

New Hampshire Nursing Home Resident Choice Initiative

Submitted by:

The New Hampshire Department of Health and Human Services

To: The Health Care Financing Administration

CFDA# 93-779: Nursing Home Transition Initiative

July 21, 1999

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Narrative Application

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Project Abstract — New Hampshire Nursing Home Resident Choice Initiative

Background and Goals

New Hampshire is in the process of attempting substantial system change in how it provides long term care to its elderly and disabled citizens. Driving the reform efforts are the central tenets that elderly and disabled people should have the right to receive care and services in their communities, to have a choice in the services they receive, and to direct their own care and services. For New Hampshire, the proposed project is more than a pilot program but a vehicle to significantly advance the desired reform and its central values. The project provides an opportunity to reorganize how care is provided, to develop new consumer-directed systems of providing care and new, more flexible service/support options. The project provides a concrete vehicle to educate and communicate this new vision of long-term care and to provide a set of real world successes of this approach for individuals who have been in nursing facilities. It is anticipated that in year one 2828 nursing home residents will be offered the opportunity to work with the consumer-directed independent service coordinator and to choose to return to the community. The state expects to transition 20 participants.

Covered Benefits

The project will develop and utilize a new consumer-directed independent service coordinator (ISC) model. All residents of nursing homes in the pilot areas will be approached and offered the option of hiring as their representative any of the certified service coordinators. Together they will develop and implement a community based care plan that reflects the consumer's life goals and preferences. The ISC will work with the resident and their personal network to implement the community care plan. The ISC will then follow the individual to the community and continue to work as the agent for that individual in improving, monitoring and coordinating the consumer's formal services, flexible benefits and informal supports network in order to meet the desired outcomes of the consumer.

The Project will develop and make available the following new services to project participants:

1. Consumer-directed independent service coordination,
2. Expanded HCBC waiver services/choices — approved by HCFA in November, 1998, but not yet available,
3. Banking of any unspent HCBC authorized funding for use in high need periods,
4. Access to innovative housing resources -- in collaboration with the state housing finance authority,
5. Consumer-directed personal care attendant pilot - in partnership with the independent living movement,
6. Transitional/bridge funding for transition to community,
7. Emergency and crisis respite services by nursing facilities and provider networks,
8. Reserve of nursing home bed for 10 days of exploratory placement in the community,
9. Community based volunteer ombudsman services,

10. Explore reimbursement opportunities for ISC management of consumer s acute care,
11. Development of community based, consumer-directed outcome measures for future years, and
12. Develop a volunteer network collaborative.

Target Population

All interested nursing home residents in the two pilot geographic areas will be approached by the ISC to explore their desire to return to the community, their goals in doing so, and the options available to fulfill those goals. This service will be made available to both public and private pay residents. If private pay residents choose to return to the community, they may utilize the ISC and other community services but must pay for them out of pocket. The 47% of nursing home residents who fall within the state s four lowest acuity based reimbursement categories will be prioritized for contact. Recognizing the limitation of any data tool to identify individuals who would choose to participate, the project will also work with nursing home staff to identify other likely participants for priority contact. As a consumer-directed model, however, the program will be actively made available to all nursing home residents, irrespective of acuity rating.

Reimbursement Methodology

Medicaid waiver funds, up to the maximum per person allowed under that program, will pay for the expanded community based services available to participants through the HCBC program. Banking of unspent HCBC authorized funds is an individualized accounting benefit that will permit shifting of authorized HCBC funding to high need periods but will remain within HCBC spending limits. Medicaid case management funding will pay for the ISC service function on a per client per day basis once eligible participants return to the community. ISC outreach and planning for residents while in the nursing home will be paid out of project grant funds. Innovative housing resources will be made available using state and federal housing resources for qualified individuals. Community-based housing options that include services will be available through the HCBC program. Consumer-directed personal care attendant pilot services will be similar to our state s independent living model and paid for using a fiscal intermediary with grant funds together with other available funding sources. Transitional funding for non-Medicaid reimbursable expenses will be paid out of project grant funds on an as needed basis up to \$2,500 per person. Emergency and crisis respite care will primarily be funded as respite services under the waiver program. Nursing home bed reserve days for exploratory community visits will be paid out of the resident s Medicaid leave of absence allotment if he/she ultimately transitions to the community. Project grant funds will pay for any resident that does not end up transitioning so that he/she does not lose this benefit. Development training and oversight of the community based volunteer ombudsman services will be covered as an expense under the project grant.

New Hampshire Nursing Home Resident Choice Initiative

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A. Description of New Hampshire's current home and community based care systems for Medicaid clients and the status of Medicaid pre-admission screening and nursing home reimbursement systems.

A1. Medicaid home and community care programs:

A1a. Number and Kinds of Clients

The state's existing 1915(c) home and community based waiver program for elderly and chronically ill individuals (HCBC-ECI) currently serves approximately 1200 adults. For categorically eligible individuals, the program offers the following services as alternatives to nursing home placement: homemaker, home health aide, personal emergency response, in-home day care, respite care, adult medical day care, and private duty (skilled) nursing. In September 1997, the Health Care Financing Administration (HCFA) approved a five-year extension to the state's HCBC-ECI waiver program.¹ The New Hampshire Nursing Home Resident Choice Initiative builds upon the success New Hampshire has had in developing innovative community based programs for other subsets of the long term care population served by Medicaid.

The state's 1915(c) waiver for persons with developmental disabilities, which currently serves 2370 individuals, has succeeded in eliminating the need for ICF-MRs for adults in the state and has successfully piloted the introduction of consumer—directed services.

The state's 1915(c) waiver for persons with acquired brain disorders, which currently serves 81 individuals, provides customized home and community-based service packages that allow persons with significant impairments to be served at home. This waiver serves those who were formally institutionalized and those who have been diverted from institutional placement. Both of these waiver programs have strong consumer and family involvement in terms of ongoing design and operations.

¹ A copy of the waiver extension is attached as Appendix A.

New Hampshire also has a Medicaid funded personal care attendant (PCA) program for wheelchair mobile individuals who are capable of self-direction. This program is operated by Granite State Independent Living Foundation (GSIL), and currently serves 128 individuals. In order to maintain people in their own homes, PCAs provide medically oriented assistance including, assistance with medications and nutrition, essential household services, assistance with bladder and bowel care and personal grooming. The PCA is formally an employee of GSIL, but the person with a disability is responsible for locating, hiring and training his/her own personal care attendant.

This proposal and the consumer-directed independent service coordinator model are based on key principles embraced by the community care programs described above; specifically, consumer autonomy and choice, focus on consumer-defined quality of life and structuring funding streams to follow the consumer rather than the provider organizations.

A1b. Plans for Expansion and the Status of Pending Waiver Applications

New Hampshire is implementing widespread systemic reform to its long term care system. As part of this process, the state is transitioning its Medicaid long term care system from one dominated by nursing homes to a balanced approach which provides consumers with options for community support, choice of services and direct control. A description of the state's system reform efforts is provided in Section A4: System Reform and Expected Results. As part of that reform, the state filed an amendment request for its HCBC-ECI program.

On November 17, 1998, HCFA approved the extensive amendments to the state's existing HCBC-ECI waiver to facilitate the rebalancing of the long term care system.² The approved amendment permits the expansion of HCBC-ECI eligibility to those that are medically needy in addition to those that are categorically eligible. It also permits up to 1,998 individuals to be served for the period July 1, 1999 through June 30, 2000 and up to 2,388 the year after that.

The approved amendment allows the HCBC-ECI program to offer the following new services: personal care services; adult group (social) day care; environmental accessibility adaptations; assistive technology; specialized medical equipment and supplies; adult (senior) companion services; home delivered meals; consolidated long term care services and six types of residential care. The residential settings permitted are adult family care, assisted living, congregate living, residential care facility, supported residential care facility and shared housing.

As described in Section A4 below, the state has been unable to implement these extensive changes to its HCBC-ECI program because of all of its other long term care reform activity as described in section A4.

A1c. Status of Medicaid Pre-Admission Screening and Reimbursement System for Nursing Homes

Pre-admission screening for Medicaid long term care services, both in nursing homes and through the HCBC-ECI program, has traditionally been carried out by the state. In recent years the Division of Elderly and Adult Services (DEAS) has developed with input from providers, consumers and the public a uniform assessment tool known as the Comprehensive Assessment Form (CAF).³ This format is now used for pre-admission screening in the three counties with assessment and counseling programs. In those regions, it is also used by the HCBC-ECI program nurses in developing care plans. The CAF assesses consumers functional self-care and independence in regards to their ADLs, IADLs, and ability to manage their medications. In this way, the pre-admission screening functions are transitioning to some of the counties. In the counties without assessment and counseling programs, the state is solely responsible for pre-admission screening.

As part of the state s long term care plan, DEAS has recently implemented an acuity based reimbursement system for nursing home residents. As a result, nursing homes are no

² A copy of the approved waiver amendments is included in Appendix B.

longer paid an average rate for every resident. The ten categories for acuity based reimbursement in the state are based on the Minimum Data Set (MDS) information and the Resource Utilization Groups (RUGs) which groups residents into 44 different categories based on their MDS information.⁴ The NH acuity system further filters the lowest 36 RUGs groups into 10 acuity based reimbursement groups which cuts across case mix categories but is based on acuity and functional status within those categories.⁵

A2. Availability of Data

Two major data sources exist regarding the individuals in nursing homes and in HCBC-ECI programs, the acuity-based reimbursement categories and the comprehensive assessment form (CAF) data, both of which are discussed in detail in the previous section.

The acuity based system is based in large part on functional status and provides a wealth of data regarding nursing home residents. Individuals in nursing facilities are assigned one of ten acuity reimbursement categories. The proposed project will use the acuity based reimbursement categories to assist in prioritizing likely residents to participate in the transition program.

The CAF is specifically designed to assess an individual's functional status and includes modules that assess an individual's behavior, home care potential, caregivers, health history, emotional/mental health, and need for nursing facility level of care. In counties with assessment and counseling programs, including Merrimack County, one of the pilot areas for this project, the CAF is used for all individuals seeking Medicaid nursing home or HCBC-ECI services.

A3. Assessment of the State's Home and Community Based Infrastructure

The state's home and community based infrastructure is not different from most states that have a nursing facility dominated long term care system. As such, services tend to be

³ See Appendix C for a copy of the Comprehensive Assessment Form.

⁴ The top 8 RUGs categories are not included in the acuity reimbursement system for they are seen as Medicare level categories rather than Medicaid categories of reimbursement.

supported by a patchwork of programs resulting in fragmentation and inequitable distribution of services in some areas. The community based infrastructure has a difficult time responding to crises or emergencies, especially health related ones. Additionally, the community based care infrastructure is limited in its ability to respond to individualized preferences that do not fall into established service categories and to support the consumer s primary (informal) caregivers.

New Hampshire has a large core of community based providers of supports and services. These organizations have responded to community needs by providing a wide range of quality services over a long period of time. This core of providers includes among many others, nutritional programs, senior centers, home health, and community action programs. Additionally, there exist many community hospitals that have been building effective working relationships with the network of local community providers so as to improve service delivery.

Formal community based services are enhanced by the historical commitment to volunteerism that exists in New Hampshire. As a result there is a strong community based volunteer component to caring for elderly and physically disabled adults in the state. Many successful volunteer programs exist including numerous interfaith volunteer caregiver programs, a robust statewide senior companion program, many local community caregiver programs, as well as AARP sponsored programs.

The strengths of the existing home and community based infrastructure will benefit the state in its commitment to and activity in reforming the long term care system. New Hampshire has implemented a number of home and community based care programs for the elderly and disabled through Title XX of the Social Security Act (Social Services Block Grant), Title III of the Older Americans Act, and state-funded programs for congregate housing services,

⁵ The approved state plan amendment regarding the acuity based reimbursement system and a document outlining the matrix of acuity based reimbursement categories are attached as Appendix D.

Alzheimer's respite care, and adult in-home care. The state also has a strong adult protective service system.

In contrast to other states, New Hampshire does not use area agencies to ensure adequate and integrated services in all regions. However, as a single unit on aging, New Hampshire is able to implement systems reform across the state in a more efficient and effective manner. On balance, New Hampshire is poised to develop its community based infrastructure, based on consumer need rather than on organizational criteria.

A4. Systems Reform and Expected Results

In December 1996, the state's Department of Health and Human Services (NH-DHHS), pursuant to state law, RSA Chapter 310, Laws of 1995, adopted a long term care policy which sets out the values that would guide the evolution of long term care services and supports. New Hampshire's long term care policy affirms the right of elderly and disabled citizens to receive care and services in their communities, to have a choice in the services they receive, and to direct their own care and services. Within this consumer-directed approach, the long term policy establishes that among other things, services must be accessible, affordable and of high quality. The policy resulted from a broad-based effort to involve consumers, providers and the various communities around the state in developing a policy that would directly affect them.⁶

In August of 1998, NH-DHHS, as required by Chapter 309 of the Laws of 1997, adopted its long term care plan for implementing the State's long term policy. The plan, entitled *Shaping Tomorrow's Choices*, is an initial step towards rebalancing the long term care continuum by adding more community based service and support options while supporting the consumer's right to control the provision of care.⁷ The state legislature subsequently enacted the

⁶ A copy of the state's long term care policy is contained in Appendix E.

⁷ A copy of the state's long term care plan, *Shaping Tomorrow's Choices*, is attached in Appendix F.

necessary statutory changes to proceed with the plan, Laws of 1998 Chapter 388, known as Senate Bill 409.⁸

In 1998, NH-DHHS culminated a three-year process of reorganization to ensure a comprehensive and coordinated state system. As a result, all programs, services and funding streams related to the long term care of elders and other adults who have physical disabilities, whether in nursing homes or in the community, have been brought together under one administrative structure within the Division of Elderly and Adult Services (DEAS).

DEAS has worked tirelessly to make substantial progress in implementing many of the important long term care reforms contained in the state's plan. It has established a system of sharing financial reimbursement with the counties for community care so as to eliminate any state financial incentive for nursing home care over community care.⁹ DEAS has developed and is utilizing an acuity-based reimbursement system for nursing home care funded by Medicaid. Furthermore, DEAS has supported three pilot assessment and counseling programs in partnership with counties. As required by the new legislation, these programs must offer every person seeking new long term care services, whether private pay or Medicaid funded, with screening, information about non-institutional, community based services and referrals. Finally, DEAS has held a series of statewide focus groups with consumers and providers to plan the development of a system of integrated long term care focal points in the community.¹⁰

The expected results of all of these reform efforts, including the proposed initiative, are to restructure the Medicaid program in order to expand the community based care options available and to redesign the care system so as to fulfill the central goals of the state's long term care

⁸ A copy of the law is attached as Appendix G.

⁹ The county now pays the same percentage for HCBC-ECI care as for nursing home care. Prior to this change, the county only paid a percentage of nursing home care, creating a financial savings to the state (as opposed to the counties) if the individual were cared for in an institution, even at a greater total cost.

¹⁰ With all the systemic reforms required by Senate Bill 409 and time constraints of changes DEAS is already working on, the state has been unable to implement the extensive amendments to its HCBC-ECI waiver.

policy. Those goals are that elderly and disabled people should have the right to receive care and services in their communities, to have a choice in the services they receive, and to direct their own care and services. The specific system reform expected as a result of the proposed initiative is discussed in section C3, below.

B. Proposed Nursing Home Transition Program

Introduction

At the heart of this proposal is the development of a consumer-directed independent service coordinator service that will be made available to all residents of nursing homes in two designated pilot areas. The project will first attempt to contact all residents through group activities at each nursing home. Independent service coordinators (ISCs) will then make individual contact with residents and offer their assistance to explore each person's desire for returning to the community. The ISCs will work with each person to develop an individualized care plan that reflects his or her needs and desires. The ISC will then advocate on behalf of the person to obtain, coordinate and monitor the services to fulfill the consumer-directed plan. The ISC will also help the person expand his or her existing personal network by making community and volunteer contacts. The ISC will be available to follow the resident to the community and continue to provide services in that setting. Since the ISC works for the person, they can be hired, fired or replaced by a different ISC at the resident/consumer's will.

The proposed project will make available to the resident, through the trained ISC, a set of new services to help support the transition to the community. These expanded benefits will include special access to housing resources, an expanded array of HCBC-ECI waiver service options, linkages with the consumer's acute care system, emergency and crisis respite coverage, community based ombudsman services, and consumer-directed personal care attendant services. All of these new or expanded services will be developed or made available as a result of the project activity.

B1 Target Population

Independent service coordination will be offered to both public and private pay residents of nursing homes. Although the primary focus is on people funded through Medicaid, private pay residents will also benefit from the viable consumer-directed alternative that will be established which will allow them to return to the community and to utilize their available resources at a slower rate, thus further delaying any need for Medicaid funding. Only Medicaid eligible individuals will qualify for publicly funded use of the independent service coordinator in the community. Nevertheless, it is expected that non-Medicaid residents may want to hire ISC services on a private basis.

As a consumer-directed service, the ISC will be available to work with and advocate for all residents. It will not be their job to limit access to community care. Rather, it is the state's regulatory duty to consider feasibility issues in approving residents for HCBC-ECI waiver services. The ISC will explore safety issues with consumers to ensure that the consumer understands and is comfortable assuming any risks involved. The ISC will help minimize those risks to the extent possible within the consumer's preferences, and will advocate for the provision of services pursuant to the individualized care plan.

It is expected, however, that the residents most likely to choose to participate and to return to the community are those who are relatively medically stable, are either functionally and/or cognitively limited, and who can benefit from living in the community in a safe way.

B1a. Identification of Program Candidates: Data

The project plans on utilizing residents' acuity based reimbursement categories and, where available, comprehensive assessment form (CAF) functional data in order to prioritize individualized contact with those residents who are interested in the program. These sources provide a wealth of functional data regarding nursing home residents.

For purposes of this project, residents who fall into the four lowest acuity levels of the state's acuity based reimbursement system¹¹ will be considered more likely to benefit from the community based options and will be prioritized for outreach activities by the ISC. The four lowest acuity levels in nursing homes constitute 47% of the statewide nursing home population. Furthermore, Medicaid funded residents have a higher proportion of individuals in these categories than the general nursing home population. The project will prioritize contact with those residents who fall into the four lowest acuity-rating groups.

Similarly, the project will review available CAF data to prioritize making individualized contact with those interested individuals for whom that data indicates a greater likelihood that they may benefit from the project. The CAF is specifically designed to assess an individual's functional status and ability for independence and self-care regarding ADLs, IADLs, and medications. It includes modules that assess an individual's behavior, home care potential, available caregivers, health history, emotional/mental health, and need for nursing facility level of care. The project will also work with nursing home staff and, where available, assessment and counseling program personnel to identify other likely participants.

Data tools are limited in identifying individuals who would choose to return to the community. As a result, the project plans on ensuring that at least 25 percent of the interested residents prioritized for individual contact be identified by other non-data driven mechanisms, most notably resident or family initiative and identification by nursing home staff.

All residents, however, shall be offered education and information about the project and given the opportunity to work with an independent service coordinator to explore their desire and ability to return to their homes and communities.

¹¹ See section A1c and Appendix D for more information about the acuity based reimbursement system.

B1b. Geographic Area and Estimated Number of Nursing Homes

The consumer-directed independent service coordinators will make their services available to all residents of nursing homes within the two designated pilot areas of Grafton County and the Manchester/Merrimack County urban corridor.¹² There are approximately 30 nursing facilities within the pilot area with a total of 2828 beds.

B1c. Estimated Number of Individuals Offered the Choice to Transition

The estimated number of residents that will be informed of the project, offered the opportunity to work with a ISC and thereby offered the choice of community living through the project will be 2,828.¹³ This represents more than one quarter of all the nursing home beds in the state. As described above, the project will be able to use available functional data sources as well as recommendations of nursing home and assessment and counseling staff to identify those most likely to participate.

B1d. Estimated Number of Individuals to Transition

Up to twenty (20) nursing facility residents are expected to transition back to the community as a result of the project. The state feels this is a realistic estimate based on the newness of the consumer-directed ISC concept, a lack of history in New Hampshire in making placements out of nursing homes and the difficult process of having families revisit previous decisions around nursing home placement. It is prudent to proceed slowly and carefully because of the many project activities that can impact on implementation outcomes and timetables. Furthermore, New Hampshire has substantial previous experience in moving individuals with developmental disabilities and acquired brain disorders out of institutions and onto community waiver programs. Through this experience, the state learned the importance of careful advance

¹² Pilot areas were chosen based on the following criteria: local community resources (services and social supports), county cooperation, nursing facility cooperation, housing options, volunteer base, family support system, transportation options (for medical and social needs), assessment and counseling pilot (one with and one without), rural and urban (one of each), diversity issues (existence of minority population), respite opportunities, and labor considerations.

planning, redundancy in communications and infrastructure development. Finally, it is critical to ensure success with a more limited number of individuals in the beginning in order to resolve unanticipated problems and secure widespread support for reform in the future, rather than undermining that reform for the benefit of placing greater numbers in the short term.

B2 Services to be Made Available

Project participants will have access to a full array of community based services. These will include existing services such as currently available HCBC-ECI services (described in section A), Title XX -Social Services Block Grant services, Title III - Older Americans Act services such as nutrition programs, and state-funded programs for congregate housing services, Alzheimer s respite care, and adult in-home care.

In addition, participants will be offered an array of new services developed specifically as a result of grant activity. Some of these direct services will be paid for through grant funding. These will include: outreach and pre-transition services provided by the consumer-directed independent service coordinator, consumer-directed personal care attendant pilot services, transitional/bridge flexible funding, and nursing home bed reserve during exploratory placement in the community.

Grant funds will be used for development of other services and the system changes they require, but once established, the services will be paid for through other non-grant fund sources. These services include: fourteen (14) new HCBC-ECI services (described in Section A4 and below), banking of unused HCBC-ECI allocation for the future, and post-transition consumer-directed independent service coordinator services paid through Medicaid. Access to innovative housing resources and community based volunteer ombudsman services will also be made available through grant activity and partnerships. The initiative will ensure that the existing

¹³ If the project is successful, it is the state s intention to expand the service in the following year to a wider geographic area covering more potential participants.

Medicaid funded independent living PCA program will be made available to eligible participants. The project will also develop Medicaid funded emergency/crisis respite services through community response protocols.

Below is an in-depth description of the new services that will be made available to participants through grant funded activities. The described services include those that will utilize grant dollars for direct services as well as those that use grant dollars only for development.

Consumer-Directed Independent Service Coordination

The central service to be offered to nursing home residents through this project is the consumer-directed independent service coordinator (ISC). NH-DHHS, through the Bureau of Health Facilities, already licenses and regulates case management service providers. See NH Rules HE-P 819, attached as Appendix H. For this project, ISCs will need to be licensed pursuant to these regulations. Additionally, ISCs chosen for this project through a RFP process will be provided with 80 hours of additional training in order to ensure their ability to provide the identified set of services to project participants. ISCs will have the following responsibilities:

ISC Scope

- ◆ ISC hired and fired by the consumer.
- ◆ ISC services will be offered to nursing facility residents in the pilot areas.
- ◆ ISCs will work with residents in nursing facilities and follow them into the community — in the community setting, paid by Medicaid state plan s case management reimbursement.
- ◆ Serves public and private clients — non-Medicaid recipients, pay out of pocket, once in the community.
- ◆ Zero reject policy for publicly funded referrals.
- ◆ In future, services will become available to individuals who originally reside in the community to divert them from nursing home placement.

Fosters Consumer-Directed Community Based Care

- ◆ Provides guidance and counseling related to consumer choices.

- ◆ Guides individualized planning using the consumer's values, preferences and perceptions of quality of life.
- ◆ Fosters consumer choice and control in all informal and formal service arrangements.
- ◆ Supports informed decision making by providing technical expertise about options and choices.

Develops Consumer's Personal Network

- ◆ Inventories support capacity of family, caregiver, friends, personal network, and other informal supports.
- ◆ Investigates support capacity of volunteer network.
- ◆ Builds and enhances the consumer's personal network from the volunteer network.

Arranges for Consumer-Directed Community Based Care Plan

- ◆ Reviews assessment with the consumer and their family, caregiver, personal network.
- ◆ Reviews the resource allocation in relation to informal supports and formal services and the consumer's choices.
- ◆ Develops with consumer a comprehensive care plan that reflects the consumer's desires and preferences.
- ◆ Advocates for the consumer with service providers and the state in order to achieve the consumer-directed care plan.
- ◆ Implements consumer-directed plan by arranging for informal supports, formal services with home health, senior centers, nutrition programs, and housing.
- ◆ Purchases formal services using outcome-based contracting in order to facilitate consumer's goal of gaining independence over time.
- ◆ Conveys service choices to the NH-DHHS district office systems management to ensure that payment system responds to consumer's choices.
- ◆ Fosters consumer-directed services, such as personal care attendants, as appropriate, using fiscal intermediary models and assures the consumer understands his/her role in the various models.

Monitors/Oversees Care in the Community

- ◆ Monitors the provision of formal services.
- ◆ Monitors the stability of the informal support network (family, friends, caregiver personal network and volunteers).

- ◆ Makes changes in the use of resource allocation as directed-decided by the consumer (and their family), and notifies service providers, county and district office so that system billing changes are revised to match updated choices.
- ◆ Advocates for resource allocation adjustments.
- ◆ Participates in community based quality assurance activities including personal outcomes and system outcomes.

Plans for Emergencies and Is Available in Times of Need

- ◆ Prepares contingency plans for potential difficulties as part of individualized planning process.
- ◆ Responsible for ensuring that consumer and family have access to ISC services on a 24 hour 365 day basis.
- ◆ Arranges for the banking of unspent resource allocation to be used in the future for higher cost transitional care periods when certain criteria are met.
- ◆ Provides intensive case management during periods of transition for the consumer in order to minimize the need for higher cost services.

Provides Linkages with Acute Care

- ◆ Coordinates care with the acute care system on behalf of the consumer.

Maximizes Resources for Community Based Care

- ◆ Uses generic services- resources available to all citizens to the maximum extent feasible.
- ◆ Assists consumer in utilizing long term care insurance, reverse mortgages, home equity loans, and viatical settlements to extend home and community tenure as appropriate and feasible.
- ◆ Expands consumer s personal network.

Assists with Advance Planning and Benefits Management

- ◆ Encourages consumer and their family to consider advance directives planning.
- ◆ Assists consumer with all Medicaid eligibility issues as well as eligibility for other programs and services.

The consumer-directed independent service coordinator service will be available to nursing home residents through grant funds. Once the individual transitions to the community,

ongoing service coordination will be paid out of existing Medicaid case management funding.

Private pay participants will pay for the service in the community out of pocket.

Expanded HCBC-ECI services

In addition to the new services listed below, the approved amendment expands HCBC-ECI eligibility to those that are medically needy in addition to those that are categorically eligible. By mirroring the Medicaid financial eligibility rules for nursing home care, HCBC-ECI will now become a more realistic and attractive alternative to those Medicaid medically needy nursing home residents.

This project will assist in developing new services to be provided to project participants and others through the waiver program. The new services approved by the waiver include:

- Personal care services
- Environmental accessibility adaptations
- Specialized medical equipment & supplies
- Home delivered meals
- Six Types of Residential Care: Adult Family Care, Assisted Living, Congregate Living, Residential Care Facility, Supported Residential Care Facility and Shared Housing.
- Adult group (social) day care
- Assistive technology
- Adult (senior) companion services
- Consolidated long term care services.

Combined with the existing HCBC-ECI services, previously described, these new services will offer consumers greater choices for community based services to meet their long term care needs. Access is improved through the assistance of the independent service coordinator who works with the consumer in developing their individualized plan, coordinating and monitoring services, and expanding the consumer's personal network.

Access to Innovative Housing Resources

In addition to the six new types of HCBC-ECI reimbursable residential care listed above, other innovative housing options will be available through the project. The NH-DHHS and the New Hampshire Housing Finance Authority (NHHFA) are working together to expand the

availability of housing resources for elders and adults who are low income and have significant service needs.

It is important to note that the innovative programs discussed below that rely on Section 8 vouchers, particularly housing funds for project participants and the HOPE EI program, can now be use to support individuals who own their homes, in addition to those who rent. Thus, housing resources will be available for project participants who are also homeowners.

Housing Funds for Project Participants

NH-DHHS and NHHFA are working on developing special housing resources for those individuals who want to participate in the nursing home transition project but who need help with paying for their housing. NHHFA uses its own fund to support an emergency housing program which provides a Section 8 like benefit. NHHFA will make this resource available to project participants for a 3-6 month period. Furthermore, NHHFA can amend its Section 8 administrative plan in order to give a preference to nursing facility residents who are project participants. Such a preference will result in the participant securing an actual Section 8 voucher that would replace the emergency housing funding. Through this arrangement, a project participant who needs housing assistance can return to the community without a lengthy wait for housing assistance. These services are currently available but require administrative and programmatic changes to facilitate their timely use by project participants.

Hope for Elderly Independence Funding

NHHFA provides the HOPE for Elderly Independence (HOPE-EI) program for low-income frail elders throughout the state. Along with a Section 8 Voucher, HOPE EI provides participants with services including, meals, personal care, homemaking, transportation, adult day programs, personal emergency response systems, and occupational and physical therapy evaluations to improve independence with personal care. The HOPE for Elderly Independence program could be made available for eligible project participants. By leveraging the HOPE EI

service funding, Medicaid HCBC-ECI services could reach a higher need group through the transition project. This service is currently available.

Assisted Living Pilot

Over the past year, NHHFA and NH-DHHS have also united to create a pilot assisted living program to facilitate the development of assisted living units that can serve the low income population. Two developments were awarded access to housing and service resources to construct these pilot assisted living facilities. These developments, both of which are located in the Manchester/Merrimack County urban corridor, are now under construction and will be available as an optional housing resource to participants in the proposed nursing home transition project. These services will be available without the need for any additional grant funds.

Consumer-Directed Personal Care Attendant Services

As part of the project, NH-DHHS will pilot its current consumer-directed personal care attendant program with project participants. Currently, the state's program serves a specific population of severely physically disabled persons who are clients of the independent living program. The project will work with Granite State Independent Living Foundation (GSIL) to offer pilot services to project participants. It is envisioned that GSIL would serve as the fiscal intermediary for the pilot consumer-directed personal care attendant program under the project. Susan A. Flanagan, a national expert on the development of consumer-directed personal assistant service programs, is consulting with the NH-DHHS to assist in designing self-directed care infrastructure in the state. She will also be retained through the grant to provide training and technical assistance to the pilot program. Together with other available funding, grant funds will be used for this pilot.

Community Based Volunteer Ombudsman Services

In order to assist in monitoring, project participants will be offered community based volunteer ombudsman services. This service is the outgrowth of a pilot program operated by the

state Office of Ombudsman in part of Grafton and Coos counties. In the pilot, the Office of Ombudsman trained volunteers from the Interfaith Caregivers Program to serve as ombudsman for individuals receiving community care.

As part of this project, the volunteer ombudsman program will be expanded to cover both geographic areas designated for this project. Furthermore, as part of the individualized planning process, participants will be provided access and services from a volunteer ombudsman. The volunteer ombudsman will provide additional monitoring of quality and safety monitoring for program participants. The grant will provide some development funding to expand the service to the project areas and to train and coordinate the new volunteers. The ongoing service will not be billed to clients as it is largely volunteer based.

Emergency and Crisis Respite Services

In addition to the emergency contingency and coverage plans included in the independent service coordinator function, the project will work with the county nursing homes and the network of community providers to develop an emergency/crisis respite service for project participants. This service will provide the reassurance to the participants that additional backup coverage is available from a provider that has a presence in the community on a 24 hour and 365 day basis. The project will work with the county nursing homes and the providers to develop protocols for this service. It is envisioned that the service will be reimbursable under the existing HCBC-ECI program.

Transitional/Bridge Funding

Project participants will have access to transitional or bridge funding to pay for services, supplies and other expenses incurred to assist in community placement that are not Medicaid reimbursable. Additionally, these funds will be made available to pay for services so that project participants can test and refine their community placements prior to their formal transition to the HCBC-ECI program. Transitional funding will be supported with grant dollars.

Nursing Home Reserve Bed Days

In order to allow project participants to test and refine their community plans, the project will permit the reserve of their nursing home bed for up to ten days of community placement to allow for this exploratory process. Ten days of leave of absence coverage currently exist under Medicaid. Initially, all leave of absence coverage will be paid out of the Medicaid program. However, if a project participant ultimately decides to remain in the nursing home, grant funds will be used to reimburse the resident so that the resident may still have up to the full ten days of leave of absence coverage for non-project purposes.

Banking of Unspent Resources

Project participants will be permitted to bank unspent services resources that were allocated to them for use at a time when they have greater service needs. The banking of allocated resources will be an accounting process of HCBC—ECI funds that have not been spent. The participant's total allocation within the program will comply with programmatic limits and rules. The availability of these funds encourages consumers and the ISC to refrain from maximizing expenditures because of an allocation limit in favor of banking unspent resources for future periods of greater need.

B3. Communication /Access Plan

Outreach to the residents and their families, as well as to the nursing homes will be undertaken with great care and forethought. System change, even in the form of a pilot project based on consumer choice, can be threatening to all involved.

B3a. Outreach to Residents and Families

Outreach to residents and families must be done with great sensitivity. It is important to provide them with clear guidance, and realistic expectations regarding services, as well as, accessible contacts to provide them with help if they run into problems with the program. The project coordinator will prepare uniform project information material and make available

informational presentations at each of the participating nursing facilities. These materials and presentations will be made available to all interested residents of the nursing homes in the two pilot areas.

The presentations and material will explain the project and introduce the service coordinators. It will attempt to educate individuals about the voluntary and consumer-directed nature of the program, resident rights related to the program and the service limits that may apply. The presentations will be organized through collaborations with resident councils and nursing facility staff. All interested residents, family members and staff will be welcome to attend.

Finally, the ISC will initiate individual contact with interested nursing home residents to explore their interest in participating in the project. As discussed earlier, the ISC will utilize the identified functional data sources to prioritize up to 75% of their individual contact efforts. The project will require that at least 25% of the ISC's individualized contact efforts be targeted to individuals by other mechanisms, most notably resident or family initiative or identification by nursing home staff.

Independent service coordinators will work with willing residents and their families and friends to develop care plans and provide further information about services available to them through the project.

B3b. Access Plan: Nursing Homes

New Hampshire has had a moratorium on issuing certificates of need for new nursing home beds since 1995 and that moratorium will continue by statute through December 31, 2001. Thus, demand for nursing home beds remains high. Throughout the legislative debates regarding implementation of the state's long term care plan, the nursing home industry strongly supported a consumer's right to choose service location as long as nursing homes were available as one of the viable choices. Also, the shift to an acuity based reimbursement system for nursing home

residents makes it possible for nursing homes to benefit in the long term from replacing lower acuity residents with higher acuity, more highly reimbursed residents. Thus, support for the project is expected to run high in the nursing home industry.

The project recognizes that the nursing and social work staff of the facilities can provide valuable screening information about residents who would be interested in participating in the project. Thus, these nursing home staff will also be approached for assistance in identifying likely participants.

NH-DHHS has approached each of the administrators of the three county nursing home in the pilot areas, Grafton, Merrimack and Hillsborough, as well as the state nursing home association to discuss the project and to obtain their cooperation. It is expected that the nursing homes will cooperate as indicated by the attached letters of support. It is the intention of the state to find ways through the State Committee on Aging and other public mechanisms to acknowledge and honor those nursing facilities that cooperate with the project.

B4. Removal of Barriers

The project has been designed specifically to support residents of nursing facilities to return to the community and to remove identifiable barriers to doing so. The independent service coordinator model provides the needed support in the context of a consumer-directed process to remove many of these barriers. The ISC educates the consumer about community options and services. The ISC works with the consumer to develop a care plan based that responds to the consumer's individual goals and preferences, not the system's or provider's preferences. The ISC addresses fragmentation by coordinating available services and funding streams in order to fulfill that consumer's plan. The ISC supports and expands the consumer's personal network of informal caregivers. Furthermore, the ISC monitors the quality of services provided and the success of the care plan. Additionally, the ISC supports the consumer through emergencies and transitional periods of higher need or acute episodes.

The project includes a set of additional services that remove other identified barriers. It provides flexible transitional/bridge funding to pay for non-Medicaid reimbursable expenses to facilitate the move back to the community. It pilots a consumer-directed personal care attendant program to better meet the individual support needs of the participants without burdensome regulatory barriers. The project also establishes a fiscal intermediary to support elders with this new service. A wide array of more flexible service choices are also made available to consumers by operationalizing an expanded set of new services through the HCBC-ECI program.

The project allows consumers the benefit of testing and refining their community plan by providing up to ten days of reserve nursing home bed days. The ability to test their community plan and make adjustments will further facilitate successful transitions.

The project further addresses barriers associated with episodes of greater care needs. It allows for banking of unspent allocation of service dollars to be used during such periods. Furthermore, crisis respite protocols will be developed to support individuals in emergency situations. These protocols will facilitate the evolution of nursing homes and the community network of providers into new roles that better support individuals in the community.

The project will also develop mechanisms for monitoring and protecting individuals in the community. See the description of monitoring plan below. In addition to that plan, the project will initiate the development of consumer-directed community care outcome measurements for use in future years.

The lack of appropriate and affordable housing options is one of the major barriers associated with transitioning residents to the community. This project, in partnership with the state housing finance authority, will develop and make available an extensive array of housing options to remove this barrier. A full description of the housing components of the project is located in the section below.

In the end, the greatest barriers to transitioning nursing home residents to the community lie within the person's own history and in the experience of having already been placed in a nursing facility. These barriers are intertwined within the individual's life and involve the individual's history of family support, emotional state, finances and service/support resources. Thus, a key factor to success is helping the person to define a goal of independence and develop a commitment to returning to the community. The ISC will work individually with people to assist them in this process.

B5. Waivers

No new waivers will be needed. However, the grant will assist the state in making available the recently approved amendments to its HCBC-ECI waiver program. Project funds will be used to support the New Hampshire Division of Elderly and Adult Services in developing the systems to implement the approved amendments to its waiver services. Funds will be used to contract with the fiscal intermediary to establish the new services within the reimbursement system, provide resources for rule development, and provider/personnel training. It is planned that these new HCBC-ECI services will be available for nursing home residents transitioning to the community.

B6. Partnerships

In order to succeed, this project will need to develop a broad range of partnership with a wide array of different entities. In addition to the innovative partnerships described below, the full panoply of HCBC-ECI, Title XX and Older Americans Act providers will be utilized through the ISC to support the participants in the community.

The New Hampshire Housing Finance Authority — to develop innovative housing resources for project participants, including emergency and permanent rental subsidies, service enriched housing subsidies or placements, access to assisted living pilot for low income individuals jointly developed with NH-DHHS and reverse equity mortgages.

Granite State Independent Living- to assist in the development of the pilot consumer-directed personal care attendant program for this project and to serve as the fiscal intermediary.

New Hampshire Office of Ombudsman —to further develop its pilot community based volunteer ombudsman program to provide ombudsman services to project participants who return to the community.

Nursing Homes in the pilot areas— to cooperate with the project and for their staff s assistance in identifying potential participants for return to the community.

County Nursing Homes — to develop new roles together with community provider network to provide crisis respite and emergency services.

Merrimack County Long Term Care Coordinator- to assist in identification of likely participants based on their assessment and counseling process and the CAF data.

State Committee on Aging - to provide support of its long term care task force in refining and implementing the plan and to assist in honoring nursing homes who cooperate and participate in the project.

Independent Service Coordinator Entities - two per pilot area chosen by RFP - to be trained for and participate in the project.

Network of community-based providers and social service agencies in the pilot areas —to work with the ISC in implementing this new approach to providing and integrating available services as well as in developing crisis respite and emergency care protocols.

NH-DHHS Bureau of Health Facilities and Office of Information Systems — to develop mechanisms for utilizing individual resident acuity-based reimbursement ratings for identification of priority contacts by ISC.

DHHS Office of Planning and Research — to assist with the development of consumer-directed community based outcome measures and to coordinate recent work conducted in this area.

New Hampshire Legal Assistance: Senior Citizens Law Project and Fair Housing Project — to provide legal representation to participants in the event they run into discriminatory practices in trying to secure housing.

B7. Monitoring Plan

Monitoring the quality of care and the safety of residents has traditionally been easier to accomplish in institutional settings through ombudsman programs, facility inspections and the public nature of the nursing homes. Systems are not yet in place to achieve the same protections in the privacy of individual homes. However, they can be developed. This project builds multiple systems of monitoring in order to provide such protections. The consumer-directed service coordinator is actively involved in all aspects of the care plan. As the direct representative of the consumer, the ISC provides unprecedented ability to monitor all informal and formal community caregivers.

The ISC function also includes building and supporting the individual's personal network. By expanding the consumer's personal network more caring individuals are involved in the consumer's life and can watch out for the individual's best interest.

Other systemic protections and monitoring are included in the project to ensure that the ISC is providing quality services, complying with a consumer-directed policy and ensuring that the consumer's needs are met. As part of the planning process, each participant will be linked with the New Hampshire Office of Ombudsman's innovative community-based volunteer ombudsman pilot program. This pilot program which provides trained volunteer ombudsman

and companion services to HCBC-ECI clients, will be expanded to encompass the project participants. The volunteer ombudsman will develop an ongoing relationship with the participant, initiate frequent contacts and in so doing, monitor services.

In addition to the new monitoring systems discussed above, project participants will still enjoy the full range of existing systemic protections. These protections include adult protective services, HCBC-ECI program oversight, and the benefit of interactions with multiple providers who are appropriately licensed and certified by the state.

The project manager will monitor independent service coordinator performance by periodic review of cases and interviews with participants. The project manager will also facilitate meetings, at least monthly, of all project ISCs. These meetings will provide a forum for support and continued learning. The availability of a support group such as this is critical to ensure that the ISCs are not isolated and have adequate support. Additionally, the project will set up a computerized bulletin board, list serve or intranet to provide real time sharing of information and support among the ISCs.

One of the project goals is to initiate the development of consumer-directed, community-based outcome measures that can be used in future years to monitor care and assess the program. NH-DHHS Office of Planning and Research has already initiated some related research in this area. Among the projects it has sponsored are the Elderly Services Outcomes Project of the NH Dartmouth Psychiatric Research Center, the Dartmouth Medical Schools Outcome Measures for End of Life Care and the NH Quality Outcomes Project of Community Developmental Services. The project plans on using information from these previous community based outcome projects to initiate the development a set of measures specifically for consumer-directed care models.

B8. Housing

As part of the consumer-directed planning process, the ISC will work with the consumer to utilize available housing resources and programs in order to secure the consumer's desired community housing, including the option of returning to the individual's pre-admission home.

Numerous housing resources are being made available to the project participant. Through the expanded HCBC menu of choices, six types of community residences will be available for reimbursement: adult family care, assisted living, congregate living, residential care facilities, supported residential care facilities and shared housing.

The project is also developing a rental assistance program for project participants. Through the emergency housing program, low-income participants will pay no more than 30% of their income toward their housing costs. Long-term rental assistance will follow HUD's regulations for the Section 8 voucher program. By using the state housing finance authority's resources, through its emergency housing program, this rental assistance will be made available immediately without the prolonged wait for a Section 8 voucher. However, the New Hampshire Housing Finance Authority (NHHFA) will explore their ability to amend the state's Section 8 administrative plan to provide a priority to project participants (nursing home residents) so that the emergency housing payments could be replaced by a Section 8 voucher within 3 months. Another NHHFA program, HOPE for Elderly Independence could provide supplemental supportive service funds along with a Section 8 voucher to participants.

As a result of a recent change in HUD rules, the Section 8 voucher benefits discussed above can now also be used to support an individual who owns their own home. Thus, these resources will also be available to homeowners.

For participants whose interest is homeownership rather than rental, other important benefits will also be available. The Home of Your Own Program, which began in New

Hampshire, could assist in making homeownership a reality for some individuals with disabilities. For those who already own homes, the NHHFA Home Keeper Program, which provides a reverse equity mortgage, could assist in converting home equity into a cash resource while the consumer continues to live in the home. The NHHFA Single Family Rehab Program operated through the state's Community Action Programs could provide funding for home improvements.

The partnership with NHHFA will also provide the project with access to their Supportive Services Program that is making a range of service enriched housing available to low income residents of the state. The ISC could work with that program to identify further service enriched housing alternatives. The new assisted living pilot projects that are currently under construction as a result of a joint financing program sponsored by NH-DHHS and NHHFA is one example of the innovative housing opportunities that will be made available.

In the event participants are faced with discrimination in their attempts to secure integrated housing in the community, New Hampshire Legal Assistance provides two services that can help. The Fair Housing Project and the Senior Citizens Law Project could provide legal representation to participants in the event they run into discriminatory practices in trying to secure housing.

C. Milestones, Timetables and Expected System Reforms

C1. Work Product

A) Develop Fourteen New HCBC-ECI Services:

- a) Adopt rules relative to new HCBC-ECI services,
- b) Train providers in new HCBC-ECI services,
- c) Make new services available to consumers, and
- d) Institute accounting and tracking system for banking unspent resources allocated to consumer for future use.

B) Independent Service Coordinators:

1. Issue RFP for independent service coordinators for project,
2. Develop ISC rules and policies for project,
3. Select at least 2 ISC (people or organizations) in each pilot region,
4. Provide 80 hours of training to selected ISC,
5. Institute system for identifying likely participants,
6. Begin providing ISC services to residents in nursing homes,
7. Institute mechanisms for ISC to authorize payment of HCBC-ECI providers,
8. Begin transitioning participants to the community,
9. Conduct monthly meetings with all ISCs,
10. Establish electronic medium for real time sharing and support among ISCs.

C) Outreach Plan:

1. Disseminate materials and present information at nursing homes for residents, staff and family,
2. Institute recommendation system with nursing facility staff,
3. Institute recommendation system with assessment and counseling program staff.

D) Partnership with state housing finance authority:

1. Finalize changes to emergency housing program and Section 8 administrative plan,
2. Formalize linkages between ISCs and supportive service and other housing programs.

E) Community Based Volunteer Ombudsman Program:

1. Expand program to project areas.
2. Partner with local volunteer groups,
3. Recruit volunteers,
4. Train volunteers,
5. Link ombudsman volunteers with project participants, and
6. Develop reporting system and response protocols with ombudsman office.

- F) Pilot Consumer-Directed Personal Care Attendant Program:
1. Obtain necessary administrative and state regulatory changes/waivers for pilot,
 2. Implement training and consulting services from Susan Flanagan,
 3. Formalize GSIL's role as fiscal intermediary,
 4. Train participants and ISC about utilizing the program,
 5. Make program available to participants, and
 6. Develop final rules for continuation of personal care attendant program.
- G) Crisis respite and emergency services
1. Finalize protocols for responding to crisis and emergency services to be provided by county nursing home and community providers,
 2. Implement protocols for community based crisis respite services, and
 3. Offer last resort crisis respite service in nursing homes for project participants.
- H) Initiate work on consumer-directed outcome measures:
1. Review existing data on such measures,
 2. Convene a group to map out process for developing and utilizing such measures,
 3. Synthesize all information in report for management review and use in future system change activity.
- I) Begin making available a volunteer network collaborative service.
1. Assess local volunteer resources available to benefit participants,
 2. Invite volunteer groups/communities to network collaborative meetings with ISCs to discuss ways to better meet the needs of project participants.
 3. Facilitate network collaborative meetings,
 4. Provide ongoing information sharing between and among volunteer groups and ISCs.
- J) Explore and plan implementation strategy for Medicare ISC role in management of consumer's acute care.

C2. Timetables

The timetables for grant activity is set out in Attachment 1.

C3. Expected Systems Reform, Implementation Potential and Phase Down

The project expects to have profound impact on systems reform in the state. Below is a listing of the expected impacts. The details of each follow after a discussion on implementation potential and phase down.

- Advance New Hampshire's goal of reorganizing all long term care services,
- Develop effective consumer-directed independent service coordinator model for nursing home residents who want to return to the community,
- Reorganize services to respond to consumer's needs rather than agency needs,
- Significantly expand HCBC-ECI services and choices available to all waiver clients,
- Develop systems to provide needed housing resources to nursing facility residents and others needing community based long term care services,
- Expand consumer-directed personal care attendant services to elder and adults with disabilities through a pilot program,
- Develop community based respite alternatives, crisis respite and important new roles for nursing homes in supporting individuals in the community,
- Develop mechanisms to ensure consumer safety in the community,
- Initiates development of outcomes for community-based, consumer-directed LTC,
- Explore new mechanisms to reimburse independent service coordinators for acute care management through Medicare, and
- Develop a volunteer network collaborative.

Implementation Potential

This initiative has tremendous implementation potential both in New Hampshire and beyond. The consumer-directed independent service coordinator model can expand to support additional nursing home residents, including those in other regions of the state, in transitioning

back to the community. Even greater potential lies in the diversionary value of the model, as consumer-directed independent service coordinators help people access the supports they need and want to live in the community and prevent or significantly delay nursing home placement. Well trained ISCs have the potential of working on an individual basis and in a flexible manner to promote the maximum autonomy and control for the consumer while still providing sufficient supports to help the consumer manage the difficult and constant challenges he or she faces.

At the end of the grant period, all project participants in the community will continue to benefit from all ongoing services, including ISC services, which will be paid for out of existing or newly developed sources. Expansion of the project to nursing home residents in other regions will require identifying a funding source for outreach and pre-placement activities.

Advance New Hampshire's Goal of Reorganizing All Long Term Care Services

New Hampshire is attempting substantial system change in how it provides long term care to its elderly and disabled citizens. Driving the reform efforts are the central tenets that elderly and disabled people should have the right to receive care and services in their communities, to have a choice in the services they receive, and to direct their own care and services. For New Hampshire, the proposed project is more than a pilot program but a vehicle to significantly advance the desired reform and its central values. The project provides an opportunity to reorganize how care is provided, to develop new consumer-directed systems of providing care and new, more flexible service/support options. The project provides a concrete vehicle to educate and communicate this new vision of long-term care and to provide a set of real world successes of this approach for individuals who have been institutionalized in nursing facilities.

Develop Effective Consumer-Directed Independent Service Coordinator Model

The ISC educates the consumer about community options and services. The ISC works with the consumer to develop a care plan based on the consumer's individual goals and

preferences. The ISC coordinates available services and funding streams in order to fulfill that plan, and expands and supports the consumer's personal network of informal caregivers. Furthermore the ISC monitors the quality of services provided and the success of the care plan. Additionally, the ISC supports the consumer through emergencies and transitional periods of higher need or acute episodes. The ISC will also be trained to employ outcomes-based contracting with providers to facilitate enhanced consumer independence and compliance with the consumer-directed care plan.

Developing and implementing systems of care that maximize consumer autonomy is a difficult task. As Bart Collopy points out, autonomy is an internally problematic concept, bristling with distinctions and polarities that can be ethically perplexing even in settings where professionals are committed to client self-determination.¹⁴ The five polarities he establishes, decisional vs. executional, direct vs. delegated, competent vs. incapacitated, authentic vs. inauthentic, immediate vs. long range, and negative vs. positive, sets out the complex nuances involved in promoting autonomy for long term care recipients.¹⁵ Well trained ISCs have the potential of working on an individual basis and in a flexible manner to promote maximum autonomy and control for the consumer while still providing sufficient supports to help the consumer manage the difficult and constant challenges he or she faces.

Reorganize Services to Respond to Consumers Needs not Agency Needs

The ISC model also fosters the development of community based resources and services that are responsive to consumers' needs rather than agency needs. The ISC can arrange for service that are otherwise unavailable especially as the service options and funding streams permit more flexibility, such as the use of a consumer-directed personal care attendants.

¹⁴ Bart J. Collopy, Ph.D., *Autonomy in Long Term Care: Some Crucial Distinctions*, The Gerontologist, Vol. 28, Suppl., 1988, page 11.

¹⁵ Id.

Once the ISC model is proven successful in transitioning nursing home residents back to the community, it can expand as the dominant service for individuals residing in the community who need long term care services, whether public and private pay.

Significantly Expand HCBC-ECI Services and Choices

The initiative will hasten implementation of expanded service options under the HCBC-ECI waiver as approved by HCFA in November, 1998. These expanded options will increase the ability of the waiver program to meet the consumer's needs and desires through such services as personal care, community residential options and consolidated long term care services.

Develop Systems to Provide Needed Housing Resources to Nursing Facility Residents and Others Needing Community Based Long Term Care Services

This initiative results in development of joint programs with the state housing finance authority to make emergency funding for housing, permanent funding for housing and service enriched housing available on a timely basis to residents of nursing homes who want to return to their communities. The project also works on developing six new Medicaid reimbursable residential based service options available to HCBC-ECI clients including, assisted living, shared housing and adult family care.

Expand Consumer-Directed Personal Care Attendant Services to Elders and Adults with Disabilities Through a Pilot Program.

Consumer-directed personal care attendant services are limited in New Hampshire to the program run by Granite State Independent Living for wheelchair mobile individuals who are capable of self-direction. The project will implement a pilot of this service to a broader range of elders and disabled adults who have different physical disabilities, surrogate decisionmakers and/or chronic illnesses. The pilot will allow the state to test the applicability of this service to a broader range of individuals, determine appropriate limits to the service and implement needed regulatory changes.

Develop Community Based Respite Alternatives, Crisis Respite and Important New Roles for Nursing Homes

As the state shifts to a new system of organizing long term care in the community, it is critical that the nursing home industry evolves with that system. While nursing facility care will remain a real choice for consumers, the expected increase in community care will present important new roles for the nursing homes. Of particular concern is the need for crisis respite services on a 24 hours a day-365 days a year basis. Whether these services are provided in the community setting or in a facility, nursing homes can assist community providers in providing such care. This project will develop a pilot service for crisis respite and work on local protocols between local providers and the county nursing homes to make such services available to project participants. Toward the later stages of the grant, the project will also explore new alternatives for community based respite alternatives.

Develop Mechanisms to Ensure Consumer Safety in the Community

Mechanisms exist to protect residents' rights and to prevent abuse and neglect in nursing homes through ombudsman programs, facility inspections and the public nature of the homes. Such protection is more difficult in the privacy of individual homes. The project incorporates a system of safeguards to provide such protections by using the ISC to monitor all informal and formal caregivers on an ongoing basis. The expansion of the community based volunteer ombudsman pilot program also provides additional protections to project participants. Administrative oversight of the HCBC-ECI program, as well as the involvement of project staff add additional monitoring. Finally, the intention of building and supporting the individual's personal network add more caring individuals into the care plan who can watch out for the individual's best interest.

Initiate Development of Community Based, Consumer-Directed Outcomes

The project will begin to develop outcome measures specifically designed for community based, consumer-directed long term care for use in future years.

Explore New Mechanisms to Reimburse Independent Service Coordinators for Acute Care Management through Medicare.

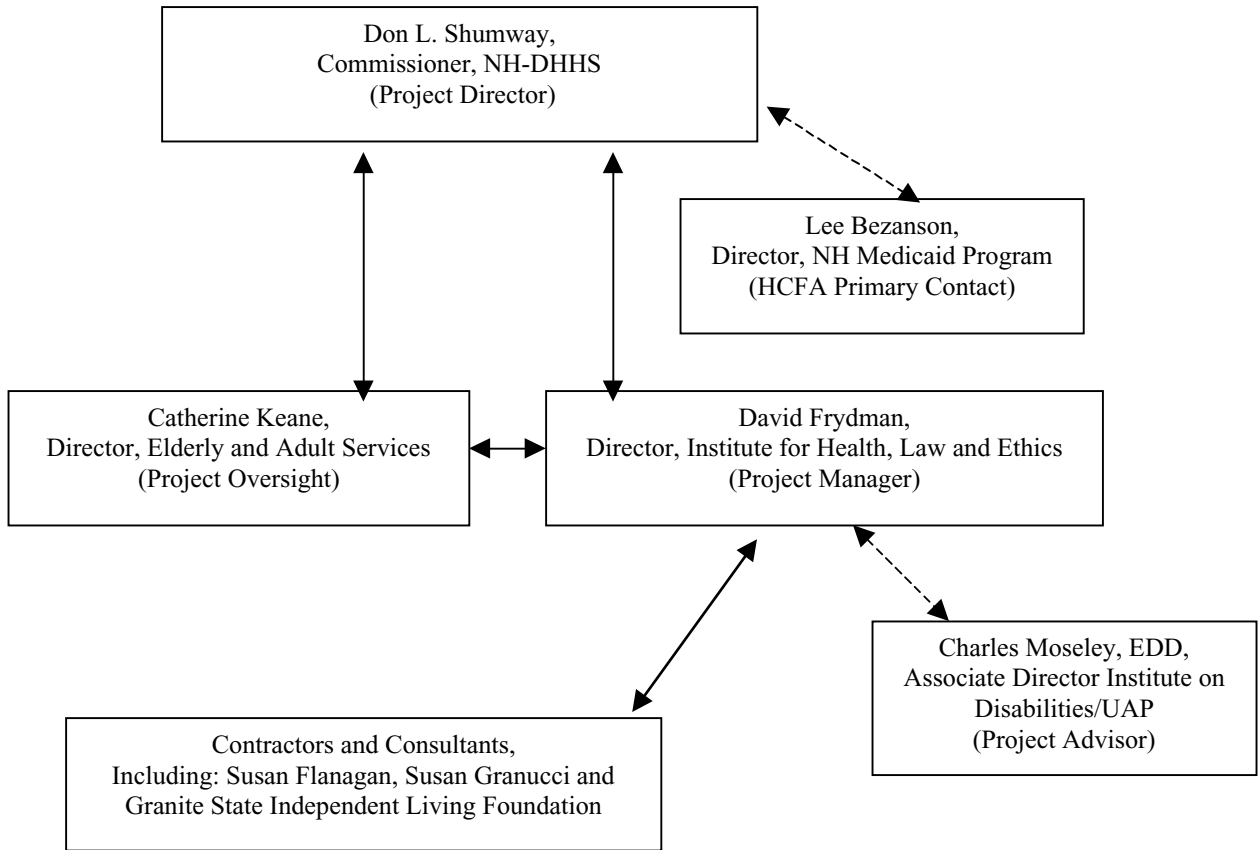
A key aspect of the ISC is to provide linkages that extend from long term care to acute care on behalf of the consumer. In order to enhance these linkages, the project will seek creative funding sources for the ISC to provide acute care case management to the consumer.

Develop a Volunteer Network Collaborative

This network will facilitate information sharing and communication among volunteer communities and the ISCs. The network will help local volunteer communities better respond to the needs of project participants. The network will also provide information about workable strategies to fund volunteer coordination and integration of volunteer networks into system changes and service provision. ISCs will look to volunteer groups to assist in expanding a consumer's personal and informal networks. The project will facilitate meetings between the volunteer groups and the ISCs and provide mechanisms for continued communication.

D. Project Organization and Staffing

D1. Management Structure



D2. Biographical Sketches of Key Personnel

Donald L. Shumway, Commissioner of the New Hampshire Department of Health and Human Services, will serve as the project director. In that capacity, he will be in charge of the general direction of the project and ultimately responsible for its completion. The department he leads is charged with ensuring the health and welfare of all the state's residents and is comprised of Medicaid, elderly services, welfare, mental health, public health, child support and protective services. Prior to his current appointment, he served as the co-director of the Robert Wood Johnson Foundation, National Program Office, \$5million national initiative: Self-Determination for Persons with Developmental Disabilities. As the director of the state's Division of Mental Health and Developmental Disabilities between 1984 and 1996, he

successfully developed a statewide developmental disabilities system and managed the first closing, nationally, of all institutional services for persons with developmental disabilities.

Lee Bezanson, New Hampshire Medicaid Director, will serve as the primary federal contact for this project. In that capacity she will serve as the liaison between HCFA, Commissioner Shumway and other project personnel. Prior to her appointment as Medicaid Director, she served as NH-DHHS Director of Long Term Care. In that capacity, she was responsible for developing the New Hampshire model for integrating service delivery for dual eligibles and still serves as the state's representative on the New England Dual Eligibles Consortium.

Catherine A. Keane, Director of the Division of Elderly and Adult Services, will provide project oversight for the NH-DHHS and act as liaison between the project and the Commissioner. As the manager of the statewide public service infrastructure for elderly and disabled adults, including institutional and community based care, she is in a position to ensure that all NH-DHHS system changes needed for the project are fulfilled. As Director of DEAS, she lead the effort to develop and adopt the state's long term care plan and she currently oversees its implementation.

David Frydman, Director of the Institute for Health Law and Ethics (IHLE) at the Franklin Pierce Law Center, will serve as the project manager. In that capacity he will be in charge of the daily management of all grant activity. In 1998, he completed a two-year project entitled Toward a Community Support System for the Elderly which examined in great depth the barriers to community care in New Hampshire and made extensive recommendations to improve the system. He also developed a leadership series for older citizens so they could have a greater voice in designing the state's long term care system. As a former staff attorney at New Hampshire Legal Assistance, he has experience advocating on behalf of low-income elder and

disabled citizens. IHLE staff also has a great deal of experience in drafting regulations and assisting in the rulemaking process. He will devote .8 FTE to the project.

Charles R. Moseley, Associate Director, Institute on Disabilities/University Affiliated Program at the University of New Hampshire, will serve as a project advisor. In that capacity he will serve as an advisor to the project manager. He is currently a co-director of the RWJ s national project on self-determination. He is the former Director of the Vermont Division of Developmental Services and has a great deal of experience as a program director and consultant.

Most of the tasks will be completed using contractors to the project. The level of contractor effort per task is reflected in the budget narrative which estimates contractor hours necessary to complete the tasks.

Resumes of project personnel is provided in Attachment 3. Also included there are the resumes of project consultants Susan Flanagan and Susan Granucci.

An advisory group was formed to assist in the conceptualization of this proposal. The advisory group will continue to serve through quarterly meetings. A list of current advisory group members is provided in Attachment 4.

E. Endorsements and Commitments

Letters of endorsement or commitment are included in Attachment 2 and include correspondence from the New Hampshire Housing Finance Authority, the New Hampshire Health Care Association, the State Committee on Aging, county nursing homes within the project areas, the Granite State Independent Living Foundation, the Grafton County Area Committee on Aging, the Greater Manchester Area Committee on Aging, the Merrimack Area Committee on Aging, the state Office of Ombudsman, New Hampshire Legal Assistance , New Hampshire AARP, the Institute for Health Law and Ethics, and from the gerontology program director of Springfield College School of Health and Human Services.