

NEW HAMPSHIRE SYSTEMS TRANSFORMATION FINAL EVALUATION REPORT

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

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CHAPTER I EXECUTIVE SUMMARY

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 within 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



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 be 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-EI 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 services 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 objectives 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

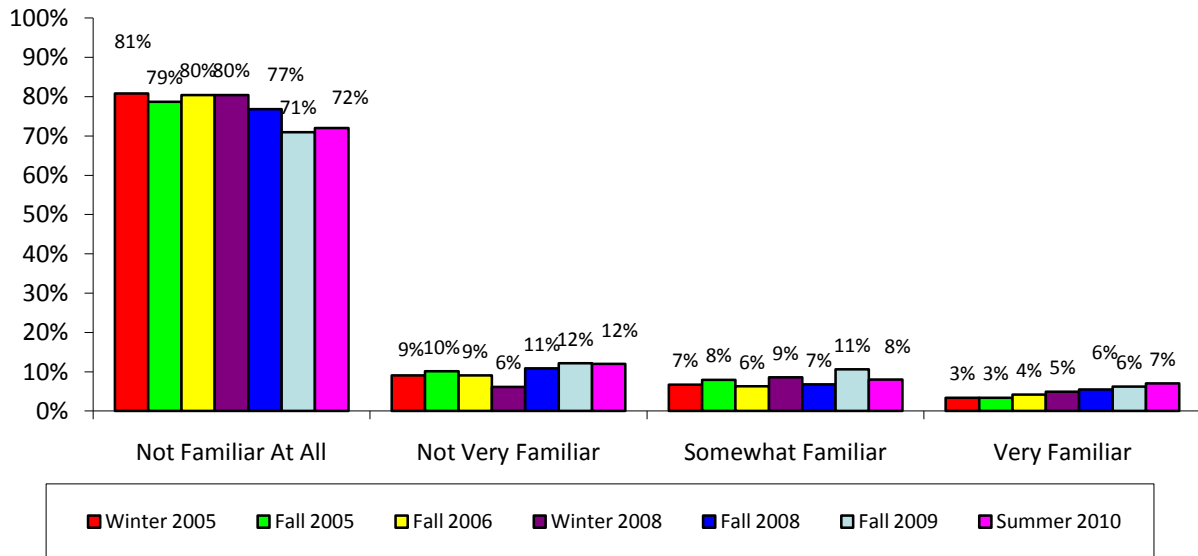
Increased rate of public awareness of home and community long-term care supports

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

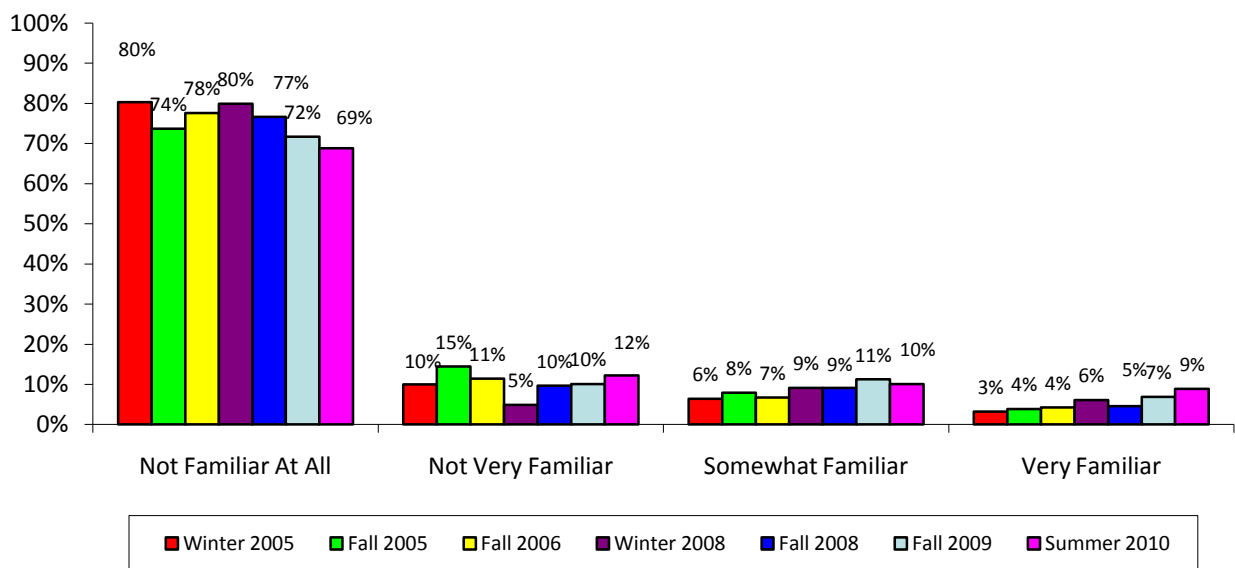


*Source: Granite State Poll



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 ($\chi^2=9.696$, $df=1$, $p=0.002$). This increase is also evident in those who say they are very or somewhat familiar from 9% in 2005 to 19% in 2010 ($\chi^2=9.911$, $df=1$, $p=0.002$).

Figure 2
Familiarity with information service called ServiceLink Resource Center
Respondents 50 or older

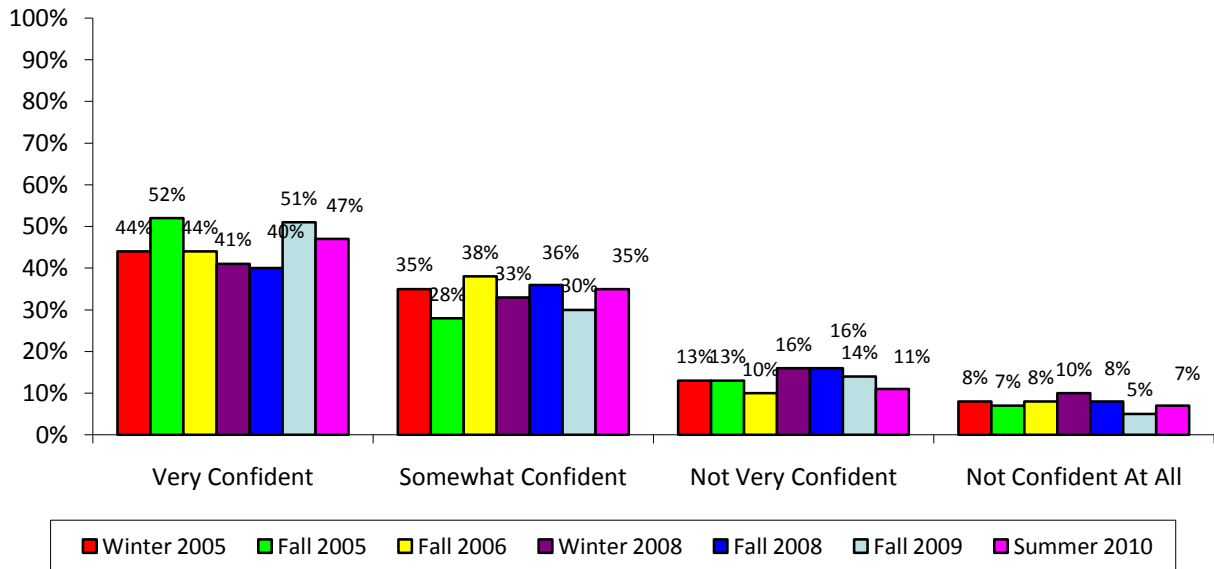


*Source: Granite State Poll

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).

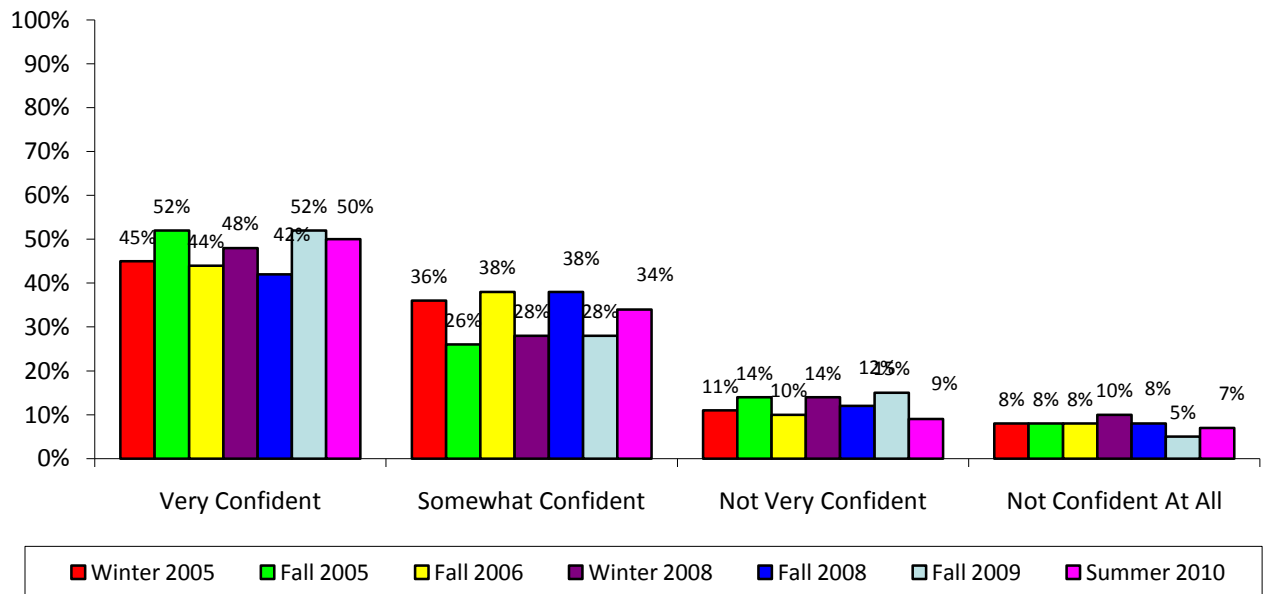


Figure 3
Confidence to find out about how to get long-term support services in community if you or someone in your household needed them



*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

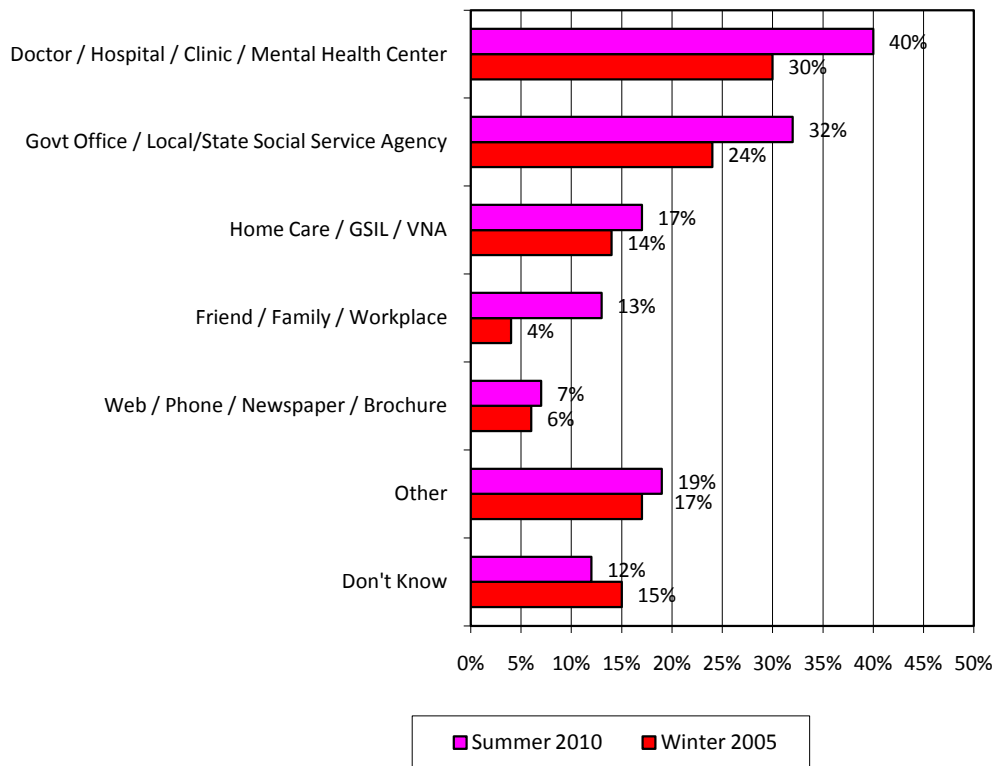


*Source: Granite State Poll



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.

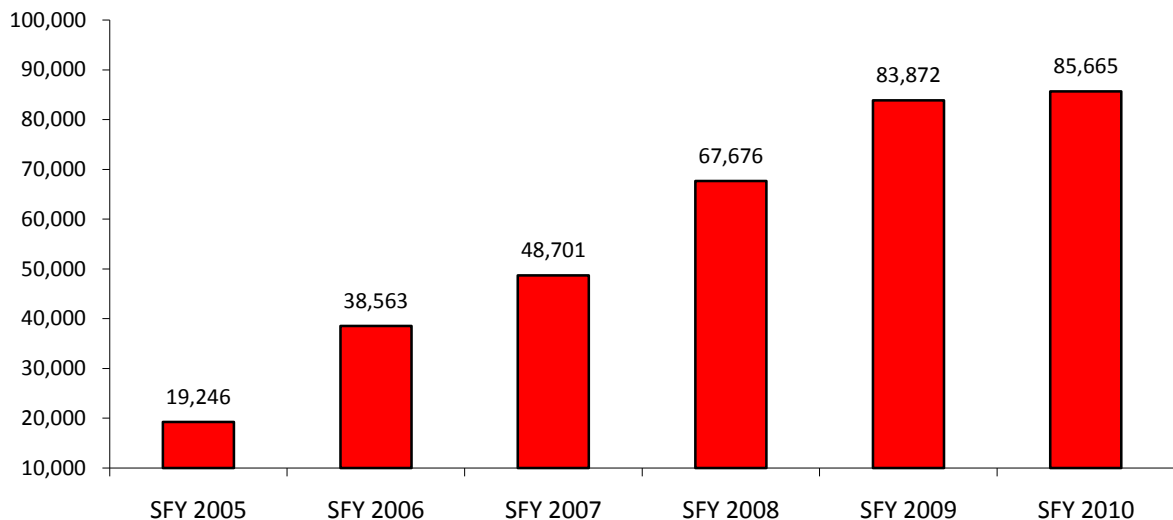


Objective 1.1.2
Increase in rate of ADRC consumer contacts

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.

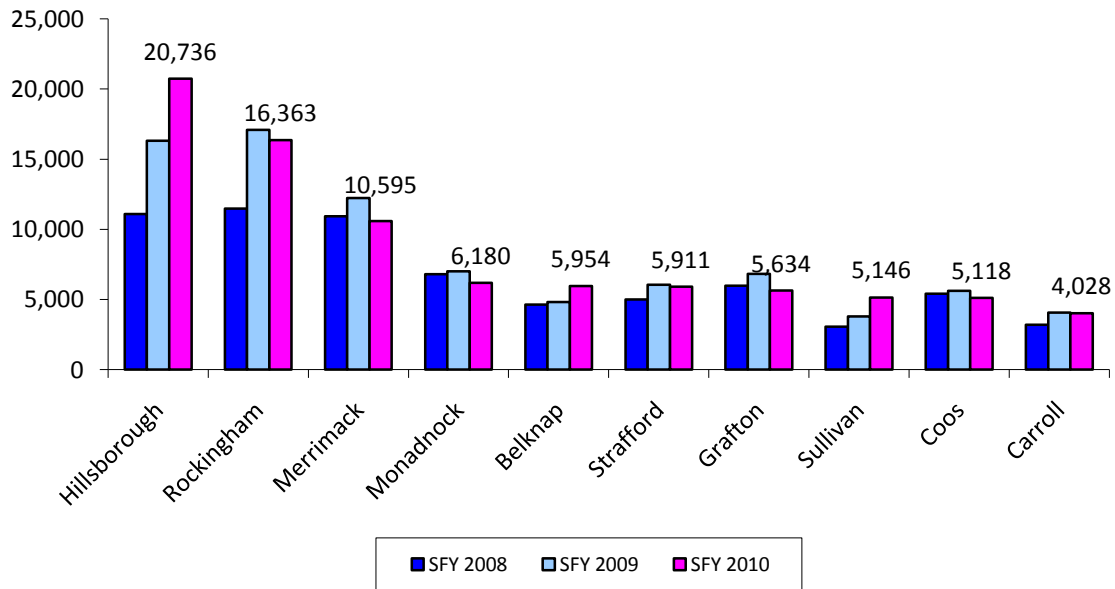
Figure 6
Total Number of SLRC Contacts



**Source: Refer7 Database*



Figure 7
Total Number of SLRC Contacts by Center



*Source: Refer7 Database

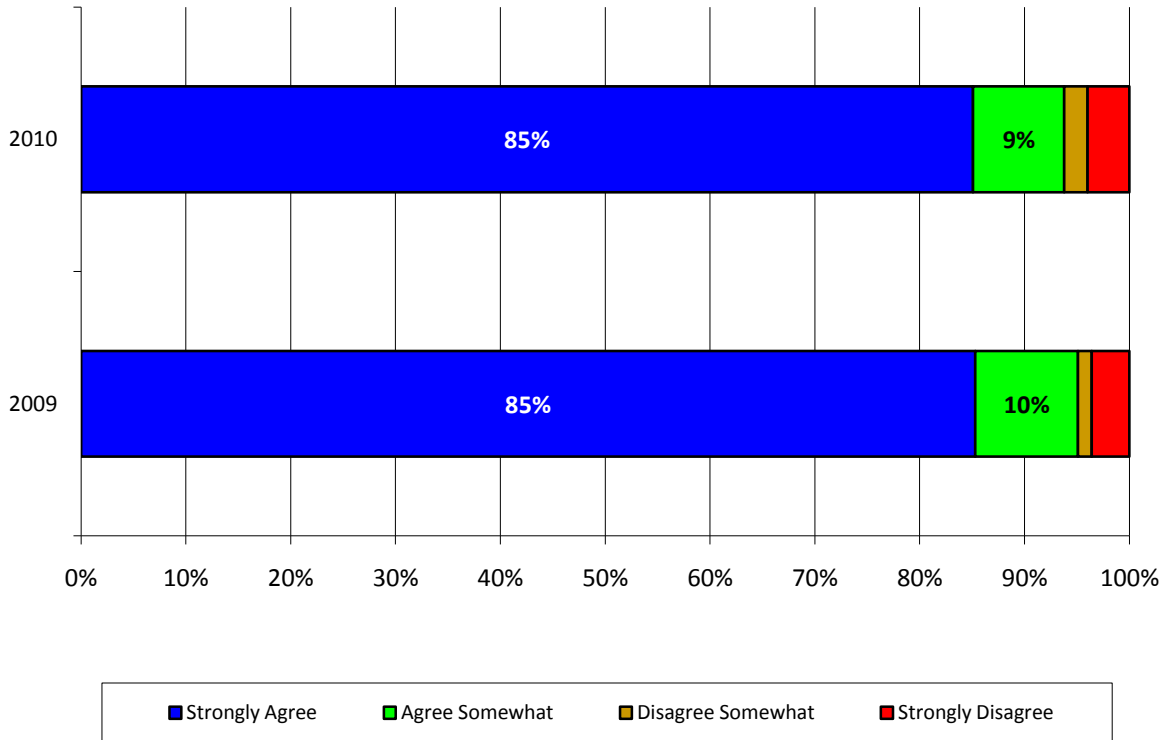
Objective 1.1.3
Analysis of gaps between service need and service availability

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.



Figure 8
The referral(s) I received resulted in my needs being met



*Source: ServiceLink Consumer Satisfaction Survey

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

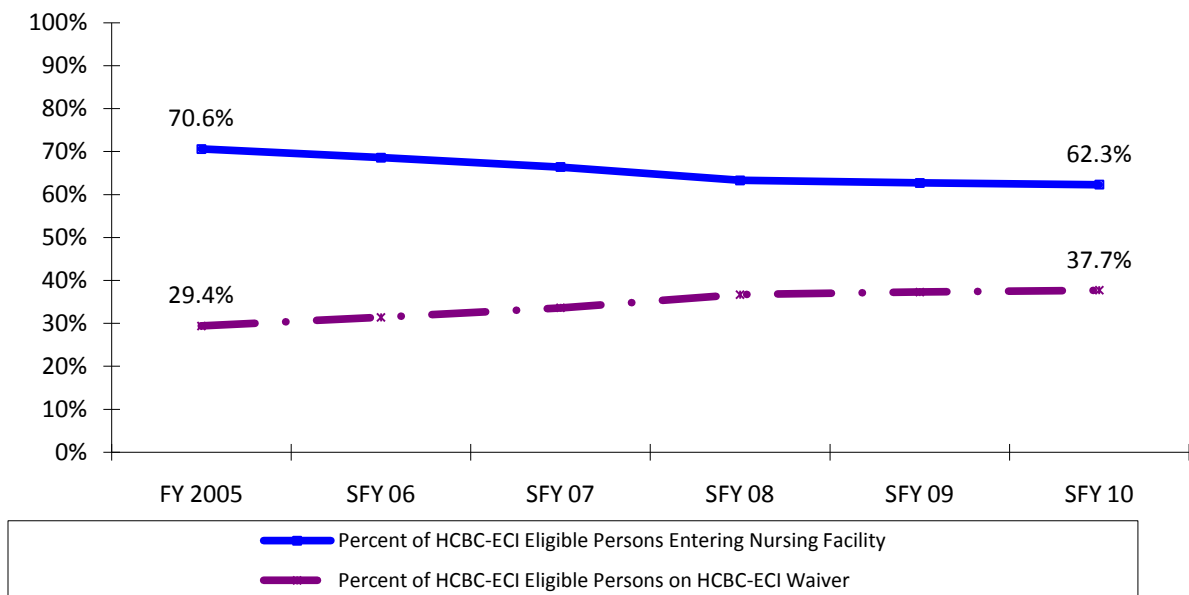
Decrease in rate of nursing home admissions of HCBC-ECI consumers

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%).

Figure 9
Percent of HCBC-ECI Eligible Participants who Enter Nursing Facilities or who Enroll in HCBC-ECI Waiver

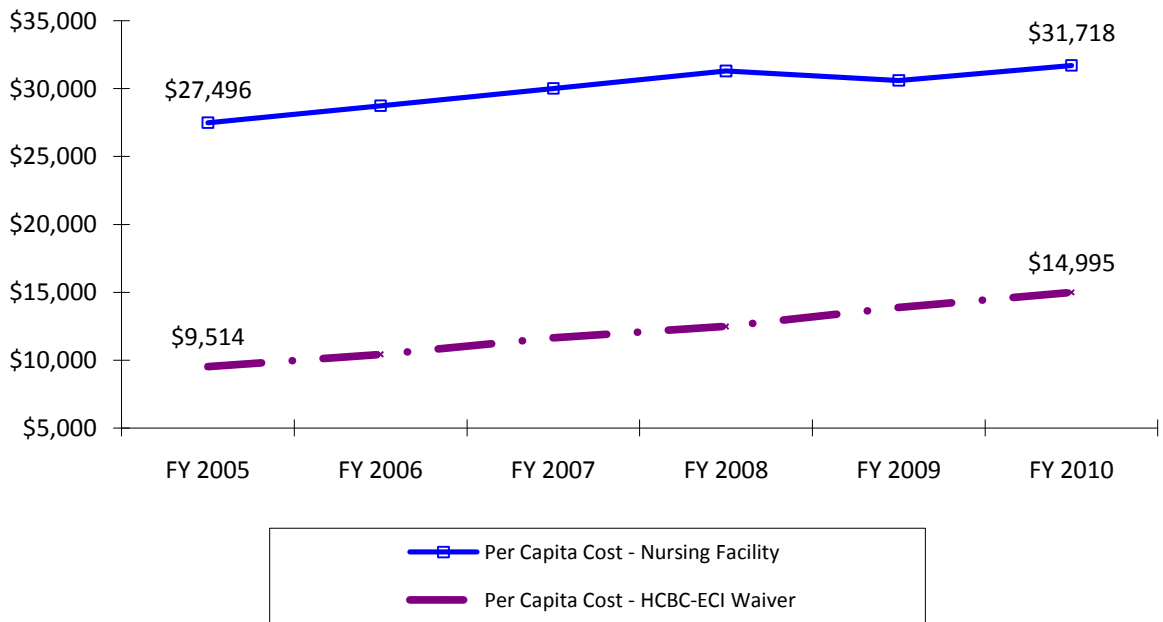


*SOURCE: NH DHHS – Medicaid Decision Support System (MDSS)



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.

Figure 10
Per Capita Cost of HCBC-ECI Eligible Participants Who Enter Nursing Facilities or Enrolled in HCBC-ECI Waiver



*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

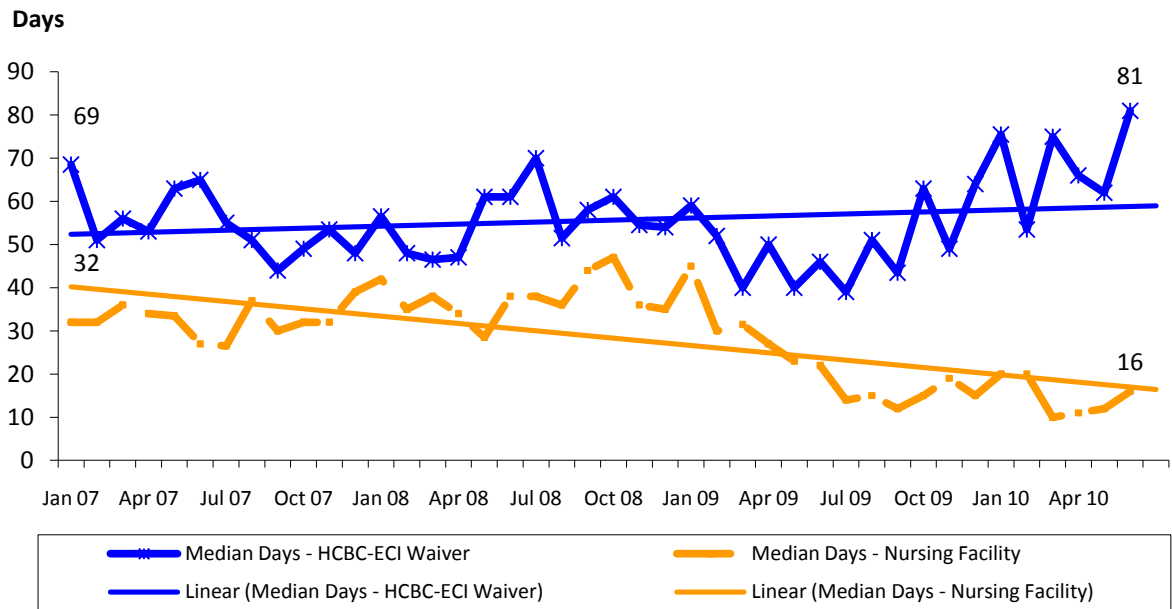
In 2009, as a result of staffing shortages in its nursing staff, which adversely impacted the ability to process long-term care applications in a timely way, BEAS authorized nursing facility nurses who were trained in the clinical eligibility process to complete the MED form for new admissions. The MEDs 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

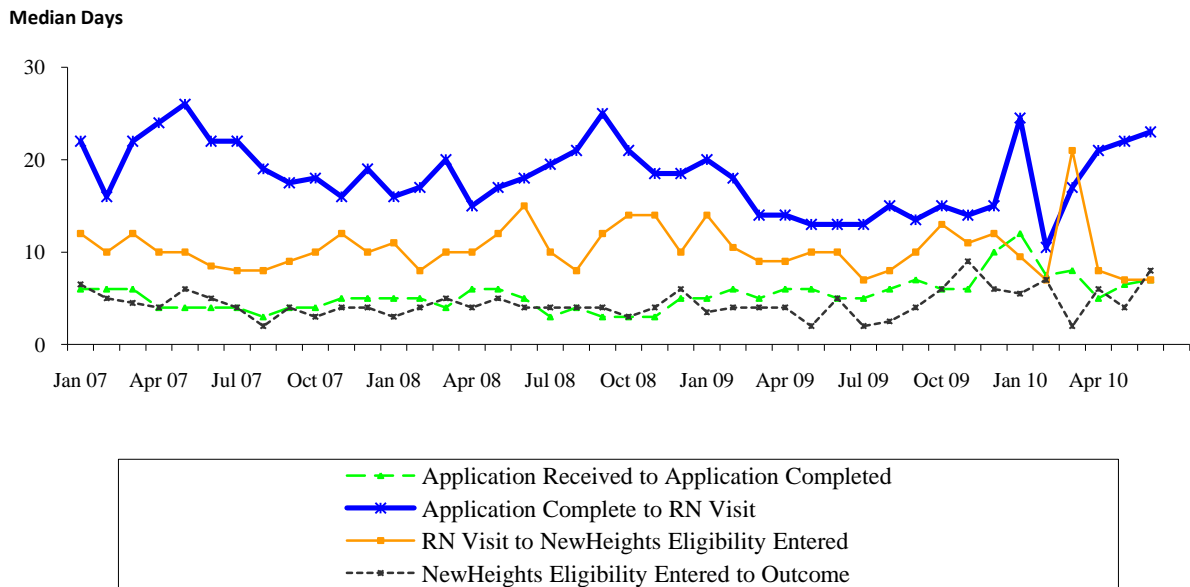


*SOURCE: NH DHHS – BEAS Options system



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



*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.



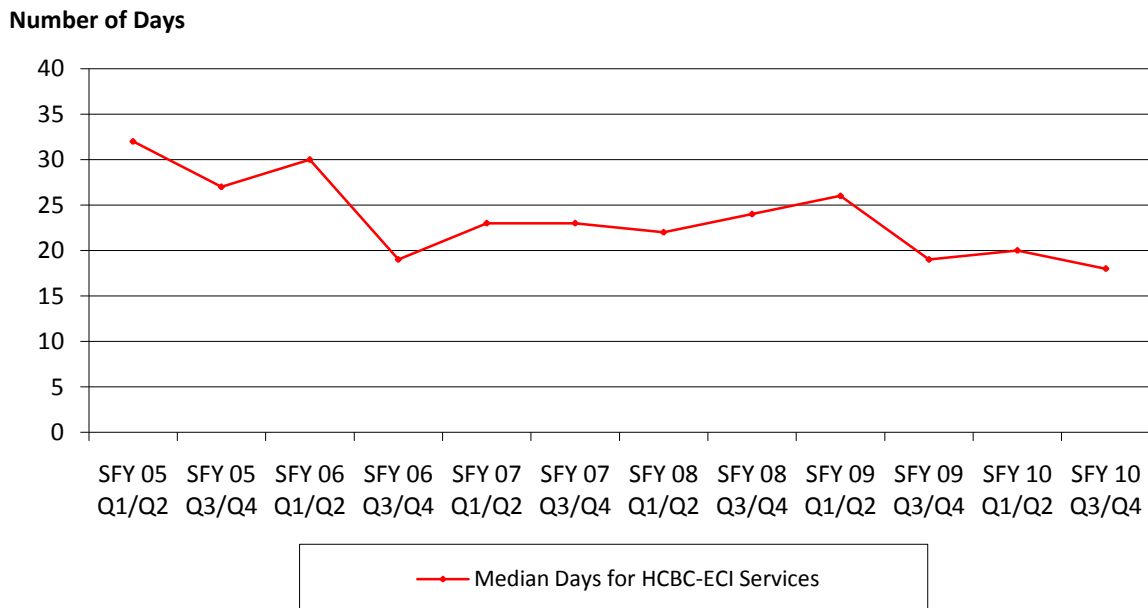
OUTCOMES FOR OBJECTIVE 4: REDUCE THE IMBALANCE BETWEEN INCREASED DEMAND AND CAPACITY TO DELIVER HOME AND COMMUNITY-BASED SERVICES

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

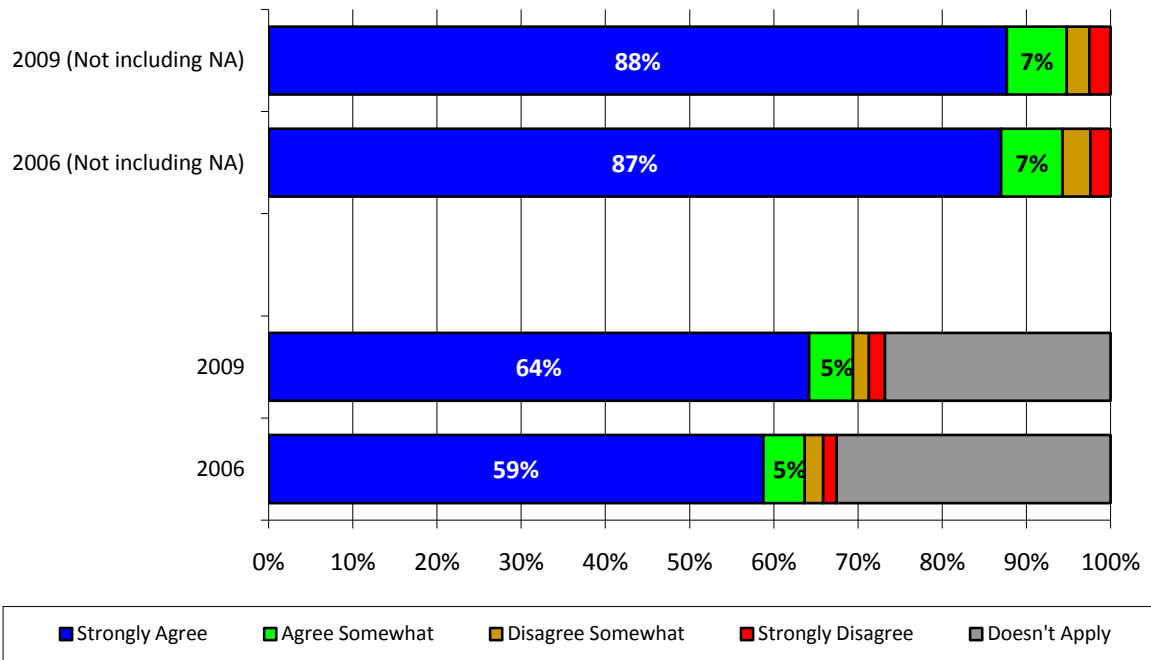


*SOURCE: NH DHHS – Medicaid Decision Support System (MDSS)



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.

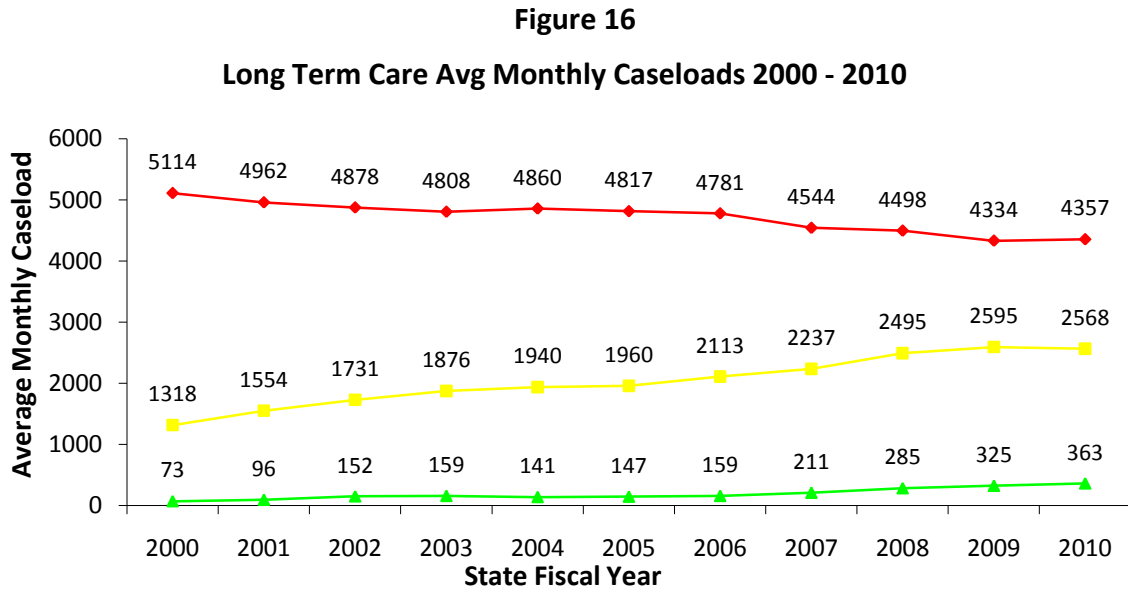
Figure 15
Funding for services provided by BEAS through grant period

	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010
Nursing Facility					
Final Adjusted Authorized Budget	\$ 252,291,923	\$ 242,821,980	\$ 260,663,498	\$ 258,263,952	\$ 274,900,188
Actual Expenditure (with MQIP)	\$ 247,583,220	\$ 249,953,417	\$ 257,233,311	\$ 257,347,452	\$ 270,574,168
Average Enrollment	4781	4544	4498	4334	4357
Average Cost per Enrollee	51,785	55,007	57,188	59,379	62,101
HCBC-ECI Homecare					
Final Adjusted Authorized Budget	\$ 29,503,080	\$ 34,560,742	\$ 39,452,108	\$ 42,315,809	\$ 50,007,656
Actual Expenditure	\$ 29,248,177	\$ 34,146,415	\$ 39,964,055	\$ 46,140,629	\$ 49,717,256
Average Enrollment	2113	2237	2495	2595	2568
Average Cost per Enrollee	13,842	15,264	16,018	17,781	19,360
HCBC-ECI Mid-Level					
Final Adjusted Authorized Budget	\$ 4,003,522	\$ 4,755,747	\$ 5,833,319	\$ 7,651,024	\$ 6,365,253
Actual Expenditure	\$ 2,108,682	\$ 3,646,460	\$ 5,109,583	\$ 5,387,449	\$ 6,238,902
Average Enrollment	159	211	285	325	363
Average Cost per Enrollee	13,262	17,282	17,928	16,577	17,187

**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



*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).



Figure 17
New Hampshire's Projected Direct Care Workforce Shortage



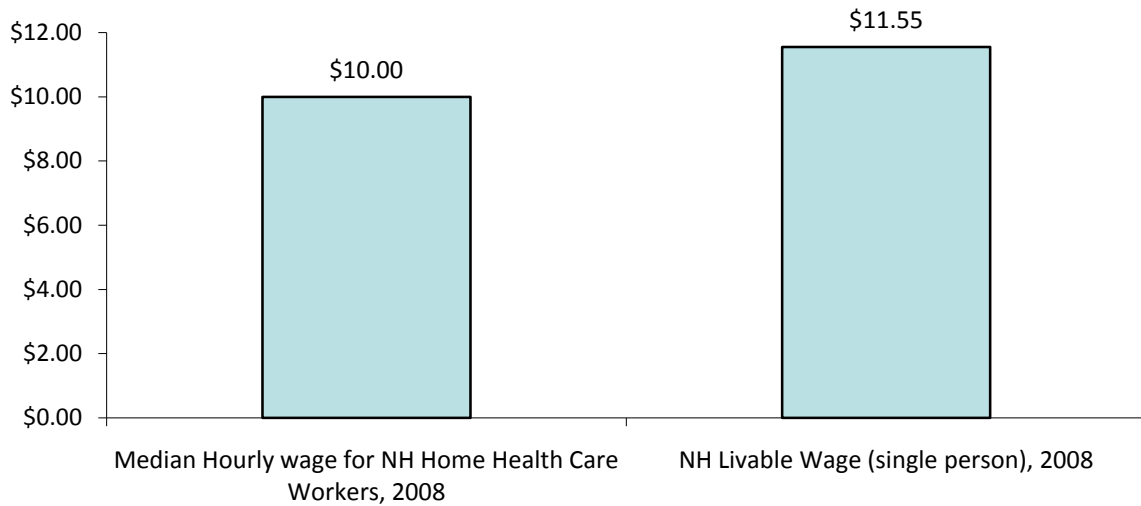
*SOURCE: Paraprofessional Healthcare Institute. (2009). Internal Analysis. New Hampshire Direct Care Workforce Shortage Analysis and Wage Benchmarking.

In addition, demand for new directcare 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



Figure 18
New Hampshire HCBS Worker Wage Compared to State's Livable Wage, 2008



**SOURCE: Smith, K. "Home Care Workers: Keeping Granite Staters in their Homes as They Age." New England Policy No. 2. Durham, NH: Carsey Institute, University of New Hampshire, 2009.*

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.

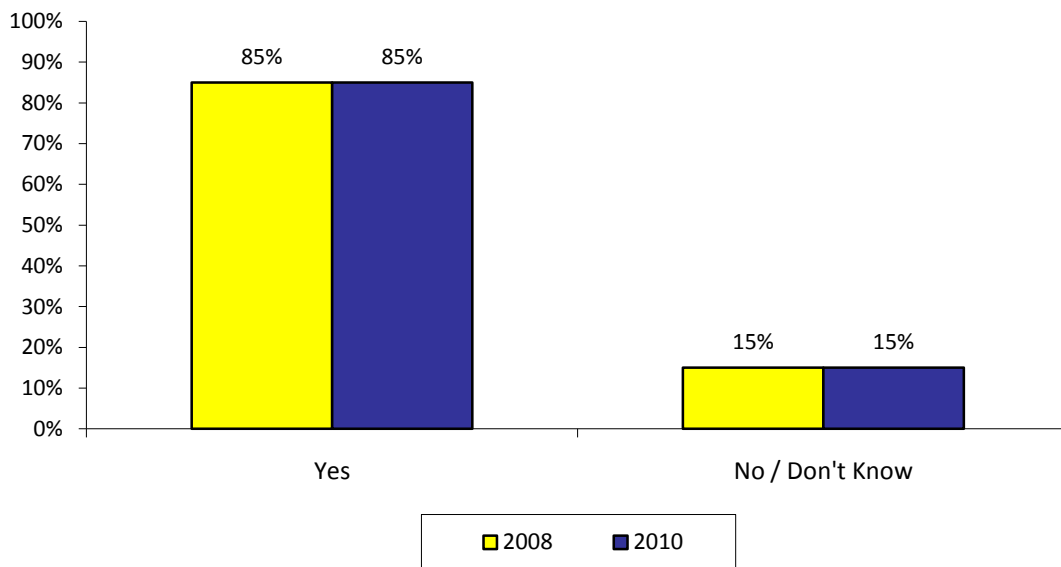
Nearly all waiver participants (85%) felt that their plan addresses all their service needs and concerns, and they report they are receiving all services described in their plan for services (Figure 19). However, this did not reach the goal of 90% and there has been no change between 2008 and 2010 ($\chi^2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

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?

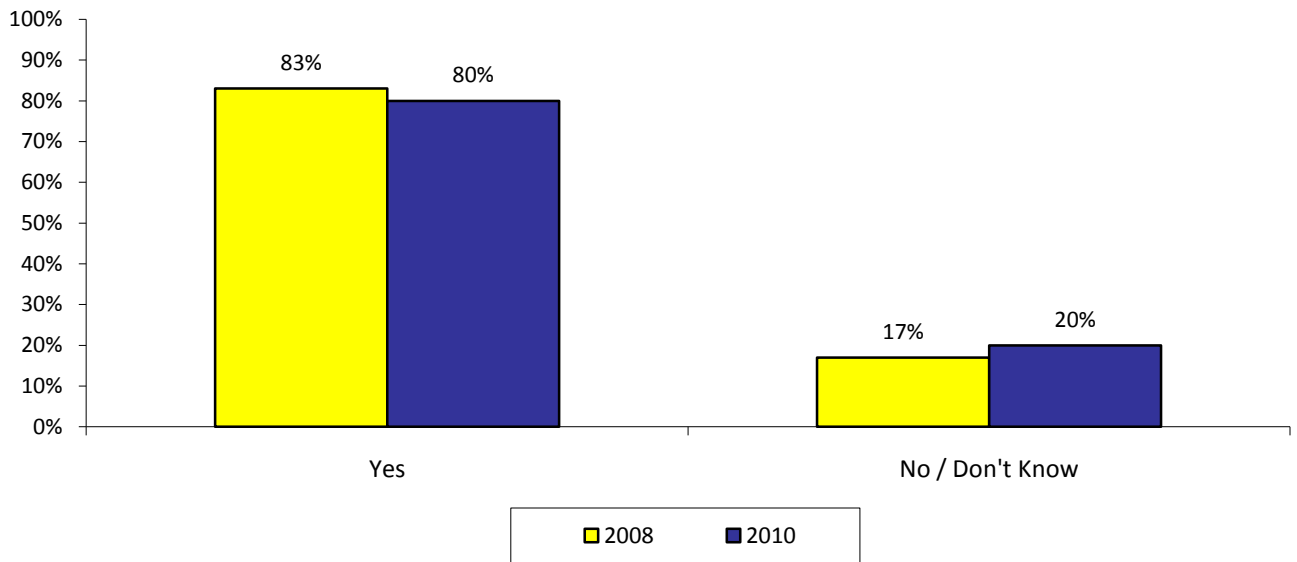


**SOURCE: NH Participant Experience Survey*



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/>.

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.

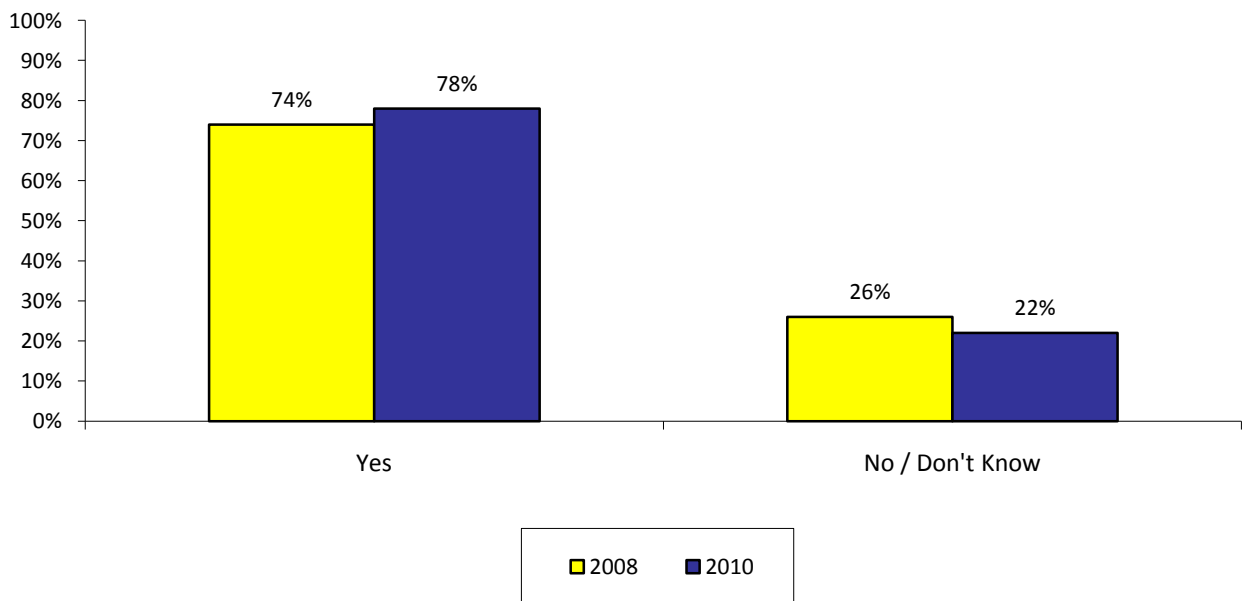
Community listening sessions were held and additional feedback was obtained on the design and implementation of person-centered planning. A copy of this report can be found at <http://realchoicenh.org/CommunityListeningSessions%20Final%20Report.pdf>. To date, over 500 people have provided some level 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?



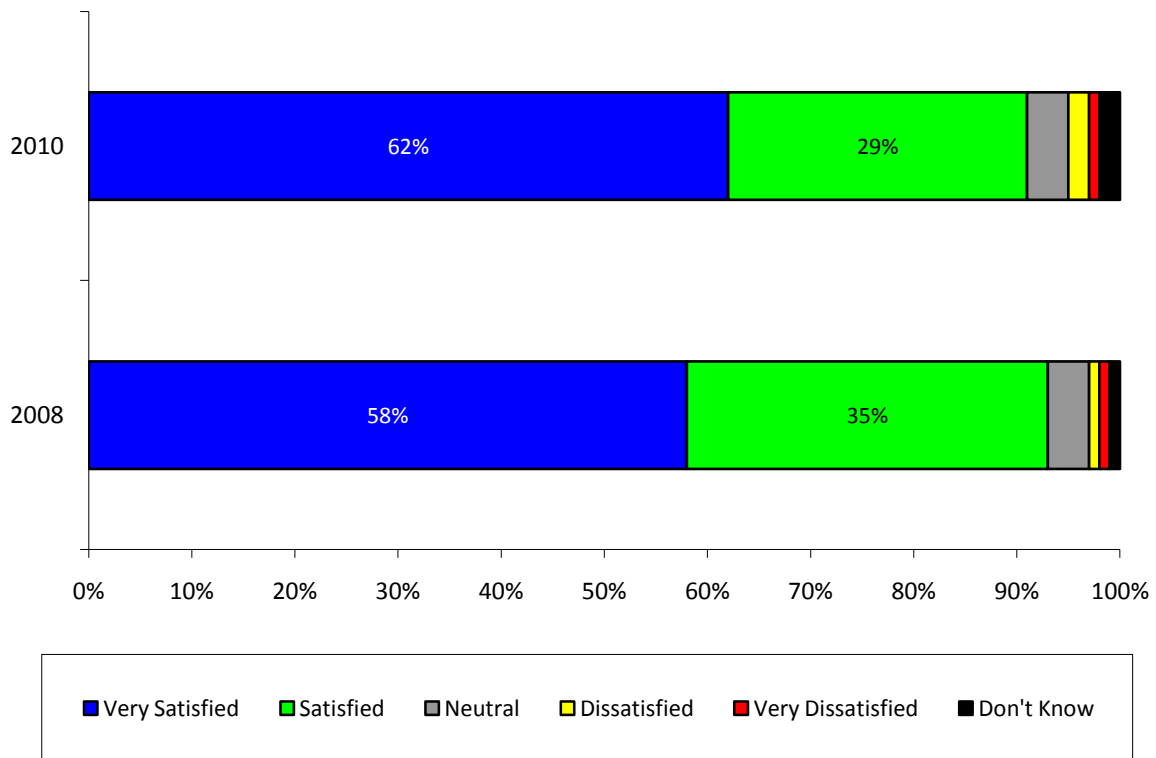
*SOURCE: NH Participant Experience Survey



Most HCBC-EI 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

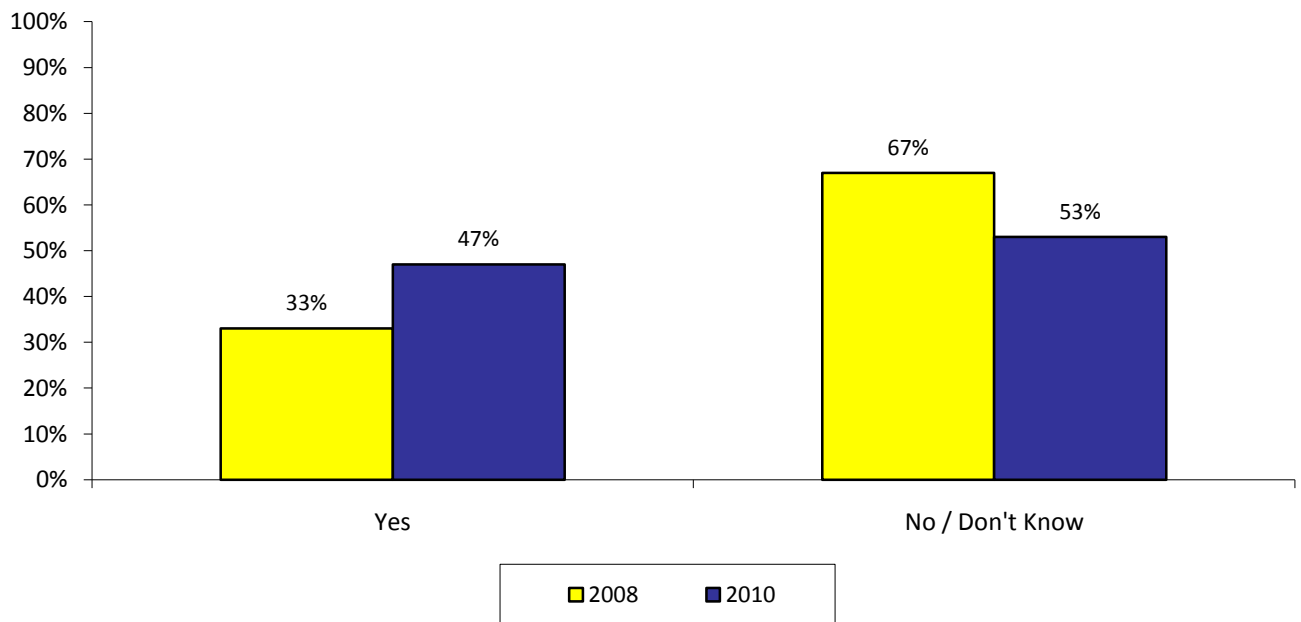


Objective 2.1.4

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?

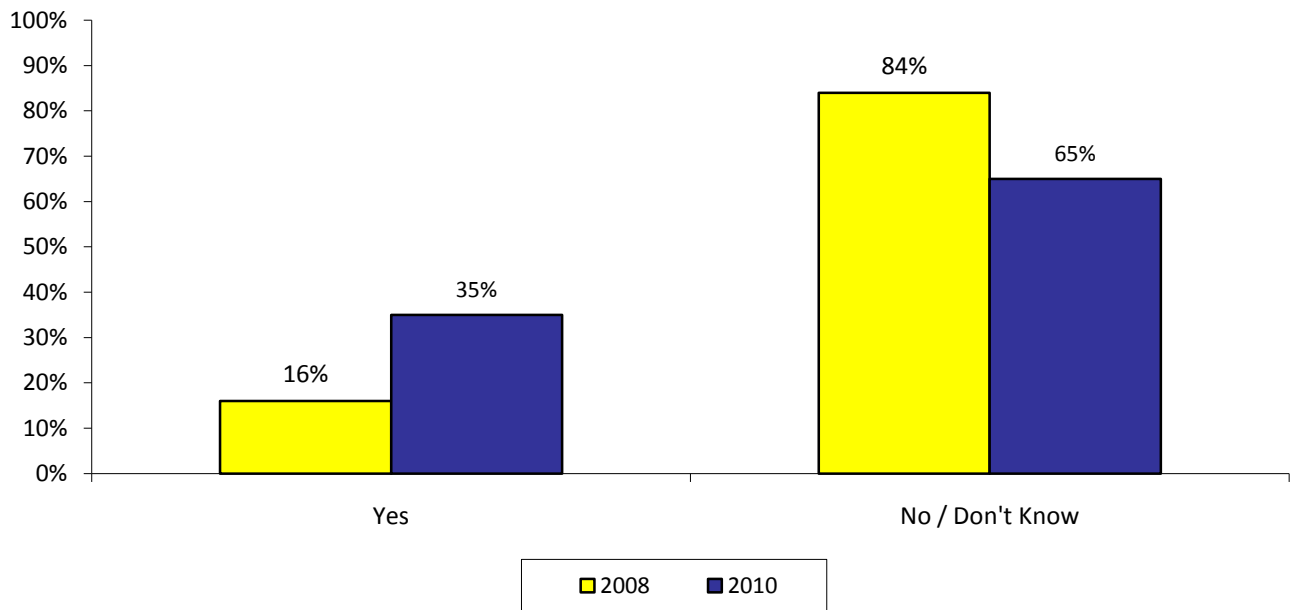


**SOURCE: NH Participant Experience Survey*



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-EI 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>.

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

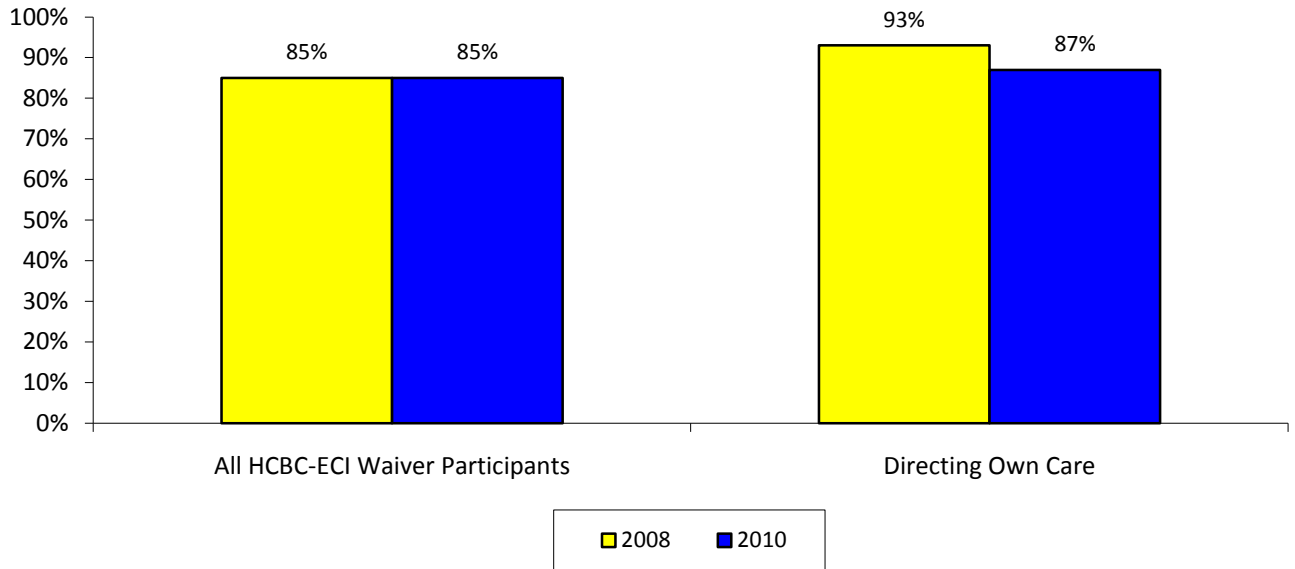
95% of participants who direct their own care will express high satisfaction with services and report on unmet needs

In 2008, a fully consumer-directed service package had been designed but had not yet been implemented in the HCBC-EI 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).



Figure 25
Does your plan address all your service needs and concerns?
All HCBC-ECI Waiver Participants and those Directing Own Care that responded “Yes”



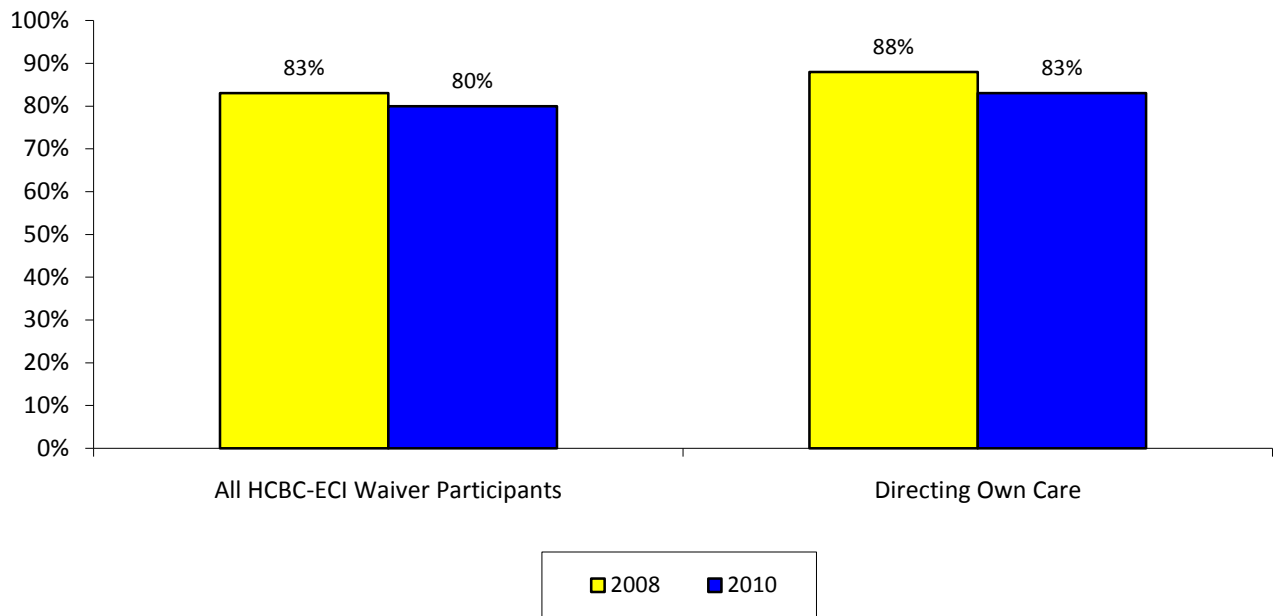
**SOURCE: NH Participant Experience Survey*

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.”



Figure 26
Are you receiving all the services listed in your plan for services?
All HCBC-ECI Waiver Participants and those Directing Own Care that responded “Yes”



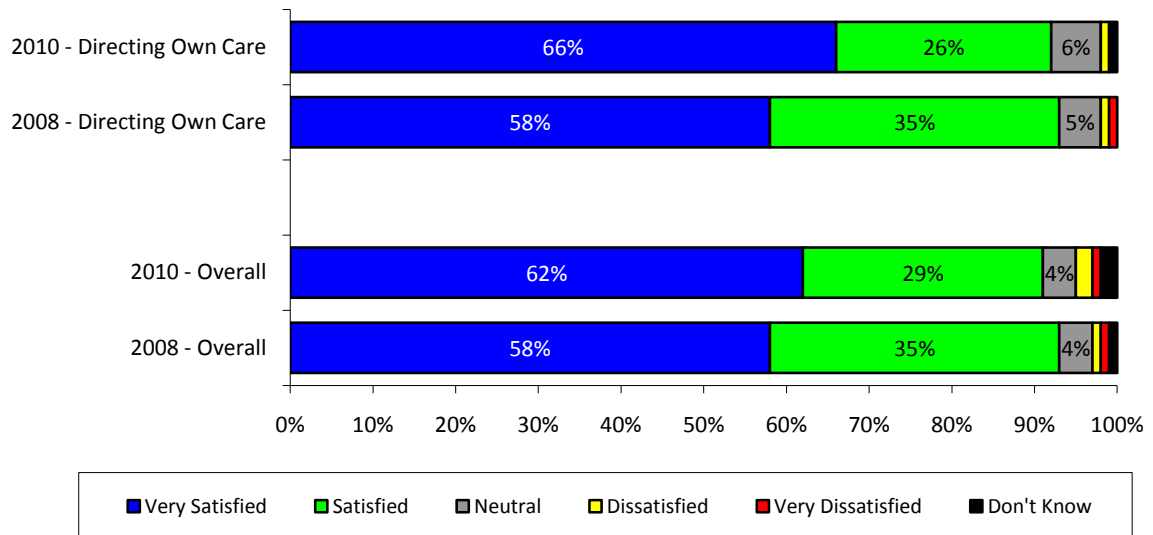
*SOURCE: NH Participant Experience Survey, 2008, 2010

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 ($X^2 = 3.818, df = 5, p = 0.576$).



Figure 27
Overall how satisfied are you with the services you receive from this program?
All HCBC-ECI Waiver Participants and those Directing Own Care



*SOURCE: NH Participant Experience Survey, 2008, 2010

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

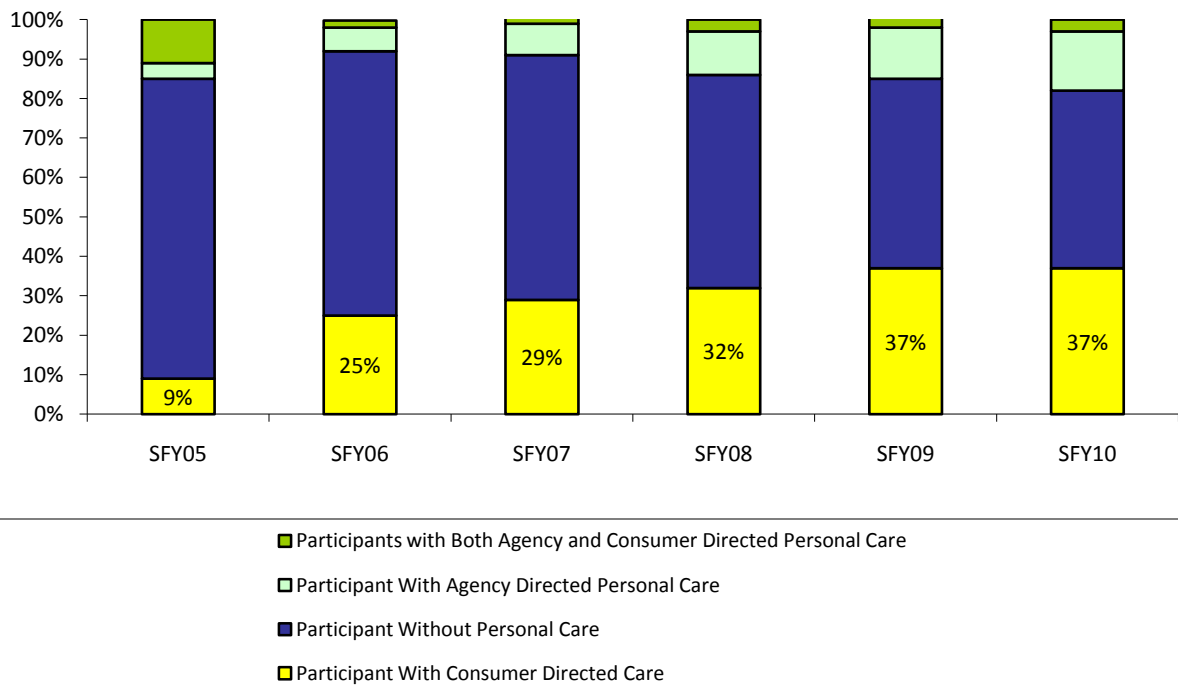
10% of participants eligible for HCBC-ECI services choose a participant-directed model

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% ($X^2= 780.205$, $df = 5$, $P=.0000$).

Figure 28
Percent of Persons Eligible for HCBC-ECI Services who
Choose a Participant-Directed Model



*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 1 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-EI 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(S).

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.



New Hampshire Systems Transformation Grant
Final Evaluation Report

Appendix A: Technical Report



UNIVERSITY of NEW HAMPSHIRE

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.



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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

Poll	Dates	Telephone Numbers used	Number of Interviews	Response Rate AAPOR #4
Winter 2005 *	Feb. 1 – Feb. 8, 2005	3805	544	22%
Fall 2005	Oct. 25 – Oct. 30, 2005	5068	511	23%
Fall 2006	Nov. 13 – Nov. 16, 2006	4878	507	20%
Winter 2008	Jan. 18 – Jan. 27, 2008	7258	555	18%
Fall 2008	Sep. 14 - Sep. 21, 2008	5762	550	20%
Fall 2009	Oct. 2 – Oct. 9, 2009	4222	502	30%
Summer 2010	July 19 – July 27, 2010	7209	504	26%

**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.



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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:

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

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

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

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

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

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

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

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%)



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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 trouble shoot 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).



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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:

Source Code	Description	Source Code	Description
A	GENERAL PROVIDER - MEDICAID	N	HCBC - ECI PAYMENTS - MEDICAID
B	NURSING HOMES - MEDICAID	O	SPECIAL EDUCATION
C	OTHER NURSING HOMES – MEDICAID	P	NH HOSPITAL - PHILBROOK CTR
D	LACONIA DEVELOP SVCS	Q	NH HOSPITAL - APS UNDER 22
E	GLENCLIFF HOME FOR ELDERLY	R	DCYF MEDICAID
F	NH HOSPITAL-TH-DS	S	HCTF POVERTY LEVEL/170-185
G	TRANSITIONAL HOUSING SVCS-MI	T	ACQUIRED BRAIN DISORDER WAIVER
H	COMMUNITY MENTAL HEALTH	U	DCYF OUT OF HOME SERVICES
I	DS-CASE MANAGEMENT	V	DMHDS EARLY INTERVENTION
J	PROVIDER PAYMENTS-LTC	W	DCYF IN HOME SERVICES
K	DS-COMMUNITY CARE - WAIVER	X	MEDICAID EXPANSION-CHIP
L	NH HOSPITAL - ICF/IMD	Y	DISABILITY DETERM - PAYMENTS
M	IHS WAIVER PAYMENTS		



Figure 13: Days to Start of Services

- a. For each state fiscal year, clients with a HCBC-ECI program start date during that year were identified from the Options system.
- b. This list of clients was used to pull their Fund Code N (HCBC-ECI) Claims from MDSS with dates of service during that year.
- c. 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.
- d. 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.
- e. 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



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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:

Completed Interviews	316	31.8%
Participant does not wish to participate	155	15.5%
Unable to arrange for interpreter or adequate proxy	2	0.2%
Surveyors not to survey people known to them; name will be transferred to other interviewer	3	0.3%
Participant was unable to participate per provider, guardian or family member/advocate	72	7.2%
Participant was unable to be reached after 3 attempts were made including having the participant's telephone number checked with BEAS	74	7.4%
Answering Machine	46	4.6%
Missed Appointment	1	0.1%
Busy	4	0.4%
No Answer	25	2.5%
Changed Number	14	1.4%
Disconnected	43	4.3%
No Contact Information / No Contact Made	185	18.5%
Deceased	15	1.5%
Other	39	3.9%
Unknown	8	0.8%
Total Records Selected	1002	100%

