

The New Hampshire Community Passport Program (NHCPP)



Money Follows the Person (MFP) Demonstration Program Towards Rebalancing
NH's Long-Term Care System for Elderly & Disabled Individuals

Operational Protocol, February 2013, Version 4

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A. PROJECT INTRODUCTION

With a population aging faster than the national average, New Hampshire faces the prospect of providing care and support for an increasing number of its residents in a time of economic challenge. As it rises to meet this challenge, the State is committed to rebalancing its long-term care system. New Hampshire has traditionally served more individuals and spent greater dollars on nursing facilities as compared to home and community based care. To rebalance this system, New Hampshire is working to create a wider array of home and community based options for older citizens and those with disabilities who require support. An important element of this rebalancing is ensuring that individuals and families not only are afforded choices, but also have a say in how their services are delivered. To this end, New Hampshire is utilizing a person-centered planning process and honoring individual participation in decision making about supports and services.

New Hampshire's journey to rebalance its long-term care system for older adults began in 1995 when the State legislature enacted a moratorium on new nursing home beds; nearly fifteen years later this moratorium continues to be in effect. New Hampshire's work on system change has steadily gained momentum, supported by an infusion of resources from ten Real Choice Grants awarded to the State. These grants have been instrumental in the development of new programs that are responsive to the needs and desires of the individuals receiving long-term care services and have enabled New Hampshire to improve the community infrastructure needed to support its more vulnerable citizens. Examples of these efforts include: 1) the development of the consumer-directed Personal Care Service Provider program and Other Qualified Agency certification; 2) two nursing home transition projects that assisted over 60 individuals to return to community living; 3) a person-centered planning training curriculum that is being implemented statewide; 4) the engagement of five communities in finding local solutions to supporting older adults and adults with disabilities; 5) the implementation of a quality management plan which includes the utilization of the Participant Experience Survey; and 6) the development of a consumer-directed option within the State's HCBC-CFI waiver program.

Additional support for New Hampshire's rebalancing efforts have included two nursing home transition grants from the Centers of Medicare and Medicaid Services (CMS); the first was awarded in 1999 and the second, focusing on older adults with mental illness, in 2001. In 2006 CMS awarded New Hampshire a Money Follows the Person (MFP) Rebalancing Demonstration Program grant. The MFP project, now titled New Hampshire Community Passport (NHCP), is administered through the New Hampshire Department of Health and Human Services (DHHS), Division of Community Based Care Services (DCBCS), which includes the Bureau of Adult Services (BEAS), the Bureau of Behavioral Health (BBH), and the Bureau of Developmental Services (BDS). NHCP is specifically administered under BEAS. In September, 2010 NH was awarded the AoA/CMS Nursing Home Transition Grant Section C to (1) Train and educate all qualified LTC facilities in NH about MDS 3.0 and section Q and a person-centered approach for community transitions; (2) Identify 100 individuals requiring further assessment, care and discharge planning through MFP or the other SLRC resources; (3) Increase the number of individuals referred to the MFP by 50 and the number transitioned by 10; (4) Build a formal

process and policy regarding section Q referrals; (5) Develop a data tool or report from MDS data that can be used to support the functioning of MFP; (6) Increase awareness of SLRCs and MFP in LTC facilities across NH and with the Long Term Care Ombudsman Programs (see addendum on Page 26 for the specifics of this two year grant for 2011, and 2012).

NHCP has enabled New Hampshire to build on the lessons learned from the previous Real Choice and transition projects and to further support the rebalancing of the State's long-term care system. The NHCP offers care in community settings to individuals who reside in nursing or rehabilitation facilities and assists those who wish to move out of institutions in making the transition to home and community based services. NHCP, in conjunction with the State's other systems transformation efforts, has enabled New Hampshire to make considerable progress in securing funding for home and community based care and increasing the number of individuals served in these settings. The State's strong commitment to rebalancing its long-term care system will ensure that in addition to nursing facility care, New Hampshire residents will have equitable access to home and community based services.

In 2005, as part of the Long-Term Care Systems Transformation Grant, key stakeholders came together to create the framework for developing New Hampshire's home and community-based programs. The vision statement adopted by stakeholders provides the guiding principles for this effort:

“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.”

The values expressed in this vision statement are the foundation for the New Hampshire Community Passport Project. The adoption of a person-centered approach to service planning and delivery ensures that project participants have the opportunity and support to direct their own care to the extent that they choose and that NHCP will meet the grant's four demonstration objectives.

Objective 1—To increase the use of home and community based, rather than institutional, long-term care services.

NHCP will achieve this objective by:

1. Developing new waiver services in response to needs that are identified during the course of the project.
2. Increasing service flexibility through implementation of a consumer-directed portion of the waiver for seniors and adults with disabilities.
3. Increasing awareness of community based care alternatives to institutional care through outreach at both facility and community levels.

4. Providing transition case management to individuals living in qualified institutions under the Choices For Independence who want to return to the community.

Through these activities nursing facility staff and residents will have an increased awareness that community based care is available to meet the needs of older adults and those with disabilities. NHCP will offer increased supports and resources to assist individuals choosing to transition from residential institutions to community settings. In addition, people in need of long-term care and their families will have a better understanding of the services available in their communities and will choose to utilize community based and in-home supports rather than entering nursing facilities.

Objective 2—To eliminate barriers or mechanisms, whether in the State law, the State Medicaid Plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

In addition to those services already offered under New Hampshire's 1915 (c) Waivers, NHCP will continue to be a resource to provide services and needed transitional items to support individuals to make a smooth transition from institutional settings to community living. Some of these supports are one-time investments, for example the NHCP program uses enhanced match MFP funds for security deposits or to purchase home furnishings for CFI participants. Part of the future initiative for NH will be trying to find demonstration services funding for the State Plan Child and Youth Behavioral Health Services. Other supports will be ongoing services to meet the individual's need for care. NHCP has been able to offer program participants in the CFI waiver, their authorized representatives, and their Case Managers maximum flexibility in deciding how funds will be used to meet the individual's needs.

New Hampshire's experience with its two previous CMS nursing home transition grants demonstrated that the availability of flexible funding makes a *significant* difference in the ability of nursing home residents to return to their homes and community. This has been the case with this program. NHCP continues to work at identifying programmatic changes that are needed within existing waivers to ensure that there is ongoing support and the availability of flexible funding for participants in these programs. The CFI waiver program continues to work on strengthening its program. DHHS has and will continue to advocate for increased funding for home and community based care services in its budget. As evidence of this NH has a "Direct Care Workforce" committee who continue to convene to meet the challenge of providing a livable wage to direct work force staff.

Rebalancing Fund: Savings derived from MFP nursing home transitions will be used to fund other long-term home and community based care expenditures. Present methodologies have budget neutrality factors applied to both Home Health Care and Nursing Facility Care, so with any reduction in caseloads resulting from MFP will allow the available budgets to be spent on the remaining clientele in these areas. The enhanced match will be reinvested into long-term care to support services. However, for NH there has not been a significant decline in total nursing home facility census. The July 2008 nursing home facility census was approximately 4,150, the July 2009 census was 4,500 and the June 2010 census is at 4,400. NH is finding that the decline

in the overall state economy has resulted in a decrease or faster spending of private funding which has resulted in individuals meeting Medicaid financial criteria more expeditiously as well. Despite this, NH's ADRC, "ServiceLink", has been made into a single point of entry and a "no wrong door" access to care system. NH has been recognized by CMS for this initiative. NH has also been able to support staff for key transition activities by creating and using, since the beginning of 2010, the transitional Case Management (tCM) service in which a community Case Manager can be assigned to coordinate much earlier in the process of transitioning than ever before.

Objective 3--To increase the ability of the State Medicaid Program to assure continued provision of home and community based long-term services to eligible individuals who choose to transition from an institution to a community setting.

NHCP participants who are moving from an institution to a community setting will be provided enhanced case management through a new service, Transitional Case Management. This service will increase access to obtain long-term community supports that are available through the State's 1915(c) Waivers, the Medicaid State Plan, the Social Services Block Grant, the Older Americans Act, as well as connecting them to ongoing programs and resources that are available in their community. A Transitional Case Manager (tCM) will work with NHCP participants to plan their move to the community and to ensure that all needed supports and resources are in place. For those who have made a successful transition to community living, on going case management services will be provided by a Waiver Case Manager; this service is provided to all waiver participants. The Waiver Case Manager will be responsible for coordinating all aspects of the person's care plan, including monitoring the services provided under the comprehensive care plan to ensure ongoing access to appropriate supports. Savings from expenditures from people who transition will be reinvested into long-term community care services (RN Services, Personal Care Services, Home Health Services, Respite).

Objective 4—Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community based long-term care services and to provide for continuous quality improvement in such services.

As an outcome of its Real Choice Quality Improvement/Quality Assurance Grant, New Hampshire is developing a unified approach to its quality assurance strategy across its 1915(c) Waivers. Creating standardizing quality measures across programs and across populations is anticipated to strengthen service delivery and improve outcomes for individuals. As NHCP is being implemented in parallel with the 1915(c) Waivers, it will share the same quality assurance protocols. (These are specified in the Quality Assurance section of this document.)

This Operational Protocol, a requirement for funding under the MFP Grant, has been developed with the focus on the individual participant and how the person interacts with the program. The intent - to the maximum extent possible – is to assure that NHCP is responsive in meeting the individual's needs and honoring his or her choices for supports and services. This effort is part of New Hampshire's commitment to create a dynamic and enduring community based system of long-term supports that will enable all Granite State residents to live and age with respect and dignity and to have the ability to exercise choice and control until the end of life.

(Please note that the “Case Studies” can now be found on Page 86)

1. BENCHMARKS

The New Hampshire Community Passport Project will measure a minimum of five benchmarks, two that are required by CMS and three that have been chosen by the State. Based upon stakeholder input, BEAS has identified the initial benchmarks for the project and recognizes that as things move forward it may be necessary to change or add to these; any changes will be detailed in subsequent reports. Ongoing participant assessment and community reviews of provided services will be used to direct expenditures and make decisions concerning reinvestment of funds. These decisions and their impact will be reflected in State reporting to CMS.

CMS REQUIRED BENCHMARKS

1. Over the course of the demonstration period, 300 individuals (see table below) will be transitioned from a qualified institution to a qualified community setting.

The table below includes, for each fiscal year, the projected numbers of eligible individuals in each target group who will be assisted in making the transition from a qualified institutional setting to a qualified program. This benchmark illustrates an overall increase in HCBS participation. NHCP will be an important addition to the New Hampshire Department of Health and Human Services’ (DHHS) overall effort to rebalance the State’s long-term care system and increase the number of people served in the community as compared to institutional settings. As a result of this project, more individuals, both those living in the community without program supports and those living in institutional settings, will become aware of community options for support and will access services and supports to maximize their independence.

With the 2010 announcement of the extension of the MFP program through 2016, NH evaluated opportunities to offer the MFP program to additional institutionalized populations who also were meeting the MFP criteria and eligible for Medicaid State Plan Services. The numbers below are reflective of the increased estimates of individuals transitioned out of institutions. NH believes these are conservative numbers and will reevaluate in one year regarding needed adjustments.

Number of participants transitioned					
FFY Year	CFI Elderly	MR/DD/ABD (DD/ABD waiver adults & I.H.S. children)	MI (adults 65+ & children/youth 21 & younger)	Physically Disabled (CFI adults)	Total
1: 2007	0	2	0	0	2 (actual)
2: 2008	5	7	0	10	22 (actual)
3: 2009	10	8	0	6	(24 actual)
4: 2010	8	14	0	5	27 (actual)

5: 2011*	13	9	0	11	33(actual)
6: 2012	18	12	3	28	61 (actual)
7. 2013	10	14	10	15	70
8. 2014	10	14	10	15	70
9. 2015	10	14	10	15	70
10. 2016	10	14	10	15	70
Total	66	91	53	110	449

(*2011 is the year MFP is offered to non-waiver, State Plan eligible institutionalized populations)

2. Qualified expenditures

The qualified expenditures for HCBS during each year of the demonstration program are projected to be:

	Combined HCBS Expenditures
FFY 1 2007	\$0
FFY 2 2008	\$741,238
FFY 3 2009	\$806,498
FFY 4 2010	\$1,134,179
FFY 5 2011	\$1,484,287
FFY 6 2012	\$1,765,072
FFY 7 2013	\$2,868,413
FFY 8 2014	\$3,035,811
FFY 9 2015	\$3,126,885
FFY 10 2016	\$3,220,692
Total	\$18,183,075

These expenditures include the costs of all four waiver programs (ABD, CFI, DD & I.H.S.), home health and rehabilitation services, and targeted case management services. This does not include state behavioral health services targeting children and adults 21 years and younger as well as individuals 65+ transitioning from qualified psychiatric institutions that are certified to receive State Plan behavioral health services. While budget constraints restrict the rate of growth in programs administered by the Department of Health and Human Services, in SFY 09/10 New Hampshire fully funded the waiting list for persons on the DD and ABD waivers. Therefore, continued growth in funding is reflected in the projected numbers presented in the table.

BEAS SELECTED BENCHMARKS

1. BEAS will work with licensed providers of case management services to define and implement transitional case management (tCM) services. This new service will assist seniors and adults with physical disabilities make the transition from a nursing facility to community living.

Participants in the brain injury and developmental waiver programs (HCBC-ABD, DD, and IHS) are served through a statewide network of ten Area Agencies. Case management is a core service within each Area Agency; Service Coordinators work intensively with program participants and their families/guardians to procure or establish needed community supports. Community case managers from the State's community mental health centers work with the transitional coordinators during the transition with the behavioral health population. Such a network does not exist for the people who are served through the HCBC-CFI waiver program. CFI participants receive targeted case management as a State Plan service delivered by licensed and enrolled providers, of which there are currently six. These participants may choose an enrolled agency to provide their case management services or be assigned a Case Manager through the rotation assignment process administered by BEAS.

During project year two, BEAS contracted with providers to provide Relocation Coordination services. Their tasks included explaining the service at facilities and assisting people through the transition process. BEAS learned that, not only was this service costly when provided in this manner, but the support needed could be provided in a more sustainable way by creating a new waiver service to specifically address transition needs. Through NHCP, BEAS is expanding its capacity to provide intensive person-centered planning for institutional residents who are returning to the community; this planning may begin before the person becomes a waiver participant. All agencies that are licensed to provide case management services, including those that currently provide targeted case management to CFI participants, will be invited to participate in this project. Case Managers will be responsible for assisting the participant to develop an individualized comprehensive service plan; this plan details the supports and services that are needed by the individual and identifies the provider(s) the individual has chosen to provide his or her services. Once services are in place, the Case Manager will maintain at least monthly contact with the individual to ensure that the person is satisfied with services and that they are being delivered in the amount and scope needed and authorized.

Transitional case management (tCM) will be provided to NHCP eligible participants who enroll in the CFI waiver program. This service is a redefinition of the service formally provided by contracted Relocation Providers (this contract no longer exists and tCM is now the service) during project year two and is more intensive than the targeted case management provided under the State Plan to CFI participants. Transitional case management is focused on supporting the participant to become re-established in the community, including providing the individual with active assistance in locating and securing appropriate housing by working closely with the Housing Specialist (see Page 80 for full description), helping to furnish and set up a household, and arranging for needed community based supports. A transitional case manager may not be assigned to NHCP participants who are able to return to their previous residence or who will be making a move that requires minimal assistance, for example going to live with a family member

who is able to conduct transitional tasks. For this reason, the number of participants who receive tCM will be less than the total number of people anticipated to be transitioning into the CFI program. Initially, tCM will be developed as a demonstration service. In the final two years of the NHCP Project, NH has solicited feedback from case management providers and participants and determined that this service should become a permanent component of the HCBC-CFI program. The process to conduct this activity as a permanent component of the CFI waiver program, if approved, is expected to be in place as of June 2011 after the administrative rule is reviewed and hopefully passed. If this occurs, NH will have achieved this benchmark.

Year	Number of participants receiving tCM (CFI)			Percent increase in tCM involvement
	Elderly	Adults with Physical Disabilities	Total tCM involvement	
FFY 3 2009	0	0	0	Service not yet implemented
FFY 4 2010	5	8	13	First Year
FFY 5 2011*	6	9	15	13.4%
FFY 6 2012	7	12	19	23.6%
FFY 7 2013	7	12	19	
FFY 8 2014	7	12	19	
FFY 9 2015	7	12	19	
FFY 10 2016	7	12	19	

*2011: The ultimate goal is to provide this service as a regular waiver service for the CFI waiver program by 2011 (by FY 2012) and to add this as part of the NH administrative rules at that time.

2. Of the individuals who transition as NHCP participants, 90% will be living in the community one year following transition.

All NHCP participants who have transitioned to community based care will receive ongoing services through New Hampshire’s existing waiver programs, State Plan Behavioral Health services. To ensure that all MFP participants are receiving needed supports in the community and are satisfied with their services, the project will utilize the following quality assurance measures. The Quality of Life Survey that BEAS administers to program participants shortly before their transition to a qualified community setting will be administered twice more at one-year intervals. This survey will be used to identify any areas that may pose barriers to the participant being able to live successfully in the community, and subsequent participants will have the advantage of knowing what their potential barriers could be and plan accordingly. Results of the Quality of Life Survey will be communicated to the individual participant’s Community Based Case Manager. All the programs require regular contact and ongoing assessment of the participant’s community experience by the individual’s Case Manager who will have regular contact, including face-to-face meetings, with the participant. During these ongoing monthly case-management meetings the participants and their case managers will review their service needs and services being provided as well as reviewing any changes as necessary. State rules governing the community-based services require Case Managers to have regular

contact with participants and to document these contacts in the individual's case file. The Bureau Quality Units annually monitor adherence to this and other program requirements. As HCBC-CFI recipients, NHCP participants who have transitioned from a nursing facility to community based care also will be included in the Personal Experience Survey that is administered to a sample of all CFI participants. The quality of services provided to participants in the ABD, DD, and the In Home Support waiver, as well as the State Plan services recipients will be monitored according to the process outlined in State rules for these programs.

Participants living in the community one year post transition					
	Elderly Disabled (CFI)	HCBC-ABD/DD/IHS	Adults with Physical Disabilities (CFI)	MI (children/youth & elders)	Total
Year 1 (FFY07)	0	2	0	0	1
Year 2 (FFY08)	5	7	9	0	21
Year 3 (FFY09)	9	7	5	0	21
Year 4 (FFY10)	6	12	5	0	23
Year 5 (FFY11)	6	6	11	2	25
Year 6 (FFY12)	7	7	12	8	44
Year 7 (FFY13)	7	7	12	8	44
Year 8 (FFY14)	7	7	12	8	44
Year 9 (FFY15)	7	7	12	8	44
Year 10 (FFY16)	7	7	12	8	44
Total:					Total: 344

3. NHCP will develop and expand the Adult Family Care model (care provided to one or two individuals in a private home) for HCBC-CFI participants, with emphasis on individuals transitioning from an institutional setting.

The Adult Family Care residential service model is similar to the Enhanced Family Care model that has been successfully used by the Area Agency system to provide supported housing for individuals with developmental disabilities and acquired brain disorders. The

lack of suitable housing in New Hampshire is a significant barrier for individuals wanting to leave nursing facilities. By adapting the Adult Family Care model for this population NHCP will be tapping into a new resource for quality housing and supports. At least eleven new Adult Family Care Homes, each serving one or two participants, will be established. These homes are required to be certified, but do not have to be licensed. By expanding residential options to include Adult Family Care (home care provided to non-legally liable relatives), BEAS expects to increase the capacity and reach of NHCP. BEAS has made significant progress in defining the service and rate structure and will begin educating case management providers about this service in December 2009. Ongoing education about the Adult Family Care model will be conducted in coordination with the intensive outreach planned for the New Hampshire Community Passport Project.

New Homes Established for NHCP-CFI Participants			
Year	Elderly	Individuals with Physical Disabilities	Total
4: 2010	0	0	0
5: 2011	2	1	3
6:2012	3	1	4
7:2013	3	1	4
8:2014	3	1	4
9:2015	3	1	4
10:2016	3	1	4

BENCHMARK ACHIEVEMENTS TO DATE

Since receiving approval of the first Operational Protocol, NH has been pursuing the initial benchmarks for the project. The benchmark for Person-Centered Planning Training and Development has been achieved within BEAS. As a result of education and training for BEAS Case Managers and other staff, the person-centered planning model has been integrated into the HCBS program. Adopting a person-centered approach to planning and service delivery ensures that individuals of any age who have a disability or chronic illness are able to obtain quality services and to live in the most integrated community settings. The individual’s needs and preferences are taken into consideration and the person is able to participate in decision making about their services and is given the opportunity to exercise meaningful choices. As the program moves forward, BEAS will continue to honor the principles of person-centered care and planning. Training for new personnel will be provided to ensure that turnover of staff will not affect the quality of the program. The NH Institute on Disability jointly conducts these trainings in an on-going way. With the implementation of MDS 3.0 Section Q NH plans to train all Nursing Facilities on Person-Centered Planning as well through this opportunity. NH achieved the State’s benchmark of transitioning 27 individuals in 2010. NH has put a lot of effort and work into achieving the benchmark of offering the transitional Case Manager service as a traditional HCBC service and anticipates achieving this benchmark once approved in July 2011.

B. DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES

1. PARTICIPANT RECRUITMENT AND ENROLLMENT

a. TARGET POPULATION

The target population for the NHCP Project is New Hampshire individuals who have been residents in a qualified institution for a period of 90 days or more, are one Medicaid one day prior to discharge, and who are eligible for one of the following programs:

- i. **HCBC-DD Waiver for People with Developmental Disabilities or HCBC-ADB Waiver for People with Acquired Brain Disabilities:** This program serves individuals of any age with mental retardation and/or developmental disabilities who would otherwise require the level of care provided in an intermediate care facility for mental retardation (ICF/MR). The HCBC-ADB waiver serves individuals age 22 years and older with traumatic brain injuries or neurological disorders who would otherwise require the level of care provided in a skilled nursing facility (SNF).
- ii. **HCBC- Elderly and Chronically Ill/Choices For Independence (HCBC-CFI) Waiver** – This program serves individuals aged 65 years and older and chronically ill adult individuals between the ages of 17 and 65 who require the same level of care as is provided in a nursing facility.
- iii. **In Home Supports (IHS) Waiver** – This program serves families with children diagnosed with autism and other developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization.
- iv. **State Plan Behavioral Health Services Eligible Recipients** - 21 years or younger and 65 years or older transitioning out of a qualified psychiatric institutions who will receive mental health services through the Community Mental Health Centers (CMHC's) and will be followed by a community case manager while participating in an Elder Program or NH-STARR.

Individuals targeted from the above programs are those who want to move from a qualified institution to the community and receive services through one of the 1915(c) waiver programs listed above, State Plan Behavioral Health Services. Participants for NHCP are identified through several mechanisms; these vary depending upon which waiver program is providing their services or if State Plan Behavioral Health. NH is exploring other avenues in which to reach the target populations directly.

Identification of target populations:

Individuals who transition to the HCBC-DD, ABD, or IHS programs will be identified by: 1) the DHHS, through the Preadmission Screening and Resident Review (PASARR); 2) staff or volunteers of the Office of Long Term Care Ombudsman (OLTCO) who routinely meet with residents of nursing facilities and provide information and support when needed; or 3) Area Agencies that serve as the entry point to these waiver programs and are in regular communication with facilities serving eligible individuals, 4) MDS 3.0 Section Q: NH applied for and was awarded "Funding

Opportunity C, Nursing Home Transition and Diversion Programs” allowing identification of individuals desiring to transition to alternative community living options.

Eligibility Identification for the ABD, DD, I.H.S Waivers: Potential participants who have developmental disabilities or brain injuries are evaluated through a clinical assessment by the Area Agencies serving their geographical region. Area Agencies receive referrals from Individuals and family members, schools, facility staff, acute care and acute rehabilitation hospitals, nursing homes and through the Department of Health and Human Services, which is responsible for the PASARR process. Once the individual has been determined to meet the requirements for services under He-M 503 (Eligibility and the Process of Providing Services) or He-M 522 (Eligibility Determination and Service Planning for Individuals With an Acquired Brain Disorder), documentation is sent to the Bureau of Developmental Services (BDS), within DHHS, for waiver eligibility determination under He-M 517 (Medicaid-Covered Home and Community Based Care Services for Persons with Developmental Disabilities and Acquired Brain Disorders). BDS makes the final determination of eligibility, approves waiver funding for the applicant, and sends documentation to the Area Agency. The Area Agency is responsible for providing the individual with service coordination, oversight, and support and services.

People who transition to the HCBC-CFI program will be identified by: 1) OLTCO, 2) the individuals themselves through contact with the discharge planning staff of the facility, 3) facility staff, 4) family members who learn about transition assistance through a ServiceLink Resource Center (this is New Hampshire’s term for Aging and Disability Resource Centers), and/or contact with the facility staff, and 5) other interested persons who may be aware of the person and their desire to transition. 6) MDS 3.0 Section Q: NH applied for and was awarded “Funding Opportunity C, Nursing Home Transition and Diversion Programs” allowing identification of individuals desiring to transition to alternative community living options.

Eligibility Identification for the CFI Waiver Program: Frail individuals who are 65 years and older, and adults with physical disabilities living in nursing facilities are informed of the CFI program by BEAS staff, OLTCO volunteers, facility Discharge Planners, family, and others. Residents wishing to return to the community will work with the facility’s Social Worker or Discharge Planner. The BEAS or facility Nurse assigned to conduct the Medical Eligibility Determination (MED) assessment will complete the assessment and process to determine clinical eligibility for the HCBC-CFI program. For eligible individuals, an initial transition plan will be developed. As part of this process a tCM (an MFP demonstration service), family member, or other acting agent is then assigned or identified to individuals whose transition plan includes locating housing in the community and setting up a household. An enrolled case management agency is assigned to develop the ongoing service plan that will support the person in the community prior to the resident’s discharge date. The participant can chose to have the tCM provide ongoing case management in the community, or can ask to be assigned another community Case Manager. The individual works with the Case Manager to identify needed services and chooses who will provide supports and service in the community. The Case Manager authorizes services to start upon discharge and maintains consistent contact with the participant after he or she has moved to the community. With direction from the participant, the Case Manager makes adjustments to the service plan as needed.

State Plan Behavioral Health Services Eligible Individuals 21 years or younger, and 65 years or older: This new population will be identified by;1) Discharge planning staff from; New Hampshire Hospital (NHH), NHH Philbrook (pediatric unit), Whitney Academy, Davenport School, and Bennington School, 2) the individuals themselves through contact with the discharge planning staff of the facility, 3) family members who learn about transition assistance through a ServiceLink Resource Center 4) other interested persons who may be aware of the person and their desire to transition.

Eligibility Identification of the State Plan Behavioral Health Services Eligible Individuals 21 years or younger, and 65 years or older: The NH MFP program is now desiring the ability to serve and include individuals with a mental illness currently in institutional settings such as nursing homes, Psychiatric Residential Treatment Facilities (PRTFs), and residing in Institutes for Mental Disease (IMDs). NH will offer MFP to children and youth under 21 years old and adults 65 years and older meeting eligibility for state plan behavioral health services and meeting the CMS MFP eligibility requirements.

- i. 21 years old and younger population: The children are assessed with the Child and Adolescent Needs and Strengths (CANS) assessment for eligibility and level of care determination. If meeting the intensive needs level of care as determined by the CANS they will then be deemed eligible. Intensive, multi-system services provide resources coordinated by the transitional care coordinator and those partnering state departments (MFP administrative funding requested in budget for this role). This population will also be considered eligible if looking to transition from a qualified institution, which also includes Psychiatric Residential Treatment Facilities (PRTFs) and Psychiatric Hospitals for this particular age group. NH is working towards building a system of care that meets the needs of the most intensive children. As it currently stands, for the most intensive pediatric cases these intensive services are available in a couple of pockets of the state but not in all of the state's communities. NH has been sending children meeting these criteria of care to out-of-state facilities. NH is working towards building this infrastructure in the community "one child at a time" with a coordinated effort through the NH Systems Transformation and Realignment (NH-STAR) program. The NH STAR program is a NH pilot program that embraces the concept of a centralized care coordination effort of multiple systems to meet the needs of high-need children. By having MFP involved, this will allow further leveraging of state and local resources towards this initiative. The program will have approximately one year of development and the initiative under its belt by the time this OP comes into operation. This is beneficial as this MFP opportunity will come at a time in which the state will be poised to broaden the services statewide and will have learn from those lessons learned over the past year.
- ii. For those individuals 65 years and older: These individuals will be assessed and deemed eligible or not thru the Older Adult Assessment Tool. If the level of care is determined to meet criteria these individuals will enter into the elder programs at the Community Mental Health Centers. At that time

the individual will be assigned a case manager and treatment team. There they will receive mental health treatment services through the State Plan, be followed by a community case manager, and NH will demonstrate and offer very similar transitional services provided to the CFI population.

Important Role Of Adult Protective Services in NHCP: NH has been working hard for decades to move a variety of medically complex individuals out of nursing institutions to receive their care in their preferred community setting. It is at this point now that NH is finding that generally those individuals who are in institutions for a lengthy period of time are those with complicated medical profiles *as well as* challenging psychosocial situations. Examples of challenges include; rural settings with limited resources, lack of education and knowledge of needs or supports available, complicated or unsafe relationships/supports, no housing or unsafe environments to return to, lack of financial supports, behavioral health or substance use/abuse histories and many more. Hence, NH has recently folded in the assistance of the BEAS Adult Protective Services (APS) Social Worker (1 FTE), who reviews the prospective MFP transitioning caseloads, and may become involved early in the process to help the individual consider and assess all aspects of living more independently. The BEAS APS workers are familiar and well versed in the local community resources available to individuals with high medical needs, and a past history of or current complicated psychosocial situations. They are a valuable resource in assisting with the transition plan and knowledgeable in determining whether or not a community has additional appropriate supports available for this particular individual. BEAS has learned the importance of obtaining clinical input and has incorporated the role of the APS Social Worker into the new planning process. The NH APS staff come from a client-centered stance and is supportive. When a particularly challenging transition is presented, and after the initial planning meeting, the Nurse Supervisor and NHCP Program Director may meet with the Division Assistant Director to review the recommended transitional plan. The Division Assistant Director is an RN and also responsible for the Bureaus of Developmental Services and Behavioral Health providing additional insight and perspective regarding the transitional plan.

ServiceLink Resource Centers (SLRC), NH's ADRC, are also available (13 across the state) to provide counseling to individuals and families requesting services, through either DHHS-funded or locally funded programs and assist individuals with the Medicaid application process. SLRCs are knowledgeable about and can provide individuals and families with information about the Home and Community Based programs. They can counsel individuals about their choices for long-term care via their Long-Term Care Counselor service. In addition, transition supports are available through the SLRCs. ServiceLink is the official MDS 3.0 Section Q Point Of Contact for nursing facilities to refer to if indicated.

Initially after enrollment into the program, the NH CP Program Specialist will work with the referring agency or facility, the other identified agencies working on the transition (state and local), the individual, and others to initiate, coordinate transitional services, support resources, and other necessary transitional activities. The exact amount of involvement from the NHCP Program Specialist depends on the program the individual is eligible for, as well as the individual's needs that are presented for the transition to occur. For example, the BDS waiver program contracts with local Area Agencies who conduct all aspects of the transitional activity for the three BDS waiver participants and the NCHP Program Specialist may have limited direct

participation in the transitional activities themselves. However, on the other hand, it is very common for the NHCP Program Specialist to be very involved in the CFI Waiver transitions coordinating all the transitional activities in tandem with the transitional Case Manager. Each case is tailored and each case has a varying degree of formal and informal supports.

The Behavioral Health Program Specialist/Transition Coordinator (1 FTE): In this OP NH is requesting an additional staff position of The Behavioral Health Program Specialist/Transition Coordinator for the behavioral health transitions and will be directly involved and may be the lead entity coordinating much of the transitional activities, as well as orchestrating multiple systems (not just behavioral health services, but particularly for the youth population, also services from Juvenile Justice and Department of Education). The duties will, in addition, include and mirror all the duties of the non-behavioral health Transitional Coordinator/Program Specialist but work specifically with behavioral health transitions.

b. QUALIFIED INSTITUTIONS

All qualified institutions will be included in the project. These include, but are not limited to: county nursing homes, private nursing homes, skilled nursing facilities, rehabilitation facilities, hospitals, Cedar crest Home for Children (ICF-MR), Crotched Mountain Rehabilitation Center, Glenclyff Home for the Elderly, and the New Hampshire State Hospital. It will include one in-state PRTF, the Davenport School located in Bethlehem, NH and also will include two out-of-state qualified PRTF's located in Massachusetts that NH pays for and utilizes to serve it's children. The State sends their highest service needs children to receive services because there is one qualified PRTF's available to NH's children, but not at the level of highest need. By including these out-of-state facilities, it will not only allow children in these PRTF's come back to NH but also back to their home communities. NH is committed to optimizing the MFP resources towards this over-all initiative of deinstitutionalizing its children and youth populations, as well as building community care infrastructure to meet the needs of its highest needs children.

Challenge of Transitioning Individuals Facing Complicated Medical and Psychosocial Circumstances From Nursing Institutions: One of the most significant challenges in the State's earlier Nursing Home Transition Grant was convincing facility administrators to buy into the concept that nursing home residents are capable of making a successful transition to community based care. Getting administrators on board eventually was accomplished by having one-on-one meetings with facility management; these discussions provided the opportunity to explain the program in detail, answer questions, and quell administrators' fears about the potential loss of facility revenue. Personal outreach to facilities took place during calendar year 2008; BEAS has continued to nurture the relationship with nursing facilities and hospitals through face-to-face meetings, telephone conversations, and direct mail. In its communication with facility administrators BEAS has emphasized the importance of working in partnership to support individuals who wish to make a transition to community living. To date the response from facility administration has been positive. As mentioned earlier, having Adult Protective Services involved earlier in these cases has also been very helpful as they too forge and have on-going relationships with facilities.

Challenges of Building New Community Infrastructure, and Utilizing A Multi-System Approach To Support Acute Population: A new challenge NH faces by offering MFP to the younger psychiatric populations will be the work of engaging, pulling-in and building a multi-systems which include; Juvenile Justice System, Department of Education, Behavioral Health System, Developmental Services System. This multi-system care infrastructure is the NH-STAR program model of care, which mirrors the work of “Wrap-Around Milwaukee”: a program with a demonstrated track record and cited as a national model of care. Currently intensive behavioral health services and supports are very limited in NH and even non-existent in parts of the State for children and youth. NH has not had an in-state institution to send it’s most needy children to and has sent them out of state (to MA). However, as the NHCP/NH STAR transitions occur the philosophy is and will continue to be, “one-child-at-a-time”. The NH STAR program will have been rolled out initially as a pilot program to Belknap County in late 2010 funded initially through a grant. By 2011 and with MFP as part of this initiative, NH will transition small numbers of children back to their own NH communities from in and out-of-state facilities statewide. NH will have the opportunity to examine the long-term financial structuring of current state agency positions and resources with a small amount of children in the pilot beginning in 2010 to find out how the process would work with the project broadened statewide. Only children identified as meeting the criteria indicated in the NH STAR program identified by utilizing the Child & Adolescent Needs Assessment will be part of the MFP program. The NH STAR program transition process and services will be mirrored statewide; again, will conduct each transition “one child at a time”. Outcomes will be available for policy makers to examine as well to decide to expand the model and reach the goal of a real system transformation and realignment statewide. The state’s leadership is behind this initiative. Having a dedicated MFP Transition Coordinator for the behavioral health population will greatly leverage the State’s current efforts.

The Challenge of Addressing Nursing Institution Concerns about Lost Revenue:

The program’s outreach and education process with nursing facilities has included clarification to address administrators’ fear that the program will result in lost revenue for the facility. However, since the project began in 2007, NH has not experienced significant declines in nursing facility placements. While there is a moratorium on Medicaid nursing home beds, and thus no new beds are created, there has not been a significant nursing home census decline. If a resident with Medicaid transitions into the community, the nursing facility is *not* obliged to fill that resident’s place with another Medicaid patient. The Department of Health and Human Services at least annually, determines/redetermines the number of nursing home beds allocated to Medicaid recipients, based on the nursing home utilization rates. Each nursing facility determines how many Medicaid-certified beds it will have and may withdraw beds from the Medicaid program.

To allow nursing facilities to adapt to the changing needs of the State’s older residents and those with disabilities, the New Hampshire Legislature amended the State’s Certificate of Need (CON) law to allow nursing facilities to provide mid-level care (at the residential care level) without losing any nursing home level of care beds. These beds may be switched back with no change in the facility’s CON bed number.

New Hampshire State Law Chapter 151 Section C:6m IV states that:

Any nursing home may surrender its license for any nursing home beds and redesignate those beds as mid-level care beds (the term “mid-level” refers to a type of licensed facility care such as assisted living and residential care), without being subject to any requirements pursuant to this chapter. Such redesignation shall take effect upon notice to the commissioner. Any such beds so redesignated may be converted back to nursing home beds without being subject to any requirements pursuant to this chapter. Such conversion shall take effect upon notice to the commissioner. Any moratorium on the creation of new nursing home beds shall not apply with respect to beds, which are converted back to nursing home beds pursuant to this paragraph.

With a rapidly growing older population, New Hampshire can expect the demand for nursing facility beds to increase dramatically within the next two decades. This, coupled with a moratorium on expanding the number of nursing beds through Certificate of Need Limitations, should reassure facility administrators that there will be few empty beds in the state’s nursing facilities.

c. MINIMUM RESIDENCY CONFIRMATION

Although NHCP enhanced funding will be available to transition only people who have resided in a facility or combination of facilities for 90 days or more, BEAS and the other Bureaus are encouraging facilities to request the Bureau’s help in working through difficult transitions for any individual. Offering support and encouraging communication is part of a conscious strategy to foster positive working relationships between the bureaus and qualified institutions as well as the community agencies supporting individuals after the transition. The MFP staff will confirm whether the person meets the residency requirements before including him/her in the NHCP report. Service utilization data from the MMIS and its subsystems will be the source of this verification for those interested in the NHCP. The new CMC/AoA award allows ServiceLink the opportunity to be not only the Point of Contact (POC) for nursing facilities to refer to for any resident indicating a positive response on the MDS 3.0 Section Q that they would like to explore the option of living in the community verses a nursing institution, but to be an actively involved resource in the transition process.

d. ELIGIBILITY CONFIRMATION

The New Heights System will be used to determine participant financial eligibility for community-based services. This management information system is used for financial eligibility determinations for all DHHS programs, including all Medicaid categories and Food Stamps; required information is sent electronically to the MMIS. The MFP staff will access New Heights to determine the status of the individual’s financial eligibility for Medicaid and to confirm that the individual has been determined to be Medicaid eligible for at least a day at the time of transition. For all populations, cost sharing requirements are part of the eligibility discussions.

e. RE-ENROLLMENT PROCESS

Disruptions in project participation will be addressed in accordance with CMS guidance. A NHCP participant who is re-institutionalized for a period of time *greater than 30 days* is deemed disenrolled from the project. However, a disenrolled individual may be reconsidered for NHCP without needing to re-establish the 3-month institutional residency requirement. The nursing institution, case manager, family member or individual informs the NHCP program staff when a resident is ready to re-engage in the transition process. As long as the former participant meets Medicaid waiver eligibility criteria, he/she continues to be eligible for NCHP services at the enhanced federal matching rate. If a former participant remains in a qualified institution beyond 3 months and reenters the program he/she will be treated as a “new” NHCP participant.

A former participant may be referred to NHCP for re-enrollment in the program by any of the parties involved with the person’s care, including family member, case managers, and nursing facility staff. Once a referral is made, a clinical re-evaluation is conducted appropriate to the individual’s needs and a new service plan is developed. Special attention will be given to understanding why the individual was re-institutionalized and what safeguards will need to be in place to ensure that this does not happen again. Once the individual is found appropriate for HCBC by DHHS, an individualized Plan of Care is developed that addresses: (a) changes in the status of the NHCP participant and/or (b) any lack of necessary supports in the community that contributed to the person returning to a nursing facility.

f. PROCEDURES TO ENSURE THAT PROSPECTIVE PARTICIPANTS HAVE ADEQUATE INFORMATION

Information about NHCP will be provided to participants in a variety of formats. Through experience, the MFP staff has found while working with the bureaus and nursing facilities that written materials and presentations by only the NHCP program staff about NHCP do not provide prospective participants living in nursing homes with sufficient information. To remedy this, the NH MFP program now has a mechanism in which also an Adult Protective Services Social Worker, or Long Term Care Counselor who is available can meet individually with prospective participants to explain the program in detail, answer questions, assess needs, and address concerns. It is anticipated that this additional support will result in individuals having clearer and more realistic expectations about what is involved in moving back to the community. The additional information also can help individuals and their families to begin thinking about what supports they will need to live successfully in the community and what their preferences are regarding services; this can help to set the stage for the development of a successful transition plan.

Informational materials and participant forms are included as part of the Attachments Section of this document.

2. INFORMED CONSENT AND GUARDIANSHIP

a. PROCEDURES TO OBTAIN INFORMED CONSENT

CFI Waiver candidates: As the NHCP has developed as a program, additional personal contacts with nursing facility residents who are interested in returning to the community have been put in place. In addition to the initial planning meeting where a potential participant meets with BEAS

and nursing home facility staff, an Adult Services Social Worker or Long-Term Care Counselor can also meet individually with residents who are considering transitioning into the HCBC-CFI program. These personal meetings offer the opportunity for residents to discuss both their hopes and concerns about moving out of the nursing facility. Building in time for these candid conversations provides residents with a better understanding about the transition process and more realistic expectations about life in community. BEAS believes this will help individuals to be better emotionally prepared for making the transition and will reduce the likelihood that participants will return to the facility due to dissatisfaction with their community placement.

The Informed Decision Making Form/Risk Assessment & Back-Up Plan Development Form (see attachments) is also a tool that individuals will be encouraged to utilize and fill out (there is a provider and individual versions). This is a form that walks individuals and providers through all the areas that must be addressed when a transition is being considered. It allows individuals to consider needs, risks and explore available supports.

Once the decision is made to indeed proceed with a transition as a NHCP participant (after confirming that the individual meets eligibility) the individual or his or her guardian will have the opportunity to speak with the MFP staff, with the discharge planning staff, and ask questions. The individual (or representative) signs the consent form after feeling comfortable and the MFP staff signs off documenting they have explained the program.

ABD, DD, I.H.S Waiver programs: For those participants with acquired brain disorders and developmental disabilities who are served by the State's developmental services system, Area Agency staff provides this additional support as part of the transition planning process. The MFP staff work collaboratively with the area agencies and assist as needed.

Eligible Individuals for State Plan Behavioral Health Services (elder and youth):

- Potential participants diagnosed with a mental illness 65+ years old residing at NHH, facility staff will work with individuals and community case managers to discuss the NHCP program and review needed supports and services. The MFP staff will work with individuals and will be involved in transitional activities, support and outreach. The Behavioral Health transition specialist's time will work with this elder group population specifically to ensure adequate information regarding the MFP program, to coordinate the community supports, and ensure the Community Mental Health Center intake assessment is conducted. They will also assess resources to divert nursing home placement as appropriate and potential eligibility for the CFI waiver as a potential support. The NHCP staff will be conducting the consent activity.
- For children 21 years and under: The Behavioral Health Transition Specialist will be working closely with facility staff, families, community case managers, and state staff to provide information to parents and guardians regarding the NHCP program. Information presented will be tailored to the individual depending on age and development. For example the 17 year old may be perfectly capable of understanding the information presented, however, the 8 year old will need their parent and/or guardian present but may also want to be involved in understanding the presentation of the NHCP program information.

All individuals who are found eligible are provided with full information about the specific program they will receive services from and how the NHCP program will serve them. Those wishing to enroll in the program are asked to sign a consent form indicating that: 1) they have freely chosen to make this transition, 2) are aware of and understand the community transition process, 3) have full knowledge of the supports and services to be provided, and 4) have been informed of their rights and responsibilities as participants 5) have had their questions answered. If an individual has a legal representative (parent, guardian etc), the representative also is provided with this information and asked to sign a consent form. A sample of the consent form is included in the Attachments Section of this document.

DHHS will adhere to all applicable New Hampshire State laws concerning consent and guardianship. Although New Hampshire statute does not specifically refer to “informed consent,” it does define “informed judgment” as “a choice made by a person who has the ability to make such a choice, and who makes it voluntarily after all relevant information necessary to making the decision has been provided, and who understands that he is free to choose or refuse any alternative available and who clearly indicates or expresses the outcome of his choice.” (*New Hampshire RSA Chapter 464-A:2,XII*) Under New Hampshire law there is the presumption that the individual is capable of making an informed judgment unless he or she has been found legally incapacitated. A person who is legally incapacitated is defined as one who “has suffered, is suffering or is likely to suffer substantial harm due to an inability to provide for his personal needs for food, clothing, shelter, health or safety or to manage his property or financial affairs.” Minors, unless legally emancipated, will have parents or guardians involved.

b. ENSURING GUARDIANS HAVE ONGOING CONTACT WITH THE INDIVIDUAL

Any competent person who agrees to serve as an individual’s guardian may be appointed to do so. Agencies and institutions providing care and custody to a legally incapacitated individual are prohibited from becoming that person’s guardian; however, if there is no one else available to serve, an employee of the agency or institution may be appointed guardian if that employee is *not* providing direct care to the individual and the court finds that the appointment presents no risk of a conflict of interest. (*NH RSA Chapter 464-A:10*) Guardians of any individual who wishes to enroll in the NHCP Project will sign a consent form indicating: 1) that the guardian consents to the individual’s choice to participate, 2) is aware of and understands the community transition process, 3) has full knowledge of the supports and services to be provided, and 4) has been informed of their rights and responsibilities. Case Managers are aware of the participants’ level of communication with their guardians; if a guardian appears not to be fulfilling his or her responsibilities or if the participant expresses a desire for better communication with the guardian, the Case Manager will speak with the guardian and will document any concerns.

New Hampshire’s Guardianship laws, RSA Chapter 464-A, define the purpose of a guardianship (464-A:1) as follows:

464-A:1 Purpose. – It is the purpose of this chapter to promote and protect the well being of the proposed ward in involuntarily imposed protective proceedings. This chapter is designed to provide procedural and substantive safeguards for civil liberties and property

rights of a proposed ward or an individual already under guardianship powers. It is the further purpose of this chapter to encourage the development of maximum self-reliance in the individual; to encourage rehabilitative care, rather than custodial care for incapacitated individuals; and to impose protective orders only to the extent necessitated by the individual's functional limitations.

It is noteworthy that one of the stated purposes of the New Hampshire Guardianship Law is “to encourage the development of maximum self-reliance in the individual.” Guardians of project participants will be expected to follow the “Ethics and Standards for Guardians” developed by the National Guardianship Association. As a project requirement, Adult Service Social Workers will engage in a minimum of one face-to-face meeting with the participant and his or her guardian prior to any transition occurring. This meeting will help to ensure that the resident and guardian are well informed about the project and will provide additional assessment information. After the individual has left the nursing facility, the Social Worker will follow up with both the participant and his/her legal guardian to ensure that the individual has made a successful transition to community living. Adult Services Social Workers will document their contacts with participants and guardians and, wherever appropriate, share this information with the individual’s Case Manager. The Waiver Case Manager will assure that ongoing contact is maintained with the guardian following the transition and, if needed, will facilitate meetings between the participant and guardian.

c. REPORTING CRITICAL INCIDENTS AND COMPLAINTS

During the transition period, the NHCP program staff, care coordinator, discharge planner or the individual’s Transition Case Manager will fully inform NHCP participants and their guardians about their rights and responsibilities in the project. The tCM, NHCP staff, discharge planner or care coordinator also will explain to participants and their guardians the procedure for reporting complaints or critical incidents. Once the participant has moved into the community, the community Case Manager will be responsible for fully informing participants and their guardians about their rights and for advising them about how to report any complaints or critical incidents. Detailed information regarding the reporting of critical incidents and complaints is included in Consumer Support Section of the Operational Protocol and Section Q under *Critical Incident Protocols and monitoring*.

3. OUTREACH, MARKETING, AND EDUCATION

Promotional information and materials were developed during the first year of the project for the Community Passport program. In conducting outreach for NHCP, the bureaus also distribute standard materials about the State’s waiver programs and State Plan Services. This will be done to clarify that NHCP is not a stand-alone program, but rather a tool for assisting individuals who are making the transition from a nursing facility to an existing waiver program or specific State Plan Behavioral Health Services that will provide ongoing support for them in the community. The Marketing Protocol Stakeholder Workgroup in 2008 recommended that the project be titled New Hampshire Community Passport, rather than retaining the Money Follows the Person title that was initially used for the project. The project’s Operational Protocol Steering Committee

approved this recommendation. Both stakeholder groups agreed that the original name would be both misleading and confusing to potential participants and to their representatives and/or families. NH's ADRC, Service-Link" has also been very helpful in distributing materials, announcing presentations, as well as referring and guiding individuals to the program. This will be further reinforced with the new two year grant awarded in September to strengthen NH's ADRC and roll out the MDS Section Q initiative and work conducted under this new grant funded initiative.

The NHCP informational materials are targeted to:

- Potential Participants
- Family Members
- Service Providers
- Families of Children of HCBC Services
- Hospital and Rehabilitation Hospital Discharge Planners
- Outreach to Elder Wrap Around Teams
- The Single ICF-MR in New Hampshire
- The Single IMD in New Hampshire

Now that NH plans to offer the MFP program to other eligible populations, NH has already met to begin revising the informational brochures, and other outreach materials once this OP is approved to reflect these changes. Links on the BBH website will be pursued. Meetings with the University of New Hampshire were conducted to gain assistance with the updating of these materials. The new materials, once developed and approved, will be posted on the NHCP website.

a. OUTREACH TO NURSING FACILITIES

History of Outreach & Education Efforts: At the start of the project for NH in late 2007, BEAS anticipated that most transitions would involve seniors and individuals with physical disabilities who enroll in the HCBC-CFI program, hence outreach efforts were concentrated on the nursing facilities serving this population. Through a contract in year two of the project, a collaborative whose members included representatives from Granite State Independent Living (GSIL), an independent living agency; the association of Medicaid-enrolled Case Managers, the New Hampshire Independent Case Managers Association (NHICMA); and the association that represents most of New Hampshire's private nursing homes, the New Hampshire Health Care Association (NHHCA), held outreach meetings at several nursing facilities throughout the state. The collaborative also introduced the NHCP at the annual convention of the state association of nursing facilities. In May 2009, the New Hampshire Office of the Long Term Care Ombudsman (OLTCO) invited nursing facilities to a meeting with BEAS, and representatives from more than a dozen of the 79 facilities enrolled in the Medicaid Program. The meeting focused on discussion of the discharge planning process and lessons learned during the first year of outreach. Those attending expressed a great deal of interest in collaborating with BEAS to support residents in making successful transitions to community settings. BEAS has subsequently mailed information to all nursing and rehabilitation facilities.

2011 and forward: With these current OP revisions and the Return to Community project funded by the Section C of the AoA/CMS grant awarded in 2010, the facilities now receive this newer information, the new Returning to the Community brochure and training as a result of the protocol now implemented and created by stakeholders. As it currently stands the NHCP Project Director and Transition Coordinator make regular contact with all nursing facilities on an on-going basis and will be available to make presentations to facility staff, to community agencies, however will be looking to the Ombudsman to assist with MDS 3.0 Section Q information to the Resident and Consumer Councils.

Eligible State Plan Behavioral Health Plan Services Populations: Now that there are other eligible populations included in this Operational Protocol so that NH may take full advantage of the extended program opportunity, outreach and education to all the nursing facilities named will be conducted. The new populations utilize different nursing institutions, community resources, and staff will need outreach and education conducted by NHCP staff. These efforts will continue to be conducted in existing nursing institutions. This includes working in partnership with facility discharge planners and community agencies. MFP Staff and their partners (ServiceLink, Ombudsman, Independent Living Center etc) will provide detailed written information about the project to facility discharge planners and will follow up with personal contacts to ensure that they have the information they need to assist interested residents in applying to the NHCP. NHCP staff will continue to meet with nursing institution consumer councils in qualified institutions to present information about NHCP, distribute informational materials, and be available to answer questions. Any individual who expresses an interest in moving out of the qualified nursing facility, is on Medicaid, and has met the 90 day institutional stay requirement and is eligible for one of the waivers or the named State Plan services will be referred to the New Hampshire Community Passport Project to explore all options for community supports and services. In hospitals and rehabilitation centers, MFP staff will work with the social service, nursing and discharge staff to assure they have a thorough understanding of NHCP. To assess each audience's understanding of the information presented about NHCP, the project will follow up presentations with a post-meeting survey.

The MDS 3.0 Section Q is now a tool for a variety of individuals including, naturally, the NHCP program, discharge planners, and OLTCO to identify those residents that desire an alternative care setting in the community. The NHCP receives referrals from a variety of sources and will continue to rely on these networks.

b. COLLABORATION WITH OLTCO, SERVICELINK, AND AREA AGENCIES

BEAS and NHCP staffs are collaborating with the State's Office of Long Term Care , (OLTCO) to help inform individuals residing in nursing facilities about NHCP. Established under New Hampshire statute, RSA 161F:10, OLTCO is guaranteed access to all licensed or certified facilities that serve seniors. OLTCO may act on behalf of any nursing facility resident, with a special focus on seniors. New Hampshire OLTCO staff and volunteers have regular and ongoing contact with nursing facilities statewide, and are able to identify residents who may be interested in moving back to the community. OLTCO will review MDS 3.0 Section Q, assist residents in making their interests known to facility discharge planners and will offer support during the transition planning process.

he ServiceLink Resource Centers (SLRC), BEAS has a well established and significant, statewide network for outreach and education. ServiceLink works in partnership with BEAS and local communities. With thirteen sites throughout the New Hampshire, ServiceLink is a valued community based resource for seniors, adults with disabilities, and their families. The SLRCs provide information, outreach, resource development, and education to participants, providers, and the general public. SLRCs have recently expanded their service capacity adding staff to provide long-term support counseling and outreach to the disability community. SLRC now integrates existing New Hampshire DHHS functions providing individuals and families with easier access and support in completing the clinical and financial eligibility process for Medicaid benefits, including HCBC-CFI and nursing facility care. Individuals in need of services and providers are now able to contact one office to determine what options and services are available to them and to check on the status of their applications. BEAS will provide education and training about NHCP to ServiceLink's Long-term Care Specialists and solicit their support in promoting this project.

New Hampshire's long-established statewide network of Area Agencies will distribute information about the project and be responsible for all outreach efforts to those individuals and families who will be served through the HCBC-ABD, DD, and IHS waiver programs. They will receive referrals from any source and will work with BEAS and the ServiceLink agencies to outreach to qualified institutions. Area Agencies also will distribute outreach materials to families and individuals who might benefit from NHCP.

Intake & Triage Ombudsman Liason: A full-time, three year 100% administrative federal match position was formally requested to work on the Ombudsman team as a Long-Term Care Counselor to not only work with the MFP eligible participants but to conduct this work to assist ServiceLink (NH's ADRC) with building, strengthening state and stakeholder established protocols and referral pathways for nursing facilities to follow when a Section Q referral is indicated. The role of the Ombudsman is positioned perfectly to conduct this work. The Regional LTC Ombudsmen will communicate with all resident and family council presidents and request permission to present an overview of MDS 3.0 Section Q to either the resident and/or family councils. This is an important feature of this position to get information out to consumers living in institutions that they have a right to know that Section Q not only exists, but that they should expect needed referrals in order to make a transition occur to go out on their behalf within a reasonable timeframe.

As the NH program as progressively grown each year it has become apparent that there is a need for an MFP intake and triage point person. This position will assist with intake and triage tasks a percentage of the time, and be trained as a back up interviewer for the QOL interviews. This position will also work to conduct training needs focus groups, provide training and assistance to facility social workers and community case management agencies in regards to person centered planning, conduct technical assistance as needed to facilities around difficult or high acute cases, assist facilities and ADRCs with section Q referrals or identified individuals via the MDS tool by LTC RN supervisor or NH MFP Director, and assist with liasoning between the Ombudsman's office and the MFP Transition Coordinators.

Regional LTC Ombudsmen will continue to make referrals in general to the MFP program and may also assist the resident in overcoming any barriers that are identified in the person centered planning process that would interfere with the potential community move and would support any resident identified as desiring to move back into the community. They play a significant role in advocacy and ensuring the resident has the right to hear about their community living options and a formal liason continues to be needed between the MFP program and the LTC Ombudsman office. Once an MFP transition is in effect that the Ombudsman were involved in, any of the Regional LTC Ombudsmans may visit the former resident in their new community residence to assure that all services and supports are in place before closing the case.

The Ombudsman team will be trained on the MDS 3.0 Section Q internal state referral protocol and tracking materials. This work is vital to educating the individuals living in institutions about this new change, how it impacts them, and what to expect. It is vital in supporting the two year work being rolled out as a result of the ADRC grant Section C work recently awarded (this will make a full circle by educating the consumers directly about MDS 3.0 Section Q), and it is anticipated it will enhance referrals to MFP and the use of the created protocols by nursing facilities that NH is planning on developing and implementing over the two year time frame.

c. EDUCATION AND OUTREACH STRATEGIES

BEAS is working statewide to support qualified individuals to make successful transitions to community living. New Hampshire's southern tier is by far the most populous region of the state and has the greatest need, for this reason the majority of NHCP outreach efforts are concentrated in Merrimack and Hillsborough Counties.

As first identified by DHHS and stakeholders when the NHCP program began, the following education and outreach strategies have been implemented and will continue to be updated:

- BEAS will utilize the expertise of the DHHS Public Information Office to create printed material that effectively conveys information about the project. However, recently UNH has been involved in discussions to decrease costs by utilizing expert students majoring in the field of graphic arts or advertising to create needed materials.
- BEAS will work with an already established group of stakeholders to aggressively promote NHCP particularly the nursing home institutions where the majority of the participants transition. DHHS has regular Technical Advisory Council meetings with nursing facility administrators and county government officials and will keep them informed about the project and ask for their support in sharing project information with nursing facility staff.
- BEAS will communicate directly with hospital and nursing facility Discharge Planners to provide information about the services available through NHCP. To date, facilities have been very welcoming and interested in learning how the project can assist them in supporting residents to make the transition to community life. The NHCP Project Director, the Transitional Coordinator along with BEAS, will personally visit each facility to promote use of NHCP. In situations where facilities have identified barriers to discharging a resident, NHCP will work with Discharge Planners to help them with problem solving and to ensure that all community options for support have been explored. This personal outreach not only

increases staff understanding of NHCP, it is key to building strong long-term relationships between DHHS and nursing facilities.

- NHCP will meet with Resident Councils at nursing facilities to explain the project, talk about available community supports and services, and answer residents' questions about the transition process. The project will follow-up with those individuals who are interested in further exploring the opportunity to move back to the community. Referrals to appropriate resources will be made as needed.
- NHCP will provide a concise and clear diagram of the transition process that can be used by the participant and members of the planning team as they proceed through the transition process when needed.
- BEAS will use a consistent process to address all facility-to-community transitions, regardless of whether or not NHCP funds are involved. This process will remain in place after the project is completed (this process has been outlined and is currently in place for the CFI waiver transition process)
- BEAS regularly will provide information and project updates about NHCP to nursing facility administrators and their associations at DHHS meetings and forums.
- NHCP will provide New Hampshire physicians, nurses, and hospital personnel written materials about the project.
- BEAS enlists the support of the New Hampshire Office of Long Term Care Ombudsman (OLTCO) staff and volunteers and work in partnership with them to inform facility residents about NHCP. OLTCO routinely has direct contact with nursing facility residents and their families. They are a vital part of the outreach efforts that NH has embraced however, as mentioned, they have recently struggled to have staffing to conduct this task of promoting the NHCP. With the roll out of MDS 3.0 Section Q NH sees them needed more than ever to advocate and educate in the facilities. OLTCO experienced a position cut over the past year and this was a deficit area felt by the NHCP. Their presence in nursing homes and advocating for the use of community alternatives is a resource that NHCP values. With the roll out of the MDS 3.0 Section Q and desiring more NHCP transitions, this OP requested the 1 FTE for this reason.
- BEAS will include the Adult Services Social Workers in the pre-discharge preparation process and risk assessment and barrier identification. These workers are familiar with community services and supports and can help facility residents understand and make realistic plans for their future.
- BEAS will ensure that all DHHS program staff are knowledgeable about NHCP and regularly will provide them with information and updates about the project.
- BEAS will inform State and Regional Housing Authorities about the project.
- BEAS will maintain updated information about NHCP on the DHHS website.
- NHCP reviewed information from the Minimum Data Set (MDS) form completed by facility staff. Responses to the MDS question "Do you want to transition to the community?" has helped inform the work of the project. NHCP staff will work collaboratively and in tandem with the individuals working on the State's rollout of the MDS 3.0 Section Q in an effort to follow up on referrals. There is a large effort underway with multiple community partners with the recent CMS/AOA award (see attached at the end of this document) to maximize and fold this work in with the current NH MFP program and efforts.

- NHCP will utilize information from the BEAS Medical Eligibility Determination (MED) assessment that is used to evaluate every long-term care applicant. This will ensure that participant's medical needs are addressed in the care planning process.
- NHCP will educate and coordinate efforts with the Elder WrapAround Teams as appropriate.
- BEAS will educate and work closely with Area Agencies to ensure that individuals with developmental disabilities and persons with acquired brain disorders and their families are informed about NHCP.
- NHCP will educate and work with NHH and New Hampshire's Community Mental Health Centers to ensure that there is consistent support for those participants who need mental health services. With the addition of the behavioral health population this effort will take on new formal outreach strategy to get to all the sites now included.
- BEAS will provide training and information to ServiceLink Resource Center staff to ensure that family members of facility residents who seek services through SLRC are informed about the project.

NHCP will disseminate information about the project to the following organizations and programs and will encourage them to share NHCP information with individuals and families who may be interested in transition:

- State and District Offices (DHHS, BEAS, BBH, BDS)
- ServiceLink Resource Centers
- Area Agencies
- Community Mental Health Centers
- Community Action Programs
- Meals on Wheels
- Senior Centers
- Nursing Homes (by Ombudsman volunteers/staff)
- Hospitals (by Social Workers)
- Case Management Agencies

BBH eligible youth and children: NHCP staff or facility staff along with families, state staff, community mental health center staff will work towards identifying eligible individuals in qualified psychiatric institutions named in this protocol. Part of the challenge NH faces will be building appropriate community supports and ensuring the supports are appropriate, are able to meet the needs of the children and available and in place upon discharge. Part of the community care infrastructure development initiative and planning NH plans to tackle is the careful matching of children with high needs to appropriate high level supports as well as understanding how to use and even leverage the collective resources available in the collective system. This will be new work for those involved in identifying and transitioning the pediatric population at this level of care. This is important and needed work in NH. A full-time dedicated behavioral health care transition coordinator is being requested.

Other Challenges: NH has faced challenges in general due to the fact that there has not been a dedicated individual to conduct outreach & marketing work specifically. No one is spending a large percentage of his or her time in the field at facilities or in the ADRC offices. In July of 2010 NH decided to apply for the AoA and CMS grant funding offered to strengthen these goals

and was awarded. NH intends to have one full-time individual through that opportunity educating facilities about the new MDS 3.0 Section Q. See Page 86 for details on the AoA/CMS Nursing Home Transition Grant Section C Addendum, which strengthens the ServiceLink work with NH's MFP program. This individual will be working closely with NH's ADRC, the Long-Term Care Counselors, and communities to ensure that individuals living in nursing facilities have the resources they need to transition.

d. ELECTRONIC MEDIA

Assistance in utilizing electronic communications will continue to be provided as needed through the DHHS Communication Access Coordinator. For individuals with sight impairments, electronic formats with magnified print and images and audio versions of NHCP materials and related information are available on State of New Hampshire website: <http://www.dhhs.state.nh.us/DHHS/DCBCS/nhcp.htm>. The website also includes personal stories from NHCP participants, families, and providers. A NHCP brochure can be downloaded from the DHHS website.

NHCP outreach and training materials are included in the Attachments Section of this document. As mentioned, there is an active effort currently to update the materials.

4. STAKEHOLDER INVOLVEMENT

For several years, the Department of Health and Human Services, Division of Community Based Care Services (DCBCS) has been bringing together stakeholders to work on Long-Term Care Systems Transformation in the state. (System transformation is the term used in New Hampshire for rebalancing long-term care.) This ongoing public process has involved a full spectrum of partners, including providers, advocates, policy makers, State administrators, and individuals and their families. With these partners New Hampshire is working to ensure that all individuals who are served through DCBCS programs receive quality care and are supported to be fully included as valued members of their communities.

When CMS awarded New Hampshire the Systems Transformation Grant in 2006, the State engaged in a nine-month strategic planning process that included over 70 individuals representing a broad range of interests across all disability groups. Those who participated in the planning process included recipients of services, family members, community members, State agency staff, community providers, county officials, nursing home administrators, legislators, and health care workers. The report was finalized and published in October of 2010. For the NH Systems Transformation Final Evaluation Report please go to: <http://realchoicenh.org/products.html>

In designing the New Hampshire Money Follows the Person (NH MFP) Rebalancing Demonstration DCBCS again relied on the expertise and assistance of a wide array of stakeholders. A workgroup with representation from the Bureau of Elderly and Adult Services (BEAS), including the BEAS Medical Director; Bureau of Behavioral Health (BBH); Bureau of Developmental Services (BDS); the Institute on Disability at UNH, Granite State Independent

Living (GSIL); and Community Mental Health developed the outline for the initial grant submission.

As part of the planning process for the grant, workgroup members made presentations to a significant number of consumer and advocacy groups and sought their input on this project. Those consulted included members of the Medical Care Advisory Council, the Elder Rights Coalition, the Real Choice Consumer Advisory Council, the ServiceLink Resource Center State Advisory Council, the Mental Health and Aging Consumer Advisory Council, the State Committee on Aging, the Coalition on Substance Abuse/Mental Health and Aging, and the District 1 Health Planning Council. In all, over 90 advocates and service recipients took part in planning meetings and shared their ideas on how to best address the needs of New Hampshire's more vulnerable citizens. Feedback from these stakeholders was incorporated into the final project design.

With the preliminary approval of the project proposal, stakeholder involvement has increased and additional stakeholders, including a variety of community partners, are now actively involved with NHCP. An Operational Protocol Steering Committee has been formed; using a workgroup structure, the Committee has been instrumental in developing this Operational Protocol. Service providers, consumers, family members, and advocates serve on the Steering Committee. Organizations represented included:

- DHHS Bureaus of Developmental Services, Behavioral Health, and Elderly and Adult Services
- ServiceLink Resource Center Network
- Institute on Disability/UNH
- Granite State Independent Living
- HCBC Case Management Agencies
- State Committee on Aging
- Legal Advocates
- New Hampshire Housing Finance Authority
- New Hampshire Home Care Association
- Personal Care Service Provider Agencies
- New Hampshire County Nursing Home Association.
- New Hampshire Health Care Association

In creating the original Operational Protocol, the Steering Committee actively sought input from individuals receiving services and their family members. Many of those working on the Steering Committee have family members who are, or have in the past, received services similar to the HCBC Waiver Services. The following efforts were made to solicit additional input from service recipients and their family members:

- Representatives from the Operational Protocol Steering Committee met with the Real Choice Advisory Council on Thursday, May 25, 2009 to seek input on developing the Operational Protocol. The Council includes individuals receiving services, family members, providers, and community representatives. Four Steering Committee members serve on this Council.

- The Steering Committee invited the New Hampshire Mental Health and Aging Consumer Advisory Council to provide feedback on the protocol elements. The facilitator for this council is a member of the Operational Protocol Steering Committee and was involved in the State's previous Nursing Home Transition Grant Project.
- At the June 14, 2009 Housing Conference on NHCP workshop participants were asked to provide input for the Operational Protocol. The audience included a mix of service recipients and families of those with long-term care needs, as well as representatives from Housing Authorities and other community providers.
 - On June 22, 2009, the New Hampshire Medicare Benefits Coalition was given a draft of the Operational Protocol and asked to seek input from its members. The purpose of the Coalition is to share and disseminate information that is relevant to Medicare recipients in New Hampshire. The Coalition is comprised of a variety of provider organizations that are directly involved with potential NHCP participants and their families. Coalition members include: New Hampshire AARP, the Office of Long Term Care Ombudsman, New Hampshire Senior Center Association, Manchester Housing Authority, Catholic Charities, New Hampshire Medicaid Office, Granite State Independent Living, CMS Regional Office, and the Social Security Administration District Manager.
 - On July 17, 2009, the ServiceLink Resource Center Long Term Support Counselors were presented with the most current MFP Rebalancing Demonstration implementation information. The counselors, who work directly with service recipients, their caregivers, and their families, were asked for input and provided valuable feedback.
 - Wrote letter to all NH Nursing Facilities on August 24th, 2009, about NH CP and enclosed the educational hand-out summarizing the May 2009 meeting regarding transfers and discharges, from the OLTCO.

The Real Choice Advisory Council serves as the consumer advisory body for this grant. The Council has cross disability and statewide representation; most importantly individuals who receive services and family members are strongly represented on the Council. With a long history of working on rebalancing long-term care and a commitment to improving New Hampshire's home and community based services, the Real Choice Advisory Council will be an invaluable resource to the project. In addition to the Council, NHCP also will seek input from community providers, Area Committees On Aging, Granite State Independent Living, and Caregiver Respite Grant recipients. The feedback and recommendations received from these groups will help shape decisions pertaining to service development and outreach plans.

Recently and specifically, in the summer of 2010, the recently developed Informed Decision Making tool developed to guide conversations regarding community life for the program after consultation with Suzanne Crisp (see page 33) is making a consumer tour to a variety of consumer groups for their feedback. They include the following groups:

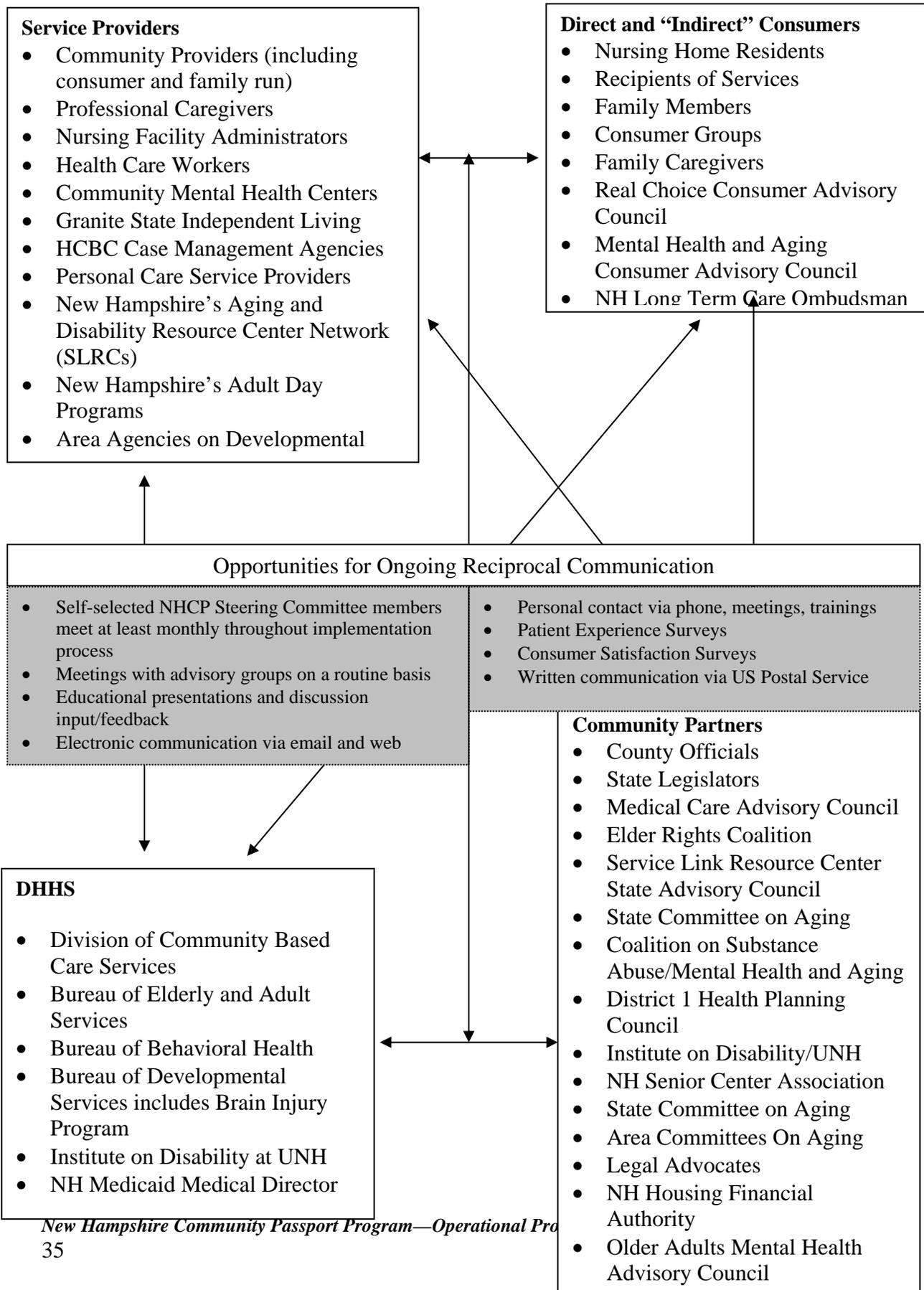
1. The NH resident councils. This group collectively is called Senior Aid NH. They meet by conference call. The program would first talk about Community Passport and then about this particular process. NHCP spoke with the Pleasant View Nursing Home and Rehabilitation Resident Council on October 5th, 2010 to present and illicit resident feedback. The tool presented was geared towards a provider perspective, as an example, the discharge planner would conduct with the individual. The resident council wanted a "Self-Assessment Tool" geared in a way that individuals contemplating transition would be able to use themselves. This feedback will be utilized and incorporated.

2. GSIL has a PCA advisory group. Michelle Winchester from UNH Law presented the NHCP document at that meeting and provided additional resident feedback.
3. Institute on Disability spoke with RC advisory council meeting.
4. Past participants who have gone through the process will be asked to get their input.

These sessions and feedback receive will be used to provide the tool and protocol some additional insight.

In addition, with the 2010 announcement of MFP extending for five additional years, NH has been working very hard with stakeholders, and program administrators to explore how MFP can work with more NH participants desiring to live in a community setting and help individuals transition. Three populations were clearly identified; (1) the children and youth populations and (2) the 65 years and older population in qualified psychiatric institutions diagnosed with mental illness (3) the OMBP State Plan Medical Services to chronically medically ill adult and youth populations that are complicated and not eligible for waiver programs discharging more commonly from pediatric hospitals treated out of state (i.e.: Children's Hospital Boston). This OP reflects NH's interest in offering these population's additional resources through the MFP program. The MFP expansion particularly to the young psychiatric population, offers a rare opportunity to expand and strengthen an active fledgling state initiative towards creating better services for a previously unmet need. This OP is addressing two of these identified populations and will work towards the goal of including the third population at a later time.

Flow Chart: Stakeholder Involvement in NHCP Rebalancing Demonstration Project



5. BENEFITS AND SERVICES

a. SERVICE DELIVERY MECHANISM

All services provided through New Hampshire's waiver programs are paid for through a fee for service mechanism. Participants in the ABD, DD, and IHS waiver programs may access a self-directed model of service provision. A self-directed model is currently being developed for use in the HCBC-CFI program. State Plan Services are in place for individuals diagnosed with mental illnesses and are available for those eligible to receive those specific services through the Bureau of Behavioral Health.

The Division of Community Based Care Services (DCBCS), an organizational unit within the Medicaid Agency, which contains the three Bureaus that will participate in this project: the Bureau of Behavioral Health (BBH), the Bureau of Developmental Services (BDS) and the Bureau of Elderly and Adult Services (BEAS). BEAS will oversee all administration activity for the NHCP Project. The NHCP Project Director, under the direction of DCBCS, will work collaboratively regarding activities the Area Agencies, CFI case Management Agencies, the discharge faculties, and Community Mental Health Centers engage in on behalf of NHCP participants, including screening, eligibility determination, assistance in transitioning to the community, transitional case management assignment and ongoing case management. DCBCS will retain authority over eligibility and determining which expenses qualify for enhanced federal match.

Bureau of Developmental Services - ABD, DD, and IHS waivers: Services will be coordinated through the State's ten Area Agencies for Developmental Services and through licensed case management agencies for elderly and individuals with physical disabilities. The Area Agencies provide service coordination (BDS' term for case management services) and either directly provide or arrange for all other home and community based services. The Area Agencies and the case management agencies are enrolled Medicaid providers.

Bureau of Behavioral Health – State Plan Services: The State Plan Services for individuals of all ages with mental health diagnosis are coordinated by the inpatient facility along with one of The State's ten Community Mental Health Centers depending on the transition community (or "region"). There, case managers are assigned to coordinate the care of those individuals and create Individual Treatment Plans to address the service needs of those participating. Once in the community the State Rule mandates contact and assessments as such:

He-M 426.15 Case Management Services

(a) Case management shall:

(3) Consist of at least one direct contact, either face-to-face or by telephone, with the client or guardian within every 90 days;

At these meetings services will be evaluated and if revisions are required then the plan will reflect this.

Bureau of Elderly and Adult Service - CFI Waiver (Elderly and Adult): For persons eligible for the CFI waiver, services are coordinated through independent case management agencies. Case Managers engage in person centered planning to develop the participant's service plan, arrange for services, and monitor service implementation. Services are provided by a variety of community-based agencies; for example, home health agencies, visiting nurses, Community Action Programs, adult group day programs, and independent living centers.

b. SERVICE PACKAGE

The service packages available to an individual through the waiver programs will vary by waiver just as the State Plan eligible population will also vary by individual need. The BDS HCBC-DD and HCBC-ABD programs provide for customized service packages that allow individuals to be served in a home or small group setting and receive community based services that include: personal care, day services, and supported employment. The In Home Support program (HIS) serves families who have children with significant disabilities and allows these families to choose and direct their own services. These programs have strong consumer and family involvement in decisions concerning program design, implementation, and oversight.

The HCBC-CFI program provides a more medically oriented, individualized service package and offers a variety of residential options including congregate and other supported housing, adult family care, and residential care in licensed facilities.

The State Plan Services for people diagnosed with a mental illness provides for individualized treatment planning ranging from needed medication services alone to Assertive Case management Teams (ACT) which is wrap around, full service provided to those individuals who are in need of intensive community based services. There are residential options specific to meet the needs of individuals diagnosed with severe mental illness, while limited, are available. The care plans are completely individualized and varies depending on individual service needs.

The chart below identifies the services that are available through each of the different waivers. The 1915 (c) Waivers and the State Plan will continue to provide services to NHCP participants after the demonstration project is finished. Program participants also will receive assistance from their Waiver or Behavioral Health Case Manager in accessing other appropriate community based services and supports for which they may qualify.

QUALIFIED WAIVER SERVICES & STATE PLAN BEHAVIORAL HEALTH SERVICES
Enhanced Match

Population	Elderly	DD	Individuals with Physical Disabilities	Other	MI Elderly (65+)	MI Children (21 and younger)
Qualified Program	HCBC-CFI, 65 years and older	HCBC-DD	HCBC-CFI Under 65 years	HCBC-ABD, HCBC-IHS	Elder Program CMHC	NH STARR
Adult Family Care	X	X	X	X		
Adult In-Home Care	X		X			
Adult Medical Day Services	X		X			
Assistive Technology	X	X	X	X		
Assisted Living/Residential Care (with 4 or fewer residents)	X	X	X		X	X
Community Support & Transition Services	X	X	X	X	X	X
Companion		X		X		
Congregate Care (Supportive Living) Services	X		X			
Consolidated Services	X	X	X	X		
Day Habilitation		X		X		
Environmental Accessibility Adaptations	X	X	X	X		
Family Support/Service Coordination		X		X	X	X
Fiscal/Employer Agent Services		X ¹		X		
Functional Supports		X		X	X	X
Home Delivered Meals	X		X			
Home Health Aide Services	X		X			
Homemaker Services	X		X			
Non-Medical Transportation		X		X		
Personal Care or Enhanced Personal Care Services	X	X	X	X		
Emergency Response Services	X	X	X	X	X	X
Prevocational Services		X		X		X
Qualified Outpatient and Home and Community-Based State Plan Services	X	X	X	X	X	X
Respite Care Services	X	X	X	X		

¹ Available as an embedded service within another waiver service² Purchases are made as necessary to supplement the participant’s furnishings and household items. These purchases are limited to a bed, bedside tabl, dresser, dining table plus two chairs, couch and end table, television and stand/table, bed linens and towels, kitchen and dining ware, and other basic household items. A washer and dryer also be may purchased if there is space in the participant’s new home and if this purchase would assist with the participant’s ability to provide self-care or assist others to provide needed care.

QUALIFIED WAIVER SERVICES & STATE PLAN BEHAVIORAL HEALTH SERVICES

Enhanced Match

Population	Elderly	DD	Individuals with Physical Disabilities	Other	MI Elderly (65+)	MI Children (21 and younger)
Qualified Program	HCBC-CFI, 65 years and older	HCBC-DD	HCBC-CFI Under 65 years	HCBC-ABD, HCBC-IHS	Elder Program CMHC	NH STARR
Skilled Nursing Services	X	X	X	X		
Specialized Medical Equipment	X	X	X	X		
Targeted Case Management		X		X	X	X
Training to Unpaid Caregivers		X				X
Vehicle Modifications		X		X		
Rehabilitative Services					X	X
Behavioral Health Services					X	X

DEMONSTRATION SERVICES

Enhanced Match

Population	Elderly	DD	Individuals with Physical Disabilities	Other	MI Elderly (65+)	MI Children (21 and younger)
Qualified Program	HCBC-CFI, 65 years and older	HCBC-DD	HCBC-ECI Under 65 years	HCBC-ABD, HCBC-HIS	Elder Program CMHC	NH STARR
Certified Services Animals and Related Training for Owners	X		X			
Health and Safety Assurances	X		X			
Home Technology	X		X			
Independent Living Skills	X		X			
Intensive Home Cleaning	X		X			
Necessary Home Purchases ²	X		X		*	*
Pest Eradication	X		X			
Products for the Maintenance of Health and Hygiene (i.e. an adjustable shower head)	X		X			
Security Deposits	X		X		*	
Telehealth Monitoring Equipment	X		X			

² Purchases are made as necessary to supplement the participant’s furnishings and household items. These purchases are limited to a bed, bedside tabl, dresser, dining table plus two chairs, couch and end table, television and stand/table, bed linens and towels, kitchen and dining ware, and other basic household items. A washer and dryer also be may purchased if there is space in the participant’s new home and if this purchase would assist with the participant’s ability to provide self-care or assist others to provide needed care.

Utility Connection Payments	X		X			
Vehicle Modifications	X		X			
Medication Bridge to Avoid Interruption in Medications	X		X			
Supportive Services to Facilitate Move ³	X		X		*	*

¹ Purchases are made as necessary to supplement the participant’s furnishings and household items. These purchases are limited to a bed, bedside table, dresser, dining table plus two chairs, couch (may opt for loveseat or lift chair due to need and space) and end table, television and stand/table, bed linens and towels, kitchen and dining ware, and other basic household items. A washer and dryer also be may purchased if there is space in the participant’s new home and if this purchase would assist with the participant’s ability to provide self-care or assist others to provide needed care.

²These services are one-time expenses (i.e., a moving van) that enable the participant to move into his or her new home. These resources may be used to help family member(s) or friend(s) with expenses (such as gasoline) that are incurred to help the participant move into to his/her new home.

³ These services are one-time expenses that facilitate maintenance of Community Living and if not covered would risk reinstitutionalization (any covered transition cost or unanticipated cost meeting that criteria after the initial move not otherwise covered or duplicated by another service or benefit).

*=state is currently discussing possible funding

Currently there is no wait list for the HCBC-CFI waiver. In 2007 the New Hampshire Legislature passed SB 138, which mandated full funding for the ABD and DD waitlists and called for the waitlist for the ABD and DD program to be no longer than 90 days by the year 2010. BDS has been working with the legislature and Area Agencies to meet this goal and there has been a decrease in the waiting time for services. In July 2009 funding was provided to eliminate the ABD waitlist and this goal has been met, there is not a waitlist at this time. While waiting for capacity to open in the DD or ABD waiver programs, Area Agencies identify the appropriate community based services and supports to ensure that these will be in place when an individual enrolls in the waiver program.

c. BILLABLE UNITS AND RATES FOR DEMONSTRATION & SUPPLEMENTAL SERVICES

Billable units and rates to be paid for Home and Community Based demonstration and supplemental services are included in the Attachments Section.

6. CONSUMER SUPPORTS

a. ACCESSING SERVICES

NHCP participants may access assistance and supports in a variety of ways. The process for accessing services will vary depending upon whether the individual is served through the HCBC-CFI, HCBC-DD, HCBC-ABD, HCBC-IHS waiver programs or State Plan Behavioral Health

³ These services are one-time expenses (i.e., a moving van) that enable the participant to move into his or her new home. These resources may be used to help family member(s) or friend(s) with expenses (such as gasoline) that are incurred to help the participant move into to his/her new home.

Services they are deemed eligible for. Typically, individuals will access services and supports through:

- 1) Area Agencies
- 2) Community Mental Health Center (CMHC's) staff
- 3) Private Non-Profit Case Management Agencies
- 4) Facility Discharge Planners
- 5) BEAS: Long Term Care and Adult Protective Program Staff
- 6) Transitional Case Managers
- 7) Office of Long Term Care Ombudsman
- 8) Assigned Transition Case Manager
- 9) ServiceLink Network

- 10) Families and friends or other informal supports

Participants who are served by the DD, ABD, and IHS waiver programs receive case management services from Area Agency Service Coordinators. Qualifications for Service Coordinators serving these populations through the NHCP are the same as those approved by CMS for these respective Waivers.

NHCP participants who are served by CFI waiver programs receive case management as a State Plan service from one of five licensed and enrolled providers. Qualifications for Case Managers serving the CFI population through the NHCP are the same as those approved by CMS for the current CFI Waiver. The CMHC's can provide transitional Case Management as part of the State Plan Services.

Identified service areas that NHCP participants have struggled gaining access to:

1. Safe, affordable and accessible housing: In this OP NH is asking for 100% Matching administrative funds to support a full-time Housing Specialist (for details of this request please see under "Housing" section in this OP Page 79). All NHCP participants will be offered this if they are struggling to secure housing.

2. Direct care workforce in rural areas: One area identified in this OP forwarded from meetings with stakeholders is the issue of Direct Care Work Force, or lack there of in rural areas presenting a barrier to transitions.

PCAs/DSWs Training: In this OP, NH would like to request and use 100% administrative match to provide training and education for PCAs/DSWs for family members or neighbors in order to get individuals into the Direct Care Workforce who could provide these services to MFP participants living in rural areas. NHCP participants will be offered this service if (a) they live in a rural area (b) do not have an identified PCSP at the time of transition. This will allow NHCP participants the opportunity to choose a family member, neighbor, or allow for the Moore Center to assist them in finding one in their area. The Moore Seniors, Moore Center in M Manchester, NH has agreed to partner with us by providing a flat fee for training. This would allow NHCP to have the opportunity to have a direct care provider in a much more timely way increasing

transitional numbers as well as decreasing transition times. Individuals would have the ability to choose who they would like as well, a stride in comparison to getting whoever is available, if anyone, at this current time in many of the rural areas. This step would also boost direct care workforce in the local area in general, and this would allow other individuals to be served in these rural areas.

In addition, The University of New Hampshire, Institute on Disability, has received the Department of Labor grant funding for the DirectConnect project. This project has the following components will be included in it:

- Establish a career lattice to include agency-based orientation and training, national best practice curriculums, professional credentialing processes, and established degree programs to prepare workers for placement and advancement in this field.
- Establish a tuition scholarship program with criteria for eligibility and will provide partner agencies with support to cover wages for workers who attend qualified trainings.
- Establish training programs to support workers to utilize the career lattice, to include:
 - Community College and University certificate and degree programs
 - Enhancement of distance learning opportunities across the state
 - Implementation of Coaching Supervision, Peer Mentoring, and Communication training statewideAddress barriers to retention of workers at both the public policy and agency levels.

The NH MFP program would like to leverage this project, the project's expertise, and current established network of partners to offer this training and other evidenced based trainings and opportunities to the MFP caregivers.

Community Partner for the DSW Training: The Moore Center, Moore Seniors Program, Manchester NH has agreed to partner with this project. The program follows all applicable laws and regulations pertaining to training, employment and oversight of PCAs/DSWs:

“In accordance with RSA 161-I, the PCS worker must be employed by either a home health agency or by another qualified agency (OQA). Under both the traditional agency-based and consumer-directed options, the agency is the common law employer of the PCS worker. However, under the consumer-directed option, the agency acts as an Agency with Choice ISO, allowing the individual or his/her representative to be the managing employer of his/her PCS worker. In this role, the individual or his/her representative is responsible for selecting, training, supervising, and discharging his/her PCS worker(s).

There are four key laws and rules that dictate how consumer-directed personal care services are to be provided and how Other Qualified Agencies (OQAs) operate in New Hampshire. The first is RSA 161-I, Personal Care Services, which was adopted by the state legislature in May 2000. This law describes in broad terms how personal care services, including consumer-directed personal care services, are to be provided.

The second is Chapter He-E 800, Medical Assistance, Part He-E 801, Home and Community-based Care for the Elderly and Chronically Ill. This section of the Medicaid rules pertain to the state's Medicaid HCBC-ECI waiver services that were amended in February 2002 to reflect the provisions of RSA 161-I related to the provision of personal care services, including consumer-directed personal care services.

The third is Chapter 500, Part He-M 524, In-Home Supports. These rules, recently proposed by the Department's Division of Developmental Services, establish minimum standards for Medicaid-covered home and community-based services and supports provided as part of a comprehensive array of services for children, adolescents and young adults under the age of 21 with severe developmental disabilities, living at home with their families. These rules will provide the operational structure for the Division's new In Home Support Home and Community-based Care Waiver for Children with Developmental Disabilities and Their Families. It is anticipated that these rules will be adopted early in calendar year 2003.

Finally, Chapter He-P 601, Certified Other Qualified Agency Providers, reflects the provisions of RSA 161-I and Chapter He-E 800, Part He-E 801 and describes the certification rules for OQAs. This rule was adopted in February 2003.

This administrative cost of providing training funds to get family, friends, or others trained will allow NH to build on it's initiative to offer more choice to CFI participants specifically and will support those living in rural areas. Consumer direction is a continuum. It can exist in varying degrees and spans many types of services. A consumer-directed support service, or program, can offer an individual a greater or lesser degree of responsibility based on the individual's desire and ability to manage his/her services and workers/providers. It also can allow individuals to have designated representatives assist them in managing their services and workers/ providers.” (See <http://www.cashandcounseling.org/resources/20060111-165702/OQATrainingManual.doc>).

b. TRANSITION PROCESS FOR INDIVIDUALS SERVED UNDER THE CFI WAIVER

1. For elderly and individuals with physical disabilities enrolling in the HCBC-CFI program, the following transition process is now in place:
 - a. The resident may directly express an interest in moving out of the nursing facility to the NHCP program directly, to a Discharge Planner or other facility staff, a staff member or volunteer from the Office of Long Term Care Ombudsman, a family member, or a friend. The resident also may be encouraged to consider this option by facility staff, OLTCO, or others who are aware of the NHCP.
 - b. Nursing facility staff completes the Medical Eligibility Assessment (MEA) form or the Minimum Data Set may be obtained to assist determine eligibility for home and community based services as well as along with other supporting documentation. BEAS has provided statewide training to facility nursing staff on how to complete the MED form. This has streamlined the Level of Care (LOC) eligibility determination process and greatly reduced the need to send BEAS nurses to facilities. Having staff on site who is capable of completing the MED makes it easier for NHCP participants who require a recent LOC to apply for community based care.
 - c. The BEAS Nurse Supervisor and/or Nurse NHCP Program Director reviews the completed MED from the nursing facility and determines if any additional information is required. At this point, the BEAS Long Term Care Unit also

confirms the resident's financial eligibility for Medicaid covered community based services.

- d. The BEAS Nurse Supervisor and/or Nurse NHCP Program Director conducts an initial planning meeting with the resident and his/her legal representative and friends or family, and facility staff to learn about the resident's preferences for community supports, evaluate the resident's needs for services, assess risks, discuss options to mitigate risks, and determine if the resident is providing informed consent to participate. The individual, along with those supporting the individual (treatment team members, family, etc) will be encouraged to discuss and consider what supports would be needed to achieve a safe discharge and what supports are known to already be available (e.g. family members, a day program, social opportunities, etc). The information gathered in this meeting is documented in the Risk Assessment and Barrier Review Form for the Community Passport Program and becomes the basis for the participant's transition plan. This form is included in the Attachments Section. The transition plan describes the individual's preferences for community supports and services and identifies the tasks and interim services that will need to occur prior to discharge. The transition plan also includes timeframes for accomplishing tasks, strategies for supporting the individual in the community, and a review of potential risks to the participant's health and welfare if services are not adequately planned and provided. To ensure the availability of all necessary emergency and back-up supports, the planning process also includes a review of service and provider qualifications and development of comprehensive care and service plans, including contingency planning for home emergencies and unexpected interruptions in service delivery.
- e. After the planning meeting, if appropriate, a BEAS Adult Protective Services Social Worker or a Long Term Care Counselor may visit the resident at the nursing facility. Experience has shown that often times the Adult Services Social Workers are familiar with the MFP participant referrals due to struggles and challenges prior to nursing home placement. The NH MFP program has found that close partnering with APS is critical to assuring a safe transition back to the community to avoid past challenges and to potential mitigate risks. The APS workers will be referred a potential participant from the MFP program to reconnect with APS to assist with the transitioning to the HCBC-CFI program. The APS worker conducts strength and needs assessment for CFI participants to evaluate and ensure community supports are adequate. The APS worker may also follow up as needed after transitioning. Prior experience has also demonstrated the value of providing residents with ample opportunity to explore options and discuss their concerns with another knowledgeable professional. The visit provides another opportunity to assess the resident's situation and will help in identifying the supports that need to be place to ensure that the individual is able to make a safe and successful transition to the community. The Transition Coordinator reviews the concerns related to community transition identified by the Risk Assessment and Barrier Worksheet and discusses these with the resident and facility social worker. The Transition Coordinator notifies the Nurse

Supervisor and or Nurse NHCP Program Director of any concerns related to the individual's proposed discharge.

- f. An RN consult form is filled out by the CFI RN and a Risk and Barrier assessment is conducted with identified participants. For challenging transitions requiring extensive support and planning, the BEAS Nurse Supervisor, NHCP Program Director and, as needed, the BEAS Administrative Director, conduct a clinical review of the information gathered at the planning meeting with the nursing facility staff and the Transition Coordinator to determine if the resident can be supported in the community through the CFI program, and to discuss risk mitigation options. The next step is to determine if indeed community supports are adequate. This decision depends on whether community services are supportive enough to support the needs of the individual, and cost effective alternative to facility care:
 - i. If BEAS determines that community services would not be adequate to support the resident, or if adequate supports would cost more than is allowed in the waiver, the resident is informed that the transition will not be supported and that he or she may appeal this decision through the DHHS Fair Hearings Office;
 - ii. If BEAS determines that community services would provide a cost effective alternative to facility care and are available, then based on the resident's needs, one of the following occurs:
 - A short-term transition planning process is used when the transition is anticipated to occur within two to three months and the resident's health is stable and he or she is able to perform or direct self care and is able to self-administer medications. A tentative and reasonable discharge date goal is established and the NHCP participant is informed that a Transitional Case Manager (tCM) will work with him or her during the transitional time period. (The tCM is an employee of a licensed case management provider and provides intensive assistance to residents in arranging for community services and assisting with the transition to the community residence.) The resident is asked if he or she has a preference of case management provider. If the resident has no preference, a tCM is assigned through the BEAS rotation assignment process. Once the Nurse Supervisor completes it, a copy of the short-term transition plan is sent to the resident and to the tCM.
 - If the resident is not medically ready to transition for several months, the transition plan is considered to be long-term. In this case, the facility and BEAS remain in contact and when the resident's health improves to the point that transition is anticipated in two to three months, the short-term plan described above is implemented.
 - In cases in which the NHCP program is involved without such advance notice, a tCM is assigned as soon as possible.

- g. The Program Specialist/Transition Coordinator identifies and facilitates the initial transition plan with the facility social worker, which is based on multiple sources, and subject to change. It is a plan that is created by taking in information from the results of the Risk Assessment and Barriers Worksheet, the APS Social Worker information, as well as in collaboration with the individual, family, and facility Discharge Planner. The Initial Transition Plan describes the anticipated individual needs of the participant, what the plan is, and who is responsible for those tasks. Once the tCM is assigned the tCM is informed of the transition plan and works with the facility Discharge Planner in collaboration with the resident to put in place the community based supports and services the individual has chosen and needs to completely transition. The tCM is a vital role and will, in most cases, may need to additionally tailor the transition plan – this is expected. The tCM role is a case manager role that follows the NH rules under He-E 805. This role is vital in assisting NHCP participants in a variety of areas that include; finding appropriate community health providers, identifying the community where the participant wants to live, assist with locating appropriate housing, and completing necessary housing applications. The Initial Transition Plan is used to guide the planning of community services, however, the tCM and Discharge Planner take into consideration the individual’s strengths and challenges and any other identified potential risks and barriers that have not been identified in the Risk Assessment and Barriers Worksheet and the BEAS Adult Services Social Worker.
- h. As stated, discharge planning begins with setting a tentative and reasonable discharge date. The NHCP participant then works with the NHCP Program Specialist, tCM, family, and nursing facility social worker to review the exact transitional items that are needed to safely return to the community. The NHCP Program Specialist reviews these needed items, prior authorizations are obtained and documented by the Program Specialist. The Program Specialist places orders for needed items and works with the tCM to ensure items will be in place on day of discharge (e.g. the Program Specialist will ensure the prior authorization for groceries is in place, and tCM will work with family or individual to get groceries at the community residence in time for discharge).
- i. A formalized discharge-planning meeting generally is held two to six weeks prior to the resident’s move to community housing. This meeting includes the resident and can also include invited friends or family members, the tCM, BEAS and facility staff, representation from the OLTCO, and the Waiver Case Manager (if this is a different person than the tCM). The tentative discharge date that was previously set, is firmed up at this meeting. Any final transitional items not authorized are reviewed, and agreement is reached on additional expenditures needed to support the transition (e.g., training for DSW needed, security deposit or items not anticipated at an earlier time). If the participant chooses to have a different Case Manager in the community, the NHCP participant and the tCM meet with the community Case Manager to share information. The tCM provides a written summary of work that has been done to date to BEAS and to the Waiver Case Manager.

- j. One or two days before proposed discharge date, BEAS authorizes any last minute allowable transition expenditures from the items identified by the tCM and the resident, and the new home is prepared for the transition.
- k. Also one or two days before discharge date, NHCP Program Specialist conducts a home outreach visit to confirm that all household purchases and utilities are in place and functioning. The tCM is encouraged to participate to ease coordination but is not required. If everything is not in place at this time, the NHCP participant, the tCM, and the nursing facility are informed. If all safety-related items are in place and the resident prefers to move without waiting for everything to be delivered, that will be facilitated. The participant may choose to move if items such as toasters, televisions, bookcases, or non-essential household supplies that are not related to the participant's health and safety have not yet arrived.
- l. On the day of discharge or very close to the day prior to discharge, the tCM or NHCP Program Specialist will collaborate and ensure that the participant has groceries in the home.
- m. On the discharge day, both the tCM and the Community Case Manager meet with the participant at his or her new home to ensure that the move has gone well. Unless the participant elects to have the tCM assume the ongoing responsibilities of the Waiver Case Manager, the individual is reminded that this is the last day of involvement by the tCM and informed that the Waiver Case Manager will visit periodically and maintain regular contact.
- n. A month to six weeks after the transition, the NH CP Transition Program Specialist or if needed, the Adult Protective Services Social Worker will follow up with the individual and case manager in the new home and assesses the overall transition. If services are not in place or if the individual is dissatisfied, the Social Worker or NHCP Transition Program Specialist will inform the Waiver Case Manager and BEAS so that the issues can be resolved.
- o. Important features of the revised CFI transition process include:
 - i. A tCM to assist the resident in securing appropriate housing, linking with needed medical providers, setting up services, referring to community resources, and in identifying items that must be purchased prior to moving in. This allows case management from the community to be involved upfront and ensuring a safe and smooth transition.
 - ii. Additional planning meetings to ensure that the resident is supported in reaching his or her discharge goals.
 - iii. The program makes every effort to have a home visit by the tCM prior to discharge to prevent transitions from occurring before services or items necessary for personal safety are in place.
 - iv. The involvement of the Office of Long Term Care Ombudsman ensures that residents' rights to participate in a discharge plan are upheld. The OLTCO will make referrals to BEAS if requested to do so by a resident.
 - v. The initial assessment by the Adult Protective Services Social Worker or Long Term Care Counselor ensures that the resident is making informed decisions and the post-discharge visit provides an additional evaluation of

the participant's well-being and satisfaction. If there are any ongoing concerns or problems, the APS Social Worker or Counselor follows up with the Waiver Case Manager and, where appropriate, with the resident's guardian or authorized representative. If necessary the participant's care plan will be revised to document the individual's needs and to specify the services and supports that need to be provided.

- vi. Household purchases and other expenditures will be made as approved by BEAS based upon individual's clinical needs and personal preferences.
- vii. The local ElderWrap team may be involved if the resident has complex medical and mental health needs. ElderWrap is a coordinated initiative that consists of 13 regionally based groups that provide assistance to older adults who have a mental illness, live in the community, or in a nursing facility and want to return to the community. ElderWrap membership includes representatives from State and local agencies, institutional providers, and local community providers and organizations. ElderWrap assists in the coordination of services that are not typically accessible through one agency alone.
- viii. The transition plan may also include involvement of REAP (Referral Education, Assistance and Prevention Program), a multi-agency program that provides early substance abuse, medication misuse, and mental health intervention. Trained Mental Health outreach workers support older adults by providing assessment, early intervention, and referral services, as well as offering educational wellness classes in community settings.
- ix. When appropriate, the Brain Injury Association of New Hampshire (BIANH) will be involved. The BIANH's Neuro-Resource Facilitation Program provides service coordination and other supportive services to individuals with acquired brain disorders and their families to aid in the transition back into the community. This program has six Neuro-resource Facilitators who have ongoing relationships with hospitals, nursing facilities, and other community groups and resources throughout New Hampshire.

In addition, DHHS has established cross division project coordination to assist in tracking and coordinating consumer access and transition. The cross-division group includes the Project Director, Program Managers and staff from both the Bureau of Elderly Adult Services and the Bureau of Developmental Services. This group collaborates on cross-division issues including referral coordination, tracking, reporting, funding, and resource assistance.

c. TRANSITION PROCESS FOR PARTICIPANTS SERVED UNDER THE ABD, DD, AND IHS WAIVERS

The NHCP Project will adhere to State regulations He-M 522 Eligibility Determination and Service Planning for Individuals With An Acquired Brain Disorder and He-M 503 Eligibility Determination and Service Planning for Individuals With A Developmental Disability. For participants eligible for services under the ABD Waiver, the DD Waiver and the IHS Waiver, within 5 business days of determination of eligibility the Area Agency shall:

- (1) Inform the individual of his or her right to choose or approve a Service Coordinator;
- (2) Designate a Service Coordinator to develop a service agreement with the individual;
- (3) Conduct sufficient preliminary planning with the individual and guardian, either at the time of intake or during subsequent discussions, to identify and document the specific services needed based on information obtained;
- (4) Request funding for services from the department.

Once funding has been obtained, the Area Agency will create a service agreement as follows:

Within 15 business days of the Area Agency's identification of the availability of funding for an individual, the Service Coordinator shall meet with the individual, family, and guardian, if applicable, and others that the individual or guardian would like to have present and develop a written basic service agreement, signed by the individual or guardian and the Area Agency Executive Director or designee, that includes the following:

- (1) A brief description of the individual's strengths, needs and interests, as applicable;
- (2) The specific services to be furnished;
- (3) The amount, frequency, duration, and desired outcome of each service;
- (4) Timelines for initiation of services;
- (5) The provider to furnish the service;
- (6) The individual's need for guardianship, if any
- (7) Service documentation requirements sufficient to track outcomes; and
- (8) For individuals with a self-directed service arrangement, reporting mechanisms regarding budget updates, and individual and guardian satisfaction.

The Service Coordinator shall convene a meeting to prepare an expanded service agreement within 20 business days of the initiation of services provided, or when requested by the individual or guardian. If people who provide services to the individual are not selected by the individual to participate in a service-planning meeting, the Service Coordinator shall contact such persons prior to the meeting so that their input can be considered. Copies of relevant evaluations and reports shall be sent to the individual and guardian at least 5 business days before service planning meetings.

Within 10 business days following a service planning meeting the Service Coordinator shall:

- (1) Prepare a written expanded service agreement that:
 - a. Includes the following:
 1. A personal profile; and
 2. A list of those who participated in the service planning agreement meeting; and
 - b. Describes the following:
 1. The specific support services to be provided under each service category;

2. The goals to be addressed, and timelines and methods for achieving them;
 3. The persons responsible for implementing the expanded service agreement;
 4. Services needed but not currently available;
 5. Service documentation requirements sufficient to describe progress on goals and the services received;
 6. If applicable, reporting mechanisms under self-directed services regarding budget updates and individual and guardian satisfaction with services; and
 7. The individual's need for guardianship, if any;
- (2) Contact all persons who have been identified to provide a service to the individual and confirm arrangements for providing such services; and
 - (3) Explain the service arrangements to the individual and guardian and confirm that they are to the individual's and guardian's satisfaction.

Within 5 business days of completion of the expanded service agreement, the Area Agency shall send the individual or guardian the following:

- (1) A copy of the expanded service agreement signed by the Area Agency Executive Director or designee;
- (2) The name, address, and phone number of the Service Coordinator or service provider(s) who may be contacted to respond to questions or concerns; and
- (3) A description of the procedures for challenging the proposed expanded service agreement, including their right to a fair hearing, for those situations where the individual or guardian disapproves of the expanded service agreement.

The individual or guardian shall have 10 business days from the date of receipt of the expanded service agreement to respond in writing, indicating approval or disapproval of the service agreement. Unless otherwise arranged between the individual or guardian and the Area Agency, failure to respond within the time allowed shall constitute approval of the service agreement.

When an expanded service agreement has been approved by the individual or guardian and Area Agency Executive Director, the services shall be implemented and monitored as follows:

- (1) A person responsible for implementing any part of an expanded service agreement, including goals and support services, shall collect and record information about services provided and summarize progress as required by the service agreement or, at a minimum, monthly;
- (2) On at least a monthly basis, the Service Coordinator shall visit or have verbal contact with the individual or persons responsible for implementing an expanded service agreement and document these contacts;
- (3) The Service Coordinator shall visit the individual and contact the guardian, if any, at least quarterly, or more frequently if so specified in the individual's expanded service agreement, to determine and document:
 - a. Whether services match the interests and needs of the individual;

- b. Individual and guardian satisfaction with services; and
- c. Progress on the goals in the expanded service agreement; and
- (4) If the individual receives residential services at least 2 of the Service Coordinator's quarterly visits with the individual shall be in the home where the individual resides.
- (5) Service agreements shall be renewed at least annually.

The Service Coordinator shall facilitate service planning to develop service agreements in accordance with the above. All service planning shall:

- (1) Be a personalized and ongoing process to plan, develop, review, and evaluate the individual's services in accordance with the criteria set forth in He-M 503 and He-M 522 and
- (2) Include identification by the individual or guardian and the individual's service providers of those services and environments that will promote the individual's health, welfare, and quality of life.

The Service Coordinator shall, as applicable, maximize the extent to which an individual participates in and directs his or her service planning process by:

- (1) Explaining to the individual the service planning process and assisting the individual to determine the process within the scope of He-M 503 and He-M 522;
- (2) Explaining to the individual his or her rights and responsibilities;
- (3) Eliciting information from the individual regarding his or her personal preferences and service needs, including any health concerns, that shall be a focus of service planning meetings;
- (4) Determining with the individual issues to be discussed during service planning meetings; and
- (5) Explaining to the individual the limits of the decision-making authority of the guardian, if applicable, and the individual's right to make all other decisions related to services.

The individual or guardian may determine the following elements of the service planning process:

- (1) The number and length of meetings;
- (2) The location, date, and time of meetings;
- (3) The meeting participants; and
- (4) Topics to be discussed.

In order to develop or revise a service agreement to the satisfaction of the individual or guardian, the service planning process shall consist of periodic and ongoing discussions regarding elements identified in He-M 522 and He-M 503.08 (b) that:

- (1) Include the individual and other persons involved in his or her life;

- (2) Are facilitated by a Service Coordinator; and
- (3) Are focused on the individual's abilities, health, interests, and achievements.

The service planning process shall include a discussion of the need for guardianship. The Area Agency Executive Director shall implement any recommendations concerning guardianship contained in the service agreement. The service planning process shall include a discussion of the need for assistive technology that could be utilized to support all services and activities identified in the proposed service agreement without regard to the individual's current use of assistive technology.

Service agreements shall be reviewed by the Area Agency with the individual or guardian at least once during the first 6 months of service and as needed. The annual review required by He-M 522 and He-M 503 shall include a service-planning meeting. The individual or guardian may request, in writing, a delay in an initial or annual service agreement meeting. The Area Agency shall honor this request.

The Service Coordinator shall be responsible for monitoring services identified in the service agreement and for assessing individual, family or guardian satisfaction at least annually for basic service agreements and quarterly for expanded service agreements.

An Area Agency Executive Director, Service Coordinator, service provider, individual, guardian, or individual's friend shall have the authority to request a service agreement meeting when:

- (1) The individual's responses to services indicate the need;
- (2) A change to another service is desired;
- (3) A personal crisis has developed for the individual; or
- (4) A service agreement is not being carried out in accordance with its terms.

At a meeting held pursuant to the above, the participants shall document whether and how to modify the service agreement. Service agreement amendments may be proposed at any time. Any amendment shall be made with the consent of the individual or guardian and the Area Agency.

If the individual, guardian, or Area Agency Executive Director disapproves of the service agreement, the dispute shall be resolved:

- (1) Through informal discussions between the individual or guardian and Service Coordinator;
- (2) By reconvening a service planning meeting; or
- (3) By the individual or guardian filing an appeal to the bureau pursuant to He-C 200.

All services shall:

- (1) Be voluntary;
- (2) Be provided only after the informed consent of the individual or guardian;

- (3) Comply with the rights of the individual established under RSA 171-A:13-14 and rules adopted hereunder; and
- (4) Facilitate as much as possible the individual's ability to determine and direct the services he or she will receive.

All services shall be designed to:

- (1) Promote the individual's personal development and quality of life in a manner that is determined by the individual;
- (2) Meet the individual's needs in personal care, employment, adult education and leisure activities;
- (3) Promote the individual's health and safety;
- (4) Protect the individual's right to freedom from abuse, neglect, and exploitation;
- (5) Increase the individual's participation in a variety of integrated activities and settings;
- (6) Provide opportunities for the individual to exercise personal choice, independence, and autonomy within the bounds of reasonable risks;
- (7) Enhance the individual's ability to perform personally meaningful or functional activities;
- (8) Assist the individual to acquire and maintain life skills, such as, managing a personal budget, participating in meal preparation, or traveling safely in the community; and
- (9) Be provided in such a way that the individual is seen as a valued, contributing member of his or her community. The environment or setting in which an individual receives services shall promote that individual's freedom of movement, ability to make informed decisions, self-determination, and participation in the community.

An individual or guardian may select any person, any provider agency, or another Area Agency as a provider to deliver one or more of the services identified in the individual's service agreement. All providers shall comply with the rules pertaining to the service(s) offered and meet the provisions specified within the individual's service agreement. They shall also enter into a contractual agreement with the Area Agency and operate within the limits of funding authorized by it.

Transition Process for Participants Served under State Plan Behavioral Health Services: 65 and older (the Behavioral Health Transition Coordinator will be assisting with facilitation)

2. For elderly and individuals 65 years and older with a psychiatric diagnosis, and is in New Hampshire Hospital applying for State Plan Behavioral Health Services as determined by the Older Adult Assessment, the following transition process is now in place:
 - a. The individual may directly express an interest in moving out of the facility to the NHCP program directly, to a social worker, other facility staff, a volunteer from the facility, or a family member. The individual also may be encouraged to consider this option by facility staff, or others who are aware of the NHCP. Any interest the individual expresses should be referred to the assigned social worker.

- b. The hospital social worker contacts the CMHC to complete an Intake if the client is not already an open case. The CMHC completes the State Eligibility Determination form to determine eligibility for home and community based behavioral health services. In addition the “Older Adult Assessment” will be conducted. For open clients these forms will have been previously completed.
- c. At this point, BBH also confirms the resident’s financial eligibility for Medicaid covered community based services.
- d. Following the intake the CMHC assigns the appropriate level of care, appropriate treatment team, and community case manager.
- e. The individual is then asked to provide informed consent to participate in the NHCP program. Program questions are asked and answered at this time.
- f. The BBH Transitional Coordinator conducts an initial planning meeting with the individual and his/her legal representative, friends or family, community case manager, and facility staff. Part of the discussion is to learn about the resident’s preferences for community supports, evaluate the resident’s needs for additional services, assess risks, discuss options to mitigate risks, and. The individual, along with those supporting the individual (treatment team members, family, etc) will be encouraged to discuss and consider what supports would be needed to achieve a safe discharge and what supports are known to already be available (e.g. family members, support groups, treatment appointments in the community, social opportunities, etc). The information gathered in this meeting is documented in the Risk Assessment and Barrier Review Form for the Community Passport Program and becomes the basis for the participant’s transition plan. This form is included in the Attachments Section. The transition plan describes the individual’s preferences for community supports and services as well as recommendations from the NHH treatment team and legal guardian, if any and identifies the tasks and interim services that will need to occur prior to discharge. The transition plan also includes timeframes for accomplishing tasks, strategies for supporting the individual in the community, and a review of potential risks to the participant’s health and welfare if services are not adequately planned and provided. To ensure the availability of all necessary emergency and back-up supports, the planning process also includes a review of service and provider qualifications and development of comprehensive care and service plans, including contingency planning for home emergencies and unexpected interruptions in service delivery.
- g. The NHH Social Worker informs the NHCP staff of any concerns related to the individual’s proposed discharge.
- h. A short-term transition planning process is used when the transition is anticipated to occur within one to two months and the individual’s mental health is stable and he or she is able to perform or direct self care and is able to self-administer medications or services are in place for medication administration/monitoring by VNA, home health aid or the CMHC. A tentative and reasonable discharge date goal is established. Please note that the community case manager is already assigned when the client is open to their local CMHC. New clients have intake appointments while at NHH and have case managers assigned at that time. The case manager is not directly involved in the transition plan. Much of the meetings and conversations while a patient is at NHH are between the NHH social worker

and the CMHC liaison to NHH. The case manager cannot provide services until the patient is at least on over night visits from NHH. So much of the transition plan will be implemented by the NHH social worker, not the CMHC case manager, at least initially. Once the patient is able to be on visiting status, then the CMHC case manager can begin meeting with the patient in the community and providing services.

- i.
 - (1) If the individual is not ready to transition for several months, the transition plan is considered to be long-term. In this case, the facility and the Passport program remain in contact and when the individual improves to the point that transition is anticipated in two to three months, the short-term plan described above is implemented.
 - (2) In cases in which the NHCP program becomes involved without such advance notice, the social worker, NHCP transitional coordinator will work with the CMHC staff and coordinate care as soon as possible.
- j. The Transition Coordinator creates the initial transition plan, which is a document-in-progress, based on multiple sources, and subject to change. It is a document that is created by collaboration with the individual, family, CMHC staff, and facility social worker. The Initial Transition Plan describes the anticipated individual needs of the participant, what the plan is, and who is responsible for those tasks. The facility social worker in collaboration with the individual will arrange the community based supports and services the individual has chosen and needs to completely transition. The NHH Social working will continue identifying appropriate community health providers and services, identifying the community where the participant wants to live, locating appropriate housing, and completing necessary housing applications. The Initial Transition Plan is used to guide the planning of community services, however, the CMHC staff and NHH social worker take into consideration the individual's strengths and challenges and any other identified potential risks and barriers that have not been identified.
- k. As stated, discharge planning begins the day of admission to NHH by the assigned social worker contacting the CMHC liaison with in 24 hours of admission. The Transition Plan begins with setting a tentative and reasonable discharge date. The NHCP participant then works with the NHCP Program Specialist, CMHC staff, family, and nursing facility social worker to review the exact transitional items that are needed to safely return to the community. The NHCP Program Specialist reviews these needed items, prior authorizations are obtained and documented by the Program Specialist.
- l. A formalized discharge-planning meeting generally is held prior to the individual's move to community living. This meeting includes the individual, and can also include invited friends or family members, the case manager, and facility staff, or other representation from the CMHC. The tentative discharge date that was previously set, is firmed up at this meeting. Any final transitional items not authorized are reviewed, and agreement is reached on additional expenditures

needed to support the transition (e.g., security deposit or items not anticipated at an earlier time).

- m. One or two days before proposed discharge date, the Passport program staff speaks with the discharging facility and if needed, authorizes any last minute allowable transition expenditures from the items identified by the NHH social worker, facility and the resident, and the new home is prepared for the transition.
- n. The NHCP Program Specialist conducts the Quality of Life Interview.
- o. If all safety-related items are in place and the individual prefers to move without waiting for everything to be delivered, that will be facilitated. The participant may choose to move if items such as toasters, televisions, bookcases, or non-essential household supplies that are not related to the participant's health and safety have not yet arrived.
- p. On the day of discharge or very close to the day prior to discharge, the NHH social worker or NHCP Program Specialist will collaborate and ensure that the participant has groceries in the home.

On the discharge day, the Community Case Manager will either meet the individual at their home or will have set up an appointment at the CMHC very close to the discharge date.

A month to six weeks after the transition, the NH CP Behavioral Health Transition Program Specialist will follow up with the individual in the new home and assesses the participant's satisfaction with the transition. If services are not in place or if the individual is dissatisfied, the NHCP Transition Program Specialist will inform the Casemanager so that the issues can be resolved.

TRANSITION PROCESS FOR PARTICIPANTS SERVED UNDER STATE PLAN CHILDREN'S BEHAVIORAL HEALTH SERVICES: 21 YEARS AND YOUNGER (BEHAVIORAL HEALTH TRANSITIONAL COORDINATOR WILL BE ASSISTING WITH FACILITATION AND COORDINGATING WITH MULTIPLE SYSTEMS – DEPT OF EDUCATION, BEHAVIORAL HEALTH SYSTEM, AND JUVENILE JUSTICE SYSTEM).

- 3. For youth and children 21 years and younger with a psychiatric diagnosis, who meets the MFP eligibility standards, and is in applying for State Plan Behavioral Health Services as determined by the Child and Adolescent Needs and Strengths Assessment Tool, the following transition process is now in place:
 - a. The child and family may directly express an interest in moving out of the facility to the NHCP program directly, to a Discharge Planner, other facility staff, a volunteer from the facility, or a family member. The child and family also may be encouraged to consider this option by facility staff, or others who are aware of the NHCP.
 - b. The discharge planning staff contacts the CMHC to complete the State Eligibility Determination form to determine eligibility for home and community based behavioral health services.
 - c. The CMHC intake team and physician review the completed form and determine if any additional information is required. At this point, BBH also confirms the resident's financial eligibility for Medicaid covered community based services.
 - d. Once information is complete, the CMHC intake staff assigns the appropriate level of care, appropriate treatment team, and community case manager.

- e. The individual is then asked to provide informed consent to participate in the NHCP program. Program questions are asked and answered at this time.
- f. The BBH Transitional Coordinator conducts an initial planning meeting with the individual and his/her legal representative, friends or family, community case manager, and facility staff. Part of the discussion is to learn about the resident's preferences for community supports, evaluate the resident's needs for additional services, assess risks, discuss options to mitigate risks, and. The individual, along with those supporting the individual (treatment team members, family, etc) will be encouraged to discuss and consider what supports would be needed to achieve a safe discharge and what supports are known to already be available (e.g. family members, support groups, treatment appointments in the community, social opportunities, etc). The information gathered in this meeting is documented and becomes the basis for the participant's transition plan. . The transition plan describes the individual's preferences for community supports and services and identifies the tasks and interim services that will need to occur prior to discharge. The transition plan also includes timeframes for accomplishing tasks, strategies for supporting the individual in the community, and a review of potential risks to the participant's health and welfare if services are not adequately planned and provided. To ensure the availability of all necessary emergency and back-up supports, the planning process also includes a review of service and provider qualifications and development of comprehensive care and service plans, including contingency planning for home emergencies and unexpected interruptions in service delivery.
- g. The Discharge Social Worker communicates to the NHCP staff any concerns related to the individual's proposed discharge.
- h. A short-term transition planning process is used when the transition is anticipated to occur within one to two months and the individual's mental health is stable and he or she is able to perform or direct self care and is able to self-administer medications. A tentative and reasonable discharge date goal is established and the NHCP participant is informed that a CMHC case manager will work with him or her during the transitional time period. The case manager is an employee of the mental health centers and provides assistance to individuals in arranging for community services and assisting with the transition to the community residence. A copy of the short-term transition plan is sent to the individual/Parent/guardian, the facility, and to the community case manager.
 - (1) If the individual is not ready to transition for several months, the transition plan is considered to be long-term. In this case, the facility and the Passport program remain in contact and when the individual improves to the point that transition is anticipated in two to three months, the short-term plan described above is implemented.
 - (2) In cases in which the NHCP program is involved without such advance notice, a case manager is assigned as soon as possible.
- i. The NHCP Program Specialist creates the initial transition plan, which is a document-in-progress, based on multiple sources, and subject to change. It is a document that is created in collaboration with the individual, family, community

case manager, and facility Discharge Planner. The Initial Transition Plan describes the anticipated individual needs of the participant, what the plan is, and who is responsible for those tasks. Once the case manager is assigned the case manager is given the Initial Transition Plan and works with the facility Discharge Planner in collaboration with the individual to put in place the community based supports and services the individual has chosen and needs to completely transition. The Case manager is a vital role and will, in most cases, need to additionally tailor the Transition Plan – this is expected. This role is vital in assisting NHCP participants in a variety of areas that include; identifying appropriate community health providers, identifying the community where the participant wants to live, locating appropriate housing, and completing necessary housing applications. The Initial Transition Plan is used to guide the planning of community services, however, the Case manager and Discharge Planner take into consideration the individual’s strengths and challenges and any other identified potential risks and barriers that have not been identified.

- j. As stated, discharge planning begins with setting a tentative and reasonable discharge date. The NHCP participant then works with the NHCP Program Specialist, case manager, family, and nursing facility social worker, and multiple system providers (Dept. of Education staff, Juvenile Justice staff, Bureau of Behavioral Health or Community mental Health Center staff) to review the exact transitional items that are needed to safely return to the community. The NHCP Program Specialist reviews these needed items, prior authorizations are obtained and documented by the Program Specialist. The Program Specialist works with providers to obtain needed items and works with the case managers to ensure items will be in place on day of discharge.
- k. A formalized discharge-planning meeting generally is held prior to the individual’s move to community living. This meeting includes the individual, and can also include invited friends or family members, the case manager, and facility staff, or other representation from the CMHC. The tentative discharge date that was previously set, is firmed up at this meeting. Any final transitional items not authorized are reviewed, and agreement is reached on additional expenditures needed to support the transition.
- l. One or two days before proposed discharge date, the Program Specialist identifies any last minute transition items identified by the case manager, facility and the resident, and the home is prepared for the transition.
- m. The Quality of Life Interview is conducted.
- n. If all safety-related items are in place and the individual prefers to move without waiting for everything to be delivered, that will be facilitated. The participant or his/her guardian/parent may choose to move if non-essential items that are not related to the participant’s health and safety have not yet arrived.
- o. On the day of discharge or very close to the day prior to discharge, the Case manager or NHCP Program Specialist will collaborate and ensure that the participant has needed items in the home.

- p. On the discharge day, the Community Case Manager or NCHP staff with either meets the individual at their home or will have set up an appointment at the CMHC very close to the discharge date.

A month to six weeks after the transition, the NH CP Transition Program Specialist will follow up with the individual in the new home and assesses the participant's satisfaction with the transition. If services are not in place or if the individual is dissatisfied, the NHCP Transition Program Specialist will work with the providers so that the issues can be resolved.

d. BACKUP SYSTEMS, SAFETY PLANS, AND OTHER SAFEGUARDS

Assessments and the development of a Support Plans are in place for all NHCP participants through the established eligibility and care planning provisions already present in the State's waivers and the rules identified in He-E 801.05 under "Support Plan" Here participants, the participant's representative (if applicable) , a designated BEAS registered nurse, the case manager and other community providers participate in the support plan development which would include the back-up plan.

Identification of Risk

The HCBC-ECI program: For applicants to the HCBC-CFI program, a clinical assessment that includes a review of the individual's comprehensive medical and psychosocial information is required. This is called the "Medical Eligibility Assessment" or MEA. These assessments are conducted either by a BEAS Nurse or by a community Nurse who has been trained by BEAS on conducting clinical assessments. A Community Nurse may complete the MED assessment, which is then forwarded to a BEAS Nurse who determines clinical eligibility on the basis of the data provided by the Community Nurse .The Community Nurse will have summarized in the notes any risks that have been identified through the assessment. . The Nurse, along with the individual, will also identify risks. The form (see attachment) utilized to document identified risks and barriers to transition is titled the "Risk Assessment and Barrier Worksheet (Form 1 & 2)". This form is used to help the individual to identify as well as explore appropriate supports and mitigate risks. The second phase of this process is to then develop a Support Plan for each identified risk on the form titled, "Individual Back-Up Plan to Mitigate Risk (Form 2 of 2)".In addition to the worksheets and Support Plan, CFI participants who would like to participant in the NHCP program and present with a number of high potential risk areas, are reviewed by a small committee including outside nurses and an Adult Protective Social (APS)Worker. The committee can refer to APS to conduct an objective assessment while the participant is at the institution and utilize multiple sources of information and data to compile the assessment (e.g.: chart, family, providers, past involvement with APS workers, etc). Once the APS worker report is included the committee again reviews it. It is at this point determined if the over all individual risks, needs and available community supports are available and sufficient to address needs. Once enrolled in the waiver program, the Case Manager works with the participant, and MFP Program Specialist to develop the transition plan for moving into the community; this plan identifies potential risks and plans for how these will be addressed. Once in the community, at least monthly, per NH rules and more often if necessary, the Case Manager reviews the

participant's services and assesses whether the individual's needs are being adequately met. When there are concerns or the Case Manager identifies new risks, the participant's service plan is adjusted to address these. Annually, a BEAS or other trained Nurse conducts a re-determination of clinical eligibility. This provides an additional opportunity to clinically evaluate the person's situation, identify new needs and/or risks, and address how all risks will be mitigated.

The participant's individual care plan addresses the following areas of concern:

- a. Ability to manage activities of daily living
- b. Physical health, including impairments of mobility, sight, hearing, and speech
- c. Intellectual functioning and mental health
- d. Need for supervision
- e. Need for medication assistance
- f. Need for family and community involvement
- g. Need for community, social or health services.
- h. Need for Individualized Emergency Back Up Plan

The ABD or DD waiver program:

For individuals receiving services through the ABD or DD waiver programs, risk is assessed in a number of ways. Prior to the start of services, service coordinators meet with the individual, family, and guardian, if applicable, and any others who the individual or guardian would like to have present. At this meeting a basic Service Agreement is developed, signed by the individual or guardian and the Area Agency Executive Director or designee. As noted above, plans for addressing emergency situations are part of this agreement. This service agreement includes, in part, a brief description of the individual's strengths, needs and interests and how emergencies will be managed.

Behavioral Health State Plan Services;

Prior to leaving a nursing institution, clinical assessments are completed throughout the individual's hospital or institutional stay and may be conducted by several disciplines on more than one occasion. While at the nursing facility clinical assessment items include mental health symptoms, daily functioning (ADL's, sleep hygiene, etc.), cognitive functioning, medication compliance/response, safety issues (suicide ideation, homicidal ideation, Self Injurious Behavior, etc), participation in treatment. The individualized clinical assessments are documented in the individual's chart. As mentioned, multi-discipline approach is taken and each discipline has its own approved assessment format. In addition, assessment information is documented in progress notes. At the time of discharge, each individual is discharged with a comprehensive care and assessment summary.

When individuals are participating in transitional planning to receive community-based services through the State Plan, community mental health center programs conduct an intake assessment. Depending on the community health center, the interview uses a variety of tools and reviews numerous other life domains. For the youth and children's population risk specifically is assessed in a variety of ways. Initially a Child and Adolescent Needs and Strengths Assessment (CANS)

will be conducted for youth and children. An Older Adult Needs Assessment will be conducted with the 65 and older age group. This is an objective and repetitive measure in which the outcomes can be compared and tracked over time. This tool will assess the needs and risks of individuals as well.

Ensuring Back up Coverage

For all NHCP participants, individualized back up plans will be included as part of the participant's transitional plan. The plans for back up coverage will be determined by the individual's level of need and will utilize the participant's personal network of supports.

Back-up plans specifically for each waiver program which are all monitored include the following (description of further monitoring activities are under Quality Management section 8 of this protocol):

- HCBC-CFI program: A Personal Electronic Response System (PERS) device (i.e. Life Alert) is issued to all CFI participants for 24 hour back up in case of emergency. Considerable amount of time and energy has been put forth into the development and expectation that an emergency back up plan is created for all CFI waiver participants transitioning from a nursing facility. NH has formed the "Informed Decision Making Group" which is a stakeholder group, including consumers, to improve the formalized risk management/informed decision-making process. The experience of creating, tailoring, and overseeing individualized back up plans in the NHCP Project has assisted BEAS to improve its ability to address emergency situations ranging in severity for all those who receive CFI services. After the committee developed this tool the form proceeded to the "Seniors Aide NH" group for review and feedback. This is the NH resident committee made up of participants living in nursing homes. The feedback has been incorporated into the document to provide a more in-depth tool. The feedback included making a consumer version to be filled out by the consumer. After NHCP individuals in the CFI waiver program are assessed via the Risk Assessment and Barrier form they are transitioned with a comprehensive Support Plan. The service rule for Case Managers, under He-E 805, requires Case Managers to prepare back-up plans. If ensuring 24/7 coverage and supports are needed for the participant, this will be identified in the NHCP Initial Transition Plan and then the Case Managers are expected to address this need in the Support Plan. In addition, disabled individuals requiring evacuation assistance will be encouraged to register with their local fire department. The support plans will be monitored to include emergency back-up plans to include family, friends, neighbors, agency supports, local emergency assistance programs targeted to frail elderly and individuals with disabilities. Case managers are fundamentally and regularly involved in the planning and monitoring of all participants in the HCBC-CFI program. HCBC-CFI program has also a certification rule He-P 601 for Other Qualified Agencies (OQA's), which provide agency directed or consumer-directed personal care services. This rule requires each OQA to have a policy and procedure manual for consumers that includes how they assist individuals and representatives to implement an emergency back-up plan to also include in the event that the Personal Care Service Worker fails to report for work. The BEAS Adult Protective Services (APS) is also

available if abuse or neglect is of concern, and emergency support is available to those participants in the CFI program.

- For the ABD, DD, and IHS waiver programs: Services and supports are established through the ten Area Agencies under contract with the Bureau of Developmental Services. Under these waivers, Area Agencies provide direct supports and services, which are identified and addressed in care plans to individual and families that subcontract with community providers. By State contract, the Area Agencies and subcontract agencies are mandated to develop protocols for managing situations when scheduled staff is unable provide the needed services. These back up strategies will be available to NHCP participants and include, but are not limited to: 1) a 24 hour Service Coordinator on-call system, 2) use of relief/substitute staff, and 3) use of Program Managers and Coordinators to cover the staffing shortage. All individual budgets that are approved by BDS under the consumer directed service option also must include provisions for relief/substitute staff to cover in emergency situations. Per He-M 503 and 522, the process for managing situations where support staff is unable to provide needed supports is outlined in the Service Agreement. This includes identifying relief staff and knowing whom to call to arrange for back-up staff. Additionally, per He-M 503 and 522, Service Coordinators are charged with monitoring service provision, including assuring that back up plans are in effect. Specifically for the DD individuals in He-M 503.14 (j) under “Allocation of funds for current and future Individual Service Requests” NH Area Agencies are allowed to request additional resources if planful to assist for emergency situations if appropriate. If appropriate, the NHCP program would encourage Area Agency Case Managers to utilize this mechanism for its participants. The rule states:

“An area agency shall request advanced crisis funding from the bureau to provide services without delay when there are no generic or area agency resources available and an individual is:

- (1) A victim of abuse and neglect pursuant to He-E 700 or He-M 202;
- (2) Abandoned and homeless;
- (3) Without a caregiver due to death or incapacitation;
- (4) At significant risk of physical or psychological harm due to decline in his or her medical or behavioral status;
- (5) In need of necessary residential services that are no longer the legal responsibility of DCYF or LEA; or
- (6) Presenting a significant risk to community safety.

(k) To demonstrate the need for advanced crisis funding the area agency shall submit to the bureau, in writing, a detailed description of the individual’s circumstances and needs and a proposed budget.”

- Similar provisions are found in He-M 522 for individuals served under the ABD waiver.

- Additional protection for the I.H.S. waiver group is available thru the Adult and Child Protective Services in an emergency situation where there is possible abuse, neglect, and /or exploitation. This service would be initiated and if determined appropriate, a designated worker would come to the location to conduct an investigation. The investigation would then remain open until safe resolution of the individual involved is made. In cases of immediate jeopardy, there is a 24-hr network including assisted living facilities, nursing facilities, and foster care resources, available for caseworkers to access safe emergency placement.

For the Behavioral Health State Plan Service individuals 65 years and older diagnosed and 21 years and under with a mental illness: Services and supports are established through the ten CMHCs under contract with the Bureau of Behavioral Health (BBH) as the state oversight agency. Under these behavioral health community programs, CMHCs provide supports and services, which are identified and addressed in individualized treatment plans developed by the individual, and families that work in tandem with the primary case manager and treatment team. For the older population, the elder and/or adult program will serve individuals. By State contract, the CMHC's are mandated to have 24 hr on-call emergency services and developed protocols for managing situations when scheduled staff is unable provide the needed services. This is a live person who responds to a crisis or will invite in necessary and appropriate resources if needed. These back up strategies will be available to NHCP participants and include, but are not limited to: 1) a 24 hour emergency on-call system, 2) use of relief/substitute staff, and 3) use of other team members, Program Managers and other CMHC staff to cover any staffing shortages. It is stated in HeM-426.09 (b)

(b) Emergency services shall be available 24 hours a day, 7 days per week and be accessible to clients anywhere in the region served by the CMHP

There are additional resources specifically for the children and youth programs. During non-business hours, for state-involved children/youth, there is an emergency telephone number that will connect the caller to the appropriate state agency. If a youth is in an ISO (Individualized Service Option), there is 24/7 telephone availability to the provider agency. Depending on the agency, there may or may not be 24/7 mobile emergency response. Most importantly, however, is that the wraparound process will develop an individualized emergency response plan for each youth and their family.

All Community Mental Health Centers are mandated to provide access to an on-call emergency services team as needed (for further detail under "Mental Health" for all participants).

In addition, Adult Protective Workers are available for referral if needed.

- Emergency back up for all program participants:
 - **Local Fire Department sign up:** Individuals who are identified as having difficulty or unable to evacuate autonomously will be encouraged to sign up with

their local fire departments and this action will be included in their individualized support plan.

- **A personal emergency response system** (i.e.: Lifeline, Life Alert) is part of each individualized support plan. This allows for 24-hr direct access to a medical control center through an electronic device, which alerts the control center when the device is activated.
- **NH Emergency Management:** In addition the NH Department of Safety, New Hampshire's Homeland Security and Emergency Management operations is also available to all participants. In the event of a natural or man-made disaster, this Emergency Management arm of the state is responsible for coordinating the State's response to major disasters. This includes natural disasters such as hurricanes, floods and severe winter storms, and human-caused disasters, such as nuclear power plant accidents or chemical spills. In our Homeland Security function, the Bureau also works on planning and training to prepare for terrorist attacks. The Director of Homeland Security and Emergency Management is the State's primary contact with the federal Department of Homeland Security and our counterparts in other states.
- **Public Health Emergency Preparedness and Response Plan for All Health Hazards:** The State of NH has 19 "All Health Hazard Regions" identified in case of a public emergency. In the event of a public health threat or emergency the primary purpose of the response plan is to provide a framework and methodology to the coordination of communication within the regions, applicable agencies and outside departments. It is also to ensure a system for an immediate and rapid response as well as provide a system for rapid dissemination to key partners, the media and general public.

Fire Safety

Regarding fire safety, per He-M 1001, a fire safety assessment is conducted to review an individual's ability to evacuate the residence with or without assistance within three minutes. For individuals unable to evacuate their residence within three minutes, a fire safety plan shall be developed and approved by the individual or guardian, provider, and residential administrator that identifies: 1) the cause(s) for such inability, 2) the specific assistance needed by the individual from the provider, and 3) training to reduce the evacuation time to three minutes or less.

Personal Safety

For any individual living in a community residence who is receiving less than 24-hour supervision, a personal safety assessment is completed and approved by the individual or legal guardian. The Personal Safety Assessment is reviewed at least annually and revised whenever necessary. The assessment identifies an individual's knowledge of and ability to respond to each of the following: 1) fire, 2) medical emergency, 3) unsafe conditions in the home and community, 4) abuse and exploitation, 5) being lost in one's community, 6) severe weather and other natural disasters, and 7) building maintenance problems, such as power outages. If the Personal Safety Assessment determines that the individual needs assistance to respond appropriately to the above situations, the individual's team works with the individual to develop a personal safety plan. An electronic personal safety device (i.e. Life Alert) is given to all CFI

waiver participants. The individual and/or his or her legal guardian must approve the plan before the individual can be left unsupervised.

Maintaining Physical and Mental Health

According to He-M 1001, all individuals receiving residential services shall undergo an annual health assessment by a physician or other licensed practitioner for the purpose of evaluating health status and making recommendations regarding strategies for promoting and/or maintaining optimal health. This is done in conjunction with the Service Coordinator, who makes arrangements to ensure the individual has access to medical services at all times, including emergency services. The residence shall have a written policy that specifies the procedures to be followed in medical emergencies.

Per He-M 1201, Administration of Medications, an Area Agency Nurse Trainer assesses all individuals taking medication to determine the level of support that they will need specific to medication administration. Individuals who wish to take their own medication(s) are assessed by a Nurse Trainer and determined to be capable of self-medicating if they demonstrate the ability to do the following: 1) identify each medication; 2) indicate the purpose of each medication; 3) indicate the dosage, frequency, time and route of administration for each medication; 4) demonstrate an understanding of the potential consequences of not taking the medication or of not taking the medication properly; 5) indicate circumstances for which assistance should be sought from licensed persons; and 6) seek assistance, if needed, from licensed persons. The Nurse Trainer, at least annually, reassesses individuals to determine if they continue to be capable of self-medicating.

Mental Health & Substance Abuse Services

Mental health support is available for all NHCP participants, certainly not just those identified for the NHCP program, but all who have mental health issues and/or are experiencing an emotional crisis. As mentioned Behavioral Health, Psychiatric Emergency, and Crisis Services are available 24 hours a day, 7 days a week to any person who may be experiencing psychiatric distress. The following instructions for people experiencing psychiatric distress is available on the DHHS website and at Community Mental Health Centers:

“If you are dealing with an immediate crisis, please

- Call 911, or
- Call the statewide suicide hotline at 1-800-852-3388, or
- Call the national suicide hotline at 1-800-SUICIDE (784-2433), or
- Visit the emergency room at your local hospital, or
- Contact your local Community Mental Health Center.

For less urgent situations, please contact your local Community Mental Health Center, or your local peer support agency. Several of these agencies offer "Warm Lines" which provide telephone peer-to-peer support, understanding, sympathy, and advice.”

Community Mental Health Centers provide trained personnel to address psychiatric emergencies and will call in other resources as needed.

Additionally, the New Hampshire Medical Eligibility Determination assessment for CFI, the Area Agency assessment tool for the BDS waivers, as well as the BBH eligibility tool measures risk associated with substance abuse and for mental health depression screening.

The CFI waiver substance abuse risk is determined by the CAGE test, which is one of the oldest and most relied upon screening tools for alcohol abuse. It is a short, four-question test that diagnoses alcohol problems over a lifetime. The PHQ-9 test is used for mental health depression screening. The PHQ is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.

For individuals who are served through the DD, ABD, and IHS waivers, initial clinical assessments are made, service plans developed, and services are established to meet individual needs. The Bureau of Developmental services rules (He-M) additionally ensure action and back-up for those with receiving services. Provisions include the following:

1. If an individual is demonstrating behaviors that are harmful to self or others, the Program Manager or staff shall notify the Service Coordinator. In collaboration with others supporting the individual, the Service Coordinator shall facilitate the planning, implementation, and monitoring of any behavioral change program determined necessary.
2. A behavioral program or any form of intervention that is restrictive shall only be implemented if it has been approved by the individual, his or her legal guardian, the individual's team, and the provider agency in accordance with Area Agency policies including approval by the Area Agency Human Rights Committee.
3. A provider agency shall have written policies and procedures that address behavioral issues. These policies and procedures shall be directed toward maximizing the growth and development of the individual by employing methods that emphasize positive approaches to behavioral support.
4. Behavioral support policies and procedures address the following concepts:
 - a. Behavior is a form of communication and efforts should be made to understand its purpose;
 - b. There are different learning styles, skills, and motivations of individuals;
 - c. Relationships, environments, and personal histories have an impact on effecting behavioral change; and
 - d. Intentional and unintentional responses to behavior, such as ignoring, redirecting, and reinforcing, affect behavior;
5. Behavioral support procedures include the following behavior change strategies:
 - a. Preventing behavioral difficulties by adjusting the environment, responses to the individual's behavior, or both;
 - b. Creating opportunities for meaningful participation in daily life;

Teaching of mutual respect; redirect and de-escalate harmful behavior. These rules also outline specific training requirements for providers who are authorized to use the program.

Service Plan, Re-evaluation, and Monitoring

Each NHCP participant is re-evaluated annually to determine continued eligibility for their program and to identify any changes in service planning, or identified risks. Further, He-E 805

requires that the Case Managers include risk assessment in the individual's comprehensive care plan and that this plan include strategies for mitigating any existing risks.

The care plan is designed to consider all critical areas of the individual's life including:

- 1) Psychosocial history
- 2) Functional ability, including activities of daily living
- 3) Living environment, including in-home mobility, accessibility and safety
- 4) Social/informal relationships and supports, activities and interests, including vocational and spiritual and includes initial and ongoing updates of the Emergency Preparedness Plan reflective of the individual's needs utilizing either formal and/or informal supports.
- 5) Self-awareness, including the degree to which the participant is aware of his/her own medical condition(s), medication(s), and other treatment(s)
- 6) Risk, including the potential for abuse, neglect, or exploitation by self or others, as well as health, social, or behavioral issues that may indicate a risk
- 7) Legal status, including guardianship and the availability of advance directives, such as durable power of attorney
- 8) Community participation, including the participant's need or expressed desire to access specific resources, such as the library, educational programs, restaurants, shopping, and medical providers
- 9) Any other area identified by the participant as being important to his or her life.

In reviewing care plans, NHCP will work with discharge planners, and community providers to identify supports and actions needed by individual participants and will look for emerging trends that may require program adjustments. Monitoring for this is described under Quality Management section 8 of this protocol.

7. SELF-DIRECTION

The ABD, DD, and IHS waiver programs: These waiver programs all emphasize a person-centered approach to services and through philosophy and practice, support self-direction for all program participants and its Consumer Directed Services model (He-M 525: Consolidated Services). The Service Coordinator (the Bureau of Developmental Services' term for Case Manager) works with the participant and his/her guardian to develop the individual Service Agreement (Plan of Care). The participant decides who will attend the planning meeting where the Service Agreement is developed. Those invited to this meeting typically include family, friends, support staff, and other providers. The planning team is guided by the participant's wishes and preferences and the services outlined in the Service Agreement are tailored specifically to the interests, needs, and competencies of the individual. The Service Agreement reflects the choices made by the individual and or guardian, and ensures compliance with the Freedom of Choice requirement. A Service Agreement becomes effective only after being formally approved by the individual or his or her legal guardian. Self-direction is integral to the

participant's program; participants and guardians are included in making any decisions concerning the individual's supports and services. When the demonstration project ends, participants' services will continue to be person-centered services and offer opportunities for self-direction.

The HCBC-CFI program: Currently in the HCBC-CFI program, consumers or their authorized representatives can self-direct their personal care services if they so choose and to the extent that they choose, utilizing an agency with a choice model. The State is currently finalizing the design of a self-directed service model that will satisfy the requirements of the 1915(c) Waiver Program as part of its Systems Transformation Grant, with an anticipated start date of December 1, 2009. The implementation process will include amendments to both the HCBC-CFI waiver and the Operational Protocols to incorporate consumer self-direction. Once the program components have been finalized, we will be able to provide the following information for the Operational Protocol:

- Procedures for switching from self-direction to provider-managed or other service delivery and *vice versa*
- Agencies and individuals responsible for participant level counseling related to self-directed care
- Financial management services agencies under contract to provide self-directing support services
- How the number of MFP participants choosing self-directed care will be documented and monitored

State Plan Behavioral Health Services: As it currently stands there is no Self-Direct option for those receiving State Plan Behavioral Health Services at this time. The Bureau of Behavioral Health has however initiated plans for this activity and is in the development phase of this goal. It is the NHCP's role to assist in facilitating this option for the participants as much as the system currently allows and will offer to pilot this initiative. Once this is a formal option, this OP will be updated to reflect this opportunity.

8. QUALITY ASSURANCE

a. ASSURANCE OF EQUAL QA

New Hampshire integrates the NHCP demonstration into existing 1915(c) waiver programs and incorporates the same level of quality assurance and improvement activities described in The Application for a ss 1915 © Home Community Based Service Waiver under Appendix H which describes the Quality Management Strategy of each program. CMS has approved the Quality Management Strategy of each waiver program. The control numbers of these waiver programs are: For HCBC-DD: 0053E.90.R3, For HCBC-ABD: 4177.90.R2, for HCBC-IHS: 0397.R01-IP, and for HCBC-CFI: 0060.90.R4. Please see attachment for key summary points of all the NH waiver programs. The last page of this attachment provides key QA activities.

The State's detailed Quality Management System (QMS) is responsible for the provision of quality assurance for DHHS' Home and Community Based Care waivers; however, these

programs also benefit from additional QA efforts. New Hampshire was a recipient of the Real Choice Quality Assurance/Quality Improvement (QA/QI) Grant in 2004. The State's QA/QI activities include a Quality Leadership Committee within the Department of Health and Human Services incorporating and coordinating cross-bureau QA activities. This grant has allowed for the following goals for NH to achieve:

1. Design and implement a participant-centered and participant-directed inter-departmental QA and quality management infrastructure.
2. Adopt a streamlined business operations plan to include clearly defined roles and responsibilities, standardized policies, procedures, system performance standards, and practice guidelines. This is on going.
3. Adopt a standardized, automated tool to conduct clinical eligibility assessments for HCBC-CFI applicants.
4. Engage participants in active, meaningful roles in development, monitoring, and evaluation of HCBC services and system.
5. Adopt a systematic approach to measure a participant's satisfaction with services and system performance at regular intervals to guide system improvement efforts.
6. Adopt a formal plan for risk management that serves HCBC-CFI participants which has been further crafted by the MFP program and is utilized.

b. POST-DEMONSTRATION

The Quality Management System encompasses individuals served during and after the NHCP transition year and provides the same level of quality assurance and improvement activities included in the 1915(c) Home and Community Based Care waivers.

c. ASSURANCE OF QUALITY COMPONENTS

Each waiver program utilizes CMS-approved procedures to identify qualified providers, ensure appropriate assessments for program eligibility, and assure the health and welfare of all participants. The New Hampshire Department of Health and Human Services (DHHS) operates as the New Hampshire Medicaid Agency with administrative authority over each waiver program. DHHS is also responsible for the financial accountability of each program. The waiver managers and other staff review service utilization and payment to identify inappropriate billing or service provision.

New Hampshire is in the process of developing upgrades to the State's MMIS that will support the ability to compare services authorized to services delivered by waiver program providers. A standard report will be generated to inform the waiver program managers of instances of over and under utilization. An analysis will be carried out in response to each instance to identify trends and/or provider training needs.

d. DEMONSTRATION AND SUPPLEMENTAL SERVICES

Provisions of demonstration and supplemental services (although currently NH has no Supplemental Services at this time) are monitored in the same manner that is used for monitoring

other services. Case Managers from Case Management Agencies serving the CFI waiver program participants, Area Agency Case managers serving the ABD, DD, and HIS waiver participants and Transitional Case Managers will monitor service delivery and report any irregularities. The reports for the CFI participants will be directed to BEAS and irregularities for the other waiver programs will be reported to BEAS. If services are not delivered as authorized, the appropriate bureau (BEAS/BDS) will follow up with direct contact to the provider and will determine what, if any, remediation is appropriate. It is important to note that in this OP there are no identified supplemental services. After notification and consultation in late summer of 2010 with CMS assigned Technical Assistance Bob Mollica, NH was identified as being able to move what was previously assigned as a “supplemental service” to be reassigned and met the definition of a demonstration service.

Each Waiver program under the administrative rules specific to each waiver and under Appendix H inherently incorporates a plan for risk assessment and mitigation process to ensure that a 24-hour backup system is identified and is being carried out for all NHCP participants. Under BDS the Area Agencies are State mandated to have a 24-hour backup system in place for all waiver participants to access. For the CFI waiver participants, BEAS monitors tailored personal safety systems via initial and on-going Support Care Plan reviews and personal safety alarms for all participants. The plans can range from what to do if a care provider does not show up to having an emergency evacuation plan for participants. This monitoring occurs through the quality measures that are identified in Appendix H of each approved Waiver. All MFP participants fill out a detailed emergency preparedness packet, and this is kept in the MFP file as well as the clinical file. Specifically, NH has a three level QM activity process that address both individual and systemic issues.

1. Frontline activities: Specifically for the NHCP participants, this includes the Quality Case Management quarterly and annual reviews conducted by BEAS for CFI and BDS in coordination with Area Agencies. The activity focuses on program services and the goal of ensuring the health and welfare of the participants.
2. Mid-level activities: These activities focus on the compilation, review, and analysis of information generated from front line activities. Results of these mid-level activities are communicated to front-line sources and system-wide trends are identified. Results may require additional training and clarification of policies and procedures.
3. Systematic-level activities: These activities involve the ongoing review of QM activities, reports to identify trends, systemic issues, remediation steps identified and initiated, and improvement goals. NH has established an internal QM Leadership Committee to focus on systemic view of the NH Waiver Programs. And long-term care services.

The Bureau of Behavioral Health Quality Oversight:

The Bureau of Behavioral Health (BBH) is part of the Division of Community Based Care Services within the Department of Health and Human Services. BBH is New

Hampshire's designated State Mental Health Authority, and is responsible for providing oversight to New Hampshire's community mental health system with 10 regionalized Community Mental Health Centers, as well as peer and mutual family support services. BBH is also responsible for ensuring the effective and efficient delivery of services to adults with severe mental illness and children and adolescents with serious emotional disturbance. Community mental health services are provided through 10 independent community mental health centers designated by BBH as the regional community mental health program. As the State mental health authority, BBH provides funding and oversight to each of the 10 community mental health programs (CMHP's) through contract and administrative rule. Performance audits are conducted in the community pursuant to authority granted by law and contract.

RSA 135-C:5, II:

The commissioner or designees may conduct site visits and may otherwise audit and monitor all aspects of the administration, fiscal operations, and services of the program providing the service to determine compliance with the rules authorized in RSA 135-C: 61.

RES 126-A:4, IV:

The department may establish a quality assurance program. Any quality assurance program may consist of a comprehensive ongoing system of mechanisms for monitoring and evaluating the appropriateness of services provided to individuals served by the department or any of its contract service providers so that problems or trends in the delivery of services are identified and steps to correct problems can be taken.

Contracts with the CMHCs:

The Community Mental Health Centers agrees via contract that it will perform, or cooperate with the performance of, such quality improvement and/or utilization review activities as are determined to be necessary or appropriate by BBH within timeframes specified by BBH in order to insure the efficient and effective administration of the Medicaid program. Hence, each Community Mental Health Center has its own internal quality assurance program and protocols for monitoring, oversight, reporting and remediation in coordination with BBH.

Reapproval Process Every 5 Years:

In accordance with State of New Hampshire Administrative Rule He-403 Approval and Reapproval of Community Mental Health Programs, reviews of community mental health programs (CMHP) occur upon application and thereafter every five years. The purpose of He-403 is to define the criteria and procedures for approval and operation of community mental health programs. A reapproval review of a Community Mental Health Center (CMHC) also generally includes a Board of Directors (BOD) Meeting. The State Review team includes staffs from the Department of Health and Human Services (DHHS), the Bureau of Behavioral Health (BBH), and the Office of Improvement, Integrity and Information (OIII). It also includes the following:

The CMHC submits an application for reapproval as a CMHP that includes:

- A letter requesting Reapproval;
- A description of all programs and services operated and their locations;
- The current strategic plan;
- A comprehensive listing of critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;

- The Mission Statement of the organization;
- A current Board of Director list with terms of office and the towns represented;
- The By-Laws;
- The BOD meeting minutes for Calendar for the year;
- The current organizational chart;
- Various job descriptions;
- The current Quality Improvement Plan;
- The current Disaster Response Plan.

Additional sources of information prior to the site visit may also include:

- Special Projects reports
- Evidence Based Practice (EBP) Fidelity Reviews
- BBH QI and Compliance Reports Five Year Trends;
- BBH Community Mental Health System Annual Report of Financial Condition for Fiscal Year with Five Year Financial Trend Analysis;
- Any Public Notices published in local newspapers soliciting feedback
- A letter to GNMHC constituents soliciting feedback regarding the CMHP;
- Staff surveys soliciting information from GNMHC staff regarding training, supervision, services and CMHP operations.

The site visit to a CMHC includes:

- Review of additional documentation including: orientation materials for new BOD members; the Policy and Procedure Manual; Interagency Agreements and Memoranda of Understanding (MOU); and a sample of personnel files;
- Interviews with the BOD, the CMHP Management Team, the Chief Financial Officer (CFO), Human Resources Director.

Similar front line, mid-line and systematic review activities are conducted within BBH. All complaints are mitigated with the CMHC staff and their complaint process internally. These are summarized by the CMHC, reviewed and reported to BBH. All BBH participants may utilize any of the pathways described above at the DHHS level to make an official complaint in which it would then be investigated (see attachment Page for BBH Quality Oversight Summary in general).

Other Quality Management and Monitoring:

In addition, the NHCP staff will track the number and types of participants' requests that are not addressed in a timely and satisfactory manner. NHCP staff will access information thorough the NHCP participant database to determine the wait time from application to service delivery. The database tracks the date each participant enters the NHCP project, the time from the individual's request to enroll in NHCP to the date he or she is discharged from the facility, and the time frame in which transition services and supports are provided. The database also tracks progress as the participant transitions from the nursing facility to the community and provides information about payments for transition services. Finally, each NHCP participant completes a Quality of Life survey prior to discharge, after 12-months in the program, and again at 24-months; this survey assesses participant satisfaction with their life in the community and their supports and services.

The NHCP requests all reports pertaining to participants' personal safety, rights, and satisfaction with services. The BEAS, BDS, and BBH Quality Managers receive the monthly report results that include: 1) the number of cases reviewed each month, 2) the number of incidents and incident descriptions, 3) the outcomes for each incident that required action, and 4) dates on which remedial action was taken. The bureaus also conduct annual case management records reviews and will conduct focused reviews relative to NHCP participants.

MFP staff follow up: In addition to these items mentioned above, the MFP individuals, case managers, and providers are contacted frequently for follow up to ensure identified needs are met. This is also to ensure any additional items are identified and followed up with. This is an on-going dialogue through out the transitional year.

Critical Incident Protocols, Sentinel Events, and Monitoring:

Additionally, the BEAS, BBH, and BDS identified Quality Manager receives all incident/complaint reports relevant to participants that are generated quarterly in summary format by the Area Agencies, Community Mental Health Centers, and Case Manager Agencies reported by individual participants, providers, and the general public. The various bureau quarterly Quality Management reports are prepared for bureau management and for DCBCS Quality Leadership. Each bureau at the management level monitors this information by quarterly and annual case management reviews. The reviews are then synthesized and presented to the specific Bureau management for further discussion. The results of the case management reviews and other reports regarding participants are brought to the Division's Quality Leadership Committee, which is overseen by the Deputy Director of DCBCS. Finally, throughout the course of the project, BEAS will regularly provide the Health and Human Services Oversight Committee of the New Hampshire Legislature with updates on the progress of the NHCP. For more serious events, DCBCS has a Sentinel Event Protocol to collect, review, respond to, and analyze any event of a catastrophic nature that has an adverse impact upon a project participant, regardless of the waiver program through which he or she is now being served. This protocol is utilized for not only waiver programs but for other DHHS services. The Protocol defines events as well as specific procedures. The protocol includes a case analysis process designed to identify systemic issues that may have contributed to the event. The state recognizes that understanding the circumstances surrounding the specific event is critical to identifying potential systemic improvements. An annual report is submitted to top level state agency administrators, including the various Waiver Program Managers, and Bureau Chiefs.

d. COMPLAINT PROCESS

1. Complaints by the MFP participants made directly to the MFP Program Director and staff will be followed up with depending on the nature of the complaint by following the protocols currently in place and described below. Any NHCP participant has the right to make a complaint to MFP staff. The MFP staff will forward this to the appropriate agency and/or others involved so that this complaint will be attempted to be resolved. All participants will be supported to take appropriate steps in finding out how to file a formal complaint regarding the nature of the complaint (i.e.: privacy has been violated, a complaint against a health care facility, housing complaints etc).

2. Bureau of Licensing and Certification: This Bureau is administered centrally from state offices in Concord. Most field staff are out-stationed and are generally responsible for provider licensing within their assigned geographic areas. All licensing functions focus on the safety of consumers. The Bureau of Licensing and Certification (BLC) has three distinct areas of licensing responsibilities: Child Care, Health Facilities, and the Administratively Attached Boards. Each licensing area conducts its activities through on-site inspection and monitoring visits performed by licensing specialists who have expertise in their particular fields. Additionally, licensing staff provide technical assistance to new and existing providers and are responsible for investigations of consumer complaints.
3. The Ombudsman Office at DHHS: This office serves all of DHHS and accepts general complaints about actions taken by the Department. Participants in all waiver programs also have the right to appeal any program decision; this right is clearly conveyed in both written and oral communication, in a means understandable by the participant and his or her representative. Appeals of decisions are made through the DHHS Administrative Appeals Unit. Additionally, if a participant has a general or specific complaint, he or she may bring it to DHHS' attention through: 1) the assigned Case Manager; 2) the BEAS Adult Services Social Worker; 3) the Area Agency or subcontractor; and 4) police, fire, local health, safety, or other local officials.
4. The Office of Long-Term Care Ombudsman (OLTCO) provides another avenue for bringing forward complaints for BEAS participants. OLTCO receives, investigates and resolves complaints or problems concerning residents of long-term health care facilities, including residential care homes. The program also provides advocacy services to long-term care residents, and it comments on existing and proposed legislation, regulations, and policies affecting long-term care residents. Education is provided to residents, family members, and facility staff concerning a wide variety of long-term care matters, including the rights of residents.
5. State rules, He-M 202, Rights Protection Procedures, safeguards the rights of individuals served by the developmental services or the behavioral health systems. The purpose of this rule is to "define the procedures for protection of the rights of persons applying for and receiving services in facilities, CMHCs or their subcontractors, Area Agencies or their subcontractors, alcohol or other drug abuse treatment or prevention programs, and emergency shelters." The complaint system outlined in He-M 202 is administered by the Office of Client and Legal Services and requires that each facility, Area Agency, alcohol or other drug abuse treatment or prevention program, and Community Mental Health Program must have one or more persons designated as complaint investigators.
6. Adult Protection: Any complaint involving abuse, neglect, or exploitation is a priority and investigated promptly. The Adult Protection law, RSA 161-F:42 *et seq.*, identifies who is obligated to report suspected abuse, neglect, or exploitation of any incapacitated adult. The purpose of this civil (not criminal) law is to provide protection for

incapacitated adults who are age 18 years and older who are abused, neglected, exploited, or who are self-neglecting. The Adult Protection Program now includes a structured decision making process to ensure social workers follow a consistent approach in investigating complaints. The Central Intake Unit is responsible for receiving complaints from all areas of the state. A special investigation unit within BEAS is responsible to investigate reports involving incapacitated adults who live in or who are participating in homes/programs administered by or affiliated with the DHHS Bureaus of Behavioral Health or Developmental Services.

7. New Hampshire State law RSA 151 includes a Bill of Rights for residents of licensed residences and for individuals receiving home health services.
8. The approved HCBC-CFI waiver document includes a plan to develop a complaint intake and investigation process; this process however at this time has been developed and is now in use. Complaints are received and addressed by BEAS RNs, Case Managers, and Case Manager Supervisors and State agency staff. The new process enables the CFI Waiver Program Manager, the BEAS Quality Management Coordinator, and the Quality Management Leadership Committee to analyze the type and number of complaints from a systemic level to look for trends by geographic region and provider, to identify statewide issues, and to develop plans for improvement.

e. Quality Assurance Summary (four critical components)

1. Description of NH's incident reporting system

All MFP individuals in the waiver programs follow the same reporting system the CMS approved waiver programs follow. New Hampshire integrates the NHCP demonstration into the existing 1915(c) waiver programs and incorporates the same level of quality assurance and improvement activities described in the Application for a 1915 © Home Community Based Service Waiver under Appendix H which describes the Quality Management Strategy of each program (the control numbers of these waiver programs are: for HCBC-DD: 0053E.90.R3, For HCBC-ABD: 4177.90.R2, for HCBC-IHS: 0397.R01-IP, and for HCBC-CFI: 0060.90.R4). Under the waiver programs the State's detailed Quality Management System (QMS) is responsible for the provision of quality assurance for DHHS' Home and Community Based Care waivers. The Division of Community Based Care Services (DCBCS) has established the Sentinel Event Protocol, which is a process for identifying and reporting unexpected serious events involving individuals served by DCBCS. This protocol is in the process of becoming a department wide policy. At the discretion of the DCBCS Deputy Director, who is also the DHHS Quality Improvement Director, a review of a sentinel event may be conducted. The purposes of a sentinel event review are to review relevant information, to discuss recommendations designed to reduce the risk of a similar event occurring in the future and to determine whether an action plan is necessary. An annual report is submitted to the office of the DHHS Commissioner, DCBCS bureau administrators and the DCBCS Quality Leadership Committee.

As mentioned, to ensure that these processes are followed so for complaints and incidents, BDS and BEAS have a process of review in place. For the BEAS participants, the QA

manager receives all incident/complaint reports in summary format on a quarterly basis from the case management agencies. BDS has a committee of staff from the 10 Area Agencies that meet monthly to review complaints and incidents. A summary is generated quarterly and sent to The Bureau of Elderly and Adult Services (BEAS) Long Term Care and Bureau of Developmental Services (BDS) waiver administrators receive all reports relevant to NH Community Passport participants and are responsible for analyzing these, and ensuring that remedial action is taken whenever it is warranted. Community providers are not required to send complaints and incidents reported to them on an individual basis to BEAS or BDS; however the bureaus require a quarterly report that summarizes the complaints and incidents received by the case management and area agencies. BEAS Complaint and Incident Reporting and Management policy addresses those complaints and incidents reported to BEAS; community providers, such as case management agencies, as well as BDS Area Agencies receive complaints and incidents and are responsible for reviewing and investigating those as well. BEAS' semi-annual Quality Management reports are prepared for BEAS management and for the DCBCS Quality Leadership Committee

An annual long-term care case management program evaluation is conducted which includes a review of a representative sample of Choices for Independence cases. The results of the case management program evaluations and other reports regarding participants are brought to the Division's Quality Leadership Committee, which is overseen by the Deputy Director of DCBCS, and distributed to the BEAS management team. Finally, throughout the course of the project, BEAS will regularly provide the Health and Human Services Oversight Committee of the New Hampshire Legislature with updates on the progress of the NHCP.

The Bureau of Behavioral Critical Incident reporting is very similar process as the BDS process. The CMHC's are contracted with and must follow the Quality Assurance program protocols outlined by BBH. BBH staff along with other DHHS quality oversight staff ensures with the CMHCs, via site audits, protocol and process review, document audits, and staff interviews that the process is adhered to.

b. POST-DEMONSTRATION: The Quality Management Systems of the waiver programs and the state plan services will encompass individuals served during and after the NHCP transition year and the same level of quality assurance and improvement activities included in the 1915(c) Home and Community Based Care waivers will be provided thereafter.

2. A summary of NH's oversight of the MFP community services provided how NH ensures that this system is working as planned

The NH State Administrative Rules governing the state waiver services require that the case management, area agencies, CMHCs, and providers serving the NHCP participants must report and follow the reporting protocol for any situation meeting the sentinel event criteria. In addition, long term care case management, community mental health centers, and area agencies are required to submit quarterly quality management reports that include the results of their case record reviews, descriptions of any deficiencies noted, identification of any remedial actions taken and/or planned and summaries of unmet needs.

In addition, DHHS BDS, BBH, and BEAS Quality Assurance teams conduct a number of quality management activities that monitor the case management agencies, area agencies, and

CMHCs. This feedback system allows for each bureau to have information to monitor and evaluate the quality, appropriateness and effectiveness of its program.

3. A brief description of NH's risk assessment and mitigation process for all MFP individuals as well as a description of NH's oversight of this activity

The risk assessment and mitigation process and activities for the three waiver programs administered under the Bureau of Developmental Services (I.H.S., D.D., A.B.D.) are conducted by the Area Agencies in collaboration with State Waiver Managers, the discharging institutional health care providers, the participating individual and any involved family or identified support. Once it is determined that the needs of the individual can be met in the community, the Area Agency develops a Support Plan and budget. Risks are identified and mitigated by a variety of individually tailored solutions depending on need. This process was fully developed and implemented by BDS as well as 24-hour on-call availability. Each NHCP participant is re-evaluated annually to determine continued eligibility and to identify any changes in risk.

The risk assessment and mitigation process for individuals discharging from IMD's or PTRF's are conducted by the discharging social workers, the treatment teams, and the CMHC liaison staff and any involved family or identified support. Once it is determined that the needs of the individual can be met in the community, facility staff develops a community Treatment Plan and the eligibility determination form is reviewed by BBH. Risks are identified, a Crisis Plan is created (a mandated document for the CMHC staff to create and have on file) and plans are put in place depending on need. This process is developed by the facility staff, the CMHC liaison staff, and implemented by the CMHC upon discharge, as well as 24-hour emergency on-call availability. Each NHCP participant is re-evaluated annually to determine continued eligibility and on-going assessment by cmhc staff to identify any changes in risk. The NHCP Behavioral Health Transition Coordinator will be reinforcing this process for the pediatric population as the NH STAR program continues to build infrastructure for this population. Each NHCP/NH STAR participant will have a community mental health center involved (as well as other systems).

He-E 805 requires that the CFI waiver long-term care Case Managers include risk assessment in each individual's comprehensive care plan and that this plan include strategies for mitigating any existing risks. CFI NHCP participants work very closely with MFP staff during transition preparation regarding risk identification and mitigation who in turn work very closely with family, community providers (case manager, community nurses, and other supports) and the institution staff. This process continues to be developed, strengthened, and as a result new tools have resulted. For example as mentioned, The Informed Decision Making tool, the Risks and Barriers tool, the Emergency Preparedness Packet, as well as the Transitional Support Plan worksheet are all examples of documents created to assist with this process. The State has also added a service, transitional Case Management service, that allows the Community Case Manager to begin coordination of services before discharge and to fine-tune the community Support Plan developed after the Medical Eligibility Determination assessment is completed.

4. A brief description of the 24-hour backup system for MFP individuals and NH's oversight of this activity, i.e. how will NH ensure that this system is working as planned.

ABD, DD, and I.H.S: NH has a 24-hour on-call service for MFP participants served under the BDS waiver programs (ABD, DD, I.H.S). This service is mandated by administrative rules. This service is operated and monitored by the Area Agencies. Normal use activity is logged and monitored by the Area Agency.

CFI: NH has a 24-hour on-call Personal Electronic Device Systems or PERS (i.e.: Life Alert, Medi-Alert) in place for all MFP participants for the year they are on MFP. This is newly implemented as a needed service as there is no administrative rule mandating case management agencies servicing this population to have a 24-hour on-call service available. Upon discharge from an institution each MFP participant must now have the PERS in place. Reports will be requested on individual use of the PERS from the company utilized. In addition all participants fill out the Emergency Preparedness packet for an individualized, comprehensive emergency plan in case of emergency. Once filled out a copy is in the participant's clinical file as well as in the state office MFP file.

Long term care case managers are responsible for ensuring that the Support Plan identifies any risks and documents an Emergency Plan to address the risks.

The State Plan Behavioral Health: These participants will have access to a Community Mental Health Center provided 24/7 Emergency Services Worker to answer their call which is mandated by the state. All 10 of the state's community mental health centers provide an emergency services line in the area and will provide assessment response as needed. These are specially trained counselors who will bring in additional resources as needed.

9. HOUSING

a. DOCUMENTATION AND TYPES OF HOUSING

NHCP participants will be able to transition from the nursing facility to any qualified residence. Qualified residences include:

- Adult Family Home Care, this is care provided in private homes by the homeowner, to one or two residents. The homeowner lives in the residence with the residents. These homes are certified by DHHS
- Residential care homes for individuals with developmental disabilities limited to four or fewer residents per residence; these homes are certified by DHHS.
- Individual private homes and apartments; these are private residences owned or rented by the participant and/or his/her family or friends.
- Residential care homes for adults with disabilities or seniors, with four or fewer residents; these homes are licensed by DHHS. This will include the residential apartments under the direction of the CMHCs.
- Congregate care and other supported apartments. These apartments are private residences, typically in public housing, to which one home care provider provides a range of HCBC services to individuals in several units.

The Area Agencies are responsible for tracking all individuals participating in the HCBC-DD, ABD, or IHS programs. The BEAS utilizes the Options System to track participants in the

HCBC-CFI program. Options is the electronic tracking system that contains case management and nursing case notes and reflects each person's long-term care eligibility status. The housing arrangement for each HCBC-CFI waiver participant is documented in his or her individual file and maintained by the Case Manager. Although Case Managers are responsible for authorizing services and ensuring that adequate services are in place, NHCP staff within BEAS will be responsible for identifying which individuals will be counted as having transitioned into qualified residences.

b. HOUSING SUPPLY AND DEVELOPMENT PLANS

Housing availability is a chronic and ongoing problem in New Hampshire, with accessible housing being hardest to find. The provision of home modifications through NHCP is helpful to some extent, but is not always the solution to securing accessible housing.

The two counties initially targeted for NHCP, Hillsborough and Merrimack, are home to New Hampshire's most urban/suburban areas and offer the greatest array of resources and opportunities. Beginning in year two, NHCP was expanded to include the state's other eight counties. Supported housing is available statewide with new construction due for completion through the Manchester Housing and Redevelopment Authority, which will include the availability of 37 additional units with supportive services availability. The BEAS Director of Operations, the NHCP Project Director, and project partners will collaborate with programs and initiatives that are working to develop and expand home and community based housing and supportive services options in New Hampshire.

DHHS promotes the availability, affordability, and accessibility of qualified residences. The Department has worked to identify and address the barriers that have hindered the expansion of home and community based long-term care. In addition, DHHS is collaborating with a wide variety of public and private stakeholders to increase the availability of affordable and accessible housing in the state. The Department is working in partnership with State and local Public Housing Authorities (PHAs) and housing finance agencies to enhance the ability of these organizations to provide assistance with referrals and housing supports for those individuals served through DHHS programs. The New Hampshire Housing Finance Authority (NH Housing) Directory of Assisted Housing, which is published regularly, provides individuals and organizations with a comprehensive listing of federal and State subsidized housing, including a list of accessible units within each housing facility. NH Housing also provides data on identified housing shortages for persons who are transitioning from nursing facilities under the NHCP demonstration grant. DHHS is providing education and training about the NHCP Project to NH Housing, PHAs, and other State housing programs and asking for their assistance in helping to address the housing needs of participants, including access to rental subsidies. This will be accomplished through the utilization of the Consolidated Plan process for HUD funded housing programs, the Qualified Allocation Plan process for Low Income Housing Tax Credits, and consultation with local PHAs on individual cases.

DHHS also is promoting housing availability by partnering with funders and housing developers to access a variety of housing production and rehabilitation programs including:

1. HOME Investment Partnership Program, funded through the US Department of Housing and Urban Development (HUD) and administered by NH Housing -This program finances the development of rental housing for low and very low-income households. Through this federal program, projects are provided with subordinate, deferred mortgage loans payable on resale or refinancing. Approximately 60 -70 units receive are financed annually in New Hampshire. A portion of funds is reserved for the exclusive use of community housing development organizations (CHDO).
2. Low Income Housing Tax Credit Program (LIHTC) – This program, also administered by NH Housing, provides an effective vehicle for encouraging private investment in new affordable rental housing. Eligible projects receive federal income tax credits over a ten-year period, commensurate with the percentage of the units set aside for eligible households. In order to be eligible, a minimum of 20% of the project must be targeted to households earning 50% or less of median area income or 40% of the project must be targeted to households earning 60% or less of median area income. Sponsors commit to these affordability levels for 99 years.
3. Community Development Block Grant Program (CDBG) - Funded through HUD and administered by the NH Community Development Finance Authority (CDFA), this program provides funding for rehabilitation, land acquisition, and site preparation for housing that is occupied or will be occupied by low and moderate-income households. Only municipalities and counties are eligible to apply, but they can do so on behalf of for-profit or non-profit housing developers.
4. Community Development Investment Program (CDIP) - Administered by CDFFA, this program is used to expand affordable housing production. Approved project sponsors raise project money within an allocated time frame; CDFFA issues State tax credits to project donors for 75% of the donation value (a \$100,000 donation provides an approved donor a \$75,000 State tax credit). The tax credit may be applied against the business profits tax, business enterprise tax, and/or the insurance premium tax and also may be taken as a charitable contribution.
5. Section 202 Supportive Housing for the Elderly/Section 811 Supportive Housing for Persons with Disabilities - The Section 202 and 811 Programs, funded through HUD, provide capital advances to finance the construction, rehabilitation, or acquisition with or without rehabilitation of structures that will serve as supportive housing for very low-income elderly persons, including the frail elderly (202) and persons with disabilities (811). The programs also provide rental subsidies for the projects to help make them affordable. Programs are highly competitive and allocated on an annual basis.

DHHS will continue to help to assure promotion of affordable housing through partnering with NH Housing and local PHA's programs to:

1. Assist individuals in applying for Housing Choice Vouchers through the ACCESS Preference offered by NH Housing. Households with a family member eligible for services through the Home and Community Based Medicaid Waiver Program currently receive this preference.
2. Assist individuals in applying for Housing Choice Vouchers through NH Housing's ACCESS 2000 Nursing Home Transition Program that provides rental assistance to

very low-income non-elderly persons who reside in a State licensed nursing home or assisted living facility to enable them to move to a lower level of care or independent housing.

3. Promote NHCP to PHA's to establish a preference for NHCP participants in their Housing Choice Voucher Administrative Plans.

Further, BEAS will continue to work with interested agencies to establish a supported housing service for seniors and adults with disabilities similar to the Enhanced Family Care model that is available to people with developmental disabilities. Adult Family Care offers care in a private home to one or two people whose needs are met by the homeowner(s). The enhanced federal matching rate that is available through NHCP will assist us in this development.

NHCP will verify that for participants who are transitioning into qualified residences, these residences have been licensed or certified by the appropriate State or local entities.

Housing Specialist: Despite these above mentioned on-going efforts, partnering, applying for the NOFA vouchers back in the summer of 2010 and the recent 2012 opportunity which NH did apply for etc, it is in this Operational Protocol as a result of the 2010 legislation allowing the extension of the program that NH has decided to request formal 100% administrative support in this area to dedicate one FTE Housing Specialist to the above tasks through to 2016. This has been an on-going barrier to successful transitions and a repetitive stakeholder concern that people in institutions have difficulty securing safe, affordable, and accessible housing by themselves. One full-time employee position is being requested for the next five years to assist MFP individuals statewide looking to transition from a nursing facility as well as any individual receiving Medicaid, for whom accessing safe affordable housing is a barrier to living independently. This position will partner with NH's Bureau of Housing & Homeless and supervisor Maureen Ryan. This position will initially begin with the MFP population and will work with ServiceLink (NH's ADRC), housing agencies (HUD, VA VASH, NH Housing Authority), Community Action Programs, nursing facility discharge planners, and other community members to assist find appropriate housing. After a year of implementation, the position will expand to assisting individuals identified with the MDS 3.0 Section Q struggling to find housing as well. BEAS has wanted to utilize the Family Home Care Model to increase housing options to the CFI waiver population and this position will also be working hard to make those connections for people interested in this option. This position will be dedicated to forge new infrastructure building by partnering with area agencies to find families who are willing to offer their homes despite the reimbursement. They will be expected to create participant profiles for families interested in offering their homes, and arrange for home visits, or family meetings. There is no one person dedicated to this work.

The Housing Specialist duties will also include:

1. Working with facility social workers to guide them through resident housing search;
2. assisting individuals with all aspects of housing search and placement into appropriate housing;

3. working with clients to develop an appropriate housing search strategy (scanning the newspapers and on-line community resources, creating personal profile to show interested families);
4. completing housing applications as needed;
5. preparing necessary documentation; and negotiation with landlords, housing authorities and realtors.
6. The position will conduct housing stabilization activity with the individuals for 6 months post placement to ensure that the move was supported, needed items obtained, and that the individual is connected with community resources such as: the D.O, medical services, social services, independent living centers, and other social services such as food pantries and other needed linkages.
7. Data will be collected on the following: Housing history, current housing, and service needs.

NH anticipates that this dedicated resource will allow for individuals living in institutions to have the resource needed to find a safe and affordable home, will increase the utilization of the Family Home Model and OP benchmark, will increase MFP transitional numbers, as well as decrease total length of time from application to transition. NH often times cannot transition a person without housing to go to without a long wait.

The Family Home Model Benchmark: This benchmark continues to be important yet has not been highly utilized in general and certainly not by the MFP participants. A dedicated person is needed to get this new concept for elders to expand. It is successful in NH in the BDS system thus far. However, NH has discovered a financial barrier in that the reimbursement for this model of care is much lower than the offered BDS current reimbursement. NH BEAS is utilizing the BDS network for families and home, and unfortunately the lower reimbursement rate has been the biggest reported barrier. A Housing Specialist will dedicate time to bring actual MFP participants interested in this model to meet families, create a personal profile for that individual so the family can learn about that person as an individual so that the financial aspect is not the main issue, but that the person interested in transitioning to a family home becomes the focus. This position would be expected to widen the network to other state areas as well.

2013 Update: NH partnered in 2011 with its Center for Independent Living (CIL) and their successful housing program. The CIL was contracted to provide 1 FTE for the NH MFP program.

10. CONTINUITY OF CARE POST DEMONSTRATION

Continuity of care is guaranteed for NHCP participants following the designated demonstration period. Each DHHS waiver program accepts an increased number of applicants through this project, with the understanding that each new program participant will continue to be served through the waiver after the end of the first year of a supported transition. Waiver participation starts on the day of discharge, and continues for as long as the person remains eligible for the program. Eligibility criteria are defined in each approved waiver and participants are not

anticipated to become ineligible unless their condition improves substantially, their income increases above the allowable limit, or they can no longer be supported in the community.

State-Plan services will continue on after the one-year in the MFP program has ended. These services are an entitlement and will be provided as long as the participant is eligible.

Post-transition continuity of care is assured for each project participant through the following mechanisms:

1. The clinical eligibility screening process ensures that people meet all waiver and state plan services eligibility requirements prior to discharge planning. The screening process will:
 - a. Assess the person's needs and the person's awareness of his or her needs;
 - b. Assess the person's expectations for community living;
 - c. Assess the availability of the individual's social support network in the community;
 - d. Identify any barriers to transition that must be resolved prior to transition;
 - e. Identify what is needed to support a successful transition for the individual; and

Develop an action plan that assigns staff and services with responsibility/accountability for meeting specific expected outcomes.

2. The person-centered planning process begins on the day of referral and ensures that the participant has the support to move swiftly through the eligibility and service planning process. The planning process includes:
 - a. A sustainability plan to avoid a disruption in necessary services and supports;
 - b. An oversight plan to ensure that the necessary measures are in place for service continuity and to guarantee the individual's safety;
 - c. A site visit prior to discharge to the participant's new home in the community to ensure that everything needed is in place prior to the transition.
3. DCBCS ensures that community based services have been arranged and are in place prior to the participant's transition. NHCP, case managers, and care coordinators will work collaboratively with the participant and care team to:
 - a. Identify the needed services;
 - b. Identify the providers that will be engaged and establish the start date(s) for services; and
 - c. Plan and set the time frame to re-assess the participant's situation post-transition to ensure that individual is adequately supported and satisfied with his or her services. (If needed, changes to the individual's Plan of Care will be made and when necessary, additional supports will be provided.)
4. Post MFP: MFP Staff also ensure that upon MFP program discontinuation that at the time of the 1-year QOL the individual is assessed as having the needed services or resources in place. If not, they will work with case managers, NH's ADRC ServiceLink, and other supports to find other resources as needed.

C. ORGANIZATION AND ADMINISTRATION

a. ORGANIZATIONAL STRUCTURE

The NHCP project is managed through the Division of Community Based Care Services (DCBCS). The Project Director reports to the BEAS Administrator; this organizational structure ensures that NHCP is well integrated within this Division. The NHCP Project Director attends the monthly DCBCS intra-Bureau meetings that are convened by the Deputy Director of DHHS; this ensures that the Project Director has frequent and regular communication with the Bureau of Developmental Services, the DHHS office responsible for administering the DD, ABD, and IHS waiver programs. The DCBCS Director is also the Associate Commissioner of New Hampshire's single state Medicaid Agency, the Department of Health and Human Services.

The NHCP Project will have a high profile within DHHS and open access to DHHS administrative leadership, including the State Medicaid Director. The Director of DCBCS and Associate Commissioner will provide direction for the project, ensuring that NHCP benefits from the input and oversight at the highest administrative level within DHHS. The Bureaus of Elderly and Adult Services, Developmental Services, and Behavioral Health are all housed within the DCBCS and the Bureau Administrators report directly to the DCBCS Director. This structure provides significant coordination of services across programs, as well as a high-level support within the DHHS. The Office of Medicaid Business and Planning (OMBP) is part of the Office of the Commissioner within the Department. Day-to-day business operations between DCBCS and OMBP ensure frequent communication and collaboration. For example, a Medicaid/Medicare Part D monitoring group meets monthly and includes representation from each bureau and from OMBP. DCBCS also works closely with the Division of Family Assistance, which is responsible for determining financial eligibility for Medicaid and waiver eligibility.

The DHHS organizational chart slides were submitted with the original OP. The current New Hampshire Department of Health and Human Services organizational chart and the BEAS organizational chart, which shows the reporting relationship of the NHCP, is found in the Attachments Section.

b. STAFFING PLAN

NCHP will be staffed through DHHS and the Institute on Health Policy and Practice at the University of New Hampshire. DHHS staff positions have been filled and Margaret Almeida, BS,BSN,RN,BC,MBA, began her duties as Project Director on January, 4, 2010.

- a. **Project Director:** Due to New Hampshire's current hiring restrictions within State agencies, and the expertise the Institute has with programs, the new Project Director is hired through the University of New Hampshire and will work with the Institute for Health Policy and Practice at UNH. The Project Director is responsible for overall project management, outreach development, policy development, budget management, training and supervision of project staff, and program analysis. The Project Director reports to the BEAS Administrator and 100% of the Project Director's time is dedicated to the NHCP. .

- b. **A Waiver Program Specialist/Transitional Coordinator:** Caroline Trexler has been hired and started in the position on September 17th, 2010, working 100% for the NHCP project. This Program Specialist is responsible for managing the project plan and assisting with project management, including supporting NHCP's day-to-day program operations. The Program Specialist is NHCP's liaison to the tCMs and coordinates education, outreach, and training activities. This transitional coordinator works with the waiver program participants, gathers the consents and release of information documents, is active in transitioning planning for discharge over the following year.
- c. **Behavioral Health Program Specialist/Transition Coordinator:** This position was filled in October of 2011 to work 100% for the NHCP project. This position is responsible for managing the project plan and assisting with project management, including supporting NHCP's day-to-day program operations for the State Plan Behavioral Health Services eligible participants. This position is NHCP's liaison to the State's Community Mental Health Center network, the state's hospital specifically for people with acute mental illness (state IMD), the state's nursing home called The Glencliff Home, which is a specialized facility serving nursing home level of care individuals with co-morbid major mental illness. This position coordinates transitions, provides education, outreach, and training activities to these facilities and agencies. This transitional coordinator works with the behavioral health referrals and is specially trained with a mental health background. They will be responsible for explaining the program, collecting the consents, will be active in the transition planning, and will follow the participants in the program over the year while in the program (see Page 18 and Pages 52-59 for job duties and process/role description).
- d. **CFI Nurse Supervisor:** The BEAS Nursing Supervisor provides clinical direction and oversight and directs the clinical transition planning for CFI participants. This position is part of the risk assessment and mitigation process and review team. No administrative assistance is being requested at this time.
- e. **Program Support:** .25 FTE thru the end of the project to coordinate intake flow and referrals as well as conduct administrative functions (details outlined on page 88).
- f. **Intake/Triage Coordination and Ombudsman Liason:** Over a three-year timeframe, 1 FTE **Intake/Triage Coordination and Ombudsman Liason** is being requested at 100% Administrative Match to continue the ongoing partnership with the ombudsman office which has proved to be beneficial in advocating for clients right to community living options. In addition, the position will work with social workers and community case managers to provide technical assistance with complex care transitions and support the recently developed Section Q protocol. With increase referrals this position will formalize current informal intake process. Take all information down for new referrals, assist with intake process, assist with MFP referral data entry, recording protocol, data evaluation. Triage ongoing case calls to MFP director and coordinators. Assist with upfront procedures to ensure consistent performance of routines such as ensuring all applicant packets are complete and if not, will follow up with the referring institution. With the program's increase in intakes and transitions we are looking for formal intake support and duties to be overseen by this position, which traditionally had been part of the transitional coordinators role. In this OP revision this activity will account for .30 FTE of intake and triage time.

- g. to conduct the Resident and Family Council MDS 3.0 Section Q Trainings and follow up tasks at the nursing facilities for the MDS 3.0 Section Q identified participants (see full description of duties in OP Page 26).
- h. **.80 FTE Data Specialist/Analyst:** Over a three-year time frame, is being requested to assist with all aspects of the MFP IT and Data Analyst tasks (see full description of duties in OP page 85).

1 FTE Housing Specialist: Over a five-year time frame, a Housing Specialist is being requested at 100% Administrative Match to conduct housing searches and stabilization for 6 months to MFP participants the first two years and then will be assessed to expand to the MDS 3.0 Section Q identified population needing housing (for full description of duties see in OP page 79).

c. BILLING, MONITORING AND REIMBURSEMENT PROCEDURES

All claims for services are submitted to the New Hampshire MMIS, which rejects duplicate and other inappropriate payments. The Surveillance Utilization Review Subsystem (SURs) unit within DHHS pro-actively monitors the program’s fiscal integrity. A variety of onsite or desktop audits are performed to monitor service provider billing practices. Occasionally, some audits lead to civil or criminal prosecution. The SURS Unit also maintains a third-party contract with a vendor that reviews inpatient hospital claims. The SURs reports are now a function of the Medicaid Decision Support System and include post-payment reviews of randomly select claims. In the past years the MFP program in NH has not had a dedicated staff person and currently this is conducted manually without any integration into the current system. With the extension of MFP to 2016 and the MDS 3.0 Section Q opportunities, NH is desiring a full-time position to oversee and ensure that these programs and IT systems are synchronized, monitored, and overseen in a direct manner with a dedicated person. The goal is to create a sustainable system and tracking infrastructure (financially and programmatically with policies and methods) that will be sustainable once the position is no longer funded at the end of three years.

The equivalent of 1 FTE Data Specialist): The 1 FTE data specialist over the next three years will work with a diverse group of stakeholders to standardize and support MFP Program reporting, acquiring the claims data, converting the data from a manual process to an automatic process, and data processing for the MFP program. This position will define requirements, construct, and implement tools to allow MFP and ADRC staff to have usable, meaningful and sustainable reports towards the implementation and work of MDS 3.0 Section Q, as well as management of the MFP program. This person will work closely with the MDS 3.0 Section Q contractor, as well as state staff to ensure sustainability of the work. The position will be responsible for/or assist with the following tasks:

- Reconciliation and reporting between different systems, i.e., MS Access database, NH Medicaid Management Information System, the BEAS Options Application, and NH First Financial system.
- Develop, refine and query information in a Microsoft Access database to track and report on program participants according to CMS and BEAS requirements and specifications;
- Monthly/Quarterly CMS reporting;
- MDS 3.0 Section Q reporting and implementation of tools for BEAS utilization of this data;
- Implementation of the MFP program in the MMIS implementation;

Must be proficient in Microsoft Access database development and data queries. This position will work independently with minimal supervision and collaboratively with state partners.

- Liaisoning with DCBCS: working with DHHS as a whole towards provision of population-based health care data and standardized datasets on health care cost and quality for long term care populations.
 - a. Work with BEAS and OMBP staff to add updated years of Medicare eligibility, claims, and provider files from CMS via the RESDAC or other CMS-determined acquisition project.
 - b. Work with a DHHS sub-group (BEAS, OMBP, DPHS) to finalize an analytic plan for the NH Medicare to inform programs and policy
 - c. Analyze Medicare claims, eligibility, and provider files according to the agreed upon analytic plan.

D. EVALUATION

Evaluation is not a required component of the NHCP Operational Protocol. Although states may propose to evaluate unique design elements from their proposed MFP programs, NH DHHS has opted not to include its own evaluation component in its NHCP demonstration design. Instead the Systems Transformation Grant (STG), which addressed person-centered planning and consumer direction, included an evaluation plan that had been approved by CMS. The New Hampshire Systems Transformation Final Evaluation was conducted and the report was issued in October 2010. This report is available at the following website address:

<http://realchoicenh.org/products.html>

The State will utilize data and findings from its STG evaluation as well as data collected by the national evaluator for the MFP evaluation as indicators of the project's effectiveness.

E. FINAL BUDGET

New Hampshire proposes to continue implementation of the New Hampshire Community Passport Project, CMS' MFP initiative, through September 30, 2016. A Project Director will continue at the 100% MFP allowed for this purpose to manage reporting and other aspects of the project. This project will support facility-to-community transitions for people who will be served by any one of New Hampshire's four HCBS programs: Elderly and Chronically Ill, Acquired Brain Disorders, In Home Supports, and Developmental Disabilities. This version of the OP includes new populations that increase the State's benchmarks to be reflective of these new groups. This OP also includes several new administrative positions to further support the work of the MFP program as well as includes the advantage of the newly implemented MDS 3.0 Section Q in an effort to exceed the current benchmarks. In addition, project funds will be used to forge new and additional relationships with hospital, rehabilitation, and nursing facilities across the state. The project reinforces the State's strong commitment to community based long-term care and demonstrates the value of supporting individuals' preferences in the design and delivery of services. NHCP also provides DHHS with a key opportunity to identify effective services models for supporting increased independence that have not yet been included in the State's HCBS programs.

All services that will be part of the NHCP project are listed in Part 1 of the Operational Protocol.

Budget Narrative

a. Personnel.

1. **NHCP Project Director:** A full-time, one FTE, Project Director was hired and began January 4th, 2010 through the University of New Hampshire to supervise the NHCP Project. In addition, to being responsible for overall Project Management, participating in all MFP and/or CMS trainings and expectations of this role, the position will assist with the streamlining of applicants into the NHCP program by conducting as needed MED's for the CFI waiver program, and will work closely with waiver administration to assess adequate community supports for NHCP applicants. The Project Director will submit all required State and CMS reports.

2. **Housing Specialist:** One full-time employee position is being requested for the next five years to assist MFP individuals statewide looking to transition from a nursing facility who needs housing, may be interested in Family Home Model, for whom accessing safe affordable housing is a barrier to living independently (see under Housing, page 77).
Intake/Triage Coordination and Ombudsman Liason: NH has had good working relations with it's Long Term Care Counselors, however, with the MDS 3.0 Section Q roll out, NH is requesting one full-time position (1 FTE) to formally support the MFP project and continue the ongoing partnership with the ombudsman office which has proved to be beneficial in advocating for clients right to community living options. In addition, the position will work with social workers and community case managers to provide technical assistance with complex care transitions and support the recently developed Section Q protocol. With increase referrals this position will formalize current informal intake process. Take all information down for new referrals, assist with intake process, assist with MFP referral data entry, recording protocol, data evaluation. Triage ongoing case calls to MFP director and coordinators. Assist with upfront procedures to ensure consistent performance of routines such as ensuring all applicant packets are complete and if not, will follow up with the referring institution. With the program's increase in intakes and transitions we are looking for formal intake support and duties to be overseen by this position, which traditionally had been part of the transitional coordinators role. In this OP revision this activity will account for .30 FTE of intake and triage time.
Section Q Technical assistance: .25FTE Provide on going technical assistance and guidance with Local Contact Agencies, Centers for Independent Living, and Nursing Facilities to utilize existing developed Section Q protocols, training materials, and to provide education supporting the Transition to Community Living Project goals. This is an ongoing effort to educate social workers concerning transition to community programs, and to provide Person Centered Planning materials. Increase education to SW with sustainable training materials based on Section Q Training Manual. Address the needs identified by BEAS to universally train nursing facility social workers in NH.
3. **Data Specialist/Analyst:** NH continues to expand our data infrastructure for usable and sustainable reports, use of current and collected data, as well as building a sustainable process and protocols. NH is requesting the equivalent of 1 FTE of a data specialist for the next two years to work towards this work (full description is on page 83)

4. **Program Specialist III/Transitional Coordinator:** This is the current Waiver Program Transitional Coordinator (non-behavioral health populations) already in effect. This staff person hired during the first year of operations assists with reporting, entering authorizations for certain moving expenses, interfaces with the NHCP participant, the tCM, family, nursing staff, and facility social worker to develop the transition plan. This ensures that all the identified items needed for transition are carefully considered and appropriately authorized, assists with education and outreach by presenting the MFP program, ensures appropriate federal claims are filed, and conducts all QOL's. This person reports to the State Supervisor. The NH Community Passport program responded to the policy guidance letter dated January 5th, 2010. NH requested the Program Specialist position to be supported 100% MFP grant from the previous 50%. The state of NH had been matching the other 50% of this 1 FTE position since the inception of the program (2007 to 2010). This would position would continue at 100% match through 2016 for the nonbehavioral health participant transitions.
 5. **Program Specialist III/Behavioral Health Transition Coordinator:** The role of this position mirrors the role of the Transition Coordinator above however will work solely with behavioral health transitions from GlennCliff Nursing Home, IMD's and authorized PTRF's. One full-time transition coordinator is being requested. This position will be responsible for the above-mentioned duties of the Transitional Coordinator. However, due to NH's desire to create and build community infrastructure for the high needs for the psychiatric pediatric population, this position will also be instrumental with the facilitation and coordination of multiple systems by documenting, communicating, and coordinating infrastructure building tasks needed to increase community supports for high need youth and children prior to discharge as they transition. Egon Jenson, the Children's Mental Health Administrator, will oversee and supervise this position (page 18, and 52-59).
 6. **Administrative Support:** NH received in the summer of 2010 a small percentage of administrative support to assist with day-to-day secretarial and office functions (calls, copying, faxes, mail, referrals, questions, filing etc). This small percentage, 25%, ensured up to date and orderly filing of MFP clinical files, assisted with scheduling outreach and educational presentations with a variety of state-wide agencies, This position assisted with updating outreach materials and letters, will help with a variety of follow up tasks, and conduct data entry (e.g.: when new participant enters to be sure we track all referrals, QOL dates and other needed information). This position takes minutes for meetings and assists in MFP file audits.
 7. **Fringe benefits:** These have been calculated in accordance with standards set by the State of New Hampshire.
 8. **Travel:** Travel is anticipated to CMS-sponsored conferences and events, and to facilities throughout the state.
- b. **Equipment:** This line purchased equipment needed for the project, such as a good quality printer for the outreach materials. Laptops are requested for the Housing Specialist and the Behavioral Health Transition Coordinator.

- c. **Supplies:** This line covers the cost of paper, printing, telephone, postage, and other supplies needed for project operations. This includes revising and updating NH’s brochures and other marketing information to gear it towards multiple audiences.
- d. **Contractual** (sum of i through vii below):
 - i. **DISCONTINUED:** Transition Coordinators (This contract ended on 12-31-08. Transition coordination will be provided through the new waiver service, Transitional Case Management.)
 - ii. **Program Project Director:** This is the expense of a full-time Project Director through the University of New Hampshire.
 - iii. **Ombudsman:** This is the expense of a full-time employee through the University of New Hampshire
 - iv. **Housing Specialist:** This is the expense of a full-time employee through the University of New Hampshire
 - v. **Data Administrator:** This is the expense of a full-time employee through the University of New Hampshire
 - vi. **Behavioural Health Transitional Coordinator:** This is the expense of a full-time employee through the University of New Hampshire
 - vii. **Training for program staff:** The Ombudsman position, the Housing Specialist and Data Specialist will all require MDS 3.0 Section Q Training, and MFP training by Program Director, or other needed conferences mandated by the project.
 - viii. **Training for PCA/DSW role:** NH would like to use 100% administrative match to provide training and education for PCAs/DSWs for family members or neighbors in order to get individuals into the Direct Care Workforce who could provide these services to MFP participants living in rural areas.
- e. **Home and Community Based Services:** This section describes the estimated budget for waiver and State Plan Behavioral Health services and targeted health services.
- f. **Demonstration Transitional Services:** This is the estimated budget for the services identified in the attached budget as HCBS Demonstration Services
- g. **Other:** This line covers the occasional allowance of “flex funds” to assist in a transition, as needed for participants who need to pay for a one-time, prior authorized item to enable them to remain in the community.
- i. **Supplemental Services:** There are no Supplemental Services in this OP. Via the Technical Support from Bob Mollica, NH was an identified state that moved the existing Supplemental Supports to qualify as a Demonstration Service. NH did not go back and create Supplemental Supports, nor did NH decide to convert the Supplemental Services and rebill them as Demonstration Services from July 1st 2010 (as the TA team indicated would be allowable). The cost and time to do this activity did no outweigh the need.
- ii. **Construction:** No construction costs are proposed.
- iii. **Other – IT/Evaluation:** Although a specific evaluation is not proposed in this OP, these funds would cover that expense if NH decides, with CMS, that BEAS should contract for this service. With the partnership with UNH and full-time Program Director in place, NH is seriously contemplating this. No plans at this time due to significant work ahead focused on MFP expansion, partnering with ADRCs, increasing transitions, and MDS

3.0 Section Q initiatives. An evaluation is anticipated as a future goal perhaps in 2014 or 2015 considering a 2-year evaluation of the work.

AoA/CMS Nursing Home Transition Grant Section C Addendum – See attachment for full description totaling \$399,995 over two years (see page 89).

Attachments:

AoA/CMS Nursing Home Transition Grant Section C Addendum

New Hampshire developed and implemented a statewide Aging and Disability Resource Center (ADRC) system, known as the ServiceLink Resource Center (SLRC) Network, in 2003. The SLRC network is in an optimal position to implement Money Follows the Person (MFP) and MDS 3.0 initiatives, based on a long partnership between the SLRC-MFP programs and current structure and function of both programs. The overall goal of this application is to continue to strengthen the SLRC-MFP partnership in NH to continue to rebalance the LTC system throughout the state. The main objectives for this project are to: (1) Develop protocols for use of the MDS 3.0 Section Q data to support referrals to SLRC's and MFP and train facilities to use those protocols; (2) Develop usable and sustainable data protocols from collected MDS data to assist Nursing Home facilities to refer to local contact agencies as well as develop data use agreements for the SLRC and MFP to use in their work; and set the stage for the development of a data infrastructure (3) Increase SLRC presence in nursing homes, work alongside community partners, and increase the SLRC's ability to refer residents appropriately to MFP, including training SLRC staff and Ombudsman program personnel.

Current Status of State's ADRC Program(s) & Current Status of the MFP-ADRC Partnership
New Hampshire developed and implemented a statewide Aging and Disability Resource Center (ADRC) system, known as the ServiceLink Resource Center (SLRC) Network, in 2003. The SLRC network is coordinated through a partnership between the New Hampshire Department of Health and Human Services, Bureau of Elderly and Adult Services (BEAS) and the New Hampshire Institute for Health Policy and Practice (NHIHPP) at the University of New Hampshire (UNH), which acts as an instrument of the state. The Money Follows the Person (MFP) program in NH is also coordinated by BEAS. In January 2010, the project director for MFP was hired through NHIHPP, establishing a similar state-university partnership for both ADRC and MFP and further facilitating partnerships between the two programs.

The SLRC network is in an optimal position to implement the MFP and the MDS 3.0 initiatives described in this narrative. SLRCs cover the entire state, with offices located in each of New Hampshire's ten counties; three counties support additional satellite offices. The target population of SLRCs includes older adults, as well as individuals with chronic conditions who are over age 18. When NH first implemented MFP in 2008, SLRC was designated as the community nexus for referrals to the program. SLRC staff initiated applications for the Home and Community Based Care Waiver Program and assisted applicants and their families to gather required documentation for financial eligibility. SLRCs currently provide support throughout the eligibility process to individuals seeking long-term care. SLRCs can process applications for presumptive eligibility for the Medicaid Waiver serving elderly and chronically ill individuals and serve as a single point of contact for consumers in a process that combines separate functions and staffing for medical and financial eligibility. Currently, the staffing pattern at each of the thirteen SLRCs includes at least one long term support services counselor (LTSC), who is trained in a supported decision making method of helping individuals and families in options counseling, particularly as it relates to long term care. LTSC and other SLRC staff regularly conduct outreach activities to area hospitals, nursing homes, rehab centers, and other referral sources to make both the staff of these agencies and consumers aware of the services that can be provided to individuals wanting to receive home and community services in lieu of nursing home

and institutional care. SLRCs are also well connected with the other service providers in their area to continue to support individuals post-nursing home transition. LTSCs frequently work collaboratively with the family caregiver support specialists assigned to SLRC, who provide supports to family members participating in the Community Living Program. Families providing care to members in the MFP project will be able to easily avail themselves of the support offered through the Family Caregiver Support Program. In summary, the design and structure of the SLRCs in NH make them well suited to support transitions through the MFP program. SLRCs have the ability to serve as a viable resource for information about available community-based services as part of the requirements of Section Q of the MDS 3.0 version. The case management system that is utilized by SLRC staff, Refer 7 includes a web-enabled resource database that can be easily accessed. This proposal would increase utilization of these resources in NH's implementation of MFP.

Goals, Objectives, and Outcomes

The overall goal of this application is to further strengthen the ADRC-MFP partnership in NH to continue to rebalance the LTC system throughout the state. The main objectives for this project are to: (1) Develop protocols for use of the MDS 3.0 Section Q data to support referrals to ADRC and MFP and train facilities to use those protocols; (2) Develop a usable and sustainable data infrastructure system from collected MDS data as well as develop data use agreements for the ADRC and MFP to use in their work; and (3) Increase ADRC-MFP presence in nursing homes, work alongside community partners, and increase the ADRC's ability to refer residents appropriately to MFP, including training of ADRC staff and the facilities' Ombudsman program personnel. Primarily the hiring of a new Program Coordinator position will support this work. As a result of this work, we expect to (1) Train and educate all qualified LTC facilities in NH about MDS 3.0 and section Q and a person-centered approach for community transitions; (2) Identify 100 individuals requiring further assessment, care and discharge planning through MFP or the other SLRC resources; (3) Increase the number of individuals referred to the MFP by 50 and the number transitioned by 10; (4) Build a formal process and policy regarding section Q referrals; (5) Develop a data tool or report from MDS data that can be used to support the functioning of MFP; (6) Increase awareness of SLRCs and MFP in LTC facilities across NH and with the Long Term Care Ombudsman Programs. While these targets may seem ambitious, NH plans to leverage a long history of partnership of the SLRC and MFP programs and the strong relationships with LTC facilities and partners (such as Granite State Independent Living) to move quickly on the education and referral process implementation.

Proposed Project

Objective 1: To train and educate facilities regarding the changes to the new MDS 3.0 form and section Q. The Program Coordinator will establish and coordinate a team of local contact agencies in NH for educating and training facilities on Section Q changes, provide community care information and transitional services, and collaborate with facilities in the discharge and transition process using a person-centered model. Local contact agencies include Granite State Independent living (GSIL; NH's Center for Independent Living), Bureau of Health Facilities Administration (BHFA; the licensing agency), and all long-term care facilities.

Objective 2: To create a data use protocols to set the stage so that the State's MDS collected data is formatted into a usable, sustainable report for the SLRCs and MFP program. With this grant funding NH will create protocols for Nursing Facilities to refer to local contact agencies

based on the data collected in the MDS 3.0 Section Q interview. The Program Coordinator will work with applicable IT departments, BHFA, and other community stakeholders (including other stakeholders willing to engage beyond GSIL and ServiceLink) to develop a process for utilizing MDS data to identify those individuals who could benefit from the opportunity to have access to transitional counseling and planning by the local contact agencies in order to return to the community. Pertinent data use agreements will be established to share relevant information with GSIL and ServiceLink. This will prepare NH for the implementation of the MDS 3.0 Section Q. **Objective 3:** Outreach to residents in institutions or long-term care settings through interactions directly in nursing facilities with residents, providers, and Ombudsman as part of the SLRC Center Team. The Program Coordinator will identify MFP participants for potential transitions and work to increase awareness of the program and boost referrals. SLRCs will work directly at the community level to support the project by providing education, outreach, referral coordination, and support as a local contact agency. The Program Coordinator will work with the SLRCs to determine needs for additional outreach materials or system changes required to support outreach activities.

Project Management

The NHIHPP and the BEAS will partner to manage the work of this project. A program coordinator will be hired through IHPP to oversee the majority of the project work. The Program Coordinator will specialize in outreach to partners to strengthen the existing relationship with the SLRC Network in NH, promoting partnering activities, and preparing for and continually supporting the implementation of the MDS 3.0, Section Q. The Program Coordinator will also work directly with the SLRC Program Administrator at BEAS. NHIHPP will coordinate trainings for this project that are related to the ADRC Enhancement grant currently managed at NHIHPP, including training in a person-centered model. The SLRC Network will continue to be a vehicle for education and outreach on the program. This work will be leveraged and expanded as outlined in the goals and outcomes. The program coordinator will work closely with Granite State Independent Living, who will be a key partner in identifying candidates for the MFP program and use of the MDS 3.0 Section Q data. The biggest challenge we foresee is getting buy-in from facilities; however, having a person dedicated to making those connections with nursing homes will be key to overcoming those barriers.

Case Study Attachment

1. CASE STUDIES

The following case studies illustrate, from the participant's perspective, how the New Hampshire Community Passport Project will work.

a. ELDERLY CASE STUDY (HCBC-CFI WAIVER)

For seven years Jeannette Gendron was a resident of the Hillsborough County Home in Goffstown. A native of Manchester, as a young woman Ms. Gendron worked in the city's mills. After the textile industry pulled out of New Hampshire, Ms. Gendron held a variety of jobs including working as a housekeeper for area hotels and nursing homes, a kitchen aide in a school cafeteria, and a babysitter. Married only briefly, Ms. Gendron shared an apartment with her parents in the Franco-American neighborhood where she grew up. She lived with her parents until their deaths, caring for them in their later years.

When she was 72 Ms. Gendron suffered a serious heart attack. On the advice of her doctor, who felt that a nursing facility could best address her medical needs, Ms. Gendron moved to the Hillsborough County Home. A Medicaid patient, Ms. Gendron came to the County Home with a number of health issues. She required medication for high blood pressure, congestive heart failure, arthritis, and a stomach ulcer. A survivor of breast cancer, she had undergone a double mastectomy. In addition, she had a hip replacement and still experienced difficulty walking.

Although a long-term patient at the County Home, Ms. Gendron continued to miss living in the community and the independence of being in her own apartment. Ms. Gendron learned about the HCBC-CFI Waiver program and the New Hampshire Community Passport project when a volunteer from the Office of Long Term Care Ombudsman (OLTCO) did a presentation for County Home residents and staff. Ms. Gendron was excited about the possibility of participating in NHCP and requested assistance to move back to her old neighborhood. The County Home Discharge Planner met with Ms. Gendron to complete the Medical Eligibility application and assessment and submitted the forms to the New Hampshire Bureau of Elderly and Adult Services (BEAS) Long-Term Care Unit (LTCU).

A planning team that included an OLTCO volunteers, the BEAS Nursing Supervisor, and County Home staff was formed to support Ms. Gendron. The planning team held its first meeting was held at the facility with Ms. Gendron to discuss her preferences for supports, evaluate the risks of moving back to the community, and determine whether adequate community services would be available to address her needs. Ms. Gendron invited a friend to attend this meeting with her. As a result of the planning meeting a person-centered transition plan was developed. The plan set out the overall transition goals for Ms. Gendron, outlined the tasks that needed to be accomplished in order for her to move to the community, established a timeframe for completion of these activities, and identified interim services (including medication instruction) that needed to occur prior to discharge. Ms. Gendron retained her own copy of the completed plan. The BEAS Nursing Supervisor reviewed Ms. Gendron's case at an internal clinical meeting held with the Bureau's Deputy Director, who is also an RN. At the clinical meeting it was determined that Ms. Gendron was a good candidate for the New Hampshire Community Passport project.

The BEAS Nursing Supervisor informed Ms. Gendron that a Transitional Case Manager (tCM) would be assigned to work with her during the transition process. The tCM would help her locate an apartment, obtain services, and assist with any other arrangements that were needed in order for her to move into the community. As Ms. Gendron had no prior experiences with case management and did not have a preference of providers, a nurse from the BEAS LTCU used the agency's assignment rotation process to designate a tCM to work with her. Under the program, the tCM's services will end when Ms. Gendron is settled in her new home and ongoing waiver case management services will be put in place. Ms. Gendron will have the choice of having her tCM continue as her Case Manager in the community, requesting a specific Case Manager, or having a Case Manager assigned through the BEAS assignment rotation process.

With her health stable, Ms. Gendron's was ready to move back to Manchester. In addition to working with a tCM, Ms. Gendron also met with a BEAS Adult Services (AS) Social Worker. The AS Social Worker provided an additional and impartial observation of Ms. Gendron's understanding of the transition process and assessed her needs to assure that the plan that had been developed was adequate. In her meeting with Ms. Gendron, the AS Social Worker explained that her role in the transition process was to help Ms. Gendron consider different aspects of moving to the community. As a result, Ms. Gendron had a clear understanding of the transition process, the services she would need in the community, and the risks associated with her transition. This process helped Ms. Gendron, as well as her team, feel comfortable that her comprehensive care plan would address her needs.

The tCM worked with Ms. Gendron to identify appropriate housing and helped her to complete all required paperwork. Ms. Gendron chose a congregate housing residence and when an apartment became available, the tCM went with Ms. Gendron to look at it. Ms. Gendron was pleased with the apartment and confirmed that this was where she wanted to move. (If a security deposit had been needed, the tCM would have informed BEAS and payment would have been authorized.) With housing secured, the tCM helped Ms. Gendron to look for household items online; she selected the items from the BEAS-prepared list of allowable household purchases. The tCM emailed BEAS the list of selected items and provided information about moving the household goods Ms. Gendron had placed in storage when she entered the County Home into her new apartment. BEAS authorized payment for approved items and services.

Next the discharge planning team met to evaluate Ms. Gendron's progress in meeting the discharge goals. While attendees at team meetings will vary depending upon the individual, the resident and any family or others the resident chooses are always included. The discharge meeting may also include:

- e. BEAS Long Term Care Unit Registered Nurse
- f. AS Social Worker
- g. Transitional Case Manager
- h. Community Services Waiver Case Manager (if this is a different person from the tCM)
- i. Staff or Volunteer from the Office of Long Term Care Ombudsman
- j. Nursing Facility Staff (Social Worker, Nurse, Physical Therapist, etc)

- k. Elder-wrap Team (generally accessed for people with mental health needs)

This meeting provided confirmation that Ms. Gendron had successfully completed medication management training and a discharge plan was drawn up. This plan identified remaining transition tasks, items that still needed to be purchased, and services that needed to be in place before Ms. Gendron left the County Home. In addition to her housing, Ms. Gendron's ongoing services included case management, personal care, meals, lifeline support, and nursing. With her housing already secured, a discharge date was set.

The tCM finalized arrangements for needed community services and arranged for the apartment's utilities to be turned on the day before the move. The tCM also conducted a "home inspection" on the day before Ms. Gendron's discharge to be sure that the household furnishings and goods had been delivered and that the utilities were operational. On move-in day, the tCM met with Ms. Gendron in her new home. (Ms. Gendron had requested that her tCM continue as her Case Manager in the community. Had a different Waiver Case Manager been assigned, this person would have been included in the discharge-planning meeting and also would have met Ms. Gendron at her home. In this case, the move-in day would mark the end of tCM's involvement.)

Three weeks after her move to the community, the AS Social Worker visited Ms. Gendron in her apartment to make sure that she was satisfied with her living arrangement and that things were going well. Confident that Ms. Gendron was settled and her services were in place, the Social Worker explained that she would no longer be coming to see her. The Waiver Case Manager provides Ms. Gendron's ongoing case management services and works with her to assure that she receives the services and supports that she needs.

b. ACQUIRED BRAIN DISORDER CASE STUDY (HCBC-ACQUIRED BRAIN DISORDER (ABD) WAIVER)

Joe Smith, age 39, sustained a traumatic brain injury in a motorcycle accident and had been living in a nursing facility for 10 months. His accident left him with deficits in his memory and judgment; he now requires care and supervision. When the facility's discharge planner learned that Mr. Smith was interested in returning to live with his wife and family, she contacted the Area Agency serving the town where he lived. (In New Hampshire, services for persons with developmental disabilities and acquired brain disorders are provided through a community-based Area Agency system. The New Hampshire Department of Health and Human Services, Bureau for Developmental Services contracts with 10 private, non-profit Area Agencies to provide services within a specified geographic region. Area Agencies serve as the access point for individuals with developmental disabilities and acquired brain disorders and provide intake, assessment, case management, and family support. Community based services and supports may be provided directly by the Area Agency or the Area Agency may contract with other providers to deliver services.)

The Area Agency Intake Coordinator contacted Mr. Smith and his family, collected his medical records, and referred him for a neuropsychological evaluation and a functional assessment. The Area Agency determined that Mr. Smith was eligible for services and sent the related

documentation to the Bureau of Developmental Services (BDS) to be approved for waiver funding. The BDS Prior Authorization Unit reviewed Mr. Smith's eligibility application and found him eligible for the ABD Waiver based on criteria set forth in the State Administrative Rules He-M 517.

Once he was found eligible for the ABD Waiver, Mr. Smith was placed on a waitlist for waiver funding and assigned a Service Coordinator. (In New Hampshire's Developmental Services System, Service Coordinator is the job title for those providing case management services.) The Service Coordinator worked with Mr. Smith and his family to identify his specific needs, determine his preferences for services and supports, and used this information to develop a preliminary budget. The Service Coordinator had several meetings with Mr. Smith and his family to explore what supports and services would meet Mr. Smith's needs and preferences and to determine the extent to which his family would be involved in his life.

The Area Agency in Mr. Smith's community uses a Request for Proposal (RFP) process to obtain services. This provides the individual and/or their family maximum choice in deciding what vendor agency will provide their services. An RFP was sent out to potential providers and Mr. Smith and his family interviewed representatives from those agencies that responded. With input from Mr. Smith and his family, treatment proposals and budgets were developed and Mr. Smith, in conjunction with his family and the Area Agency, selected a service provider from the providers that responded to the RFP. The proposed budget and its accompanying narrative were submitted to BDS for funding approval.

Funds were appropriated and within two months Mr. Smith returned to live with his wife and family in the family home. With input from Mr. Smith and his family, the Service Coordinator arranged for personal care assistance and day services. The Area Agency authorized the required home modifications and needed assistive technology (a communication board) and ensured that these were in place prior to Mr. Smith's return to the community. Mr. Smith's day services provide him with community interactions and supervised time outside of the home; this arrangement has enabled Mrs. Smith to return to work. The Service Coordinator continues to have monthly contact with Mr. Smith and his family, monitors his services, and checks in with Mr. Smith to determine whether he is happy with the support he is receiving and to assure that his needs are being met.

c. DEVELOPMENTAL DISABILITIES CASE STUDY (HCBC-DD WAIVER)

Sandra Gonzales was admitted to Rockingham County Nursing Home in August 2007 as a result of an abuse and neglect report as her needs were not being adequately addressed in her community home. Ms. Gonzales has cognitive and physical disabilities, uses a power wheelchair and requires one-to-one personal care assistance to help her with dressing, bathing, and toileting. During her nearly two years in the County Home, Ms. Gonzales experienced significant regression both physically and emotionally. In June 2009 a Service Coordinator from the Area Agency met with Ms. Gonzales to talk about the NHCP Project and asked her if she would be interested in leaving the County Home and moving back to the community. Ms. Gonzales was ecstatic about the possibility of returning to the community. The Service Coordinator explained

the transition process to Ms. Gonzales and went through the steps of the planning process that would need to happen before she would be able to move back to the community.

The Service Coordinator facilitated a number of person-centered planning meetings with Ms. Gonzales, her family, and County Home staff of Ms. Gonzales' choosing. At these meetings, Ms. Gonzales talked about her desire to move back to the community and with her team she identified the supports that she would need in order to make a successful transition to community living. The Service Coordinator informed Ms. Gonzales and the planning team about potential options for supports. With input from Ms. Gonzales and the planning team the Service Coordinator developed a Request for Proposal (RFP) that was sent to service providers in the region. The RFP outlined the services needed by Ms. Gonzales, including both residential and day supports. Ms. Gonzales and her planning team reviewed the responses to the RFPs and after considering the options, Ms. Gonzales and her family chose Living Innovations to provide her community services. Living Innovations, a private provider of in-home services to older adults and people with disabilities, offers a range of home and community based services including home care, residential supports, and day services. Ms. Gonzales chose to move to the agency's Woodridge Avenue Home in Portsmouth, a qualified residence. The Service Coordinator asked Living Innovation's Residential Manager to attend Ms. Gonzales' person-centered planning meetings and to help with the transition planning. The Residential Manager and Service Coordinator also worked together to ensure that accommodations and supports at the Woodridge Avenue Home would be in place before Ms. Gonzales moved in.

The following activities occurred prior to her move.

- Ms. Gonzales was assessed for a Hoyer Lift that would be needed in her bedroom and in the home's living room.
- Estimates for a Hoyer Lift System were received from Safe Haven and Always Accessible.
- The lift was purchased and installed. The Service Coordinator made a visit to the home to confirm that the Hoyer Lift System was in place and operational.
- Ms. Gonzales was assessed and fitted for a commode/shower chair to accommodate her special needs. The chair was purchased.
- The house was assessed to identify modifications that would be needed to accommodate her power wheelchair.
- The front door to the house and Ms. Gonzales' bedroom door were widened to accommodate her wheelchair.
- The bathroom threshold was angled to make it easier for Ms. Gonzales to use her shower chair and to make using the shower safer for her and her support staff.
- The Service Coordinator and Residential Manager accompanied Ms. Gonzales to the appointments for her assessments and consultation. This not only ensured that everything moved forward in a timely manner, it also provided opportunities for the Service Coordinator and the Residential Manager to get to know Ms. Gonzales better.

Living Innovations staff attended several person-centered planning meetings at the County Home with Ms. Gonzales and her team, including her parents, to arrange for the community based supports and services that would be needed to address Ms. Gonzales' physical, emotional, and

medical needs. On July 21, 2009 Ms. Gonzales moved from the County Home to begin her new life in her home on Woodridge Avenue.

Once Ms. Gonzales had moved into Woodridge, services were provided to address the needs that had gone unmet during the time she lived at the County Home. These included getting an assessment and support from ATECH for needed assistive technology and seeing a number of medical specialists. Ms. Gonzales also began receiving recreational, occupational, and physical therapy. A specific hospital bed was recommended and obtained to accommodate Ms. Gonzales' needs. Additionally, Ms. Gonzales requested an audio monitor to allow her to communicate at night. This request was brought to the Area Agency's Human Rights Committee and approved.

In making arrangements for Ms. Gonzales move to Woodridge, a qualified residence, her family initially agreed to allow Living Innovations to use their family's wheelchair van to transport Ms. Gonzales back and forth to her day program. The van was to be left with her and the day program would use it as needed to drive Ms. Gonzales to appointments and other activities in the community. However, once Ms. Gonzales moved to Woodridge, the family changed their minds about when the van could be used. Team meetings were held to explore possible options. When it was clear that the family van was not going to be available, the Area Agency and Living Innovations worked together to locate an affordable van; community and family resources were used to purchase the van.

Because Ms. Gonzales has multiple and complex needs, the Service Coordinator will hold person-centered planning meetings at least quarterly, and more often if needed. Ms. Gonzales decides who attends these meetings. Her team includes her parents, her Service Coordinator, her therapists, and key staff from Living Innovations. Ms. Gonzales provides the team with input on the supports that she needs and direction on what she would like to have happen. Her team is now working to have automatic bedroom door closers installed in the Woodridge home. Currently, the doors are required to be closed at all times; without automatic openers Ms. Gonzales and other residents who use wheelchairs are unable to access their bedrooms independently. At her last person-centered planning meeting Ms. Gonzales told the team how happy she is to be back in the community.

