

**ADRC Operational Plan
Addendum to New Hampshire's 2011-2015 State Plan on Aging
September 2011**

New Hampshire's 2011-2015 State Plan on Aging describes New Hampshire's plan to improve the health of the older adult population, aligning with the AoA Strategic Goals. Within the plan, there is clear recognition that the ADRC network, known in New Hampshire as the ServiceLink Resource Center network, will be instrumental in achieving the goals:

State Plan on Aging Goal 1: Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access existing health and long-term care options.

State Plan on Aging Goal 2: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.

State Plan on Aging Goal 3: Empower older people to stay active and healthy through Older Americans Act Services and the new prevention benefits under Medicare.

State Plan on Aging Goal 4: Ensure the rights of older people and prevent their abuse, neglect, and exploitation.

This addendum expands on the goals and objectives outlined in the New Hampshire State Plan on Aging to achieve these three goals, focusing specifically on the activities for the SLRC network for the 2012-2015 time period. The activities in this ADRC Operational Plan reflect opportunities identified by stakeholder feedback gathered during the development of the New Hampshire State Plan on Aging, lessons learned from New Hampshire's history in ADRC development (including its grant awards dating back to 2003), and collaboration with statewide and local aging stakeholder groups.

In a 2008 review, New Hampshire was identified as a fully-functioning, statewide ADRC. The SLRC network is committed to maintaining that status under the newest criteria (including care transitions) for fully-functioning ADRC. The goals and activities summarized in the table below represent the necessary work to continue and enhance NH's SLRC network.

This document serves as the ADRC Operational Plan as required by the 2009 ADRC Enhancement Award, 90DR0039.

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Goal 1: Statewide, fully-functioning, person-centered, sustainable ADRC network		
Objective	Activity	Timeframe
Build capacity to meet newest criteria of a fully functioning ADRC statewide: Focus on Care Transitions (hospital and nursing facility)	<ol style="list-style-type: none"> 1. Complete care transitions pilot in the three SLRC Counties - Care Transition Intervention (Carroll County SLRC and Monadnock SLRC) and BOOST (Belknap SLRC) 2. Evaluate and share the results of the pilots with stakeholders and policy makers. 3. Expand the state-wide person-centered hospital discharge planning work group to develop a unified approach for the NH SLRC Network, including partnering with the NH Chronic Disease Self Management Advisory Council, consumers, and aging network providers. 4. Create a model/protocol for all SLRC's to meet the fully functioning care transitions criteria. 5. Secure on-going funding for staff and training to meet the care transitions criteria across the SLRC Network. Explore Federal, State, local and national foundations, 3rd party reimbursement, and hospital funding for this activity. 6. Identify opportunities for aligning the current hospital-based care transition project and ongoing nursing facility transitions project (MDS Section Q). 7. Provide ongoing support for training and program development for the SLRC Network on care transitions. 	<ol style="list-style-type: none"> 1. September 2012 2. September 2012 3. September 2012 4. September 2013 5. September 2013 6. September 2013 7. Ongoing through September 2015
Develop and implement a state-wide No Wrong Door model that is sensitive to diversity at the local level.	<ol style="list-style-type: none"> 1. Complete the current pilot in Grafton SLRC. 2. Evaluate and share the results of the current No Wrong Door pilot with stakeholders and policy makers. 3. Create a design for statewide expansion of a No Wrong Door model. 4. Implement, seek funding if necessary (staffing, marketing, cross training, etc.), of the No Wrong Door model across the SLRC Network. 	<ol style="list-style-type: none"> 1. July 2012 2. September 2012 3. September 2012 4. September 2014
Provide person-centered Options Counseling that meets or exceeds the	<ol style="list-style-type: none"> 1. Complete the objectives for standardizing options counseling under the Long Term Support Counselor position across the SLRC Network, including implementation of standards, training (person-centered planning, neglect and abuse, peer support), and 	<ol style="list-style-type: none"> 1. September 2012

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<p>national standards as a core service across the SLRC Network.</p>	<p>evaluation.</p> <ol style="list-style-type: none"> 2. Develop a plan to standardize elements of Options Counseling within other SRLC positions and provide training. 3. Identify information technology needs for Options Counseling; secure funds needed for upgrade and training. 4. Collaborate on national Options Counseling workgroup to develop common training, data collection tools, and evaluation metrics. 5. Seek and secure ongoing funding for the evaluation and training of Options Counseling across SLRC staff. 	<ol style="list-style-type: none"> 2. September 2012 3. September 2012 4. September 2012 5. Ongoing through September 2015
<p>Explore the feasibility of incorporating the consumer-directed Veteran directed home and community based care into SLRC statewide.</p>	<ol style="list-style-type: none"> 1. Evaluate the Belknap pilot, including assessing the scope and size of the program and availability of funds. 2. Document the necessary expertise and infrastructure needed to implement the program statewide, based on learning from pilot project. 3. Develop an expansion plan for additional sites to implement the program, including planning for Fiscal Management Services. 	<ol style="list-style-type: none"> 1. September 2012 2. September 2013 3. September 2014
<p>Support the state-wide, consumer- directed NH Family Caregiver Support Program.</p>	<ol style="list-style-type: none"> 1. Secure ongoing funding for the care-giver specialist position at each SLRC. 2. Secure ongoing funding for consumer-directed services for caregivers. 3. Identify opportunities and implement with options counseling project and care transitions project to improve the quality of service to caregiver across all projects. 4. Provide ongoing peer-support opportunities and person-centered training (options counseling components) for caregiver specialists. 	<ol style="list-style-type: none"> 1. Ongoing through September 2015 2. Ongoing through September 2012 3. September 2012 4. Ongoing through September 2015
<p>Support the development of a comprehensive, streamlined data</p>	<ol style="list-style-type: none"> 1. Ongoing assessment, coordination, and upgrades of data infrastructure needs across all long term care system programs (ADRC, MFP, Medicaid, etc). 	<ol style="list-style-type: none"> 1. Ongoing through September 2015

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<p>infrastructure for effective program delivery, quality assurance, and data collection.</p>	<p>2. Seek and secure funding for upgrades as identified in assessments.</p>	<p>2. Ongoing through September 2015</p>
<p>Review and assess needs to maintain and sustain state-wide fully-functioning ADRC network (staffing, funding, training, content, etc).</p>	<ol style="list-style-type: none"> 1. BEAS and the SLRC Network to review and determine geographic consolidation. Issue RFP based on new geographic areas. 2. Support the use of data and information by stakeholders and policy makers state-wide to secure NH General Funds to maintain the core operations of the SLRC Network. 3. Seek national and state private and public funding opportunities to enhance the SLRC Network through innovative pilot projects, including grants offered through the Federal Transportation Administration and other agencies; assess the SLRC capacity to serve as a Mobility Center. 4. Work with Medicaid Care Management implementation team to identify opportunities for SLRC involvement in transition to Medicaid Managed Care, and ongoing SLRC role in Medicaid Managed Care (e.g., Dual Eligible Clients). 5. Review SLRC content areas and potential areas of expansion, including prevention and wellness (e.g., Chronic Disease Self Management referrals from SLRC) and emergency preparedness. 6. Continue to build statewide partnerships to promote SLRC and identify sustainability approaches. 7. Continue to evaluate and maintain standards for areas of content growth. 	<ol style="list-style-type: none"> 1. September 2013 2. On-going through September 2015 3. On-going through September 2015 4. September 2012 5. September 2012 6. Ongoing through September 2015 7. Ongoing through September 2015

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