional support to older adults and persons with disabilities in the United States. These paraprofessionals hold a variety of job titles, including licensed nursing assistant (LNA), personal care service provider (PCSP), personal care assistant (PCA), home care aide, home health aide, homemaker, and companion. They work in diverse settings, including private homes, adult day centers, assisted-living residences, hospitals, and nursing homes. Depending on their job title and the setting, a direct care worker’s tasks may include assistance with medications and measuring vital signs; assisting with personal care activities, such as bathing, dressing, using the toilet, and eating; providing comfort and companionship; and shopping, preparing meals, and cleaning the house.\(^9\)

Workers described in this brief provide either hands-on care, light housekeeping, support, or companionship. In 2008, 59 percent of Granite State home care workers were PCSPs or PCAs (which in the remainder of the brief we refer to as PCSPs), 21 percent were LNAs, and 19 percent were homemaker/companions (which in the remainder of the brief we refer to as homemakers) (see Figure 1). In New Hampshire, both LNAs and PCSPs help clients with activities of daily living, including bathing, dressing, using the toilet, and eating. LNAs are licensed and supervised by a nurse, and they also perform clinical tasks, such as range-of-motion exercises, blood pressure readings, and can assist with administering medication if they complete extra training beyond the mandated 100 hours.\(^10\) Homemakers provide light housekeeping, such as shopping, doing laundry, preparing meals, cleaning the house, and providing comfort and companionship. PCSPs often will help with housekeeping chores as well and are required to complete 10 hours of training. (Refer to the NH Coalition for the Direct Care Workforce, endnote 5, for more information on the home care workforce.)

**The Home Care Workforce in New Hampshire**

The New Hampshire home care workforce is predominantly female (90 percent) (see Table 1). This workforce is also older (on average, 48 years old) than the state’s workforce overall, which is on average 41 years old. Homemakers tend to be older than PCSPs and LNAs. The majority of home care workers are married (58 percent), and one-third have children under 18 living with them. Only 11 percent are single mothers.

Nearly one-half of the home care workforce has a high school degree or less. However, LNAs tend to have more education than PCSPs or homemakers. Two-thirds of LNAs have some college or more, compared with roughly one-half of PCSPs and homemakers. Only one-third of LNAs have
a high school degree or less, while one-half of PCSPs and homemakers do.

More than one-half of home care workers have family incomes of less than $30,000 annually. Homemakers fare the worst economically: 42 percent have family incomes of less than $20,000 annually. In contrast, 23 percent of LNAs and only 4 percent of the state’s workers overall report family incomes this low. Further, one-half of single home care workers live on less than $20,000 annually. Despite the low pay, many cite the rewards of the job as reasons for continuing. One worker sums it up for many: “What I do makes a difference in other people’s lives. That’s the most important thing to me.”

“**What I do makes a difference in other people’s lives. That’s the most important thing to me.”**

—Homemaker, 19-year-old single mother

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**Table 1. Demographic Characteristics of Home Care Workers, NH 2008**

<table>
<thead>
<tr>
<th>JOB TITLE</th>
<th>All</th>
<th>LNA</th>
<th>PCSP</th>
<th>Homemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>90</td>
<td>99</td>
<td>85</td>
<td>94</td>
</tr>
<tr>
<td>Average age</td>
<td>48</td>
<td>45</td>
<td>47</td>
<td>52</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>58</td>
<td>55</td>
<td>60</td>
<td>59</td>
</tr>
<tr>
<td>Previously married</td>
<td>26</td>
<td>23</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Never married</td>
<td>16</td>
<td>23</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Child under 18</td>
<td>33</td>
<td>39</td>
<td>33</td>
<td>26</td>
</tr>
<tr>
<td>Single mother</td>
<td>11</td>
<td>16</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Married mother</td>
<td>22</td>
<td>22</td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>47</td>
<td>34</td>
<td>50</td>
<td>53</td>
</tr>
<tr>
<td>Some college</td>
<td>40</td>
<td>57</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>College graduate</td>
<td>13</td>
<td>10</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Total family income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $20,000</td>
<td>30</td>
<td>23</td>
<td>30</td>
<td>42</td>
</tr>
<tr>
<td>$20,000–$29,999</td>
<td>22</td>
<td>23</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>$30,000–$39,999</td>
<td>14</td>
<td>14</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>$40,000–$49,999</td>
<td>14</td>
<td>18</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>19</td>
<td>22</td>
<td>19</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: NH Direct Care Workforce Survey, 2008.
Note: All numbers are percentages unless otherwise noted.

---

**Table 2. Job Characteristics of Home Care Workers, NH 2008**

<table>
<thead>
<tr>
<th>JOB TITLE</th>
<th>All</th>
<th>LNA</th>
<th>PCSP</th>
<th>Homemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time (35 or more)</td>
<td>29</td>
<td>40</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>Average hours</td>
<td>24</td>
<td>27</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>More than one job</td>
<td>41</td>
<td>51</td>
<td>41</td>
<td>29</td>
</tr>
<tr>
<td>Full-time at all jobs</td>
<td>46</td>
<td>58</td>
<td>47</td>
<td>30</td>
</tr>
<tr>
<td>Average hours at all jobs</td>
<td>33</td>
<td>37</td>
<td>33</td>
<td>27</td>
</tr>
<tr>
<td>Number of clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>53</td>
<td>24</td>
<td>71</td>
<td>23</td>
</tr>
<tr>
<td>2–5</td>
<td>29</td>
<td>37</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>6 or more</td>
<td>18</td>
<td>39</td>
<td>4</td>
<td>46</td>
</tr>
<tr>
<td>Care for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>18</td>
<td>10</td>
<td>23</td>
<td>12</td>
</tr>
<tr>
<td>Friend</td>
<td>17</td>
<td>12</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>Previously unknown</td>
<td>65</td>
<td>81</td>
<td>58</td>
<td>70</td>
</tr>
<tr>
<td>Employer size</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 20 employees</td>
<td>6</td>
<td>18</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>20–100 employees</td>
<td>25</td>
<td>32</td>
<td>13</td>
<td>57</td>
</tr>
<tr>
<td>More than 100 employees</td>
<td>69</td>
<td>50</td>
<td>86</td>
<td>39</td>
</tr>
<tr>
<td>Time worked with agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>22</td>
<td>20</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>6–11 months</td>
<td>12</td>
<td>13</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>12–23 months</td>
<td>16</td>
<td>13</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>24–35 months</td>
<td>14</td>
<td>10</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>36 or more months</td>
<td>37</td>
<td>45</td>
<td>34</td>
<td>43</td>
</tr>
<tr>
<td>Average months</td>
<td>41</td>
<td>57</td>
<td>33</td>
<td>52</td>
</tr>
<tr>
<td>Shifts worked</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days</td>
<td>89</td>
<td>92</td>
<td>85</td>
<td>95</td>
</tr>
<tr>
<td>Weekends</td>
<td>44</td>
<td>54</td>
<td>50</td>
<td>15</td>
</tr>
<tr>
<td>Nights</td>
<td>30</td>
<td>30</td>
<td>37</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: NH Direct Care Workforce Survey, 2008.
Note: All numbers are percentages unless otherwise noted.

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**Job Characteristics**

Most PCSPs provide services to only one person (see Table 2). Large proportions of homemakers, however, provide services to six or more people. This variation in number of clients likely derives from differences between consumer-directed models and agency-directed models. In consumer-directed models, the person receiving care typically knows the home care worker (usually a PCSP), as many are family members, friends, or neighbors. In con-
In agency-directed models, the agency is responsible for scheduling workers and typically hires all three types of workers to care for clients, who generally are previously unknown to the worker.11

Despite desiring more hours, fewer than one-third of home care workers work full-time hours (35 or more) in a typical week. On average, they work 24 hours per week. Although 40 percent of LNAs work full-time, only 19 percent of homemakers do. To make up for this lack of full-time work, many work more than one job. By cobbling together part-time jobs, 46 percent of home care workers attain full-time hours, but as we will show, they lack benefits and face a wage disadvantage compared with those who have full-time hours at their home care agency.

Some people require care around the clock, including weekends. Many home care workers are working nonstandard hours. Forty-four percent regularly work weekends and 30 percent regularly work nights. It is common for home care workers to combine shifts, working days and weekends or days and nights, and about one in five work all three shifts. Even though days are the most common shift across job type, large proportions of LNAs and PCSPs work all three shifts regularly. In contrast, homemakers tend to work days only and rarely work weekends or nights.

One-fifth of home care workers have been with their agency for fewer than six months, but on average workers have been with their agency for 41 months. LNAs have the longest tenure with their agency (57 months), followed by homemakers (52 months), and PCSPs (33 months). On average, full-time workers have been with their agency longer than part-time workers (66 months compared with 31 months).

The majority work for large agencies with 100 or more employees, driven primarily by the large agencies that primarily employ PCSPs. However, 6 percent work for small agencies (fewer than twenty employees). Fully 86 percent of PCSPs work for a large agency, compared with 50 percent of LNAs and 39 percent of homemakers. Seventy-one percent of part-timers work for a large agency.

New Hampshire’s home care workforce work for established agencies; 68 percent have been in existence for 20 or more years. More than one-half are private, not-for-profit agencies; one-quarter are private, for-profit agencies; and the remainder are publicly owned or part of a hospital or health system.

Wages

The median hourly wage for home care workers in New Hampshire is $10 (see Table 3).12 Although higher than the state minimum wage of $7.25 per hour, it falls short of the 2008 livable wage needed to cover basic expenses for a single person ($11.55), for a dual-earner married couple with two

### Table 3. Wages paid to home care workers, NH 2008

<table>
<thead>
<tr>
<th>MEDIAN HOURLY WAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
</tr>
<tr>
<td>$10.00</td>
</tr>
<tr>
<td>Job title</td>
</tr>
<tr>
<td>LNA</td>
</tr>
<tr>
<td>$11.77</td>
</tr>
<tr>
<td>PCSP</td>
</tr>
<tr>
<td>$10.00</td>
</tr>
<tr>
<td>Homemaker</td>
</tr>
<tr>
<td>$8.98</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>High school or less</td>
</tr>
<tr>
<td>$10.00</td>
</tr>
<tr>
<td>Some college</td>
</tr>
<tr>
<td>$10.00</td>
</tr>
<tr>
<td>College graduate</td>
</tr>
<tr>
<td>$10.00</td>
</tr>
<tr>
<td>Region</td>
</tr>
<tr>
<td>Northern</td>
</tr>
<tr>
<td>$9.75</td>
</tr>
<tr>
<td>Western</td>
</tr>
<tr>
<td>$10.00</td>
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<tr>
<td>Night only</td>
</tr>
<tr>
<td>$10.25</td>
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Source: NH Direct Care Workforce Survey, 2008.
Children (both would need to earn $12.19), and for a single mother with one child ($17.68).

The median hourly wage for all New Hampshire workers is $16.48.

Full-time home care workers earn $10.25 per hour, or $20,500 for a full-time, year-round position. The median annual salary of New Hampshire full-time workers is $40,000. Home care workers commonly cited better pay as a factor that would make their job better: “It’s hard to pay the bills. If I wasn’t on social security, I couldn’t afford to work at this job.”

“Better pay would improve my job. It’s hard to pay the bills. If I wasn’t on Social Security, I couldn’t afford to work at this job.”

—Homemaker, 63-year-old part-time worker

LNAs earn the highest median hourly wage, at $11.77 per hour, almost $2.00 more per hour than PCSPs and almost $3.00 more per hour than homemakers. Even larger discrepancies appear when examining the distribution of wages (see Figure 2). Fully 63 percent of LNAs earn $11 or more per hour, a far greater proportion than the 9 percent of PCSPs or the 7 percent of homemakers. Hourly wages for PCSPs are relatively uniform, with 81 percent earning between $9 and $10 per hour.

Typically in jobs, median earnings increase with education, but this is not the case with home care workers in New Hampshire. Median hourly wages (the wage at which half of all workers earn more and half earn less) are $10 per hour regardless of education. However, when looking behind the median levels, home care workers with more than a high school degree are more than twice as likely to earn $11 or more (26 percent) than those who have less education (12 percent).

Reimbursement levels for services may determine wages, particularly among agencies that rely on Medicaid reimbursement. This, some argue, works as a cap on wages. Recall that home care workers with some college education were more likely to work as LNAs, who receive higher wages and may perform services that reimburse at higher levels.

Home care workers living in the North Country earn $.25 less per hour than their colleagues in other regions of New Hampshire. This amounts to a $520 annual earnings disadvantage for northern full-time, year-round workers. Another important factor that influences wages is the number of hours worked per week. Full-time workers earn, on average, $.25 more per hour than those who work fewer than 35 hours per week for the agency. More full-time workers earn $11 or more per hour than part-time workers (36 percent and 13 percent, respectively). Workers earn, on average, $.25 more per hour for working nonstandard hours but just for the 4 percent who only work the night shift.

Earnings also increase modestly with time spent working for the agency (see Figure 3). In fact, 84 percent of agencies report that they have scheduled wage increases, which rewards tenure. For example, workers who have been with their agency for fewer than six months earn $9.50 per hour. Once they have passed the six-month mark, they get a pay increase to $10.00 per hour. Not until workers pass their three-year anniversary with the same agency do they see another pay raise, to $10.25 per hour. Finally, workers who have stayed with their agency for four or more years earn a median hourly wage of $10.50. This represents an increase of $1.00 per hour in four years.
Benefits

Health Insurance

Ironically, one-third of home care workers in New Hampshire lack health insurance (see Table 4), which is higher than all female workers in New Hampshire (16 percent). The principal reason given for not having health insurance coverage is that it is too expensive (see Figure 4). The average cost per month for individual coverage for a full-time worker is $91, while the monthly employer contribution is $357 (see Figure 5). The cost rises sharply when considering family coverage for a full-time worker: the average monthly employee contribution is $613 and the employer contribution is $727. Considering that home care workers earn $10 per hour, these monthly contributions are likely out of reach, especially since this cost does not include any deductible or cost sharing that many health insurance plans require. One home care worker comments, "Having affordable health insurance would improve my job. Our health insurance has a rather high deductible."

Other reasons given among home care workers for not having health insurance are that the employer does not offer health insurance or the workers are ineligible. Nearly three-fourths (74 percent) of employers report that they offer health insurance to their direct care staff, but many base eligibility on time spent at the agency and minimum hours per week (that is, they offer insurance only to full-time employees). For example, 48 percent offer health insurance to workers after three months on the job; 7 percent require two months, 32 percent require one month, and 13 percent do not have a waiting period. Although a wide range exists regarding the required minimum hours worked per week to be eligible for health insurance (from 15 to 40 hours), on average, employers require 30 hours per week. Since many workers desire full-time hours but do not get it from their direct care employer, these workers are doubly disadvantaged: their overall take-home pay is lower, unless they seek a second job, but due to their part-time status, they are not eligible for health insurance benefits.

“Having affordable health insurance would improve my job. Our health insurance has a rather high deductible.”
—LNA, 23-year-old full-time worker

PCSPs are more likely to lack health insurance (40 percent) compared with LNAs and homemakers (30 percent and 21 percent, respectively). Twenty-two percent of homemakers rely on public health insurance. Working in a large number of states, Medicare does not cover long-term services and supports, and homemakers rely on public health insurance.

Table 4. Health insurance coverage and paid leave benefits among home care workers, NH 2008

<table>
<thead>
<tr>
<th>JOB TITLE</th>
<th>HOURS WORKED</th>
<th>NUMBER OF EMPLOYEES</th>
<th>TIME SPENT WITH AGENCY</th>
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<td></td>
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<td>PCSP</td>
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<td>Paid leave benefits</td>
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<tr>
<td>Paid sick leave</td>
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<td>Paid holidays</td>
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<tr>
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<td>22</td>
<td>45</td>
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</tr>
<tr>
<td>One or more types of paid leave</td>
<td>33</td>
<td>64</td>
<td>15</td>
</tr>
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</table>

Source: NH Direct Care Workforce Survey, 2008.
Note: All numbers are percentages.
Many of the same predictors of health insurance apply to paid leave. Full-time workers are twice as likely to have paid leave than part-time workers. Nearly 60 percent of workers with a smaller agency (fewer than 100 employees) and nearly one-half who have worked with their employer for three or more years receive some paid time off. LNAS are much more likely to have some type of paid leave than PCsPs. Contrary to the patterns with health insurance, however, nearly 60 percent of homemakers, who are not likely to receive health insurance through their employer, do receive some paid leave.

Job Satisfaction

Home care workers were asked to name all the features that would make their job better. Not surprisingly, higher wages was the leading factor (see Figure 6). Better access to benefits, such as health insurance, was the second most popular factor, followed by more paid time off and more opportunities for advancement. A greater share of LNAS preferred more opportunities for advancement than PCsPs or homemakers.

Workers travel from client to client, typically in their own vehicle. Many commented on the high cost of gas (the survey was conducted during the summer of 2008, when gas prices reached record highs and the economy was in recession). Many, therefore, would like to be reimbursed for mileage or receive higher rates of reimbursement. Over eight in ten agencies provide mileage reimbursement. The federal
reimbursement rate in June 2008 was $.505 per mile, and in July 2008 it jumped up to $.585 per mile. Among those agencies who reimbursed for mileage, there was a wide range (between $.25 per mile and $.585 per mile), and the average reimbursement rate was $.49 per mile. However, when considering all agencies, the average amount reimbursed for mileage was $.41 per mile, a rate that may better reflect the reality facing the home care workforce. Behind this average, we see that 40 percent of all agencies reimbursed at between $0.505 and $0.585 per mile, closely aligned with the standard federal rate at that time. In contrast, 22 percent reimbursed at a rate between $0.42 and $0.50 per mile, and 38 percent reimbursed at a rate lower than $0.42 per mile or did not reimburse at all.

Job Turnover

Job turnover is a major and costly problem in the direct care industry, and New Hampshire is no exception.16 Only 13 percent of agencies state that job retention is not an issue. Fifty-three percent acknowledge turnover as a minor problem, and 35 percent state it is a somewhat serious or a serious problem. Further, 81 percent state they need to hire one or more home care workers to meet service demands. Agencies are more likely to report workers leaving their agency (92 percent) than joining (86 percent) in the prior 12 months.

Turnover is costly for employers, who must recruit and train a replacement worker. With paid caregivers, turnover means a lack of continuity in care for the care recipient. Low wages are linked to high turnover in the direct care profession.17 Improving the quality of these positions through increased wages, benefits, and working conditions is key to recruiting and maintaining a quality direct care workforce.18 This message is loud and clear from one home care worker: “To improve this job they need to provide full-time work with benefits. If they can’t get the work at a full-time level, they get a smaller paycheck and no benefits. They move on.”

Although we cannot directly analyze turnover with our survey, we can compare those who have worked with an agency for several years with those who are new to the agency to gain insights on those workers who remain with their agency.

On average, home care workers have worked with their agency for 41 months. Many, of course, have worked in the home care field for much longer but for various reasons have not stayed with the same agency. Homemakers and LNAs have worked with their current employer longer than PCSPs. Full-time workers have worked for their agency for 66 months, on average, with more than one-half working there for four or more years. This is much longer than part-time workers, who on average have worked with their agency for 31 months.

As noted, workers with seniority are more likely to have workplace benefits, such as paid sick days, paid vacation days, or earned time. However, they are not more likely to have health insurance.
How to Improve Home Care Work and Reduce Turnover

Research links high turnover to lower-quality services and care and negative effects on those receiving care. Improving the quality of these paid care-giving positions through higher wages, expanded benefits, and better working conditions is key to recruiting and maintaining a quality home care workforce.19

Wages

Although raising the minimum wage is a frequent policy recommendation, even a large increase of the minimum wage by $1 per hour would only directly increase the wages of 9 percent of home care workers in New Hampshire. Another option is to examine the state’s Medicaid reimbursement structure to ensure that home care workers receive a livable wage and have access to benefits, such as health insurance and paid leave, through the establishment of a rational rate-setting process and a reimbursement incentive structure based on benchmarks (refer to NH Coalition for the Direct Care Workforce, endnote 5, for more details).

Although gas prices have declined since the summer of 2008 (when this survey was in the field), reimbursement for mileage is still important to decrease work-related expenses among the home care workforce. Pegging mileage reimbursement rates to the federal rates would reduce work costs for many, particularly for those in agencies that do not pay any mileage reimbursement.

Steady, Full-time Employment

Among the 71 percent of home care workers who do not work full-time at their direct care agency, many desire more hours and take on a second job to make ends meet. Their part-time status often makes them ineligible for health insurance coverage and cuts in half their likelihood of having paid leave. Increasing work hours to full-time for those who want more hours could improve job quality, increase take-home pay, and improve access to benefits.

Health Insurance and Paid Leave Benefits

The primary reason given for not having health insurance among the uninsured is that the employee premiums are too expensive. For a home care worker earning $10 per hour, paying $613 per month for family coverage is out of reach. Therefore, considering ways to lower out-of-pocket costs among the home care workforce would go a long way to improve job quality. In addition, exploring the means for employers to reduce the overall cost of family health insurance, as their monthly contribution is high as well, could infuse cost savings. One option for making health insurance more affordable is to include funding for insurance in the Medicaid reimbursement rate, with the increased reimbursement only to be used to purchase an affordable health insurance plan.

Two-thirds of home care workers do not have any paid leave benefits. This becomes particularly troublesome in the event that they become sick and forces a hard decision: stay home and lose wages or possibly even your job, or go to work sick and put the health of your clients at risk. Some workers expressed concern about taking time off because there was no one else to provide care for their clients. Having a pool of competent replacement workers to fill in during paid time off would ensure quality care, reduce contagion, and decrease burnout.

Opportunities for Advancement

Finally, creating ladders for advancement within the direct care profession and the home care agency can improve the quality of these professions. Not all home care workers seek to become nurses, so creating opportunities within the direct care occupation is useful. Increased training, peer mentors with additional pay and responsibility, and tuition supports to encourage workers to pursue an LNA license could provide opportunities for advancement.

Conclusion

If New Hampshire is serious about its desire to reduce turnover among the home care workforce, meet the projected needs of the aging population, and provide the quality care necessary to help keep Granite Staters in their homes as they age, then the road map is clear and adeptly articulated by the home care workers themselves: increase wages, increase hours, increase access to health insurance and paid leave, and increase opportunities for advancement.

Data

The data for this brief come from the New Hampshire Direct Care Workforce Survey, developed in partnership between the Carsey Institute, the New Hampshire Institute for Health Policy and Practice, the New Hampshire Coalition for the Direct Care Workforce, and the University of New Hampshire Survey Center and funded by the Administration on Aging-Aging and Disability Resource Center (AoA-ADRC) project. During the summer of 2008, researchers surveyed employers and employees of home care agencies that provide
home and community-based services and received reimbursement from Medicaid, Medicare, and other federal and state funded programs. Researchers identified sixty-one agencies to survey. One refused to participate. Of the sixty remaining agencies, thirty-eight completed the agency survey, resulting in a response rate of 63 percent.

For the employee survey, researchers drew a stratified random sample of one-third (20) of all agencies and distributed surveys to 2,029 workers. Stratification was based on agency size. Researchers administered the employee survey through the agencies, given that employee lists were unavailable. Among the employees, 579 completed surveys for a response rate of 29 percent. Researchers sent several reminders in employee paychecks and raffled twenty gas cards worth $100 each to boost response. Data presented are not weighted. Data on the New Hampshire workforce come from the 2007 American Community Survey (ACS) analyzed by the author.

Endnotes


11. The survey results confirm that these models are working as expected—PCSPs are more likely to care for friends and neighbors than LNAs and homemakers.

12. The Bureau of Labor Statistics (BLS) reports that home health aides in New Hampshire earn a median wage of $10.97 per hour. The small discrepancy is likely owed, in part, to the inclusion in BLS figures of home health aides who work in hospitals and nursing homes, industries that pay higher wages than home care settings. In addition, the study’s sample includes only agencies that the state reimburses for Medicaid, which likely pay lower wages.

14. This calculation is based on $10.25 for 40 hours for 50 weeks. Recall that only 29 percent of home care workers have full-time positions.


17. Smith and Baughman, “Caring for America’s Aging Population.”


19. Ibid.

ACKNOWLEDGMENTS
The author thanks Laura Davie and Kim Persson at New Hampshire Institute for Health Policy and Practice; Mary Maggioncalda at the New Hampshire Department of Health and Human Services; Alex Olins and Carol Regan at PHI; Susan Young at the Home Care Association of New Hampshire; Susan Fox at the Institute on Disability at the University of New Hampshire; Mil Duncan, Erin Trainer, and Amy Sterndale at the Carsey Institute; and Barbara Ray at Hired Pen for their thoughtful comments and suggestions. Research assistance was provided by Siobhan Whalen and Kristi Gozjolko.

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The Carsey Institute conducts policy research on vulnerable children, youth, and families and on sustainable community development. We give policy makers and practitioners timely, independent resources to effect change in their communities.

This policy brief was supported in part by the New Hampshire Institute for Health Policy and Practice and the Institute on Disability at the University of New Hampshire; the Aging and Disability Resource Center Grant sponsored by the Administration on Aging and Centers for Medicare and Medicaid Services; and the Systems Transformation Grant sponsored by the Centers for Medicare and Medicaid Services. However, the contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and readers should not assume endorsement by the federal government.
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<td>Michelle</td>
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<td>Franklin Pierce Law Center</td>
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Appendix E: Community Listening Sessions Report
Community Listening Sessions

Conducted by:

Bureau of Elderly and Adult Services
NH Department of Health and Human Services

In Collaboration with:

State Committee on Aging

It really is about you. For so many years you may have been focusing on your job or career, raising a family, or giving unselfishly of your time and talents to your community. Now it’s time to concentrate on how you want to spend this time in your life. What do you need to stay engaged and active? How can the State and communities support you in living life on your terms? Please join us for a discussion on this topic at any of the sessions listed below. Representatives from the State will attend these sessions to hear your ideas firsthand.

Please RSVP to Heather at heather.tuttle@dhhs.state.nh.us or 1-800-852-3345 x4384 or TDD 1-800-735-2964 x4384.
Available in alternative formats upon request.

This document was developed with funds under grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and readers should not assume endorsement by the Federal government.
## Community Listening Sessions

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Executive Summary

Over the period of May 12, 2008 to July 22, 2008, the Bureau of Elderly and Adult Services in collaboration with the State Committee on Aging and the Institute on Disability at UNH, conducted seventeen community listening sessions throughout the State to hear what seniors and local service providers thought about the transformation efforts taking place in the long term care services system. The listening sessions were held as part of the Systems Transformation Grant work plan as a means of public outreach and comment. BEAS also plans to use the findings from these sessions as a documentation of need for the upcoming State Plan on Aging.

Sessions were held in Nashua, Laconia, Keene, Manchester, Claremont, Concord, Dover, Plymouth, North Conway, Wolfeboro, Berlin, Salem, Portsmouth, and Littleton at a variety of venues: senior centers, community meeting spaces, public buildings, and educational facilities. A total of twelve consumer/community and five provider listening sessions were held, with over 355 people attending these sessions, including community members, consumers, advocates, legislators, and community service providers. Consumer/community and provider listening sessions were held separately in order to assure that the voice of consumer/community members were clearly heard. Kathleen Otte, BEAS Administrator, facilitated the discussion. She was accompanied at each session by key BEAS program management staff and local District Office staff in order to answer questions and assist consumers experiencing problems in accessing needed services.

Feedback from these community sessions was thoughtful, direct, and indicative of the issues seniors currently face. Throughout the sessions, a number of recurring concerns became evident:

- Overwhelmingly, New Hampshire’s seniors prefer home care, but the current economic situation is making it difficult for them to stay at home. Home care workers and home-delivered meals drivers cannot afford the price of gas. Providers are anticipating they will have to cut back on the areas they serve and the frequency of home visits because they are losing workers to jobs that do not require travel.

- New Hampshire seniors are very worried about high energy costs. Many spoke of the difficulty people on fixed incomes will face this winter. Some will have to make difficult choices between paying for needed medications and heating their homes. At each session, people asked for State government to develop more programs and funding for energy assistance.

- Along these same lines, seniors requested long term care programs to help people who do not qualify for Medicaid but who cannot afford to pay privately for home health, homemaker, and other services.

- The need for additional supports for family caregivers, who provide 80% of long term care services, was heard at several sessions.
• Transportation still remains a major problem throughout the State. Many seniors rely on volunteers to take them to medical appointments, in particular chemotherapy and dialysis, and necessary shopping. The high price of fuel is limiting the ability of volunteers to continue driving because many volunteers are also on a fixed income.

• Many seniors raised other issues related to transportation such as fear of losing their driver’s license, lack of adequate parking near senior centers and other services, public transportation that does not truly meet their needs (routes, schedules, accessibility, etc.), and lack of well marked crosswalks.

• Dental care was consistently brought up as a serious lack in the State’s health care system.

• Seniors also noted the need for mental health services for older adults, particularly those who are isolated.

• People advocated for more programs that encourage socialization and keep seniors connected with the community. The State’s senior centers were recognized as outstanding resources for socialization and wellness programs, but not every community has a senior center.

• A number of seniors advocated for more support for food pantries. Many of them volunteer at these programs and are seeing a growing incidence of working families with children who rely on these resources. Food pantries are running out of food.

• Significant concern was raised about the adequacy of the direct care workforce to provide home and community based care. Many participants talked about the loss of home care workers and volunteers due to rising gas prices, particularly in the more rural areas of the state. Consumer directed services which allows for the hiring of family, friends, and neighbors was cited as one solution to this problem.

• The lack of program literature and brochures that are easily understandable was noted as a barrier to accessing various programs and services. Materials need to be clearly and simply written and available in other languages.

• The State’s interest and dividends tax and the school portion of local property taxes were identified as significant economic barriers for older people on fixed incomes. Many older people who do not have a pension rely on their investments to support their retirement and feel that taxing interest and dividends is in reality an income tax.

Comments from participants at the community listening sessions were transcribed by a CART reporter and carefully coded and analyzed for recurrent themes across the state. This report provides a more extensive analysis of the themes identified through these listening sessions as well as a summary of findings from the provider forums.
Consumer & Community Findings

Kathleen Otte, Administrator for the Bureau of Elderly and Adult Services opened each session with a brief presentation on the transformation efforts underway at the Bureau. She commented that the Bureau is working with all of their partners who help them provide support in the community to assure that services are person-centered and that all providers understand this philosophy. She noted that this is a paradigm shift and the Bureau wants to make sure that services are customized so that they are provided for the person and directed by the person. In a person-centered system, the focus is on the individual, the strengths they possess, and their network of family and friends. The Bureau is working with its partners to create a system that is flexible and cost effective and allows maximum choice over services and supports as people age. She emphasized that one of the core values of the system is “respect”. We want a system that respects the individual and responds to individual needs.

This section of the report documents the findings from the consumer/community forums which were held in Nashua, Keene, Plymouth, Conway, Wolfeboro, Concord, Manchester, Salem, Laconia, Dover, Berlin, and Claremont. In addition, comments from the Conference on Aging NH Speaks forum held on May 29, 2008 are included. In total, over 300 consumers and community members provided input for this report. A number of key themes emerged through these sessions. The following are the key themes in order of the frequency mentioned during these forums: the economy and funding for services, person-centered services, communication, prevention and wellness, transportation, workforce, “caught in the middle,” mental health, social connections and relationships, community engagement, access to services, and caregivers. In addition, the need for ongoing education and outreach to professionals, service providers, caregivers, and individuals was identified. Figure 1 illustrates the distribution of comments across each of these theme areas.
The Economy and Funding for Services

“What about the people just above Medicaid? They don’t have a lot of money. What happens if they don’t get services? They end up on Medicaid or in nursing homes. Personal care and homemaking services are not well funded. And nowadays everything is going up, these poor folks are even less able, between the gas and fuel, and heating and stuff like that.” Berlin

Throughout the state, the current economic situation is a grave concern and issues related to the economy and rising energy costs dominated the discussion in many of the forums. Concerns about the economy were raised in all forums a total 396 times. People expressed fear about staying warm this winter and being able to afford basic needs while paying rising heating costs. The economic pressures caused by increasing costs for gas, heating fuel, food, and medication are forcing many people to make untenable choices between basic necessities. The following comment from the forum in Conway exemplifies the concerns raised throughout the state:

“They need to do more for the seniors and other people because this is a fixed income area, unfortunately. The cost of living is getting extremely expensive. Home heating oil, electricity, gas, groceries, and there is no relief, and they are saying now it doesn’t look like we will bounce back from this the day after tomorrow. This could take two or three years, and the damage is done. What will be done to fix it?”

The cost of health care services was also raised as a major issue in most forums. For many, the increasing costs of medical care are becoming unaffordable. The “donut hole” in the Medicare system is forcing some seniors to forego needed medications. Medical and dental co-pays and premiums are often too high to afford, and many doctors want payments up front instead of offering payment plans.

It was noted in many forums that most people prefer to remain at home as they age and home care is typically more cost effective than institutional care. However, the economic strains of paying the increasing costs of heat, food, prescription drugs, medical care, dental care, and property taxes; make it very difficult for many people to remain at home. As one participant in Plymouth remarked:

“My biggest concern is this upcoming winter. And people who are struggling to stay in their homes. I hear stories about moving themselves into one room in their homes last year, and this year will be really brutal.”

The cost of housing is an issue across the state. There is a need for more affordable housing and more housing subsidies for low-income seniors. Concern was also raised about landlords who do not provide adequate services (heat, electricity, etc) and who take advantage of renters, especially vulnerable seniors.

Long term care insurance was raised at several forums as an option for paying for home care services. However, many participants noted that it is not an affordable option for many seniors.

Figure 2 reflects how comments about the economy were raised in each community forum.
Person-Centered Services

“We have different complications and different challenges and a person-centered system identifies that, what services you may require, and not only what services you require but how they are delivered.” Claremont

New Hampshire’s systems transformation efforts support people to remain living in their home and community, if they choose to remain there, for as long as possible. In-home services are cost-effective, and are generally preferred over nursing home care. Forum participants commented that most people want to remain living at home and want to have more control over their care. Comments related to consumer directed, home and community based services were made in all forums a total of 378 times. Consumer-directed services give more control to the individual regarding who provides their care and where and how that care is delivered. However, participants expressed concern about the availability of safe and affordable options throughout the state. Particularly in the more rural regions of the state, comments were made about the lack of options for home care services.

The lack of a wide range of options in home and community based services was raised as an issue throughout the state. Participants noted that there needs to be more options for community living such as adult family care and assisted living and that funding needs to be increased for home and community based services. In addition to a wider range of options, participants also felt that current programs and services need to be more responsive to the needs of both participants and caregivers. Programs need to be of interest to seniors, hours
need to be flexible for working caregivers, and rates need to be affordable. There needs to be more flexibility from the agencies regarding times services are provided and how long service is provided. Often services are scheduled at the convenience of the provider and many agencies set a minimum number of hours that they will provide home care services, regardless of the amount of care needed by the individual. A person-centered system would provide greater flexibility in meeting individual needs.

Forum participants remarked that community agencies need more training on consumer directed, person centered services. People need to be asked what they need, not be presented with a set agenda or service package. Consumers should have more control over how their service dollars are spent, who provides their care, and how and when this care is delivered. Participants also commented that services need to be sensitive and flexible to different cultures and address the needs of the varied communities. As one participant from Conway observed, “Quality of life is very different at each stage of our life. Services need to be flexible with our needs.”

While forum participants were supportive of home and community based care, many were also concerned about the safety of people living at home, particularly those living alone. It was noted that many people do not have family nearby and become isolated. As one participant from Dover noted:

“I like the idea of person-centered and at home care, but that isn’t the answer for everybody. If someone is living in their own home and they’re two miles out of town, their family lives on the other side of the country and they don’t have anyone to visit them or see them, having someone come in and provide services for half an hour a day isn’t going to do it.”

Concern was also raised about the increase in cases of self neglect among older adults. Ideas to address issues of isolation and safety included: using volunteers or emergency personnel to check in on older residents, building informal support networks of neighbors and friends to check in on older residents, and working with local emergency response systems to assure that they know who needs help in an emergency.

Figure 3 presents the frequency of comments related to person centered services in each forum.
Communication

“I would not have known about all these services if I wasn’t involved with the community.” Berlin

Communication was raised 200 times across all of the community forums. Many people expressed that they want information but they don’t know where to get it. Word of mouth is often how people get the information they need and those who are not well connected have less knowledge about available services. Other sources of communication that people noted are newsletters from agencies and community newspapers. Many people requested that more information be placed on the front page of newspapers and on public radio, commercial radio, and TV. The use of varied communication avenues was stressed as many seniors do not have access to computers and other modes of communication. As one participant in Wolfeboro reported:

“I don’t have a computer. I have a cell phone, I don’t have a land line so I can’t stay on the phone forever. I didn’t know about all these services, and God knows I need them.”

Whatever medium is used, forum participants noted that communications must be culturally sensitive and easy to understand. For example, there are many areas of the state that are bilingual, and there is a language barrier for many to get the info they need and want. Information needs to be presented in multiple languages, depending on the demographics of the specific community. It was noted that there may be people in the community who would volunteer to translate materials. Sometimes information is presented in a way that is difficult
to understand. Information needs to be presented simply and clearly so that people can understand what they need to do to access help.

People are often unaware of the resources and services available and, therefore, don’t use them. Information needs to be distributed through multiple venues including doctor’s offices, service agencies, businesses, and community centers. Media outlets such as newspapers, radio, and TV should be utilized to educate the public. This was emphasized by a woman at the Berlin forum:

“If the local attending physicians had said to me, to my dad, to anybody, ‘Hey, you need to give these people a call because this is what is available’. With my mom, honestly we had no clue that there were any services available.”

Many participants spoke positively about the listening sessions and suggested that they should be held more often. They also recommended that other bureaus within DHHS hold similar public meetings. The need for more sharing of information among state agencies, communities and service organizations was noted in several forums.

Figure 4 presents the distribution of comments related to communication across the communities.
Prevention and Wellness

“Know your neighbors. Check on people who are living alone. Do that on a daily basis. Promote wellness. Focus on things that help us stay vital.” **Manchester**

Issues related to prevention and wellness were mentioned 190 times across all community forums. Comments related to prevention focused on both physical health as well as advanced planning for financial and medical needs. Many participants encouraged the state to promote and support wellness programs in order to encourage healthy behaviors and prevent the need for more costly services later. It was suggested that a legislative effort to fund prevention and wellness programs would be beneficial.

The role of communities in promoting health and wellness was stressed. Opening community centers and recreation facilities in the winter months for walking groups was cited as an example of using existing community resources to promote health and wellness. Participants conveyed that information needs to be made easily accessible to the public. Community centers, senior centers, and other places of congregation are a great place to distribute information about services that can contribute to health and well-being. A participant from Claremont summed up the importance of getting information to seniors:

“If we can get the information out about services, as well as initiatives for wellness, I think that helps. If we can get that information to seniors that will help potentially lower the need for services.”

The ServiceLinks were consistently commended for their services in all regions of the state. It was noted that they are a great resource for user-friendly information, educational materials, and referral to services. The ServiceLinks are seen as an invaluable resource for families and individuals to help them connect to needed services. A participant in Keene stressed the importance of accessing the ServiceLinks for information early on:

“I would tell anyone here if you have questions, even if you don’t need the services now, check out Service Link. It is a resource. I think it’s a smart thing to do, while I still have my head on straight. I don’t want to wait until the need arises.”

The importance of preventative health care and screenings was stressed. Information about Medicare and other coverage for these services is critical. Many people put off screenings because they are unsure if procedures are covered and they don’t have the funds to cover the costs. Dental coverage was noted as an important service in preventing other, more costly medically related issues. Lack of good dental care was also raised as an issue for preventing many physical problems as good dental care is linked to overall good health.

Barriers to participating in wellness programs included lack of transportation, bad weather, and lack of money. Many participants noted that small steps to stay healthy regarding nutrition, physical wellness, dental care, mental health and spiritual wellness can prevent more serious illness and possible nursing home placement. The need to fund wellness and prevention activities was stressed in several forums.
Recommendations for prevention activities included:

1. Wellness programs need to be provided in community and senior centers.
2. More nutrition programs and nutrition education is needed.
3. Incentives should be made available for the purchase of long term care insurance to make it more affordable.
4. Provide support services to assist in long range financial planning.
5. Education on the need for advance planning documents such as end of life care and durable powers of attorney needs to be provided.

Figure 5 represents the frequency of comments related to prevention and wellness across the community forums.

**Transportation**

“Transportation is a trouble. A lot don’t want to take the bus. A lot can’t walk. It’s a big problem. But if churches can do it and get money from donations, why can’t we? We have to go through a bureaucracy in order to do that.” *Nashua*

Transportation was raised as an issue in every forum, but was of particular concern in rural areas such as Berlin, Conway, and Claremont. The issue of public transportation is complex.
and challenging. There have been numerous efforts to better coordinate transportation services across the state with varying degrees of success. While forum participants did not provide specific solutions, their input helps to illustrate the complexity of the issue. The urgency to address transportation issues will become even greater as more people remain in their homes and communities as they age. Participants stressed that the state needs to address this issue now. As one participant from Berlin stressed, “Transportation is critical for everything.”

There is a need for better transportation services in all parts of the state, but it is more pronounced in rural areas where there is less public transportation available. Even in areas that have good public transportation systems, they are often not responsive to the needs of seniors. For example, many seniors are unable to stand for long periods of time waiting for a bus or are unable to carry items home from shopping trips. Often bus stops are not close to where people live, especially those who live in remote areas or off the main roads. Many consumers at the sessions mentioned that they would like transportation available in the evenings for social events like movies and going out to dinner. Some people require the use of wheelchairs and other medical equipment that has to accompany them, and the vehicles used must be able to accommodate them. In short, even where transportation services are available, they are often not convenient for the people who need them. As one participant from Dover noted:

“There is a bus that is available at the end of a street, but it’s too far for the elderly to walk there. And we have asked that they please consider changing their routes because most of the seniors are at the other end of that street. We’ve had no success.”

The lack of transportation presents significant barriers to access to services, particularly for services such as specialty medical care which is not available locally. Some programs provide transportation to allow participants to attend and others do not. Another issue is that many seniors are unable to drive themselves and rely on caregivers and/or volunteers to drive them where they need to go. It was reported that many of the volunteer drivers were not consistent, and the cost of gas has forced volunteers to either cut back on the amount of help they can provide or stop driving others completely. Program and funding rules also serve as a barrier to accessing transportation. For example, several transportation programs are not allowed to assist a rider from their house to the vehicle. For someone with mobility issues, this can prevent them from accessing that ride. A participant at the Manchester forum remarked:

“I’m an entry level senior, what I’m finding is that there are a lot of activities out there for seniors but transportation is a very, very big issue. They would participate but can’t get there because they don’t have a license or can’t afford transportation.”

Participants related that the myriad of transportation contracts, funding mechanisms and programs could be better coordinated to utilize these resources more effectively to meet the needs of NH residents. It was commented that the brokerage model that is being discussed and piloted in several areas appears to be a promising idea.

A number of suggestions to provide relief for the current high gas prices were elicited. These included: the state purchasing gas in bulk for agencies and direct care providers, paying incentives to agencies that reimbursed direct care providers for mileage, adjusting rates to account for the higher transportation costs, and consolidating trips and sharing vehicles among
different organizations. Video conferencing was also raised as a way to reduce travel costs by to limit the need to travel to doctor or agency offices for appointments, meetings, and workshops. Figure 6 reflects the frequency of comments related to transportation across the communities.

![Figure 6: Transportation](image)

### Work Force

The quality of life for people who require care is directly tied to the quality of the workers who support them. In New Hampshire and nationally, the ability to recruit and retain a quality direct care workforce is becoming increasingly difficult. Unable to earn a livable wage and with no health insurance or other benefits, direct care workers frequently leave for better jobs. The situation is only expected to get worse. By 2030 the number of people over 65 will nearly triple and the number of those over 85 will nearly double, at the same time the workforce available to meet the needs of an aging population is constricting.

Issues related to the workforce were raised 144 times in all forums. Workforce issues range from the lack of specialized medical professional to the lack of quality direct care workers. There is concern that we do not have an adequate direct care workforce to support the State’s efforts to shift care for older adults from nursing facilities to home and community-based settings. With a population that is older than the national average, there are an increasing number of New Hampshire residents who require direct care. At the same time, there is a shrinking number of qualified workers available to meet this need. In addition to the paid workforce, the home care work force is made up of many volunteers, and the number of
available volunteers is also shrinking. Lastly, many spouses and adult children are providing personal care for their parents, and these informal caregivers need support in order to continue to provide this care.

Participants reflected that wages and benefits for New Hampshire’s direct care workforce are inadequate. Most front line workers are not paid a livable wage and few workers receive benefits of any kind. An assessment of staffing patterns and community needs should be done in order to make an informed, coherent and powerful argument for additional funding for direct care wages and benefits.

More ways need to be found to utilize volunteers who are able and willing to share their experience, talents and passions. Retraining those who have retired or been laid off from other professions to be caregivers could open the door for many workers. As one participant in Plymouth stated:

“We should encourage older citizens to come back into the workforce, people who are 55 years of age to come back in and provide care for people.”

There is a need for more physicians, nurses, social workers and volunteers, and an incentive needs to be created to encourage people to pursue and remain in the field. More effort and creativity are needed to promote direct support as a viable career option. Students enrolled in high schools and New Hampshire’s Community Technical Colleges should be informed about direct support career opportunities. It was also suggested that the state could provide incentives for medical students to specialize in gerontology and to stay in the area, such as loan forgiveness for a certain number years of service.

“For the state ought to think a little out of the box on how to have incentives for young people to pursue careers in the occupations that will help address these needs.” Plymouth

A number of issues related to the direct care workforce were raised. The lack of an adequate number of direct care workers was mentioned in many forums and the shortage is predicted to get worse. Many participants argued that the state needs to address the shortage for personal care, respite care, and other direct service needs if it hopes to increase access to home and community based services. It was also noted that there needs to be better training, staff development, and quality assurance for New Hampshire’s direct care workforce. Some participants noted that direct care services are not well coordinated and that better communication is needed among provider organizations, direct care workers, and those receiving services.

Figure 7 reflects the distribution of comments related to workforce issues across the state.
Caught in the Middle

“Our concern is for that group that falls through the cracks, who are not poor enough to qualify for public programs but don’t have enough income to pay privately for services.” Claremont

“We have people that are growing older caught in the middle. They are not eligible for services because of their income and so forth and they begin to have needs and cannot afford to pay privately for some of the services because they are caught in the middle like that.” Claremont

“Something has to be done for that person that needs a little help so they don’t spend down everything and outlive their money.” Manchester

These were common refrains across all of the forums. Participants were concerned about those who do not qualify for publicly funded services, but who do not have adequate resources to pay for services themselves. Those who planned well financially their whole lives feel “punished” because they don’t qualify for services and programs such as heating assistance even though they cannot handle current costs for these services.

Long-term care insurance was noted as a useful product but many cannot afford to purchase it and the benefit package is often limited. In its current form, long term care insurance is not adequately meeting the identified need. The following comment from a participant in Plymouth articulates the issue well:

“I’m one of the people in the gap. I work, get a pension, and get social security. I make too much for any of the program, and so I have had to spend lately, I have spent up to $500 over what I
make a month for medical and try to stay even. I have been in a rut. But there aren’t any services for the people in the gaps. It totally frustrates me.”

Some participants noted that there is a lack of awareness and information about what services people may be eligible for. Income limits vary across programs and some services are available to all residents of the state. Better communication about what is available and who is eligible is needed. It was also noted that the paperwork for applying for services needs to be streamlined and made more manageable for consumers and agencies alike. Better sharing of information across agencies would make it easier for people to access needed services.

Participants at several forums raised concerns that the rising cost of health care services will limit the number of people receiving services. While it is extremely difficult for individuals who do have insurance to afford care, concern was expressed that even those on Medicaid and Medicare are finding it hard to access care as many providers are unwilling to accept Medicaid’s and Medicare’s low reimbursement rates. A common complaint at almost every forum concerned the issue of the “donut hole” in Medicare services where prescriptions are no longer covered. Many participants noted that the program is confusing and that they pay more for prescriptions now than before Medicare Part D. Participants expressed concern that people are having to make a choice between prescriptions and other basic needs like heat or food. As one participant in Dover lamented:

“I get so angry sometimes when I think about some of the things that seniors, and I’m counting me in that, aren’t covered for. When I worked full time, it was wonderful. I had all the care I needed. When I’ve gotten old, now my teeth, my hearing is shot, my eyes, I can’t see as well, and yet none of that is covered under Medicare. Not one bloody cent of that is covered. Yet that affects so many seniors. And the cost of that is just outrageous. I’m very frustrated about it because I think there needs to be something done. There are other things this can cause with depression when people can’t communicate or they can’t hear.”

Figure 8 represents the frequency of comments related to concerns about people who cannot afford to pay for services, yet are not eligible for publicly funded services.
Mental Health

“Encouraging people and providing services for people to remain in their home is great, but we see self-neglect reports rise and isolation and depression increase.” Wolfeboro

The need for mental health services for older adults in New Hampshire was raised a total of 112 times across all of the consumer forums. The lack of access to mental health services was raised as a concern throughout the state. Many noted that they have seen an increase in self-neglect, and it was felt that this is partly because people are too proud to ask for assistance from family and strangers alike. There is a high incidence of depression among older adults. It was recommended that community based mental health and substance abuse services need to be increased.

The increasing number of people with Alzheimer’s and related dementias was specifically raised as a growing concern. Caregiving for someone with Alzheimer’s is particularly challenging and mental health services for caregivers needs to be addressed. It was suggested that there needs to be more education about Alzheimer’s disease and related dementias for both doctors and families that is culturally sensitive.

Figure 9 illustrates the frequency of comments related to mental health services across the state.
Social Connections and Relationships

“How important it is for all of us to be connected with one another. That leads to a quality life, a healthy and happy life.” Conway

“I get energized by people, and I think that each one here has a gift, and we can help each other but we don’t have a common place.” Concord

At sessions throughout the state, people commented on the importance of participation in senior programs and attending social and spiritual events. Senior Centers were praised as excellent community resources that provide low-cost programs, nutrition, social connections, physical activity, and medical support. Senior Centers are an untapped resource in many areas and it was suggested that they should be supported in every community. A Conway participant stressed how important the local Senior Center is:

“Most of us are so grateful for the Gibson Center and not just the quality of the meals, but for the people, association and friendships and to learn to get along with people…. We depend on other people for socializing, for talking, or telling jokes.”

Social relationships can improve the quality of life and keeping people engaged in the community is important for their overall health and well-being. Unfortunately, many people who are staying at home, especially in rural areas, are isolated from such activities and social
connections. Family and friends are a tremendous resource but many seniors do not have family nearby.

One thing that is overlooked is socialization. There are not the Halloween parties and availability to get people out of their apartments socializing with one another, which helps to develop friendships and also mental alertness. Socialization is key, it is one of the predominant needs that anyone has, to be with people.” Manchester

Social interaction and psycho-social needs have to be considered when planning services. In many forums it was noted that an increase in the number of social programs available to seniors that provide transportation is needed. Many comments specifically supported the need for more social opportunities on weekends. Services such as Meals on Wheels are important, but for many, the sharing of time with the person who delivers the meal can be more important than the meal itself. As one participant from Concord noted about the Meals on Wheels program, “I think that being together and talking was just as important as the meal.”

Figure 10 reflects the frequency of comments related to social connections across the state.
Community Engagement

“In my mind, it’s really about the community system. What can we be doing as friends, as neighbors, to change to make things more livable for all of us? Do we need to have community associations, neighborhood associations, more involvement with some of our civic clubs and organizations so that we are all helping each other?” Nashua

The importance of working together with local communities was stressed in all of the forums. It was noted that partnerships among community organizations can improve services by sharing resources and expertise. Collaborative efforts at fundraising could help to address the varied needs of all residents and to better manage available funds. Many participants commented that agencies need to share resources more with each other to better serve their clients. Transportation and transportation funding were raised as an example as one of the most important areas where collaborative efforts would better utilize existing resources and improve service.

Forum participants commented that local groups such as churches, Chambers of Commerce and Rotary Clubs need to be engaged to support seniors in the community as well as to share information about services and social activities. Individuals in the community could be tapped to share more of their personal and professional talents in order to make the community better for all. There needs to be more creative thinking for solutions and more thinking outside the box rather than relying on publicly funded services. One Keene participant described an innovative idea they are working on:

“We are trying to get five or six rural communities to get together, starting at an earlier age. We know the boomer are about to hit us, and that will make a lot of difference in the long run. The state can’t handle it. We have to do it ourselves. A lot of this is live free or die. And maybe live free with other people. Independence and choice, respect, those are the things that people talk about.”

There needs to be more inter-agency and inter-departmental collaboration not only with resources, but with ideas and sharing information. There should be more collaboration with colleges, universities and other educational establishments. For example, creating or utilizing programs where students in the Human Services Program become involved with the agencies and are included in the work force through internships and program requirements can reduce costs to the system, increase the work force and provide training needed for those entering the field.

It was also noted that seniors can benefit from stronger partnerships with professionals. For example, having a good relationship with a physician can provide the connection needed to feel comfortable asking questions about one’s health and available services. A strong
relationship with one’s health care providers is critical to empower seniors and foster informed decision making.

Figure 11 represents the frequency of comments related to community engagement across the communities.

![Figure 11: Community Engagement](image)

### Access to a Range of Service Options

“One of the things that I’m seeing for myself is that there isn’t anything in between independent living, whether it be in an apartment or house or whatever, and assisted living. And a lot of people who live here, including me, either have help from friends and relatives, or they don’t. And I inquired about services from VNA and I was told that I couldn’t get a home maker companion unless I also needed nursing services, which I don’t need.”  **Concord**

The need for a range of service options that are easily accessible in every community was raised at eight of the community forums a total of 80 times. Comments reflected on the lack of options for home and community based care, and the need for a broader range of services between independent living and nursing home care. The following comments reflect the sentiment heard throughout the state:

“People trying to avoid becoming ill or declining so they have to go into a nursing home, is a common theme that I have seen with people that I speak with on the phone. They worry about asking for help, because they think the only option – like this old way of thinking -- is nursing
home. And I’m not going there. Whereas if we can address their needs in the home successfully and appropriately, they can stay at home. But because that’s such a new way of thinking, a lot of the elders don’t even realize that that’s available. Then they don’t ask for help, then they decline, then they do have to go in a nursing home. Somehow we need to let people know that there is this option. Nashua

“I just need somebody to come in and help me with cooking and cleaning. And I think being a Boomer, as we age, is going to be more people needing this to stay in their homes. And we all know that that’s best for mental and physical health and it’s less expensive.” Concord

Figure 12 presents the frequency of comments related to access to a range of service options across the state.

![Figure 12: Access to a Range of Service Options](image)

Caregivers

“…we owe a lot to family caregivers. They are the unsung heroes, providing 80% of the care that is given to older adults in this country. Not through nursing homes and not through the VNA, but family taking care of family.” Berlin

“I would have killed for a haircut. I didn’t have one in over a year.” Berlin
Family caregivers provide the vast majority of all long-term care, and NH relies on this informal network of support as a primary source of care for older adults. That care is frequently complex, demanding, and may extend over a long period of time. Often, a caregiver is a spouse, adult child, or other relative. These family caregivers need support in order to continue to provide care for their family member. There needs to be greater attention paid to the needs of caregivers. As a Salem participant observed:

“I have to tell you people who have loved ones that are ill and they are frail and they are still married, the spouse that is providing the care, they are wearing out, but they are wearing out because they are scared. They are scared that their finances are dwindling and they are frightened. We have to start where we can help to support the people, so they don’t have the fear and can focus on the care giving.”

Adult day care is a great resource for both the individual and their caregiver. Alzheimer’s is a family issue and needs family care. Family caregivers need emotional respite; not all needs are financial.

People complained about being on a waiting list for respite care. Many people do the best they can until they just can’t do it anymore. When they finally ask for assistance, they need help immediately and can’t be on a waiting list. In addition to services such as respite care, many caregivers noted how helpful support groups have been for them. The need for more caregiver support programs is reflected in the following remarks:

“There is really not a lot of money out there to help the care giver who is providing that 80% of the care to their parents. We would ask additional support if that is possible in the future, to get more support for them. And also a support group.” Berlin

“We don’t have enough help. There is no money available for house cleaning and all that. When you call for that there is nothing available. They pass you around to different places. I have a husband and I can take care of him. I don’t want him in a nursing home. But how long can I care for him without certain services?” Manchester

“I hear families coming in to the support group that are caring for loved ones at home. The caregiver grants are excellent, they need that respite care, and I see that need increasing. More older people are being cared for by their spouses or children, or are trying to take care of grandchildren. There does need to be more attention to caregivers and taking care of themselves.” Conway

It was recommended at several forums that support groups for caregivers be made available throughout the state and be advertised widely. In addition, the need for more respite care providers and a backup system in the event that a worker does not show up were noted.

It was noted at a number of forums that the caregiver support grant is vitally important and funding for this program should be increased. In particular, comments indicated that the Transitions in Caregiving program is a huge help and should be expanded statewide. Transitions in Caregiving is a nursing home diversion program funded by the Administration on Aging that is transforming the state’s caregiver support system to a community-based, consumer-directed caregiver program.
Figure 13 depicts the distribution of comments related to caregivers across the state.

![Figure 13: Caregivers](image)

**Education and Outreach**

“I don’t know what we can do to target those people that need these services but are isolated in their homes. Those are probably the voices we need to keep in mind at these meetings because those are the people that can benefit the most and don’t have access to health care. They don’t have a close family situation or anybody they can count on.” *Laconia*

In order to make informed choices about long term care, people need good information about the options available. Education is power and it should be an ongoing process for professionals and consumers alike so that both are informed about available services. The areas that were expressed as being most important during the sessions were: learning about rights regarding exploitation and abuse; information about what services are available; nutrition education; money management; information on various mental and physical conditions; and caregiver education. In particular, many people asked for information about Dementia and Alzheimer’s to better understand how to assist their loved ones and what to expect down the road.

*Many participants noted that education is an ongoing issue as individual circumstances change and people don’t always ‘hear’ the information until they need it. As one participant from Wolfeboro observed, “We never think about the services until you are there and it is one of those ‘Oh My God’ moments, and you needed it almost yesterday.”* *Wolfeboro*
Other Concerns

A common refrain in many forums was that some people may be afraid to ask for help, thinking that they may be forced into a nursing home. It was also noted that some seniors may be afraid to attend a community meeting, or to speak freely, for fear of having others find out their personal business. Other concerns that were expressed indicated that many seniors don’t want to talk about getting older and fear being a burden on their family.

“It might be uncomfortable, what nobody wants to talk about, but I think we all worry we’re going to be a burden to our kids. And you know things happen. I wish the state would just be a little bit more concerned.” Concord

“Many times people don’t want to recognize that they are aging or getting older. We don’t want to talk about being old. Our state needs to have an initiative that recognizes and values growing older and there is a lot to do and a lot of things for people to experience. Seniors are the forgotten people.” Manchester

Other participants reflected on the aging of the baby boomer generation and how the increasing number of seniors will change the face of aging.

“And one of the things that’s really frightening for me standing here is that I’m realizing that the issues of the generation ahead of me haven’t really been addressed or met, and here I come as a boomer -- there are more of us. It’s going to get worse, and I’m scared half to death.” Concord

“This generation is not willing to lay back and accept what was. They’re going to challenge. And they’re going to push. And they’re going to shift the paradigm into being proactive.” Concord
Provider Findings

This section of the report documents the findings from the provider forums which were held in Nashua, Littleton, Berlin, Claremont, and Portsmouth. In total, almost 100 providers attended these sessions and provided input. A number of key themes emerged through these sessions. They include: the economy and funding for services, consumer-directed personal care services, workforce, communication, transportation, community partnerships, mental health, social connections/relationships, mental health, and prevention. In addition, a number of barriers to community services were identified.

The Economy and Funding for Services

“…the character of an individual is always tested with adversity and right now we as a system and organization are being tested mightily.” Conway

Issues related to the economy were paramount in all five provider forums. In total, 59 specific comments were raised, the largest number for any theme area. The downturn in the economy and the rising costs of fuel have increased the level of anxiety around funding at both the individual and agency level.

Forum participants remarked that the economy is unstable and it affects the state budget, county budgets, local funding, and fundraising. This will have a serious impact on the availability of services in the community. At the same time, it is anticipated that the number of people seeking services will increase as the economy worsens.

The increases in fuel costs is affecting agency budgets for both heating and travel expenses. The increasing cost of driving is an issue for agencies, workers, and volunteers. Agencies cannot afford to pay the increased mileage reimbursement, workers are not paid adequately to cover basic fuel costs, and volunteers are cutting back on driving as their fuel costs increase. Participants in the more rural areas commented that they are particularly hard hit as workers have much further distances to drive to make home visits. It was strongly recommended that the state consider differential rates between urban and rural areas to account for the increased travel costs in rural areas.

The need for more funding for dental services was also raised as an issue in the provider forums. Providers also anticipated that the number of seniors who will be exploited could increase as the economy worsens. Increased efforts should be made to educate seniors about financial and emotional exploitation.

Consumer-Directed Personal Care Services

“So we want to get to that point in a person-centered system where not only are the services determined by the clients but also the service dollars and how they’re spent by the individuals and their families, their support. I should say and also add that managing these services is a very important part of the process, not only in designing the services but managing them, and we think that is best served by the person who is receiving the care.” Claremont
Issues related to consumer-directed personal care services were raised in all five provider forums with a total of 45 comments. Comments ranged from concern about the lack of choice and availability of home care workers to strong support for a more consumer-directed system. Participants noted that one size doesn’t fit all situations and that the system needs to be more person-centered, individualized, and flexible.

The lack of access to a wide range of supportive services in the community was raised as a concern. Services areas that were noted as needing additional funding include: residential care, caregiver support, respite beds, assisted living, denture program and dental needs in general, emergency placement, assistance for the homeless, veteran’s services, transportation, adult day, and more. With the downturn in the economy, referrals for services are increasing, especially for personal care assistance, home making, and personal errands. Many areas reported the need to establish waiting lists for services.

It was noted that in a person-centered system all of the person’s existing support networks are assessed. Existing supports are augmented with agency supports. This results in a more cost-effective and higher quality service. Participants commented that procedures for determining eligibility for services and the provision of services needs to be streamlined in order to get assistance to people more efficiently and timely.

Work Force

“We have the "perfect storm" situation. We’re encouraging people to stay at home but we won’t have the workforce to support them.” Claremont

Issues related to the workforce were raised in all five provider forums. Concern was expressed about the lack of an adequate home care workforce and how this affects access to care and the quality of care provided. Concern was raised that there are not enough workers and recent cutbacks have made the situation worse. As the population ages and younger workers leave the state, it is anticipated that issues related to the workforce will be heightened. As one participant noted:

“We have a workforce problem in NH, we have many people from the ages of 24 -54, women especially, who are leaving the state, seeking higher paying wages, and this is the population that has typically provided the care giving.” Wolfeboro

In addition to the lack of a paid workforce, concern was also raised about the loss of volunteers as the cost of gas increases and volunteer cut back on travel. It was also noted that most volunteers are older and as they age they may need services themselves, rather than be providing services. On a positive note, it was suggested that consumer-directed personal care services may have appeal to workers who would not typically work for a home care agency, such as friends, family, and neighbors, and this will bring a new and atypical workforce into the field.

Participants also noted the need for more professional services for geriatric care. They observed that it is currently very hard to find doctors, nurses and social workers trained in geriatrics that are willing to come to and stay in NH, especially in the more rural areas. It was
suggested that the state consider programs to encourage professionals to work in NH, such as loan forgiveness, educational benefits, and other career enhancements.

Communication

“The biggest problem is getting information out there to the common person.” Nashua

Issues related to communication between the state and providers, among providers, and with community members were raised at four of the five provider forums. Participants remarked that the Department’s cross-bureau team could help with the lack of communication. It was felt that better communication between the managers of the various waiver programs would benefit community providers who struggle to find appropriate services and funding for their clients.

The need to have materials written in simple language that everyone can understand was stressed. It was noted that many people don’t know what services are available or how to access them. Often the written material they receive is confusing, particularly if it includes legal, bureaucratic language. Comments also indicated that people often don’t look for information or pay attention to what is available until they need it. As one participant observed:

“We’ve been here 30 years as a senior center and they don’t know there is one. On the other side of that, we have people who come to the state from another area, to be close to children, they immediately seek out a senior center because they were active in one back at home and they find us right away. To me it’s a selective process. If you don’t want or you don’t -- you just don’t see it. It’s invisible unless that’s what you’re specifically looking for. So there are a lot of things slipping by people simply because it may not be that one thing you need now.” Nashua

Issues related to outreach and education were raised at three of the provider sessions and focused on the need for more education on the Community Passport program, emergency planning, and guardianships. It was suggested that both Service Links and Senior Centers are great places to distribute information. It was remarkable how often people at the forums indicated that they did not know that Service Link existed. It was suggested that continued efforts be made to get the word out about Service Link. As noted at the Claremont forum, “ServiceLink is helpful because it is a one-stop shop where people can come in and get information about services.” Claremont

Transportation

“So people that are going to remain in their homes are going to need support for transportation, not just for groceries, but for a myriad of things, to get to the care that they need, etc.” Concord

Transportation was identified as an issue in four of the five provider forums. Issues related to transportation varied by community, based on the availability of public transportation and the rural nature of the area. Transportation issues were intertwined with the economic issues related to the increase in fuel costs.

It was noted that there is no public transportation in many areas and where there is, it often doesn’t work for seniors because of lack of proximity to bus stops, inconvenient schedules,
medical issues that prevent access, lack of places to wait for the bus in bad weather, and difficulty carrying personal items such as groceries. Transportation for people who need ongoing treatment at specialized facilities such as dialysis or chemotherapy, is particularly difficult as they often require one-on-one attention and regularly scheduled transport. For those living in rural areas, the distance to travel to these appointments is particularly challenging.

Mileage reimbursement and fuel costs are a grave concern and affect the level of service provided; particularly for services such as home-delivered meals and home health. This theme was heard widely in all communities and providers are very concerned about being able to continue to provide services in the most rural areas. Many people, especially those who live in rural areas who have to travel long distances for medical care, haven’t been able to get to medical appointments which can compromise their health. As one participant in Claremont noted:

“I’m very concerned about the lack of transportation for a lot of these folks. There is a real shortage of transportation for folks to get to life saving medical appointments. This is a rural state and public transportation is really minimal, unless you live in Manchester or Concord where there is regular transportation.”

Recent efforts to develop transportation brokerages across the state were praised as a promising practice. As one participant summarized:

“We are trying to set up what we call a transportation brokerage. The reality is that there are a number of agencies that have transportation assets in our respective communities, but they are not coordinated.” Conway

Community Partnerships

“Working together as a community and relationship building is key and paramount to just about anything that we do. Being able to establish rapport and trust is how we will weather the storm.” Littleton

Partnerships at the state and community level were raised at three of the five provider session. Participants talked about successes as well as problems with partnerships. Participants commented that there needs to be more communication, planning and cooperation among community agencies, especially in respect to sharing resources. Several communities are working to create community partnerships to help address needs at a local level. As one participant from Keene remarked:

“We are looking at ways to work with existing volunteer organizations and the business community to help people who are looking for concrete ways to volunteer.” Keene

Mental Health

“There is a real need for our seniors and also for the other folks in the community for mental health and substance abuse services. That is something on the back burner or swept under the
rug. Mental health issues will not go away without care and there are not enough health care providers who are actually facing the issues.” Conway

Concern about the availability of mental health services was raised at three of the five provider forums. Comments indicated that many regions are seeing an increase in depression and isolation among older residents. Several participants expressed concern about the increased numbers of reports of neglect and self-neglect. The need for more community based mental health services was stressed. As one participant stated:

“Mental illness is probably one of the most vexing issues that we have in the state. The root issue is inadequate services and bed capacity and substance abuse services in the community.” Conway

Social Connections and Relationships

“We are concerned about folks who are remaining at home and don’t have the social networks they need. So they are isolating themselves and not getting out and that doesn’t promote healthy living.” Keene

Issues related to social connections and personal relationships were raised at four of the five provider sessions. Participants remarked that the lack of socialization increases the likelihood of depression and has a negative effect on overall quality of life. Personal connections often result in better care and more access to services and supports. Those who do not have family and friends nearby often need more formal services as they lack an informal support network. On the flip side, concern was also raised about family members moving back in with their older parents during these difficult economic times and taking advantage of them.

Prevention

“We need to focus on prevention. I think it does keep people well longer. It keeps people from getting into the system before they really need to.” Nashua

Issues related to prevention were noted in four of the five provider forums. Issues were raised across a range of areas including: the need for places for seniors to congregate and socialize, particularly on weekends; the need for better preventative dental care; and the need for emergency planning at an individual and community level. Many participants noted the value of the contact made with individuals through programs such as Meals of Wheels which provide an extra set of eyes to check on people who live alone. Concern was raised that many agencies have had to cut back on the frequency of these visits due to fuel costs. Concern about the lack of funding for preventative services was illustrated by the following refrain:

“So there needs to be a balance. But it’s difficult to have that balance when those types of preventative services we used to have available evaporated as funding dried up and we were no longer able to do that. Our concentration became on the neediest, the most frail, and that also makes sense. When you don’t have a lot of money, you put your money where it really is going to go the furthest.” Nashua

The following table indicates the frequency with which each topic was raised at each provider listening session.
Barriers

Barriers to accessing home and community based services were raised at four of the five provider forums.

Barriers identified include:

1. The process of accessing services is confusing and disjointed;
2. Many people fall between the cracks and don’t qualify for Medicaid or other public services, yet cannot afford to pay for services on their own;
3. Some people are reluctant to ask for or accept services;
4. The availability of services varies across the state;
5. The various eligibility criteria for programs is confusing;
6. Liability concerns sometime prevent agencies from providing services people need;
7. Lack of transportation makes it difficult for people to access services, medical care, and social events; and
8. The lack of affordable, safe housing in many areas of the state makes community living difficult.

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<thead>
<tr>
<th></th>
<th>Claremont</th>
<th>Berlin</th>
<th>Nashua</th>
<th>Littleton</th>
<th>Portsmouth</th>
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Recommendations

A number of recommendations emerged from the vast array of comments collected through these forums. The following summarizes these recommendations.

1. Increase the assistance that can be provided for home and community based services to help people stay in a home setting and delay nursing home placement. Utilize some of the savings realized through nursing home diversion to increase funding for home and community based services.

2. Continue the State’s efforts to create a more person-centered, consumer-directed system. This means providing greater choice over where and how services are delivered and tailoring services to meet the needs of individuals.

3. Increase the resources available to support family caregivers. Implement the consumer directed family caregiver model statewide.

4. Increase education and outreach to better educate families, individuals, and professionals about available services. Assure that information is provided through multiple venues and that written information is easy to understand.

5. Support prevention and wellness programs in every community. Define prevention and wellness broadly to include all aspects of healthy aging to include dental care, nutrition education, physical activity, financial planning, advanced planning for health care, socialization, etc.

6. Partner with existing community resources to enhance services for seniors. Develop strong community partnerships in each community to support seniors. Work with local Senior Centers to provide programs to engage seniors.

7. Develop a comprehensive strategy to address the workforce shortage that considers the lack of geriatric medical specialties, nurses and other health care providers, and personal care workers.

8. Increase access to geriatric, community based mental health services.

9. Continue the work to coordinate transportation services statewide through regional brokerage systems.
Other

A number of ideas were generated that were not within the purview of the Department of Health and Human Services. However, the issues were important to community members and are included here for consideration.

1. Many towns and the state could follow the lead of one area that permitted citizens to go into forests to cut down previously marked and approved dead trees for firewood to offset oil costs.

2. The state could provide a credit card like those that doctors and dentists offer to pay for services. It would have a relatively low interest rate, and the interest paid could go back to the state to pay for services.

3. Provide financial relief to certain seniors through property tax relief and interest and dividends tax exemptions.

4. It would be helpful if the Department of Motor Vehicles provided handicap stickers at their locations so they could be obtained quickly when needed.

5. It would be helpful to have all medical and social services in one place, like a Senior Super Center. This would assist with transportation issues as well as make communication and collaboration between professionals easier.
Appendix
Community Listening Forums

Helping Each Other Through the Ages

Schedule 2008

It really is about you. For so many years you may have been focusing on your job or career, raising a family, or giving unselfishly of your time and talents to your community. Now it’s time to concentrate on how you want to spend this time in your life. What do you need to stay engaged and active? How can the State and communities support you in living life on your terms? Please join us for a discussion on this topic at any of the sessions listed below. Representatives from the State will attend these sessions to hear your ideas firsthand.

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
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<tr>
<td><strong>Monday, May 12</strong></td>
<td>Nashua Senior Center 70 Temple St., Nashua</td>
<td>889-6155</td>
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<td>1:30 p.m.</td>
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<td><strong>Monday, May 19</strong></td>
<td>Laconia Public Library 695 Main St., Laconia</td>
<td>524-4775</td>
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<td>10:00 a.m.</td>
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<td>3:00 p.m.</td>
<td>Monadnock ServiceLink 105 Castle St., Keene</td>
<td>352-9354</td>
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<tr>
<td><strong>Wednesday, May 28</strong></td>
<td>William B. Cashin Senior Activity Center 151 Douglas St., Manchester</td>
<td>624-6536</td>
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<td><strong>Monday, June 9</strong></td>
<td>River Valley Community College (formerly NHCTC–Claremont) 1 College Drive, Claremont</td>
<td>542-7744</td>
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<td><strong>Monday, June 16</strong></td>
<td>Horseshoe Pond Community Resource Room 26 Commercial St., Concord</td>
<td>228-4704</td>
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<td>9:30 a.m.</td>
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<td>1:30 p.m.</td>
<td>St. John’s United Methodist Church 28 Cataract Ave., Dover</td>
<td>742-3046</td>
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<td><strong>Tuesday, June 17</strong></td>
<td>Plymouth Senior Center 8 Depot St., Plymouth</td>
<td>536-1204</td>
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<td>2:00 p.m.</td>
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<td><strong>Monday, June 23</strong></td>
<td>Gibson Center 14 Grove St., North Conway</td>
<td>356-3231</td>
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<td>12:30 p.m.</td>
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<td><strong>Monday, June 30</strong></td>
<td>Wolfeboro Public Library 259 South Main St., Wolfeboro</td>
<td>569-2428</td>
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<td>12:30 p.m.</td>
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<td><strong>Tuesday, July 15</strong></td>
<td>White Mountains Community College 2020 Riverside Dr., Berlin</td>
<td>445-4525</td>
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<tr>
<td><strong>Thursday, July 17</strong></td>
<td>Salem Senior Services Center 1 Sally Sweet’s Way, Salem</td>
<td>890-2190</td>
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<tr>
<td><strong>Tuesday, July 22</strong></td>
<td>Littleton Area Senior Center 77 Riverglen Lane, Littleton</td>
<td>444-6050</td>
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Please RSVP to Heather at heather.tuttle@dhhs.state.nh.us or 1-800-852-3345 x4384 or TDD 1-800-735-2964 x4384.
To view this report online, visit:
http://www.dhhs.state.nh.us/DHHS/BEAS/