STATE OF NEW HAMPSHIRE
DIVISION OF ELDERLY AND ADULT SERVICES
HOME AND COMMUNITY-BASED CARE

PERFORMANCE AUDIT REPORT
APRIL 2003

To The Fiscal Committee Of The General Court:

We have conducted an audit of the Department of Health and Human Services, Division of Elderly and Adult Services (DEAS), to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to provide a reasonable basis for our findings and conclusions. Accordingly, we have performed such procedures as we considered necessary in the circumstances.

The purpose of our audit was to determine if the DEAS has effectively and efficiently made changes to long-term care in the State to promote a shift from nursing facility services to home and community-based services. The audit period encompasses State fiscal years 1998-2002.

This report is the result of our evaluation of the information noted above and is intended solely for the information of the Department of Health and Human Services and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

April 2003

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STATE OF NEW HAMPSHIRE
DIVISION OF ELDERLY AND ADULT SERVICES
HOME AND COMMUNITY-BASED CARE

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ABBREVIATIONS

APS	Adult Protective Services
BHFA	Bureau Of Health Facilities Administration
CMS	Centers For Medicare And Medicaid Services
DEAS	Division Of Elderly And Adult Services
DHHS	Department Of Health And Human Services
EDS	Electronic Data Systems
HCBC-ECI	Home And Community-Based Care For The Elderly And Chronically Ill
LBA	Legislative Budget Assistant
LPAOC	Legislative Performance Audit And Oversight Committee
LTC	Long-Term Care
MMIS	Medicaid Management Information System
OAA	Older Americans Act
POC	Plan Of Care
SB	Senate Bill
SFY	State Fiscal Year
SSBG	Social Services Block Grant
USDA	U.S. Department Of Agriculture
U.S. DHHS	U.S. Department Of Health And Human Services

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STATE OF NEW HAMPSHIRE
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SUMMARY

Purpose And Scope Of Audit

This audit was performed at the request of the Fiscal Committee of the General Court consistent with the recommendation of the joint Legislative Performance Audit and Oversight Committee. It was conducted in accordance with generally accepted government auditing standards. The purpose was to determine whether the Division of Elderly and Adult Services (DEAS) has effectively and efficiently made changes to the long-term care system in the State, promoting a rebalancing from nursing facility services to home and community-based services as proposed in *Shaping Tomorrow's Choices* (1998) and required by Chapter 388, Laws of 1998.

Background

Long-term care and its associated costs are a concern to the federal and state governments, particularly with the projected growth in the elderly population. The federal and state governments are increasing options for home and community-based services in an effort to contain costs and prevent elderly and chronically ill adults from prematurely entering nursing facilities.

Historically, New Hampshire's long-term care system has favored nursing facility services, however with the growing elderly population the State recognized the need to rebalance the system. Lawmakers passed significant legislation in 1997 (Chapter 309, Laws of 1997) requiring the Department of Health and Human Services (DHHS) to develop a long-term care plan. The Legislature used this plan, *Shaping Tomorrow's Choices*, as a guide in drafting the legislation adopted in Chapter 388, Laws of 1998, also referred to as Senate Bill (SB) 409.

Shaping Tomorrow's Choices and Chapter 388, Laws of 1998, encourage increased use of mid-level services (e.g. assisted living, congregate housing, or residential care program) and home-based services (e.g. home health aide, homemaker, or nursing services). The State intends to increase mid-level and home-based services to elderly and chronically ill adults by offering a continuum of long-term care services using limited resources, particularly Medicaid, more efficiently.

Using Medicaid funds to provide long-term care services outside a nursing facility requires a waiver from the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services. Since 1984, New Hampshire has applied for and received Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI) waivers. In 1998, the waiver was amended to increase the types of home and community-based services offered including mid-level services.

The DEAS, located within the DHHS, coordinates the State's long-term care plan and changes required by Chapter 388, Laws of 1998. As of June 30, 2002, the DEAS consisted of 143 staff organized in four sections: Office of the Director, Bureau of Policy and Community Planning,

Bureau of Finance and Business Operations, and Bureau of Community Services. The DEAS has a central office located in Concord and twelve district offices throughout the State.

The DEAS provides or coordinates services for elderly and chronically ill adult consumers throughout the State. In State fiscal year 2002, the average monthly number of Medicaid eligible consumers residing in nursing facilities was 4,878, for mid-level services 152, and for home-based services 1,731.

Results In Brief

As we reviewed the DEAS' efforts to implement Chapter 388, Laws of 1998, it became apparent there have been barriers to promoting a complete and successful rebalancing of long-term care services towards home and community-based care. For example, low provider rates have impeded hiring and retaining direct care staff, often resulting in consumers not receiving all their authorized services. Low reimbursement rates have discouraged developing mid-level services, creating a gap in long-term care services. These findings are consistent with those reached by the SB 167 Long-Term Rate Advisory Committee Final Report issued in August of 2002 and the House Bill 1182 Study Committee report on the development of home and community-based long-term supports for the elderly and adults with disabilities issued November 2002. Counties are responsible for paying for a wider range of services than was the case under the former structure.

Our audit presents 18 observations and recommendations to the DEAS. Observation No. 1 addresses the DEAS' efforts to inform elderly consumers of appropriate long-term care choices promoting the use of home and community-based services. Observations No. 2 through 11 address quality control improvements the DEAS can make for home and community-based services. Observations No. 12 through 17 concern the DEAS' current practices to protect consumers from abuse, neglect, exploitation as well as the complaint process. Observation No. 18 addresses the need for the DEAS to develop a better system of management controls for its programs.

Improvements Needed To Inform Consumers Of Long-Term Care Choices

The Assessment and Counseling Program pilot has not been implemented in a uniform manner throughout the State as required by Chapter 388, Laws of 1998. This impacts the DEAS' ability to assist consumers with appropriate long-term care decisions.

Quality Controls Need Strengthening

We found the DEAS needs to improve its systems for measuring, monitoring, and reporting program performance. Several different guidelines exist to determine allowable costs for home and community-based services. Our review of plans of care showed they do not reflect all services required to maintain a consumer in the community. Additionally, consumers may not receive all their authorized services and some consumers may receive unauthorized services. Controls over services providers deliver are lacking and monitoring of provider licensing is poor. Finally, outsourcing HCBC-ECI cases needs to have clear criteria and guidelines.

Improvements Needed To Better Protect Consumers

We found the DEAS could do a better job informing consumers and the public of how to make an adult protective services report or complaint. The DEAS could improve its monitoring of the investigation process. We also found the current use of the State registry is limited.

Overall Management Controls And Oversight Needs To Be Improved

DEAS management does not have a quality assurance system to monitor, collect, and report on information related to all its programs or consumers using its programs in a timely manner. Not having timely or adequate information related to programs hinders management's ability to make informed programmatic decisions in an effective and efficient manner.

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RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
1	27	No	Develop best-practices document from the Assessment and Counseling Program pilot for implementing a uniform statewide program.	Concur
2	30	Yes	Review laws, policies, and rules regarding allowable costs for HCBC-ECI services and recommend changes to the Legislature.	Concur
3	32	No	Ensure plans of care include all services consumers require to remain in the community.	Concur
4	33	No	Monitor consumer’s care through service discrepancy reports.	Concur
5	36	No	Ensure all services received are authorized through a system of routinely reviewing consumers’ plans of care with claims information.	Concur
6	38	No	Work with the Office of Health Planning and Medicaid to determine available controls to monitor HCBC-ECI provider claims.	Concur
7	40	No	Ensure HCBC-ECI providers have and maintain appropriate current licensure.	Concur
8	41	No	Ensure social service contractors maintain appropriate licenses during the contract period.	Concur
9	42	No	Ensure social service contractors are appropriately licensed before and after submission of proposals.	Concur
10	43	No	Work with the Bureau of Health Facilities Administration to determine if assisted living facilities require licensure.	Concur

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
11	45	No	Establish criteria and guidelines for outsourcing HCBC-ECI cases.	Concur
12	47	No	Develop a formalized process for collecting complaint information.	Concur
13	49	No	Develop and provide training on a formalized complaint process.	Concur
14	51	No	Expand information contained in the State registry.	Concur
15	52	No	Implement a process to ensure the 72-hour time requirement for initiating an investigation is met.	Concur
16	53	No	Develop procedures to ensure investigations are completed within the required timeframe.	Concur
17	55	No	Develop a process to inform and educate consumers and the public on how and where to report cases of abuse, neglect, self-neglect, or exploitation.	Concur
18	57	No	Strengthen oversight and monitoring of all programs.	Concur

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INTRODUCTORY SECTION

1.1 Overview

On September 18, 2002, the Fiscal Committee of the General Court adopted a recommendation by the joint Legislative Performance Audit and Oversight Committee (LPAOC) for a performance audit of home and community-based services. On April 3, 2002, the LPAOC recommended we begin preliminary audit work on home and community-based care provided by the Division of Elderly and Adult Services (DEAS) and approved a scope statement on August 6, 2002.

1.2 Scope, Objectives, And Methodology

Scope And Objectives

This report reflects our assessment of the DEAS' efforts to effectively and efficiently make changes to the long-term care system in the State by promoting a rebalancing of home and community-based services, as proposed by the Department of Health and Human Services (DHHS) report, *Shaping Tomorrow's Choices* (1998), and required by Chapter 388, Laws of 1998. The audit period includes State fiscal years (SFY) 1998 through 2002.

We developed three questions to guide our audit work:

1. Has the DEAS' efforts to inform consumers of appropriate long-term care choices promoted the use of home and community-based services?
2. Are there appropriate quality controls in place for home and community-based services provided to elderly and chronically ill adults? This includes reviewing the DEAS' current practices to protect elderly and chronically ill adults from abuse, neglect, and exploitation.
3. Have long-term care expenditures, particularly Medicaid expenditures, been contained with the rebalancing from nursing facility services to home and community-based services? In reviewing long-term care expenditures, the possible effect on shifting State and county costs will be examined.

Methodology

We obtained, reviewed, and analyzed information related to the implementation of Chapter 388, Laws of 1998, home and community-based services, and adult protective services. We reviewed pertinent federal and State laws, administrative rules, department policies and procedures, State plans, budget documents, and agency reports. We conducted a file review to determine if quality controls were evident in consumer files. Provider file information was reviewed to determine if licensing or certification was current. We interviewed DEAS personnel, private case managers, and knowledgeable individuals outside of the DEAS and surveyed ServiceLink directors and service providers.

1.3 Federal Long-Term Care Programs

Long-term care and its associated costs are a concern to the federal and state governments, especially with the projected increase in the elderly population. Nationally, the AARP projects the number of people 65 years of age and older will increase from 12.4 percent to 16.3 percent of the total population by 2020. Furthermore, according to the AARP, those 85 years of age and older, the group most likely to need long-term care services, will increase from 1.5 percent to 1.9 percent.

States rely on federal support to help fund long-term care services. The main federal long-term care funding programs available to states are: the Medicaid program, the Older Americans Act (OAA), and Social Services Block Grants (SSBG). See Table 1 on page 9 for New Hampshire's eligibility requirements for each program and services offered.

Medicaid Program

The Medicaid program, established in 1965 through Title XIX of the Social Security Act, is a medical assistance program serving low-income individuals of all ages. The U.S. Department of Health and Human Services' (U.S. DHHS) Centers for Medicare and Medicaid Services (CMS) administers the Medicaid program. The Medicaid program is the largest funding source for long-term care, an important provision of the program that will be increasingly utilized as the nation's population ages. Medicaid funding for long-term care services was "45 percent of total long-term care expenditures" for persons using a nursing facility or home health services, according to the U.S. General Accounting Office in 2000. Long-term care services covered by the Medicaid program include nursing facilities and home and community-based services such as assisted living, home delivered meals, adult group day care, and nursing services, as well as a host of ancillary services.

Using Medicaid funds to provide a long-term care program targeted to specific populations requires a waiver from the CMS. Under section 1915 (c) of the Social Security Act, states may request waivers of certain federal requirements. The waiver promotes choice for individuals who wish to receive care in their homes or community as an alternative to nursing facility placement. To receive approval states must assure CMS, on an average per capita basis, the cost of waivered services will not exceed the cost of nursing facility placement. Since 1984, New Hampshire has applied for and been granted a Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI) waiver.

Older Americans Act

The OAA, as amended, was originally enacted into law in 1965 to help ensure the inherent dignity of the elderly. The OAA established the Administration on Aging within the U.S. DHHS to administer grants. The largest program under OAA is Title III grants for state and community programs on aging. These grants are based on the number of people 60 years of age and older in the state. To participate the governor must designate a state agency to develop and implement a statewide plan on aging. In New Hampshire, the DEAS is designated as the state agency.

The OAA funds a variety of services for the elderly, particularly those at risk of losing their independence. It is a major source for organizing and delivering supportive services and nutrition to those 60 years of age and older. Additionally, projects receiving OAA funds are eligible to receive U.S. Department of Agriculture (USDA) commodity or financial assistance. New Hampshire has elected to receive financial assistance.

Table 1

Home And Community Care: Sources, NH Eligibility Criteria, And Services Funded

Sources	NH Eligibility Criteria[1]	Services Funded	
Medicaid HCBC-ECI	♦ At least 18 years of age ♦ Meet the categorical and medical eligibility requirements for nursing facility service coverage ♦ Meet the level of care requirements	<u>Home-based care</u> ♦ Adult group day care ♦ Adult in-home care ♦ Nursing ♦ Home health aide ♦ Homemaker ♦ Personal emergency response system ♦ Respite care ♦ Personal care services ♦ Home modification services ♦ Consolidated services	♦ Nutrition (home delivered) ♦ Environmental accessibility adaptations ♦ Assistive technology support ♦ Adult companion services ♦ Community support services ♦ In-home mental health services <u>Mid-level care</u> ♦ Residential care services ♦ Assisted living ♦ Congregate living
OAA	♦ At least 60 years of age ♦ No income requirement	♦ Adult group day care ♦ Elder abuse counseling ♦ Homemaker services ♦ Home health aide ♦ Outreach ♦ Nursing ♦ Health screening ♦ Advocacy ♦ Emergency response system	♦ Energy assistance ♦ Evaluation (vision) ♦ Low vision aide training ♦ Legal service ♦ Dental ♦ Support service ♦ Transportation ♦ Nutrition services
USDA	♦ At least 60 years of age ♦ No income requirement	♦ Home delivered meals ♦ Congregate meals	
SSBG	♦ At least 60 years of age or an incapacitated adult 18 years of age or older ♦ Income is less than $900 per month ♦ Residing in independent living ♦ Needs assistance with at least two activities of daily living	♦ Adult group day care ♦ Emergency support ♦ Homemaker ♦ Nutrition services ♦ Respite care ♦ Adult in-home care ♦ Information and referral	

Note: [1]Only principal eligibility criteria are listed and therefore the list is not exhaustive.
Source: LBA analysis of DEAS and program information.

Social Services Block Grant

Title XX of the Social Security Act was established in 1975 giving states flexibility to use federal funds to fill gaps in funding needed services. The Omnibus Budget Reconciliation Act in 1981 amended Title XX establishing the SSBG program. Under the program, grants are allocated based on a state's population; grants are not contingent on states providing matching funds. Grants fund community-based programs allowing elderly individuals and adults with disabilities with limited financial resources to live safely and independently in the community and prevent abuse, neglect, and inappropriate institutionalization. Services funded through the SSBG include adult day care, respite care, and nutrition services. Eligibility for SSBG services requires applicants to have a limited income and be at least 60 years of age.

1.4 New Hampshire's Long-Term Care Efforts

Historically, New Hampshire's long-term care system has favored nursing facility services, however with the expected growth in the elderly population the State is working to rebalance the system towards home and community-based care. New Hampshire faces an aging population as the "baby boomers" (those born between 1946 and 1964) approach 65 beginning in 2010. As shown in Figure 1 on page 11, the projected population of New Hampshire individuals 60 years of age and older will increase from 16 percent in 2000 to 34 percent in 2025.

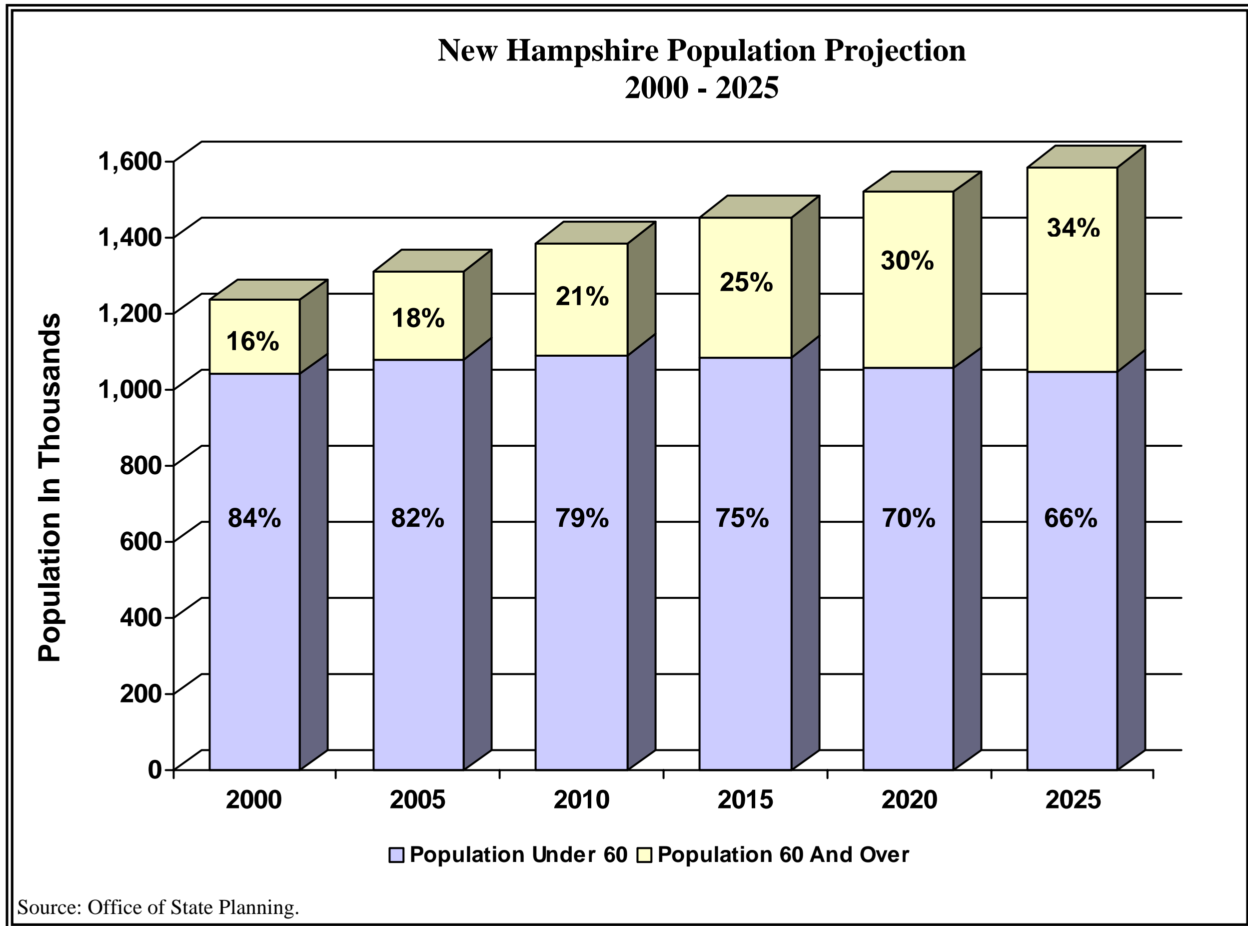
Chapter 309, Laws of 1997, required the DHHS develop a plan to begin the process of rebalancing the State's long-term care. The Legislature used this plan, *Shaping Tomorrow's Choices*, as a guide in drafting legislation adopted in Chapter 388, Laws of 1998, also referred to as Senate Bill (SB) 409. The intended impact of this legislation was to slow the rising cost of long-term care and increase consumer choice by reducing dependence on nursing facilities and increasing community-based alternatives.

The Division Of Elderly And Adult Services

Chapter 128, Laws of 1986, created the DEAS, located within the DHHS. The DEAS provides and coordinates services to the elderly and adult population throughout the State. In 1997, the DEAS became responsible for Medicaid long-term care, including nursing facilities and HCBC-ECI waiver, bringing the key services aimed at elderly and chronically ill adults together under a single division.

As part of its responsibility, the DEAS develops and administers the State Plan on Aging in accordance with the OAA. Additionally, the DEAS coordinates the State's long-term care plan, required by Chapter 309, Laws of 1997, and long-term care changes required as part of Chapter 388, Laws of 1998.

Figure 1

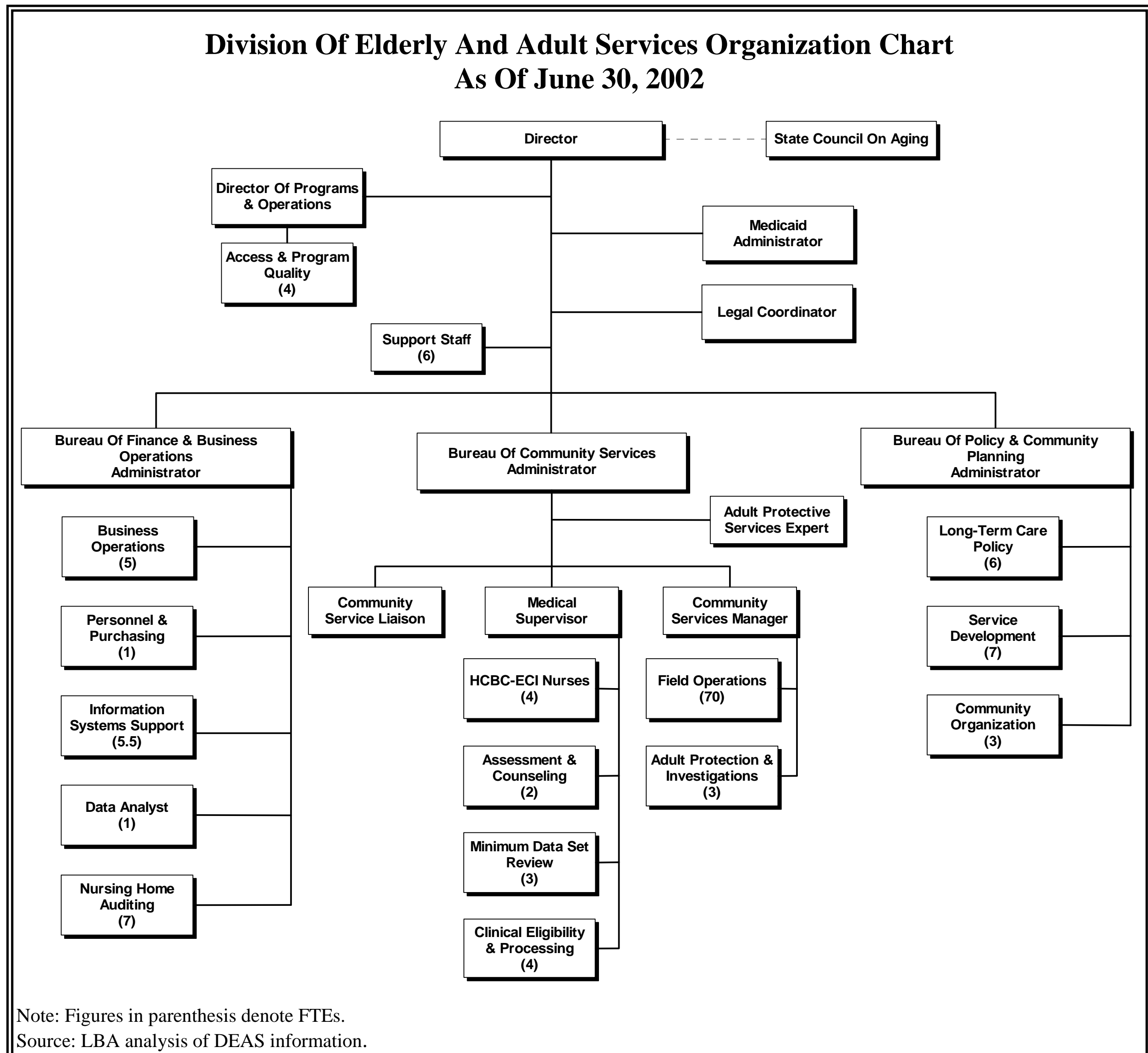


Source: Office of State Planning.

The DEAS' mission states it "shares leadership within New Hampshire in developing and funding long-term supports and advocating for elders, adults with disabilities, and their families and caregivers." The DEAS received input regarding changes to long-term care from public meetings held throughout the State. The DEAS also received input from the State Committee on Aging, members of senior and adult disabled advocacy groups, service providers, family caregivers, and consumers of long-term care services.

As of June 30, 2002, the DEAS consisted of 143 staff in four sections: Office of the Director, Bureau of Policy and Community Planning, Bureau of Finance and Business Operations, and Bureau of Community Services (see Figure 2 on page 12). In 1996, the Long-Term Care Ombudsman was moved from the DEAS to the DHHS Ombudsman's Office, and as of July 25, 2002, was relocated back to the DEAS, adding three more positions. The DEAS has a central office located in Concord and twelve district offices located throughout the State.

Figure 2



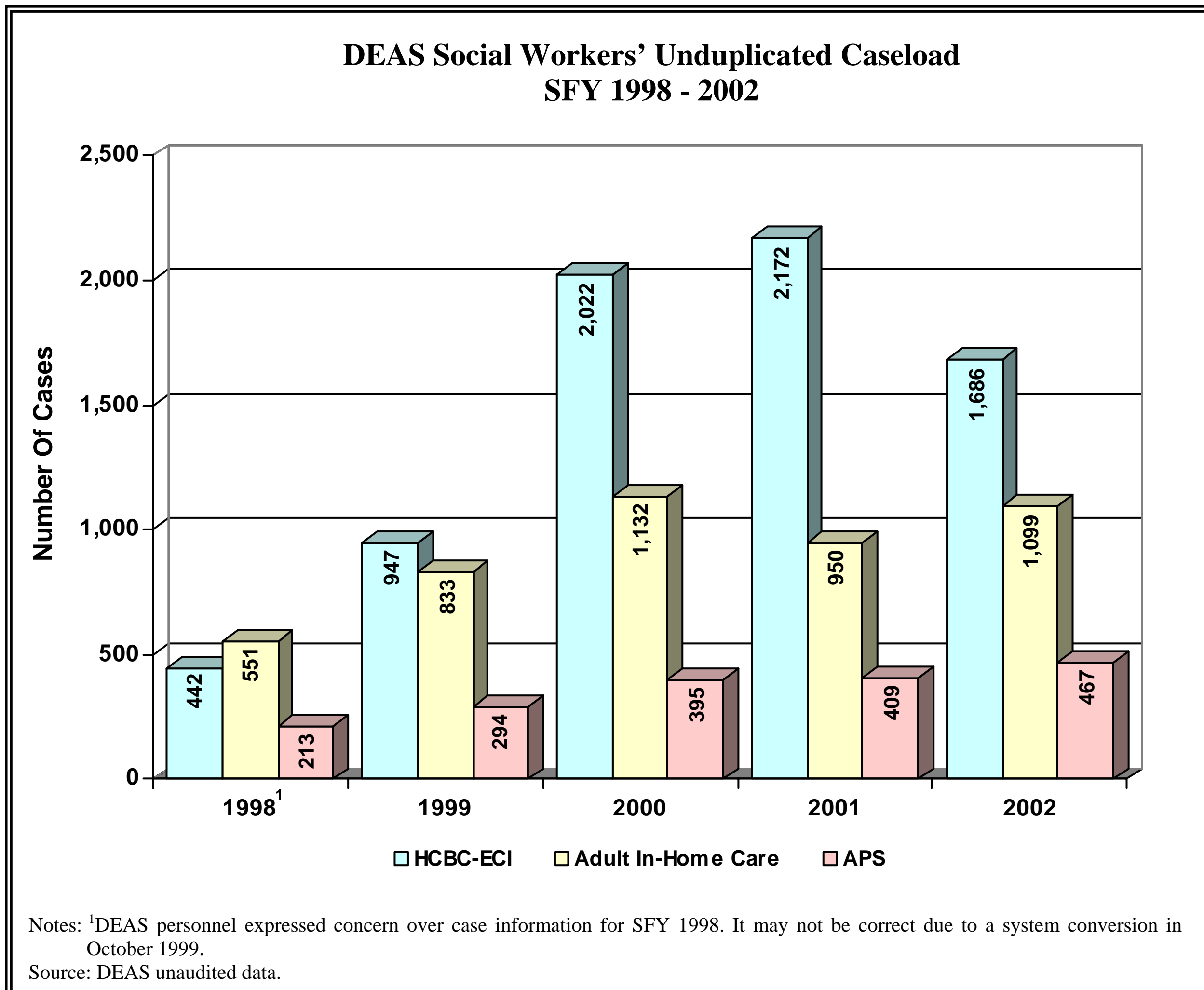
Note: Figures in parenthesis denote FTEs.
Source: LBA analysis of DEAS information.

The Office of the Director consisted of 14 personnel. The office provides leadership; establishes goals, objectives, and standards; and sets program procedures. Seventeen personnel worked in the Bureau of Policy and Community Planning providing policy analysis and development, planning, grants management, needs assessment, staff support to policy committees, and community-based long-term care resource development. The Bureau of Finance and Business Operations had 21 personnel, including one part-time, responsible for all fiscal matters pertaining to the DEAS, overall development and monitoring of contracts, performing audits, and systems support. The Bureau of Community Services had 91 staff, including social workers, responsible for coordinating the delivery of community-based care services, determining nursing facility level of care, conducting on-site reviews, and providing adult protective services (APS).

The workload for DEAS social workers includes case management and counseling services to eligible consumers. In addition, DEAS social workers provide information and referral, intake assessments, and APS to the public. Social workers manage caseloads consisting of adult in-home care, APS, and HCBC-ECI cases. Caseloads range from 40 to 75 cases. As shown in Figure 3, there has been an increase in the number of cases during SFY 1998 - 2002, realizing a high of 3,549 cases in 2000. However, we note the DEAS could not explain the increase in the number of HCBC-ECI cases. On average, DEAS social workers have four open APS investigations but some social workers have ten to 15 open investigations.

To assist DEAS social workers with their increasing workloads a significant number of HCBC-ECI cases were outsourced to private case management agencies in SFY 2001. However, DEAS management and field staff indicated DEAS caseloads have not dramatically decreased as a result of outsourcing due to an increase in new HCBC-ECI and APS cases. During the audit period, the DEAS outsourced a total of 1,040 HCBC-ECI cases to six private case management agencies. Caseloads per agency range from 35 to 433 cases.

Figure 3



Notes: [1]DEAS personnel expressed concern over case information for SFY 1998. It may not be correct due to a system conversion in October 1999.
Source: DEAS unaudited data.

Long-Term Care Services

Long-term care services are funded through various federal, State, county, and private sources. Potential consumers must meet different requirements depending on the funding source. Information and assistance and protective services do not have eligibility requirements. An applicant must qualify for long-term care services funded by the Medicaid program, SSBG, or APS to be eligible for case management services.

DEAS social workers and private case managers assist consumers in obtaining needed services from contracted and Medicaid enrolled providers. Services funded by the OAA or the SSBG are provided by contractors. HCBC-ECI services require a provider be enrolled as a Medicaid HCBC-ECI provider.

A consumer may obtain OAA or SSBG funded services directly through a contracted provider if they meet eligibility requirements. The HCBC-ECI program requires consumers be eligible for Medicaid and meet the clinical requirements for admission to a nursing facility. Once found eligible for HCBC-ECI services, a DEAS nurse develops and authorizes a plan of care (POC) with the consumer. The POC includes the types, frequency, and costs of HCBC-ECI services needed to remain in the home or community, as well as names of authorized providers. Authorized services are arranged by a DEAS social worker or private case manager. As part of developing the POC, non-HCBC-ECI services received by a consumer, such as family support or services funded through the OAA or the SSBG, are considered.

The DEAS social workers and the Long-Term Care (LTC) Ombudsman staff provide protective services to the elderly and chronically ill adults. The LTC Ombudsman is responsible for identifying, investigating, and resolving complaints of "any act, practice, policy, procedure of any facility or government agency that does or may adversely affect the health, safety, welfare, or civil or human rights of" any resident of a long-term care facility. During the audit period, the LTC Ombudsman was responsible for investigating all complaints of abuse, neglect, exploitation, or self-neglect in long-term care residential facility settings. In the fall of 2002, responsibility was transferred to DEAS social workers. DEAS social workers also investigate reports of abuse, neglect, exploitation or self-neglect of consumers living in the community. As part of the investigation process or if a case is founded or substantiated, consumers are offered and authorized to receive long-term care services through the APS program without regard to eligibility requirements. If a report is unfounded or unsubstantiated, an APS case may be opened through the normal application process with the consent of the consumer.

1.5 Significant Achievements

Performance auditing by its nature is a critical process, designed to identify weaknesses in past and existing practices. With that in mind, we mention here successful and positive practices we have observed and for which sufficient documentation is available.

Development Of Quality Assurance And Oversight Activities

The DEAS conducted a comprehensive review of HCBC-ECI consumer files to obtain baseline information relative to services received, services available, and payment history. The DEAS reviewed ten percent of the HCBC-ECI case files (both DEAS and private case management cases) for the month of September 2001. Individual plans of care were reviewed in conjunction with financial payment records. As a result of this comprehensive review two other reviews were conducted: a State office record review and a survey of HCBC-ECI private case manager files.

These reviews identified the following activities to improve program quality: increase education of providers and staff, monitor utilization and billing patterns, and system improvements necessary to assure program quality. Additionally, the DEAS instituted a quality assurance system for HCBC-ECI private case management including: training, monthly meetings, site surveys, statistical reporting, and standardized performance assurances.

Publication Of Aging Issues

The DEAS has published a quarterly newspaper, *Aging Issues*, since the fall of 1997. *Aging Issues* contains community news and other issues and subjects of interest to seniors such as long-term support system reform, Medicare, healthy lifestyles, mental health needs and services, and prescription drugs. The newspaper has a circulation of 43,500, distributed through locations serving seniors such as senior centers, banks, and medical providers.

Strengthening The Adult Protective Services Program

The DEAS has proposed reorganizing and reclassifying social workers into functionally different categories of Adult Protective Social Workers. According to the DEAS, this proposal represents a "definitive departure from the past and a reshaping of how DEAS does business on a daily basis in the district offices…." The proposal addresses the steady growth in increasingly complex and severe APS investigations, requiring a higher level of professionalism. Over the last two years DEAS supervisors and social workers have received formal training from a nationally acclaimed APS professional.

Senior Prescription Drug Discount Pilot Program

In January 2000, the DEAS implemented the Senior Prescription Drug Discount Program. The program was established to provide some relief for New Hampshire seniors 65 years of age and older to pay for prescription medications, regardless of income or resources. Participants are not charged enrollment or program fees but pay a standard $2.50 dispensing fee plus the discounted price at participating pharmacies. Discounts range from 15 percent off brand drugs and up to 40 percent off generic drugs.

The DEAS reported as of November 2002 the average rate of savings to seniors was 18 percent per prescription. Collectively the program has saved participants $3.7 million.

Health Insurance Counseling, Education And Assistance Services

Health Insurance Counseling, Education and Assistance Services is a collaborative effort between the DEAS, Community Services Council of NH, and the University of New Hampshire's Cooperative Extension Service. The DEAS exercises administrative control over it. The program has trained over 200 volunteers to provide information, counseling, and assistance related to Medicare, Medicaid, and other insurance benefits. There are over 45 counseling sites located throughout the State and 13 Medicare Information and Learning Centers located at ServiceLink sites. Information can be accessed by individuals 24 hours a day, seven days a week.

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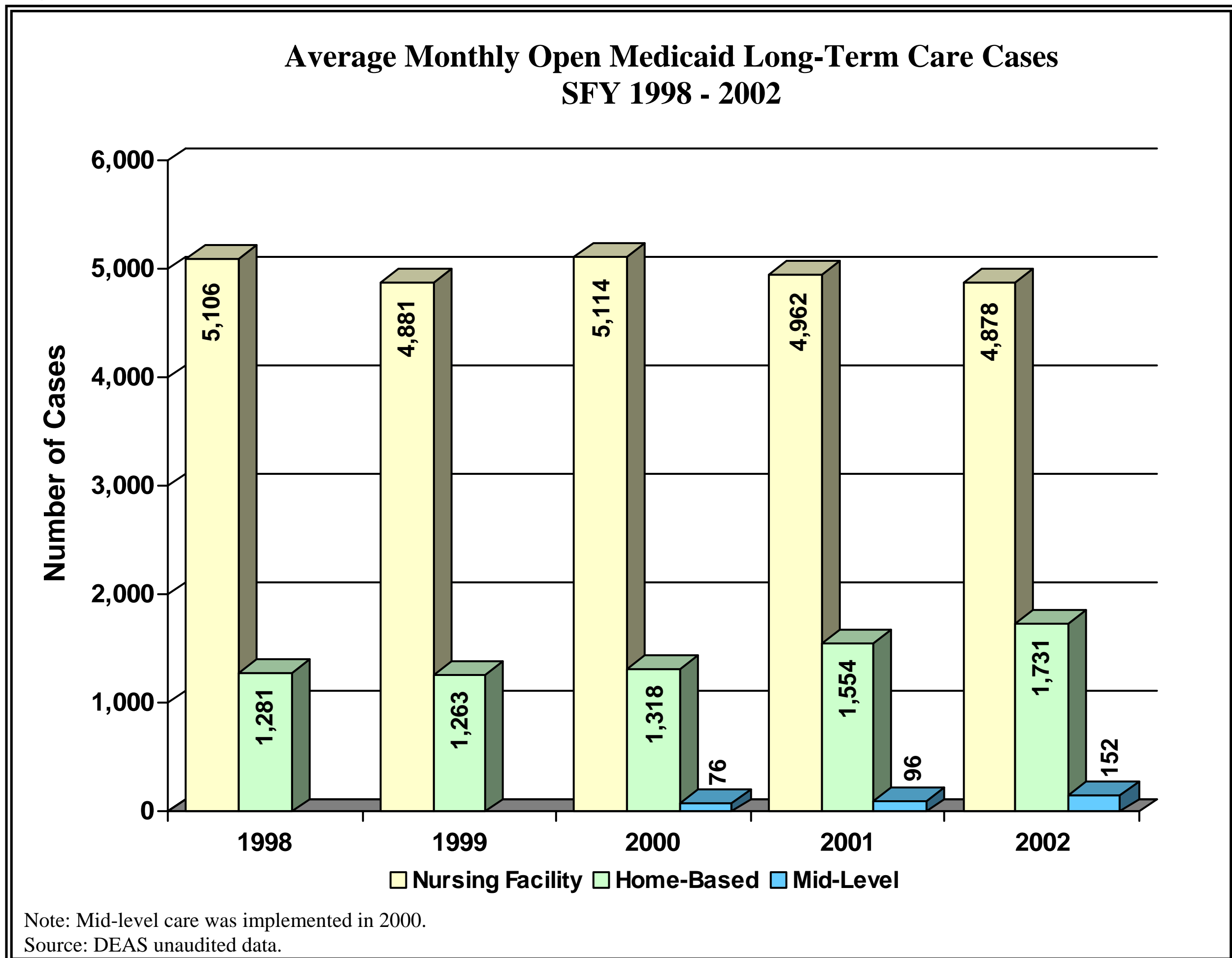
HOME AND COMMUNITY-BASED CARE

REVIEW OF CHAPTER 388, LAWS OF 1998

Chapter 388, Laws of 1998, proposed changes to Medicaid long-term care financing for the purpose of managing Medicaid resources more efficiently. However, financial barriers impeded efforts to rebalance the State's long-term care system. Worker shortages and low reimbursement rates impacted service delivery to Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI) consumers. Additionally, we found under the new Medicaid long-term care funding structure, level funding nursing facility payments in 2002 and 2003 by the State shifted more costs to counties.

Chapter 388, Laws of 1998, also required implementing information and referral systems. A statewide information and assisted referral program was established through ServiceLink. Additionally, assessment and counseling services were piloted in four counties to determine best practices, to be used for implementing a statewide program in 2003.

Figure 4



Note: Mid-level care was implemented in 2000.
Source: DEAS unaudited data.

As shown in Figure 4 on page 17, the monthly average number of Medicaid filled nursing facility beds has remained around 5,000 since 1998 with the last two State fiscal years (SFY) below 5,000. There have been increases in the monthly average number of consumers utilizing mid-level and home-based services. The average monthly number of Medicaid consumers using mid-level services, which began in SFY 2000, has increased from 76 to 152 in SFY 2002. The average monthly number of Medicaid consumers utilizing home-based services has increased from 1,281 in SFY 1998 to 1,731 in SFY 2002. The slight decrease in nursing facility use and increases in mid-level and home-based care suggests some success in the DEAS' efforts to rebalance the State's long-term care system.

In the *2002 SB 409 Annual Report*, the DEAS states "costs per case did remain within legislative limits. In fact… per case costs dropped within the home care setting." The DEAS concludes this drop may be the result of consumers "not receiving the amount of care they needed because of workforce challenges providers faced." In Observation No. 4 on page 33, we raise the concern of consumers not receiving all needed services.

2.1 Home And Community-Based Care For The Elderly And Chronically Ill Waiver

Shaping Tomorrow's Choices (1998) and Chapter 388, Laws of 1998, encourage increased use of home and community-based services allowing for a continuum of long-term care using limited resources, particularly Medicaid, more efficiently. Accordingly, the HCBC-ECI waiver was amended in 1998 to expand services available under the program, allowing eligible Medicaid consumers to choose less restrictive mid-level or home-based services as an alternative to nursing facility placement. Medicaid eligible consumers may select less restrictive care provided the services are available, clinically appropriate, and when mid-level care does not exceed 50 percent and home-based care does not exceed 33 percent of the average annual cost of a nursing facility.

The actual mid-level care participation rate, as reported by the DEAS for SFY 1999 to 2002, was 36 percent lower than projections made prior to implementation of Chapter 388, Laws of 1998. This growth rate may have been hampered by low provider reimbursement rates, limiting the number of mid-level providers participating in the HCBC-ECI program. The DEAS reported they are currently developing a proposal to revise the mid-level care rate structure to include various payment levels corresponding to the acuity level of consumers.

Home-based services through the HCBC-ECI waiver have also been affected by low provider reimbursement rates. Low provider rates contribute to staff shortages, leading to some home-based consumers not receiving all authorized services. As reported in Observation No. 4 on page 33, serious health related consequences could result when consumers do not receive all authorized HCBC-ECI services, potentially resulting in nursing facility placement and inefficient use of Medicaid resources. Table 2 on page 19 provides information related to HCBC-ECI service rates and when the rates were last adjusted.

Table 2

HCBC-ECI Provider Rate Changes				
HCBC-ECI Services	**Time Unit**	**Pre-Chapter 388 Rates**	**Current Rates**	**Date of Most Recent Change**
Home Health Aide	15 minutes	$5.25	$5.25	10/1/97
Nursing	15 minutes	15.43	18.95	2/1/99
Homemaker	15 minutes	3.41	4.00	2/1/99
Adult Day Health	day	27.50	45.00	1/1/00
Adult Medical Day Care	day	27.50	45.00	1/1/00
Adult In-Home Care	hour	7.35	12.59	3/1/02
Residential Care Services	day	N/A	20.00	7/1/00
Personal Emergency Response System	month	35.00	35.00	11/1/91
Respite Care	6 hours	22.50	36.00	1/1/00
Personal Care Services-Agency Directed	hour	N/A	16.00	7/1/01
Personal Care Services-Consumer Directed	hour	N/A	16.00	9/1/01
Home Modification Services	By PA[1]	N/A	By PA	8/1/01
Consolidated Services	By PA	N/A	By PA	10/1/01
Home Delivered Meals	per meal	N/A	6.25	9/1/01
Betty's Dream[2]	day	80.00	80.00	12/1/98
Assisted Living	day	50.00	50.00	3/1/98
Congregate Living	day	N/A	26.00	1/1/00

Notes: [1]Prior Authorization
[2]Betty's Dream supports a low-income fully accessible housing complex for the physically handicapped.
Source: LBA analysis of DEAS information.

2.2 Medicaid Long-Term Care Financing

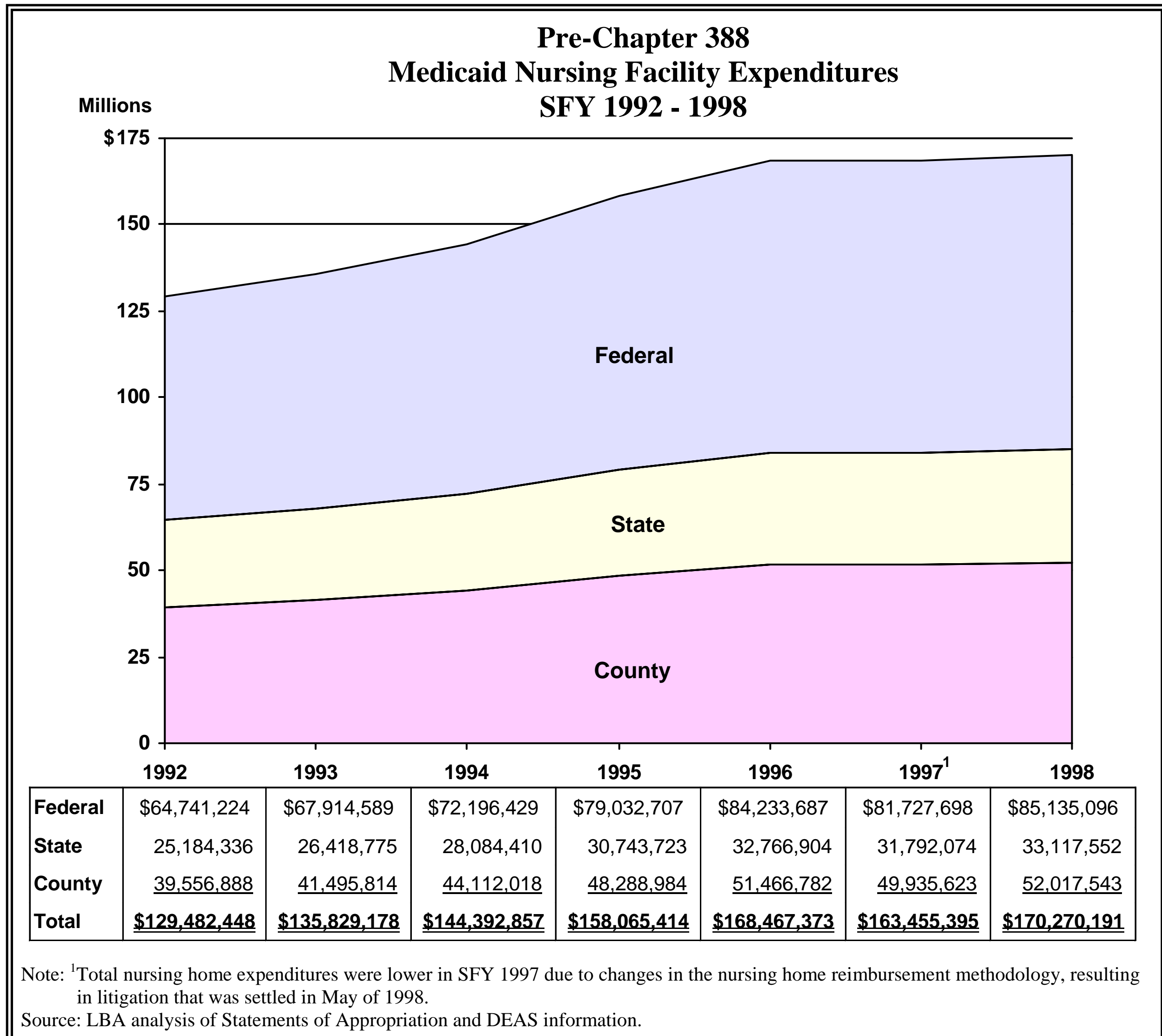
The cost of providing long-term care to New Hampshire's eligible Medicaid population has been steadily increasing for well over a decade. Concern over the ability of government to continue funding the increasing costs, coupled with the motivation to provide services needed by users of the system, resulted in policy changes brought about by Chapter 388, Laws of 1998, also known as Senate Bill (SB) 409.

Prior To Chapter 388, Laws Of 1998

The expense of providing nursing facility services has been, and continues to be, the cost driver of the long-term care system. In 1992, nursing facility reimbursements consumed approximately 20 percent of the entire Department of Health and Human Services budget (exclusive of appropriations for disproportionate share from the uncompensated care pool), representing the single largest line item in the department's budget. Prior to Chapter 388, Laws of 1998, nursing facilities were reimbursed on a cost basis. However, according to the DEAS, nursing facilities were never reimbursed for total allowable costs.

In New Hampshire nursing facility reimbursement is shared by the federal, State, and county governments. Prior to 1999, the federal government reimbursed 50 percent of the allowable amount billed by nursing facilities, with the counties picking up 30.55 percent and the State funding the remaining 19.45 percent. Figure 5 depicts the amounts paid by each to nursing facilities from SFY 1992 through 1998.

Figure 5



	1992	1993	1994	1995	1996	1997[1]	1998
Federal	$64,741,224	$67,914,589	$72,196,429	$79,032,707	$84,233,687	$81,727,698	$85,135,096
State	25,184,336	26,418,775	28,084,410	30,743,723	32,766,904	31,792,074	33,117,552
County	39,556,888	41,495,814	44,112,018	48,288,984	51,466,782	49,935,623	52,017,543
Total	**$129,482,448**	**$135,829,178**	**$144,392,857**	**$158,065,414**	**$168,467,373**	**$163,455,395**	**$170,270,191**

Note: [1]Total nursing home expenditures were lower in SFY 1997 due to changes in the nursing home reimbursement methodology, resulting in litigation that was settled in May of 1998.
Source: LBA analysis of Statements of Appropriation and DEAS information.

Prior to 1999, the federal and State governments each contributed 50 percent towards the Medicaid costs associated with providing home-based care, as well as provider payments for doctors, hospitals, prescription drugs, and medical equipment. The counties did not contribute to financing these services. Prior to SFY 1999, amounts paid to providers were not tracked based on the population served, therefore information is not available to analyze the growth of provider payments made to the long-term care population prior to that time. Without this information, we are unable to determine the total costs of providing long-term care services prior to SFY 1999.

Chapter 388, Laws Of 1998

Many changes were made in financing long-term care through Chapter 388, Laws of 1998. Effective January 1, 1999, all provider reimbursements for long-term care (e.g., nursing facilities, hospitals, and prescription drugs) are shared 50 percent federal, 25 percent State, and 25 percent counties. Therefore, while the reimbursement percentage for counties dropped from 30.55 to 25, they now share in a larger pool of costs. Table 3 below presents all Medicaid long-term care costs shared by federal, State, and county governments subsequent to Chapter 388, Laws of 1998. There is also a $2 million credit available against the current year's liability for each county to share proportionately according to their previous year's payment. Additionally, the law capped the counties total liability from SFY 1999 through 2003. However, the counties' total liability has never reached the legislated caps, which were $54 million in SFY 1999 increasing to $66 million in SFY 2003.

Table 3

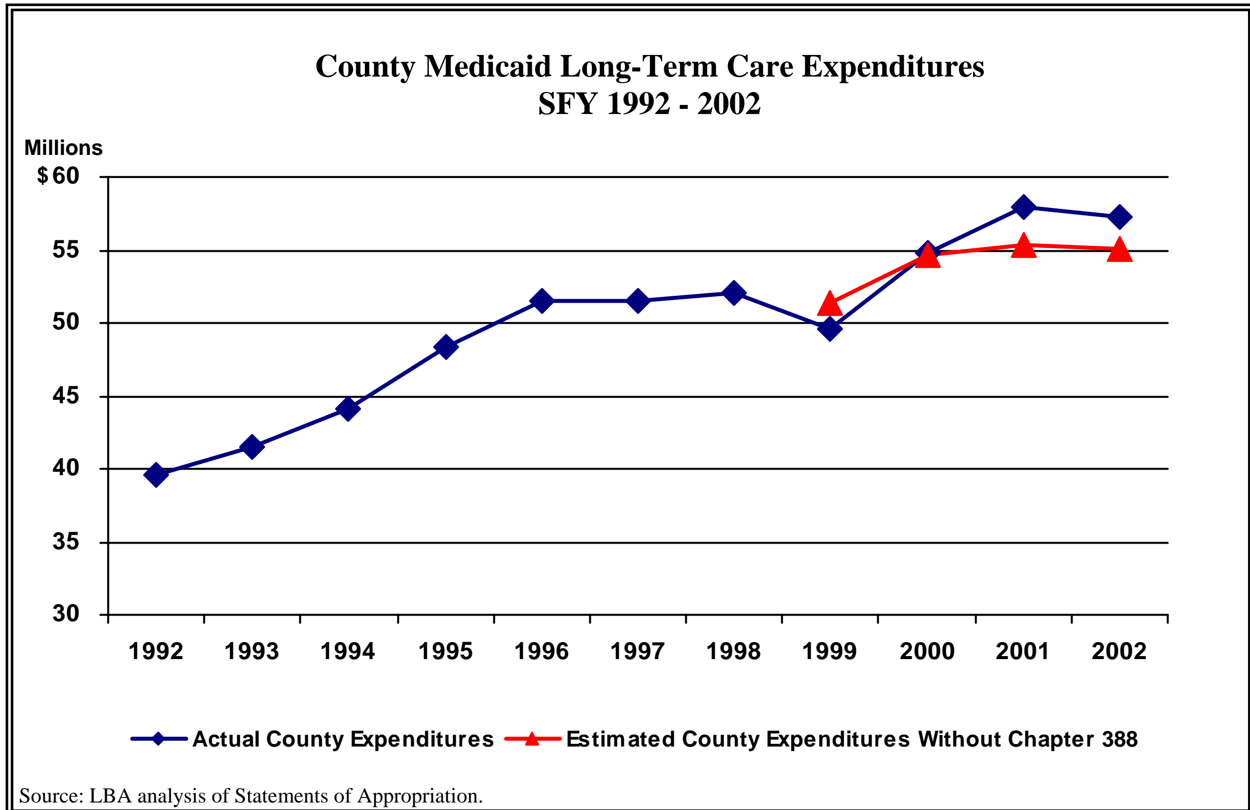
Long-Term Care Expenditures And Funding Sources
SFY 1999 - 2002

	1999	2000	2001	2002
Medicaid Expenditures				
Nursing Facilities	$ 168,050,522	$ 178,866,179	$ 181,176,845	$ 180,403,831
Provider Payments	33,510,873	36,399,213	39,618,677	42,820,352
In-Home Nursing Services	22,146,977	14,878,250	16,868,831	18,024,866
Other Expenditures	214,333	69,338	80,833	112,275
Mid-Level Care	0	210,000	1,087,632	1,384,626
Total	**$ 223,922,705**	**$ 230,422,980**	**$ 238,832,818**	**$ 242,745,950**
Funding Sources				
Federal Share	$ 111,961,353	$ 115,211,490	$ 119,416,409	$ 121,372,975
State Share	62,314,767	60,414,228	61,515,670	64,110,591
County Share	49,646,585	54,797,262	57,900,739	57,262,384
Total	**$ 223,922,705**	**$ 230,422,980**	**$ 238,832,818**	**$ 242,745,950**
Amount By County				
Belknap	$ 2,339,885	$ 2,454,382	$ 2,762,585	$ 2,689,743
Carroll	1,904,523	2,326,677	2,297,237	2,388,936
Cheshire	3,207,941	3,606,731	3,894,933	3,775,838
Coos	3,137,072	3,253,785	3,552,360	3,627,246
Grafton	3,200,957	3,678,458	3,932,093	3,718,085
Hillsborough	14,357,253	15,416,724	16,110,542	16,536,830
Merrimack	5,969,651	6,232,840	6,916,598	6,819,513
Rockingham	8,846,315	10,287,632	10,469,162	9,974,144
Strafford	4,221,864	4,925,237	5,089,160	4,938,857
Sullivan	2,461,124	2,614,796	2,876,069	2,793,192
Total	**$ 49,646,585**	**$ 54,797,262**	**$ 57,900,739**	**$ 57,262,384**

Note: Long-term care system financing changes took effect on 1/1/99. Billing difficulties occurred during the transition, the State and county share presented for SFY 1999 are reasonable estimates based on LBA analysis of the DEAS information.
Source for county billing amounts: DEAS prepared Cap analysis worksheets.
Source for expenditure information: Statements of Appropriation.

Figure 6 presents county expenditures for the long-term care system for SFY 1992-2002. Included as a distinct line for SFY 1999-2002 is the amount counties would have paid at 30.55 percent of nursing facility reimbursements. Starting in SFY 2001, counties expended more under the financing arrangement created under Chapter 388, Laws of 1998, than would have been paid under the prior arrangement. While these amounts reflect actual Medicaid reimbursements for nursing facilities, it can be argued that nursing facility reimbursements would be higher if not for a shift in policy to access more HCBC-ECI services mandated in 1998.

Figure 6



Source: LBA analysis of Statements of Appropriation.

Nursing Facility Rate Setting

In addition to the change in the way federal, State, and county governments share in long-term care funding, Chapter 388, Laws of 1998, mandated changing the way nursing facility reimbursement rates are determined. As stated previously, prior to 1999 nursing facility rates were based on costs incurred by the nursing facilities. While costs incurred continue to be used in the new acuity-based rate setting methodology, the services needed by the population at each facility are also factored into the reimbursement rates. The methodology is intended to reimburse facilities based on the level of care needed by residents, encourage cost controls, and add efficiencies on the part of facilities. Under a cost basis reimbursement system there is little incentive for the provider to control costs. While nursing facilities would no longer be reimbursed solely on a cost basis, nursing facilities agreed to the acuity-based methodology.

The acuity-based reimbursement methodology is used to calculate a separate daily bed rate for each facility based on a combination of allowable costs incurred and the acuity level of the residents at the respective facility. Facilities were reimbursed at the full acuity-based rates until SFY 2002, when rates were discounted to fit within the legislative appropriation for nursing home payments. With the level funding nursing facility payments in SFY 2002 and 2003, each facility was reimbursed approximately 96.27 percent and 93.66 percent, respectively, of the daily acuity-based rate for its facility. Statewide underpayment in SFY 2002 and 2003 has totaled approximately $19 million (see Exhibit 1). Each facility shared in the underpayment proportionately.

Exhibit 1

Medicaid Underpayment Of Nursing Facilities
(In Millions)

	SFY 2002	SFY 2003
Full acuity-based rate eligible for reimbursement	$ 188.5	$ 193.8
Amount budgeted for nursing facility reimbursement	181.5	181.5
Medicaid underpayment	$ 7.0	$ 12.3

Source: LBA analysis of rate calculation worksheets prepared by the DEAS.

Issues Specific To Counties

Counties are unique in that each functions as both a payee (provider of services) and a payer of the long-term care system. Under Chapter 388, Laws of 1998, counties fund 25 percent of the total Medicaid payment for long-term care services including nursing facilities, home-based care, mid-level care, and provider payments for prescriptions, hospitals, and doctors. As a provider through the county nursing facilities, county governments also incur costs when the Medicaid reimbursement rates fall short. It is important to recognize rates fell short of the acuity-based rates for SFY 2002 and 2003 resulting in a $19 million underpayment.

Taxpayers in counties with a higher proportion of county nursing facility beds to private beds will pay higher costs when reimbursement rates fall short, while in counties with proportionately more private beds than county beds taxpayers will pay less when reimbursement rates fall short. For example, in Sullivan County over 60 percent of all Medicaid beds are in the county nursing facility while in Hillsborough County about 17 percent of all Medicaid beds are in the county nursing facility. In terms of paying for nursing facility costs, the taxpayers in Hillsborough County pay less for providing long-term care to its citizens when reimbursement rates are short, while in Sullivan County underpayment costs more for the county taxpayer. Table 4 on page 24 estimates the effect level funding has on each county for SFY 2003.

Table 4

Effect Of Level Medicaid Funding Of Nursing Facilities On Counties SFY 2003					
County	**Percent of County Beds**	**Underpayment to Private Facilities**	**Savings to Counties[1]**	**Underpayment to County Facilities[2]**	**Net (Increase)/ Decrease in Costs to County Taxpayers**
Belknap	34%	$ 434,916	$ 108,729	$ 245,157	$ (136,428)
Carroll	35	418,367	104,592	226,228	(121,636)
Cheshire	33	522,194	130,548	270,377	(139,829)
Coos	52	348,458	87,115	403,754	(316,639)
Grafton	38	434,218	108,555	284,926	(176,371)
Hillsborough	17	3,093,521	773,380	625,361	148,019
Merrimack	38	1,007,424	251,856	585,325	(333,469)
Rockingham	24	1,562,478	390,619	512,499	(121,880)
Strafford	48	476,503	119,126	441,284	(322,158)
Sullivan	62	186,831	46,708	301,538	(254,830)
TOTAL		**$ 8,484,910**	**$ 2,121,228**	**$ 3,896,449**	**$ (1,775,221)**

Notes: [1]The underpayment to private facilities, while an unreimbursed expense of those facilities, represents a savings to the counties because counties are not liable for 25 percent of the underpayment.
[2]The underpayment to county nursing facilities represents additional costs to be incurred by county government.
Source: 2/1/03 rate calculation worksheet prepared by the DEAS.

2.3 Information And Referral Systems

ServiceLink

ServiceLink, established in 2000, is a system of community-based focal points providing information and referral services to seniors, adults with disabilities or chronic illnesses, and their families, enabling them to make informed long-term care decisions. ServiceLink is comprised of 13 regional offices (one in each county and two each in Hillsborough, Rockingham, and Grafton) and approximately 50 satellite sites. The DEAS contracts with non-profit agencies to provide core standardized services. The DEAS sets the basic guidelines allowing each site to tailor ServiceLink to reflect the values and philosophy of the community. The DEAS maintains a toll free number automatically routing callers to the ServiceLink site in their community.

Contracts are awarded to ServiceLink sites using the Long-Term Care Assistance Fund established by Chapter 388:11, Laws of 1998. A total of $4 million was appropriated to this fund when it was established. As of June 30, 2002, $2.6 million, including interest earned on the fund, has been expended for ServiceLink. The remaining funds in the Long-Term Care Assistance Fund will be expended by the end of SFY 2003. No additional funds have been appropriated to the Long-Term Care Assistance Fund. The DEAS requested appropriations for ServiceLink in its 2004-2005 budget proposal.

ServiceLink sites are required to collect and submit program information to the DEAS. In 2002, an annual report was published using this information. Additionally, work is being done to develop performance measures, particularly, outcome measures for ServiceLink.

Assessment And Counseling

Chapter 388, Laws of 1998, requires the DHHS to conduct a needs assessment to determine the clinical eligibility of each applicant seeking Medicaid funded long-term care services in a "uniform manner throughout the state." It also requires nursing facility applicants be provided information and assistance on community-based alternatives related to home and community-based services available in an applicant's community, the relative costs of long-term care options, and advice about whether a community-based setting is clinically appropriate. The needs assessment is voluntary for all non-Medicaid applicants.

The DEAS initiated an Assessment and Counseling Program pilot, administered by the county nursing facilities, in three counties (Merrimack, Belknap, and Cheshire) prior to the implementation of Chapter 388, Laws of 1998. In 1999, the pilot was expanded to Sullivan County. Medicaid funded nursing facility applicants in the pilot counties receive counseling about their service options from assessment counselors while applicants in the rest of the State are counseled by DEAS nurses or nursing facility nurses.

According to the DEAS program evaluations of the pilot are being used to identify best practices and develop the necessary policies, procedures, and rules required to implement the Assessment and Counseling Program statewide. In 2002, the DEAS convened a task force, headed by an independent facilitator with representatives from counties, home health care providers, nursing facilities, hospitals, and State Medicaid staff, made recommendations for statewide implementation that included moving the program out of the county nursing facilities into a location independent of service providers. The DEAS reported statewide implementation of the Assessment and Counseling Program is planned for 2003. See Observation No. 1 on page 27 for our concerns regarding not having a uniform statewide assessment and counseling program.

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STATE OF NEW HAMPSHIRE
DIVISION OF ELDERLY AND ADULT SERVICES
HOME AND COMMUNITY-BASED CARE

OBSERVATIONS AND RECOMMENDATIONS

3.1 Long-Term Care Education And Information

We found the Division of Elderly and Adult Services (DEAS) has not fully complied with State law requiring uniform clinical eligibility assessment for each applicant seeking Medicaid funded long-term care services throughout the State, as well as providing nursing facility applicants with information and assistance about community-based alternatives.

Observation No. 1

Uniformly Provide Assessment And Counseling

The DEAS has failed to provide uniform assessment and counseling throughout the State as required by statute. RSA 151-E:7 (I) states "the department shall assess the clinical eligibility of each applicant to a nursing facility in a uniform manner throughout the state." While RSA 151-E:7(IV) requires the department "provide information and assistance to the applicant in accordance with RSA 151-E:9."

RSA 151-E:9 identifies the following five elements of information and assistance:

I. Provide services in the setting least restrictive of the applicant's ability to live independently.
II. Take into consideration the applicant's choice of service location.
III. Include information regarding the degree to which the services sought are available at home or in some other community-based setting.
IV. Explain the relative costs to the applicant of choosing care in the home or other setting rather than nursing facility care.
V. Include advice as to whether receiving services in a home or other community-based setting is clinically appropriate for the applicant.

Additionally, RSA 151-E:10 states "Prior to the discharge or referral of any person to any nursing facility, a hospital shall notify the department that such person requires nursing facility services which necessitate an assessment under RSA 151-E:7 or the provision of information and assistance under RSA 151-E:9."

According to the Senate Bill (SB) 409 annual report for State fiscal year (SFY) 1998, the DEAS was to learn from the experiences of three pilot assessment and counseling projects (Cheshire, Belknap, and Merrimack Counties) and "are seeking to build on their best practices to ensure a quality long-term care assessment and counseling program." Additionally, the same report stated evaluations have been conducted "focused on determining the areas of strengths of the pilots, issues and challenges for improvement, and best practice models. An implementation plan for expanding the assessment and counseling initiative statewide…should be completed by December 3, 1998. The target date for these entities to be operational is June 30, 1999." In November 1999, the program was extended to Sullivan County. The SB 409 annual report for SFY 1999 states, "The Department will work in the remaining six counties to bring this Assessment and Counseling Program into existence statewide." To date no other counties have

provided assessment and counseling services under the SB 409 legislation. The SB 409 annual reports for SFY 2000 and 2001 indicated the DEAS is developing policies and procedures, data collection systems, rules, and education and training materials to assist the counties in operating a uniform, statewide Assessment and Counseling Program. The SB 409 annual report for SFY 2002 indicates "Statewide implementation of the Assessment and Counseling Program is planned for 2003."

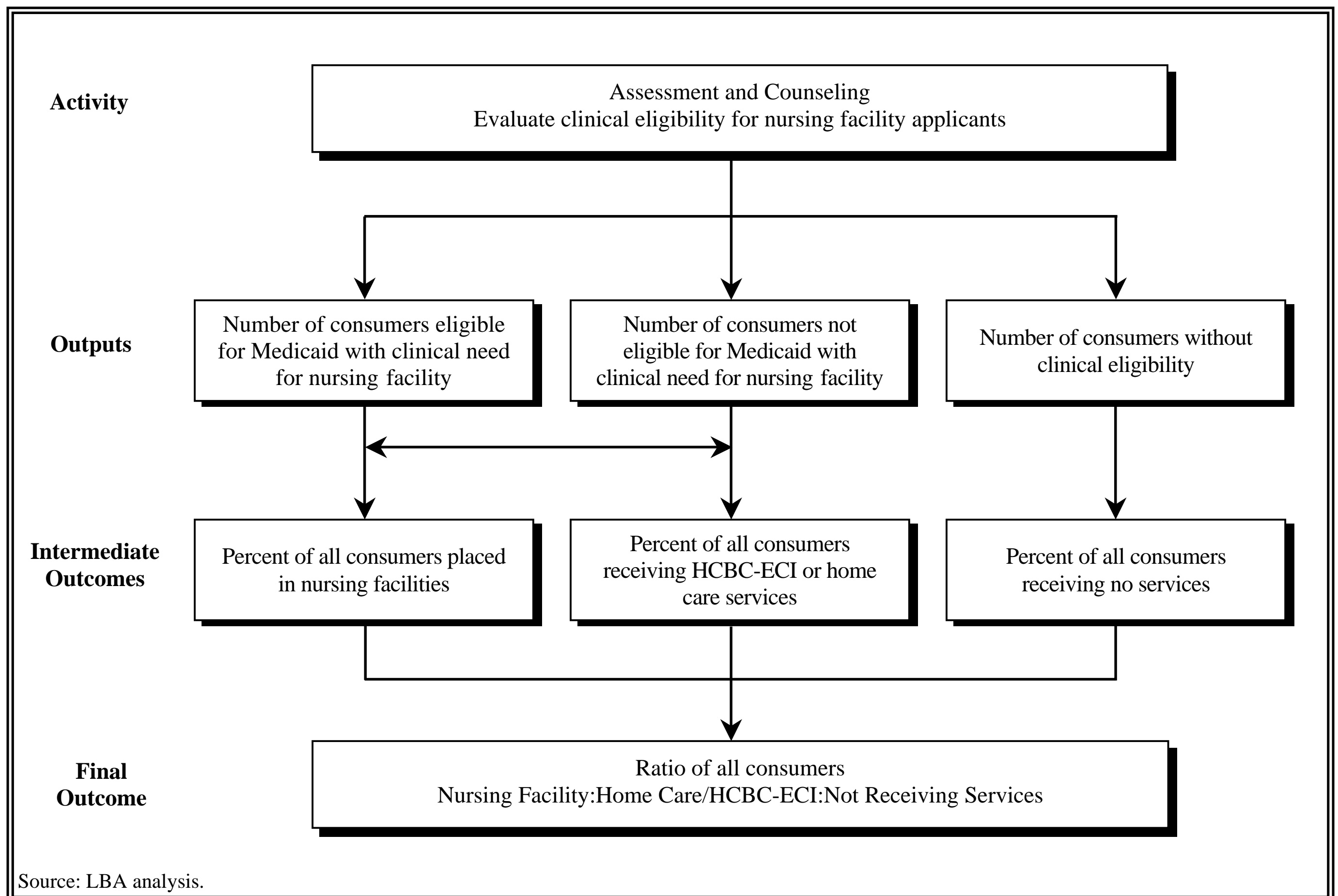
The DEAS director formed an assessment and counseling working group in October 2001, with one of its objectives to "discuss the statewide implementation of the assessment and counseling program." The DEAS has repeated itself numerous times in its annual reports and shows limited progress towards the implementation of a uniform statewide Assessment and Counseling Program.

Implementing a statewide Assessment and Counseling Program would provide DEAS management with information to evaluate the effectiveness of the Assessment and Counseling Program on maintaining consumers in their home and communities. It is unclear why the DEAS has not expanded the Assessment and Counseling Program to accomplish this, particularly since the DEAS has been evaluating the pilots since December 1998 and originally planned a statewide implementation in June of 1999.

Recommendation:

We recommend the DEAS aggregate the data and analysis of the assessment and counseling pilot projects. This information should be organized and documented into a best-practices template based upon how well program activities, outputs, and outcomes meet RSAs 151-E:7-10. This should be used to implement the uniform Assessment and Counseling Program statewide. Additionally, controls should be developed and put into place which promote accurate and complete communication between hospital discharge of patients to nursing facilities so each patient receives the appropriate assessment and counseling as required by RSA 151-E:10.

The following chart describes the program flow of the assessment and counseling process, or the relationship between activities, outputs, and outcomes. The outputs and the outcomes are suggested measures management should monitor on an ongoing basis, which provide critical program quality assurance information.



Source: LBA analysis.

The ratio in the final outcome measures the relative number of consumers entering nursing facilities compared to receiving home-based care services compared to the consumers not receiving any services after Assessment and Counseling. This method of measuring the performance of the program will show the relative growth of the different elements of long-term care and whether the Assessment and Counseling Program is successful.

Auditee Response:

We concur. As indicated in Observation No. 1, DEAS has conducted evaluations of the four pilot sites and has found that the existing program's model, which was developed before the enactment of SB 409, must be realigned to ensure that an individual receives an assessment and long term care consumer education at a point in time when it prevents a nursing home admission. DEAS has determined that the majority of the applicants for Medicaid coverage of nursing home care are not new admissions to facilities. Most individuals have been long-term nursing home residents who have depleted their private financial resources and are turning to the Medicaid Program to pay for their ongoing care. In many such instances, the opportunity to consider alternatives to nursing home care occurs too late because, during their nursing facility stays, the physical and cognitive functioning of these individuals has deteriorated to the extent that they can no longer exist safely in the community. Community supports are not enough for

these individuals because they require the 24-hour care and supervision available in a nursing facility.

DEAS' work to change the model to make it more effective has been delayed by the many implementation activities required by SB 409, and further complicated by the turnover of Assessment and Counseling Project Management staff during two hiring freezes. Working within these limitations, DEAS used its staff resources to develop and implement ServiceLink, the acuity based rate methodology for nursing home care, mid-level care, consumer-directed personal care and the rules required to put these new programs and other related changes in place. During this same time, it was also necessary for DEAS to divert staff resources to implement the Family Caregiver Support Program, a federal mandate, and to operate the Long Term Care Ombudsman Program.

Meanwhile, DEAS has continued to work on changes to the Assessment and Counseling model to make the program more visible and responsive before a person enters a nursing facility at the time of hospital discharge, not at the time of Medicaid application. On March 6, DEAS will reconvene the work group commissioned to analyze the current model in order to finalize its recommendations and proceed to statewide implementation. Assuming adequate staff resources remain in place, DEAS believes that this program can be implemented statewide by the end of 2003.

3.2 Monitoring HCBC-ECI Services

We found the allowable cost for the Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI) waiver requires clarification, as inconsistencies exist between several authoritative documents. RSA 151-E:11 states mid-level care is not to exceed 50 percent and home-based care is not to exceed 33 percent of the average annual cost of a nursing facility. DEAS administrative rules and policy require HCBC-ECI services not exceed the average annual payment for nursing facility services. Additionally, the current HCBC-ECI waiver, through the amendment submitted in 1998, provides for an annual weekly average of $566 per consumer.

We also found consumer plans of care (POC) include only HCBC-ECI services; lacking in-kind services provided by family and friends or other formal services. Finally, we found HCBC-ECI consumers are not receiving all authorized services listed in their POCs, and in some cases unauthorized services have been provided to HCBC-ECI consumers.

Observation No. 2

Ensure Consistency For Allowable Costs In Authoritative Documents

State law, agency administrative rules and policies, and federal requirements for the HCBC-ECI waiver are not consistent regarding the allowable cost for the provision of services. RSA 151-E:11 states mid-level care is not to exceed 50 percent and home-based care is not to exceed 33 percent of the average annual cost of a nursing facility. DEAS administrative rules He-E 801.03 and He-W 558.02, as well as DEAS policy 9520.6, require HCBC-ECI services not exceed the average annual payment for nursing facility services. According to the DEAS, during SFY 2002 the average cost for a Medicaid nursing facility consumer was $37,005. Additionally, the current HCBC-ECI waiver, through the amendment

submitted in 1998, provides for an annual weekly average of $566 per consumer. DEAS field staff and private case managers reported using this as a weekly cap instead of an annual average. Finally, the HCBC-ECI waiver application submitted December 4, 2002 and the one preceding the 1998 amendment, dated 1992, require services not exceed the average annual payment for nursing facility services.

Using $566 as a weekly cap when developing plans for the provision of home-based HCBC-ECI services could result in expenditures of up to approximately $29,200 per consumer. This far exceeds the legislative requirement for SFY 2002 for an average of $12,212 per consumer, or 33 percent of $37,005, thus potentially defeating the legislated cost controls.

In the 2002 SB 409 Annual Report, the DEAS reported meeting the legislated cost control requirement. However, the DEAS also reported HCBC-ECI consumers were not receiving the amount of care they needed because of workforce challenges providers faced, meaning more services were authorized than provided. If all the services authorized had been provided the legislative limits may have been exceeded, especially considering the DEAS stated HCBC-ECI expenditures reached approximately 31 percent of the average annual Medicaid cost of a nursing facility for SFY 2002.

DEAS management reported the average weekly cost of $566 was established as a guideline approximately when the HCBC-ECI program was originally implemented and continues to be used. However, documentation to support how it was established no longer exists. DEAS officials reported monitoring HCBC-ECI expenditures on the aggregate to ensure home-based care does not exceed 33 percent and mid-level care does not exceed 50 percent of the average annual cost of a nursing facility, as prescribed in RSA 151-E:11. There may not have been an incentive to review the inconsistencies between the guiding documents as the DEAS has reported costs "did remain within the legislative limits," with home-based care at 31 percent and mid-level care at 21 percent of the average annual cost of a nursing facility for SFY 2002.

Recommendation:

We recommend DEAS management review State law, agency administrative rules and policies, and the federal requirement for the HCBC-ECI waiver and recommend action to the Legislature to ensure the allowable cost for the provision of services under the HCBC-ECI program is consistent. The justification for the ultimate allowable cost selected should be documented to allow continued management review for relevance and applicability.

Auditee Response:

We concur. DEAS has managed the HCBC-ECI program to date by staying within the limits as established by state law and as stated within the HCBC-ECI waiver document, even though these limits are not consistent with each other. RSA 151-E: 11(II), enacted as part of SB 409 (Chapter 388, Laws of 1998) states that the average annual cost of home care can be no more than one-third the cost of nursing home care and that mid level care cannot exceed one-half the average annual cost of nursing home care. The HCBC-ECI waiver, on the other hand, limits per person spending to $566 per week. During the debate of SB 409 before the legislature, the legislature

made clear that it wanted cost controls that would prevent the HCBC-ECI program from experiencing runaway costs, but not at the expense of all flexibility to care for individuals who could be served in the community and within the waiver standard.

This finding makes it apparent that DEAS needs to refresh the training of case managers, social workers and HCBC-ECI nurses about the different financial standards, the fact that the one-third cost control standard applies at the aggregate level, and the need to balance or average the total cost of all cases in order to meet the cost controls within state law. DEAS staff will also be refreshed about the federal law requirement that individual care plans meet the individual's needs. This training will ensure that staff are aware that they cannot manage costs to the maximum standard for all individuals, given the state law cost controls and the federal requirements.

Continued flexibility to meet people's unique needs is the cornerstone of a community based care system that enables people to live independently and with dignity. In its 2002 report, the HB 1182 study committee called for a change in the state law to promote greater flexibility in the HCBC-ECI program and recommended that the state law be changed to align with the standard in federal law that the average annual cost of waiver services not exceed the average annual cost of nursing homes. The HB 1182 committee recognized that the standards in New Hampshire law and in the HCBC-ECI waiver are more restrictive than federal law and did not promote the kind of flexibility needed to accelerate the reduction in nursing home utilization. DEAS will ensure that staff training reflects the relevant state and federal standard and that the staff has a complete understanding of the need to average costs.

Observation No. 3

Ensure Plans Of Care Reflect All Needed Services

DEAS field staff and private case management personnel consistently reported they primarily include only HCBC-ECI services in consumers' POCs. POCs usually do not include in-kind services from family and friends or other formal services, such as meals on wheels provided through the Older Americans Act. DEAS field staff and private case managers reported other formal or in-kind services are often listed in case notes.

Our review of 196 HCBC-ECI consumers' files found the POCs contain mainly HCBC-ECI paid services. Only three percent of the POCs contained information on services reimbursed by Medicare or Title XX. We did not find evidence of family or friends' involvement with a consumer noted in the POCs.

The HCBC-ECI waiver, in addition to DEAS administrative rules He-W 558.04 and He-E 801.05, require the POC list medical and other needed services. In addition the HCBC-ECI waiver agreement and He-W 558.04 specify "informal family and community support services" are to be included in the POC.

In addition to being out of compliance with the HCBC-ECI waiver and administrative rules, the POCs as they are currently written do not reflect the true services HCBC-ECI consumers require to remain in the community. Several DEAS field staff and private case management personnel stated the in-kind and formal services provided outside HCBC-ECI are essential to most

consumers remaining in the community because HCBC-ECI alone would not provide enough financial resources to meet all the needs of most consumers. Including all needed services for HCBC-ECI consumers to remain in the community in the POCs may enhance DEAS social workers' or private case managers' ability to ensure all supports are being provided at any given time.

Recommendation:

The DEAS should comply with the HCBC-ECI waiver and administrative rules by ensuring all POCs include services consumers require to remain in the community. DEAS management should provide training to all personnel involved in the development of POCs to ensure POCs include information as required by the HCBC-ECI waiver and administrative rules.

Additionally, DEAS management should review authoritative documents to ensure they contain clear and consistent guidance with respect to the information to be included in the POC. Documenting all supports HCBC-ECI consumers need to remain in the community, including informal family and community supports, in the POC provides DEAS field staff and private case management personnel with a single document for monitoring supports.

Auditee Response:

We concur. The administrative rules being developed for case management services provided through the HCBC-ECI Waiver will require case managers to indicate all services and supports required by the consumer to remain in the community, regardless of funding source, and to include those services and supports provided by family or other "informal" sources. DEAS anticipates submitting these rules to the JLCAR in May or June 2003. In addition, DEAS will be conducting training for case managers and HCBC-ECI nurses this summer on how to develop a comprehensive plan of care that includes services and supports from all sources, not only from the HCBC-ECI Waiver. In 2004, DEAS will amend He-E 801, the administrative rules for HCBC-ECI clinical services to include this requirement and will modify the format for the plan of care to indicate that all services and resources be included.

Observation No. 4

Ensure Consumers Receive Needed Services

Not all consumers participating in the HCBC-ECI waiver are receiving all needed services listed in their POCs. The HCBC-ECI waiver agreement describes the POC as "the fundamental tool by which the State will ensure the health and welfare" of the individuals participating in HCBC-ECI. The POC is supposed to include the services consumers require to remain in the community including medical and other services. According to administrative rule He-E 801.03, an applicant is eligible to receive services included in the POC through the HCBC-ECI program if they are available from providers.

Our review of 175 HCBC-ECI consumers' POCs for September 2001, found 151 (86 percent) consumers received fewer services than called for in the POC. A total of approximately $188,000 in services was authorized for the 175 consumers during the month of September 2001, with only

$120,000 in authorized service claims paid, or for every dollar of authorized services approximately $0.64 in claims was paid.

DEAS and private case management personnel reported there can be serious health related consequences for consumers not receiving all authorized services. Depending on the services not provided and the condition of the consumer, the consumer may need to be counseled into a nursing facility.

DEAS field staff and private case management personnel reported consumers do not receive all authorized services in their POCs because there are not enough providers to satisfy the demand. Thirty-six percent of DEAS field staff and private case management personnel stated they believe agencies had difficulty attracting and retaining personnel as a result of the low pay. DEAS management raised a similar concern regarding staffing issues at provider agencies. Additionally, in a survey of providers, 39 out of 104 respondents (38 percent) indicated they have a waiting list for services.

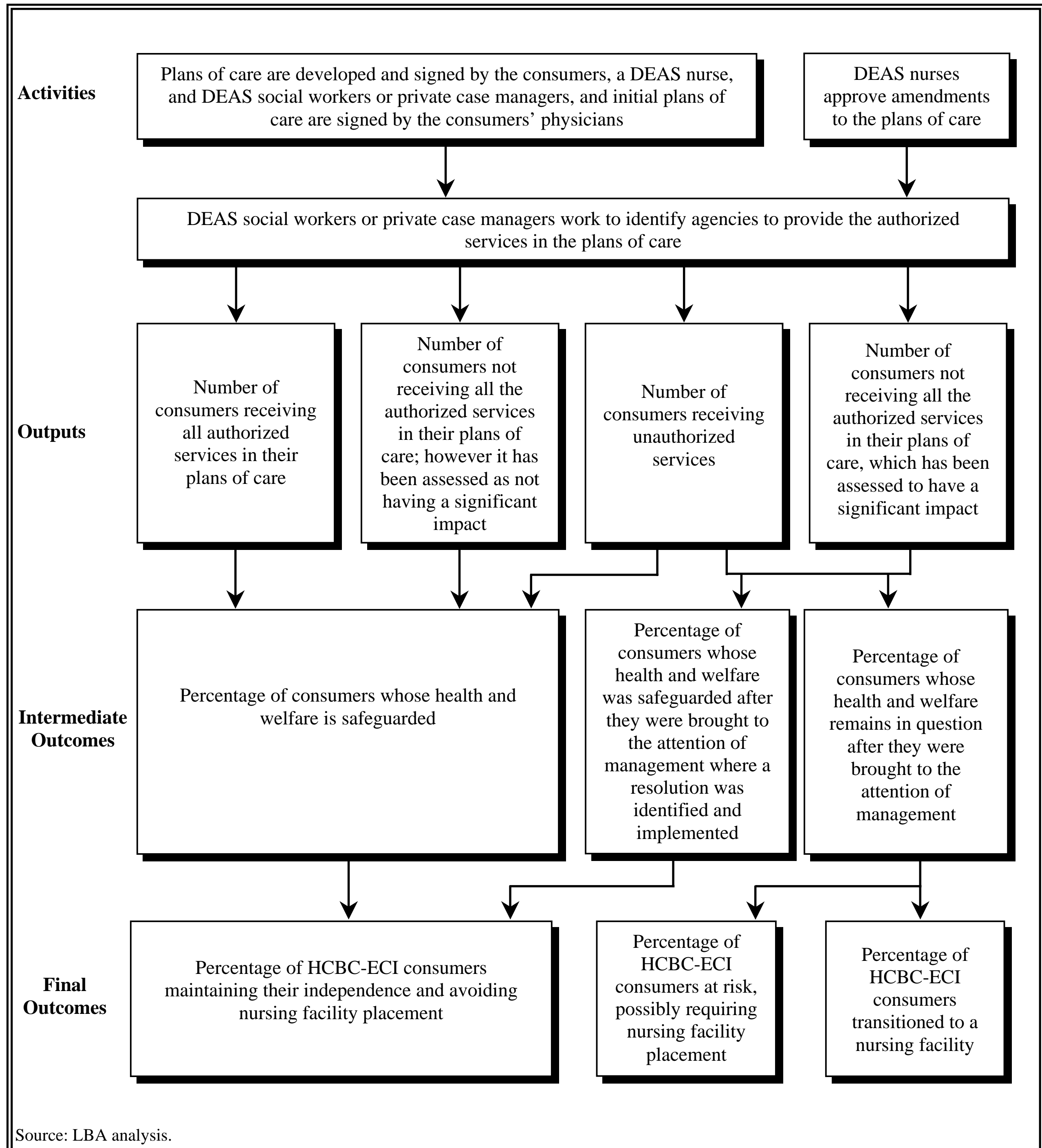
In November 2002, DEAS management began requiring service discrepancy reports from private case management agencies, listing the HCBC-ECI consumers on their caseload not receiving all authorized services in their POCs in conjunction with a rating describing the impact on the consumer. However, there has been no decision on how these reports will be used. The HCBC-ECI waiver requires assurance from the DEAS "that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals." Additionally, the Centers for Medicare and Medicaid Services (CMS) and the National Association of State Medicaid Directors suggest reviewing consumers' records to verify services in the POC have been received.

By monitoring the types and extent of authorized services consumers are unable to receive, management may have a more complete and accurate understanding of the current and long-term issues facing the HCBC-ECI program, providing the necessary information for appropriately distributing resources, and increasing program effectiveness through program planning. For example, service discrepancy reports may help management distinguish between individual issues and systemic issues over time.

Recommendation:

We recommend DEAS management require private case management agencies to continue to submit service discrepancy reports and DEAS district offices start submitting service discrepancy reports. This will provide management with more complete information for monitoring, planning, and program quality assurance. DEAS nurses should also review the service discrepancy reports, as they are responsible for consumers' clinical eligibility.

The following chart describes the program flow of HCBC-ECI (the relationship between program activities, outputs, and outcomes). The outputs and the outcomes are suggested measures management should track on an ongoing basis, which provide critical program quality assurance information.



Source: LBA analysis.

Auditee Response:

We concur. DEAS believes that the two major reasons why consumers are not receiving the services they require are the work force shortage in the health care field and the low reimbursement rates for HCBC-ECI and other publicly-funded services. While providers are creatively trying to attract new staff, the current low reimbursement rates do not allow providers to pay their employees a living wage. Many individuals who are employable as Homemakers or Adult In-Home Care providers can make more money at less stressful jobs. Many remaining candidates are not appropriate for working with vulnerable elderly and disabled consumers with complex health care needs.

Two legislative study committees, the Long Term Care Rate Advisory Committee (Chapter 198, Laws of 2001) and the HB 1182 Study Committee (Chapter 55, Laws of 2002), which reviewed DEAS' implementation of SB 409, found that low reimbursement rates are having a serious and negative impact on the quality of care being provided, on the access to care, and on the financial stability of providers. Costs of providing services are steadily increasing, but reimbursement rates remain static. DEAS has requested funding in the last two budget development processes to improve access to care but has not yet been successful.

DEAS has begun an effort to establish a case tracking system that will track the services that an individual does or does not receive. Assuming that there is funding to support such a system including a capacity to generate management reports, DEAS will be able to evaluate not just provider performance but also the strength of community care in the different regions of the state. DEAS would share this information with the legislature and the public as appropriate.

Observation No. 5

Ensure Consumers Receive Only Authorized Services

Unauthorized services have been provided to HCBC-ECI consumers. If the unauthorized services were necessary, they were not adequately documented. Administrative rules He-W 558.04 and He-E 801.05 require changes to services listed in the POC, outside of initial determination or re-determination, be documented in an amendment to the POC and authorized by a nurse from the DEAS.

Our review of 175 HCBC-ECI consumers' POCs for September 2001, found 38 consumers (22 percent) received unauthorized services. Out of approximately $129,000 in paid services, $8,800 was unauthorized. The unauthorized services were attributed to 38 consumers, with $3,700 of that amount associated with two consumers. The DEAS has reported unauthorized services are sometimes provided without the knowledge of the private case manager or DEAS social worker. Home health agencies substitute one service for another if there is a staffing shortage. In a survey of HCBC-ECI providers, only 24 out of 89 respondents (27 percent) reported they inform the DEAS social worker or private case manager when changes are made to the consumers' services. The DEAS also reported emergency services have been provided without adequate documentation.

Management is responsible for establishing effective controls to ensure program goals are met and include systems for measuring, reporting, and monitoring program performance. The HCBC-

ECI waiver states the POC is "the fundamental tool by which the State will ensure the health and welfare" of HCBC-ECI consumers, and accordingly management should monitor the status of consumer POCs. Currently, when unauthorized services are provided to HCBC-ECI consumers, DEAS management and nurses are unaware of the unauthorized services and will consequently be unaware of consumers' health and welfare. See Observation No. 6 on page 38 for recommendations related to controls needed over claims submitted for HCBC-ECI services.

With the expected growth in the HCBC-ECI waiver, the financial impact of consumers receiving unauthorized services could become increasingly significant. DEAS nurses are required to authorize all changes to POCs in order to provide a check on each HCBC-ECI consumers' budget and as a medical professional providing a second opinion about how to best meet consumers' clinical needs. Therefore, bypassing this control is not in the best interest of the consumers or HCBC-ECI waiver budget.

<u>Recommendation:</u>

We recommend DEAS management ensure all services provided to HCBC-ECI consumers are authorized, and amendments to the POC are filed and signed by a DEAS nurse when changes are made to POCs. DEAS field staff, private case managers, and home health care providers may need to be retrained on the need for and process for amending the POC.

DEAS management should develop a system to routinely review consumer POCs and amendments with claims information to ensure only those services authorized are provided. This would also allow for the tracking of services that are not delivered as authorized in POCs or its amendments.

The chart in Observation No. 4 on page 35 describes the program flow of HCBC-ECI, or the relationship between program activities, outputs, and outcomes. The intermediate and final outcomes listed illustrate the unknown impact unauthorized services may be having on the HCBC-ECI consumers.

<u>Auditee Response:</u>

We concur. DEAS's Bureau of Program Quality identified this as an issue when it sampled over one hundred plans of care to determine if authorized services are being delivered. DEAS is taking two approaches to prevent a provider from delivering services that are not authorized. Training of nursing and case management personnel will include emphasis on their roles in authorizing changes to support plans and ensuring that changes to those plans are properly reviewed and authorized. DEAS has also begun the process to develop an automated link between the service authorization and service payment functions. Assuming that funding is available to support a case management tracking system, this automated tracking system will be the ultimate solution to eliminating payment for unauthorized services. In the interim, DEAS will continue to conduct care plan reviews to determine if support plans are being properly controlled and seek recovery where appropriate from providers.

3.3 Provider Cost Controls And Licensing

Our audit identified several issues with the DEAS' practices for monitoring HCBC-ECI enrolled provider claims in addition to provider licenses, which contribute to increased risk for fraudulent claims. We question the lack of licensing required for assisted living facilities. We also raise concerns about the lack of criteria and guidelines for outsourcing HCBC-ECI cases to properly licensed case management agencies.

RSA 151:1 states the purposes for requiring licensure for facilities as providing "for the development, establishment and enforcement of basic standards for the care and treatment of persons in hospitals and other facilities…" and to "…ensure safe and adequate treatment of such persons in such facilities." HCBC-ECI providers are required to enroll as Medicaid providers.

To enroll, HCBC-ECI providers must submit proof of licensure for the service(s) they intend to provide. Providers must also sign the "New Hampshire Medicaid Program Provider Enrollment Agreement" which requires them "to maintain current required permits, licenses, certifications, or other documentation as required by applicable State and Federal laws" and to "abide by all rules, regulations, billing manuals, and bulletins promulgated by the Department pertaining to the provision of care or services." Enrolled providers are prompted annually, through two letters generated by Electronic Data Systems (EDS), to submit a copy of current licensure.

Furthermore, the State guarantees to the CMS as part of the HCBC-ECI waiver all assurances required by 42 CFR 441.302 will remain in effect. One of the assurances identified in 42 CFR 441.302 (a) is to protect the health and welfare of consumers by requiring "that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver."

Additionally, social service contract providers need to adhere to the contract provisions stating "In the operation of any facilities for providing Services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities…." This provision goes on to state, "If any governmental license or Permit shall be required for the operation of the said facility or the performance of the said Services, the Contractor will procure said license or permit…."

Observation No. 6

Improve Controls Over Claims Submitted For HCBC-ECI Services

There are no controls in place to ensure HCBC-ECI enrolled providers submit claims for only services authorized in a POC or POC amendment. Furthermore, there are no controls in place to prevent HCBC-ECI enrolled providers from submitting claims for HCBC-ECI services they may not be licensed to provide. As a result DEAS is unable to adequately monitor HCBC-ECI enrolled providers and the services they provide. Lack of controls increases the risk of fraudulent or unauthorized claims being submitted and paid resulting in increased costs associated with the HCBC-ECI program.

Our review of 175 HCBC-ECI consumer's POCs for September 2001, found approximately $8,800 was paid for unauthorized services provided to 38 different consumers. These unauthorized payments ranged from $5.25 to $2,400 per consumer.

The CMS completed a review of the HCBC-ECI program in July of 2002. One finding in the CMS report stated, "DEAS must correct its reimbursement system to prevent over billing. Currently, there are no special edits in the system to prevent providers from over billing for waiver services." The DEAS responded in a letter dated October 11, 2002, that it "is working with the [Medicaid Management Information System (MMIS)] group to develop the edits" to prevent over billing.

The Office of Health Planning and Medicaid and Electronic Data Systems (EDS) personnel stated controls could be established to ensure only appropriate claims for services by HCBC-ECI enrolled providers are reimbursed but the DEAS needs to make the decision to do this. The Office of Health Planning and Medicaid and EDS personnel further stated the only way to monitor enrolled provider billings and whether consumers are receiving authorized services is through a retroactive review of POCs by the DEAS.

Recommendation:

We recommend the DEAS work with the Office of Information Systems to determine the controls available in the MMIS to monitor claims submitted by HCBC-ECI enrolled providers. The DEAS should not limit its review of controls to those that limit over billings as stated in the response to CMS findings, but should also determine which controls would be appropriate to implement to minimize claims for unauthorized or fraudulent services.

DEAS management should develop a system to routinely review consumer POCs and amendments with claims information to ensure only those services authorized are provided. This would also allow for the tracking of services that are not delivered as authorized in a POC or its amendments.

Auditee Response:

We concur. The current Medicaid Management Information System (MMIS) does not have edits that automatically compare claims submitted to services authorized on plans of care, and is therefore unable to limit payment to services that have been authorized. DEAS has initiated discussions and will continue to work with the management of the MMIS to determine what can be done to address these issues through new automated system controls. In the interim, DEAS will continue to manually review claims to make sure that inappropriate payments are not being made and if necessary to recoup such payments.

Observation No.7

Improve Monitoring Of Enrolled Provider Licensing

Continued review over the licensure status for enrolled HCBC-ECI providers is lacking. The DEAS arranges for services to be provided to HCBC-ECI consumers without assurances that Medicaid enrolled providers continue to be properly licensed. Our review of 173 HCBC-ECI enrolled provider files found 111 files where the provider was required to be licensed. Because some of these providers offer more than one type of service these 111 files contained a total of 120 copies of licenses. Of these 120 copies we found 53 licenses (44 percent) were expired. Of the 67 copies of current licenses, 29 (43 percent) were provided on October 10 or 11 of 2002 in response to telephone contact by EDS personnel just prior to the LBA file review started on October 17, 2002.

Additionally, 42 out of the 173 HCBC-ECI enrolled providers (24 percent) were identified as not submitting a claim since October 2000, but continue to be enrolled as HCBC-ECI providers. By not periodically reviewing its enrolled providers and removing inactive providers the DEAS is increasing the risk of services provided by unlicensed HCBC-ECI providers.

Neither the DEAS nor the Office of Health Planning and Medicaid instruct EDS to enforce the requirement HCBC-ECI enrolled providers supply documentation of current licensure. If an enrolled provider does not submit copies of current licensure, there is no penalty. The Office of Health Planning and Medicaid and EDS personnel indicated HCBC-ECI enrolled providers remain enrolled unless the provider requests disenrollment or a control memorandum is issued instructing the Office of Health Planning and Medicaid and EDS to disenroll a HCBC-ECI provider. The Office of Health Planning and Medicaid and EDS personnel have stated the DHHS' philosophy towards Medicaid providers is to maintain access to services by continuing to pay claims submitted by providers even though they fail to provide required information.

Recommendation:

We recommend DEAS management ensure all HCBC-ECI enrolled providers remain current with licensure. The DEAS should work with the Office of Health Planning and Medicaid and EDS to determine the most appropriate method to ensure enrolled providers remain current with licensure. DEAS management should consider including the Bureau of Health Facilities Administration (BHFA) in discussions and determine if access to the licensing database by all parties involved would be a feasible means to monitor enrolled provider licensing status.

Additionally, the DEAS should develop guidelines for discontinuing a provider's enrollment if no claims are submitted for an established period of time.

Auditee Response:

We concur. DEAS has begun to explore with the Bureau of Health Facilities a process to allow appropriate DEAS staff access to their provider licensing database. DEAS will also work with Office of Health Planning and Medicaid and the fiscal agent, EDS, to ensure that all HCBC-ECI providers are licensed or certified as required by law, and that proof of such is maintained in the

provider enrollment files at EDS. Further, DEAS will work to develop guidelines for discontinuing a HCBC-ECI provider's enrollment if licensure has expired or if claims have not been submitted for an established period of time.

Observation No. 8

Review Contractors' Licensing Status During Life Of Contract

The DEAS requires copies of licensure as part of proposals submitted by social service contractors. However, the DEAS does not monitor social service contractors to ensure they remain licensed for the life of a contract. Our review of social service contracts found that of the 33 contractors requiring licensure, 28 had provided copies of licenses that expired by December 31, 2001 for contract agreements covering the period of July 1, 2001 through June 30, 2003.

Many of the contractors provide social services, such as adult day care, home health aide, and homemaker, that require licensing under RSA 151. RSA 151:1 identifies one purpose of licensing as ensuring "safe and adequate treatment" for consumers.

Not ensuring social service contractors have and maintain required licenses for the life of a contract may place consumers at risk. Additionally, contractors who are not meeting their contract obligations to maintain licensure still receive contract payments.

Recommendation:

We recommend DEAS management ensure all social service providers remain licensed during the life of contract by requiring copies of licenses at the time of expiration. The DEAS should work with BHFA to obtain access to the licensing database. Access to the licensing database will allow DEAS personnel to quickly and easily review the status of providers' licenses.

Auditee Response:

We concur. All DEAS service contracts require the contractor to comply with all laws, orders and regulations of federal, state, county or municipal authorities. As has been done in the past, DEAS will ensure that all applicable service providers submit proof of licensure with their contract proposals for the period July 1, 2004 – June 30, 2005. In addition, as stated in Observation No. 7, DEAS has begun to explore with the Bureau of Health Facilities a process to allow appropriate DEAS staff access to their provider licensing database. DEAS will also take the additional step of contacting the contractor and requiring it to submit proof of renewed licensure when the previous one expires during the contract term, or in the alternative, will suspend payment if licensure is not renewed within a defined corrective action period.

Observation No. 9

Ensure Social Service Providers Are Licensed

The DEAS is contracting with two providers, possibly three, who do not have required licensing. As a result these providers are operating without external oversight to ensure their facilities meet all requirements and are providing safe and adequate treatment to consumers using the facilities. Additionally, the DEAS is making contract payments to contractors who are not meeting their contract obligation to be properly licensed. That the DEAS continues to pay for unlicensed services may be interpreted by a contractor to mean they have met all the conditions of the contract and further complicates the contractor's understanding as to why licensing is needed.

The DEAS contracts for SFY 2002 with the two unlicensed providers offering adult day care services totaled $249,111 to provide services to 493 consumers. However, as of October 28, 2002, one of the providers was pursuing licensure and had submitted an application with the BHFA.

A third contracted provider licensed for adult day care in one location is providing this service in two other locations. In response to an inquiry from the BHFA regarding the adult day care services, the provider sent a letter dated September 12, 2002, stating they were providing services to five adults in both facilities. The BHFA responded to the provider on November 18, 2002, that based on the information provided licensing is required. The provider had not submitted a license application as of January 21, 2003. According to a DEAS official, the provider is limiting the number of consumers using the adult day care services in the locations in question to two consumers until appropriately licensed.

In specifying facilities requiring an adult day care license, RSA 151:2 I (f) defines adult day care services as "offering medical supervision, care or treatment, or providing assistance in daily living activities, to 3 or more individuals, whether operated for profit or not." Per the contracts with the social service providers, the adult group day care services "shall mean caring for an elderly/incapacitated adult's needs for food, activity, rest, and other necessities of personal care, including minor medical care, for a portion of the 24-hour day in a day care center or agency."

A DEAS official stated that RSA 151 initially did not require all adult day care facilities to be licensed, only those facilities providing adult medical day care were required to be licensed. In 1991, RSA 151:2 was amended requiring the licensing of all adult day care facilities. The official further stated that for at least one of the providers, it was an oversight not to obtain licensing information from the provider with the change in RSA 151.

Recommendation:

We recommend DEAS management ensure all social service providers submitting proposals to provide services are appropriately licensed and licensure is maintained during the life of a contract. The DEAS should work with BHFA to remain current on licensing requirements to decrease any confusion that might exist regarding the licensing of service providers.

The DEAS should make the BHFA aware of unlicensed social service providers and encourage providers complete the licensing process. If providers do not submit applications for licensing or are unable to meet licensing requirements, the contracts should be terminated.

Auditee Response:

We concur. The DEAS Request for Proposal for social services for the contract period July 1, 2003 through June 30, 2005 includes a requirement that all contractors, as appropriate, provide proof of licensure when submitting a bid and that the contractor provide proof of any update in licensure status throughout the contract period. DEAS has been working collaboratively with the Bureau of Health Facilities Administration (BHFA) to improve understanding of licensing requirements and to keep BHFA informed of any changes in licensure status by a contract provider. In addition, DEAS has also informed BHFA of its concerns when a community provider that is not under contract with DEAS appears to require a license but is not licensed. DEAS will provide staff training about licensing requirements, including training about tools to monitor and ensure that contract providers maintain licensure throughout the contract period.

Each of the three providers referenced in the observation have since applied to become licensed. DEAS will follow their progress through the licensing process and require proof of licensure before the next contract is approved.

Observation No. 10

Review Assisted Living Facility Licensure Requirement

Three assisted living facilities where HCBC-ECI consumers reside may lack appropriate licenses. According to a DEAS official "Since the three facilities do not directly provide services, they are not required to be licensed under RSA 151:2." The DEAS official also stated the facilities "work with licensed home health agencies that provide case management and direct care support that meet the long-term support needs of the residents."

Our review of 28 assisted living facilities licensing applications, submitted to the BHFA, found facilities provide a broad range of services ranging from room, board, linens, and personal services, as well as nursing and personal care attendants. In our review of licensing applications: ten facilities indicated they do not provide any health care services and four facilities indicated they assist residents in contacting and arranging services from a visiting nursing association, private nurses, or home health aide agencies.

In specifying the licensure classification for residential care facilities RSA 151:9 VII (a) states "the rules adopted under RSA 151:9, I for residential care facilities shall, in establishing licensure classifications, recognize the following licensure levels which correspond to a continuum of care requiring different programs and services to assure quality of life in the least restrictive environment possible." RSA 151:9 VII (a)(2) further states "Supported residential health care, reflecting the availability of social or health services, as needed, from appropriately trained or licensed individuals, who need not be employees of the facility…."

It is unclear as to why these facilities would not require licensing while other facilities, that appear to be providing the same level of service, are licensed by the BHFA. There appears to be a misunderstanding regarding whether these facilities are required, according to State law, to be licensed.

Recommendation:

We recommend DEAS management work with the BHFA to determine if the three assisted living facilities are required to be licensed.

Auditee Response:

We concur. DEAS relies upon the Bureau of Health Facilities Administration (BHFA) and professional boards, such as the Board of Nursing and the Board of Medicine, to establish licensing criteria and to determine whether providers meet the appropriate health and safety standards to be licensed. Although DEAS does not have direct control over licensure decisions, DEAS can and does report concerns to BHFA about licensed and unlicensed facilities, and BHFA has welcomed DEAS' participation in clarifying which entities are facilities that must be licensed according to law. Currently, the determination of whether a residential entity is a provider of care services or merely a housing location is key to whether or not that entity must be licensed, and that determination is within the jurisdiction of BHFA.

As stated in DEAS' correspondence to the LBA dated December 6, 2002, the issue of whether an assisted living facility should be licensed as a residential care facility depends on the nature of the services that the facility undertakes to provide. RSA 151:2, I (e) requires a residential care facility to be licensed if it provides services "beyond room and board."

A facility that provides room and board as well as services to meet the health care needs of its residents must be licensed as a residential care facility. A facility that provides only room and board and contracts with a licensed health care provider to meet the health care needs of its residents does not require a license. In the three assisted living facilities where HCBC-ECI clients live, the facility provides room and board and contracts with a licensed health care provider to provide the direct care. Therefore, under current law, these facilities do not require a license to operate.

Nevertheless, DEAS and BHFA share the LBA's concern that the public may not be fully aware of the nuances in state law and thus has a reasonable expectation that a facility that calls itself an assisted living facility will provide for the direct care needs of its residents. Accordingly, DEAS is working with the sponsor of SB 34 to request an amendment to the bill to require licensure of any facility calling itself an assisted living facility. DEAS believes that such a provision in the law will clarify for the public that the facility is responsible for coordinating care for its residents.

Observation No. 11

Strengthen Process For Outsourcing HCBC-ECI Cases

The DEAS does not have a standardized process for awarding HCBC-ECI cases to Medicaid enrolled private case management agencies. The DEAS began its outsourcing program in the Spring of 2001 in an effort to decrease the caseloads of DEAS social workers and allow them to focus attention on other areas such as adult protective services. Prior to 2001, cases in the Portsmouth area and Hudson-Pelham area were outsourced. As of September 2002, the DEAS had outsourced a total of 1,220 HCBC-ECI cases.

The DEAS requires private case management agencies enroll as Medicaid providers. Additionally, the private case management agencies are required to complete an addendum to the enrolled Medicaid provider agreement including various assurances and case management responsibilities. This has resulted in a field of six private case management agencies managing a total of 1,220 HCBC-ECI cases. Table 5 shows the number of cases managed by each private case management agency:

Table 5

Outsourced HCBC-ECI Cases		
Private Case Management Agency	**Number Of HCBC-ECI Cases At The End Of 6/02**	**Number Of HCBC-ECI Cases At The End Of 12/02**
Agency One	433 (41.6%)	433 (35.5%)
Agency Two	348 (33.5%)	348 (28.5%)
Agency Three	135 (13.0%)	315 (25.8%)
Agency Four	45 (4.3%)	45 (3.7%)
Agency Five	44 (4.2%)	44 (3.6%)
Agency Six	35 (3.4%)	35 (2.9%)
Total Outsourced Cases	**1,040 (100%)**	**1,220 (100%)**
Source: LBA analysis of DEAS information.		

Agencies One and Two provided case management services prior to 2001 and account for 781 of the outsourced cases as of December 2002. Approximately, seventy percent of the remaining 439 outsourced cases were awarded to Agency Three, while the remaining three agencies received between eight and ten percent. All three agencies with 45 cases or less have indicated they would like to expand and take on more cases but have to wait for the DEAS to allow for more outsourcing.

The lack of documented criteria and controls for awarding HCBC-ECI cases increases the risk of abuse and creates the appearance of favoritism. This lack of criteria and guidelines results in limiting private case management agencies' ability to manage more cases and continue to meet performance expectations. Furthermore, the current system for outsourcing HCBC-ECI cases has the potential to discourage the enrollment and competition of new private case management agencies and existing private case management agencies resulting in limited choices to consumers.Good management controls would indicate that a formalized and documented plan

should exist related to the goals and objectives of outsourcing HCBC-ECI cases. This plan would include policies and procedures for program operations.

Recommendation:

We recommend DEAS management develop a plan detailing its goals and objectives for outsourcing HCBC-ECI cases and operationalize them through the DEAS' administrative rules. This should include how HCBC-ECI cases are competitively outsourced to private case management agencies.

Auditee Response:

We concur. The plan to outsource HCBC-ECI case management began in 2000, with the long term goal of establishing several providers of state-wide services and developing a provider system that will give individuals choice between provider agencies for their HCBC-ECI case management services. For such a provider system to develop and to be sustainable, provider agencies must support consistent delivery of high quality services, and develop a strong business that is viable over the long term. When this framework is in place, case management providers can openly compete with each other for individuals to have a choice of providers.

Case management services is a developing field. Because development is incremental, it requires conservative, thoughtful program growth. DEAS recognized the importance of assigning individuals to case management agencies by the caseload, generally consisting of 45 individuals, so that the case management providers could hire and train appropriate staff person(s) to provide services. Such gradual assignments have been successful in supporting the long term growth and viability of the service model from only two licensed providers in 2000 to six providers in 2002, serving a total of 1220 individuals. Three of these providers maintain state-wide catchment areas, and the other three providers maintain local service catchment areas. This diversity provides a richer service model that better meets the varied needs of the individuals being served.

Quality assurance of case management has been, and continues to be, a major priority as DEAS continues to develop the business model. DEAS supports high quality case management services in two ways: case reviews by the DEAS review team, and monthly meetings of the case managers with DEAS HCBC-ECI management. Monthly meetings at times include DEAS social workers and nurses for discussion on program direction and issues to ensure that all staff interacting with individuals have the same understanding of program goals and requirements.

As shown in the statistical report contained in this observation, the methodology utilized by DEAS to outsource caseloads for HCBC case management has been successful in achieving the first long term goal noted above. This achievement brings DEAS toward the next stage of operational objectives, which coincides with the recommendation of the LBA. DEAS is in process of achieving the recommendation as follows:

1) *DEAS is currently developing administrative rules for targeted HCBC-ECI case management. The rules will include the requirements for provider agencies as well as the*

methodology and criteria for outsourcing future caseloads. DEAS plans to submit these administrative rules in June 2003.

2) *DEAS will also develop a written plan detailing its goals and objectives for outsourcing HCBC case management prior to submitting the administrative rules, and shall implement that plan in all future outsourcing of HCBC case management.*
3) *DEAS continues to give focused attention to training, consultation, quality assurance reviews, and development of practice guidelines for the current six providers in order to enhance their capacity to compete for future caseloads.*

The ultimate long-term goal of the HCBC-ECI case management outsourcing is for the providers to operate in a free market environment in which individuals choose their provider. At that point, free market dynamics, and not DEAS, will decide the caseloads of the providers.

3.4 Complaints, Investigations, And The State Registry

We reviewed DEAS practices to protect elderly and other adults from abuse, neglect, and exploitation to determine whether appropriate controls are in place. Additionally we sought to determine if procedures are in place to handle complaints. We found the complaint process, the APS program, and the State registry need improvement. We recommend the DEAS improve information tracking and reporting related to consumer complaints, APS investigations, and the State registry to ensure consumer health and welfare is safeguarded as an element of a complete quality assurance program.

Observation No. 12

Consistently Collect And Retain Complaint Information

Implementing Chapter 388, Laws of 1998, expanded less costly home and community-based care alternatives to nursing facilities. Since then the number of consumers residing in the community through the HCBC-ECI program has increased.

There is no formal process or mechanism in place to gather and review information on complaints made by consumers of these services. DEAS field staff or private case managers resolve the majority of complaints informally. DEAS management is rarely made aware of complaints and is unable to report on the types of complaints consumers have made, how many complaints have been made over a given period of time, or which agencies or DEAS personnel have received complaints.

Residential facilities employ a formalized complaint process through the Long-Term Care (LTC) Ombudsman Program, which collects and reports annually on complaint related actions with which they have been involved. Specifically, the LTC Ombudsman reports on the number of complaints made, who the complaints were received from, the number of resolved and outstanding complaints, and the types of complaints.

Management is responsible for establishing effective controls to ensure program goals are met and include systems for measuring, reporting, and monitoring program performance. Additionally, the CMS and the National Association of State Medicaid Directors suggest maintaining a log of complaints as a quality assurance mechanism to ensure consumer health and

welfare. Developing a formal procedure for collecting complaint information and storing it in an electronic repository would provide DEAS management with essential program performance information for quality assurance efforts, monitoring, and planning.

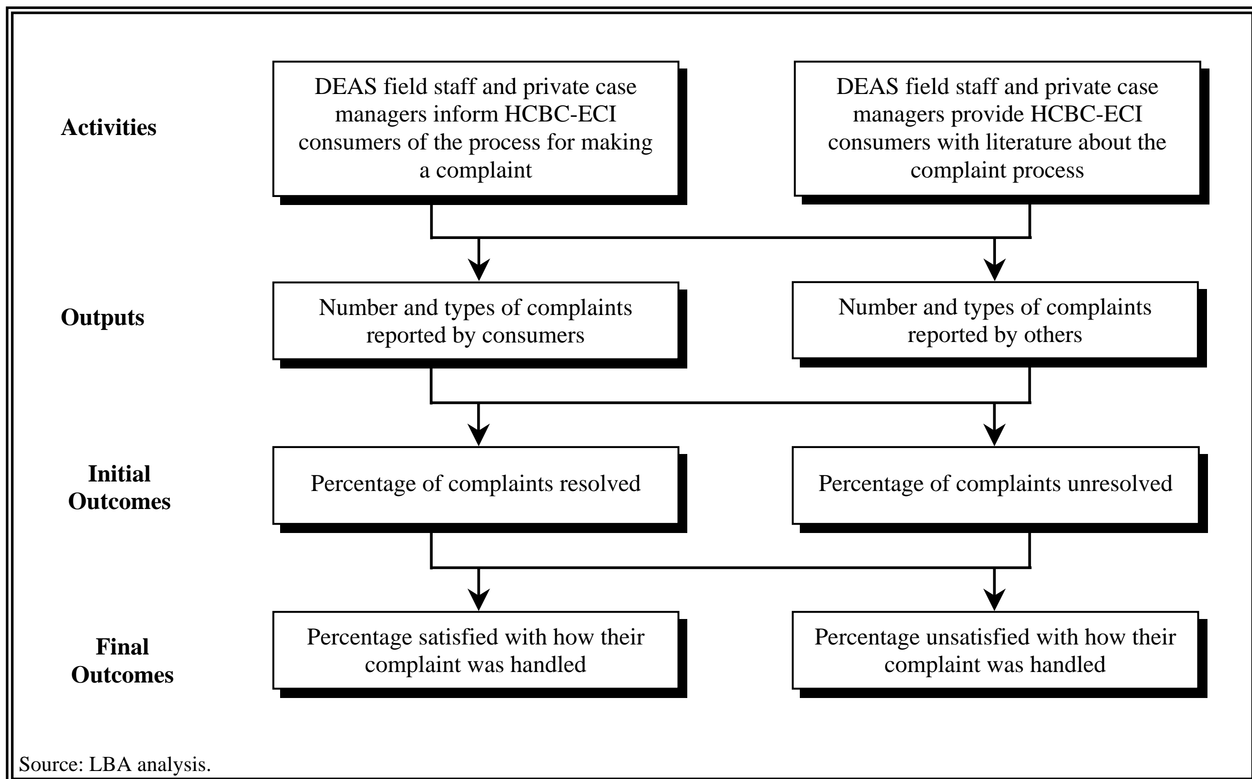
As the HCBC-ECI program grows and becomes a more predominate service model, the DEAS should ensure performance evaluation measures are in place to meet management's need for obtaining adequate and timely information for program quality assurance efforts, monitoring, and planning.

Recommendation:

We recommend DEAS management develop a formalized process for collecting complaint information. The process should include procedures for collecting information in an electronic repository. Information collected should include the number of complaints made, who the complaints were received from, the number of resolved and outstanding complaints, and the types of complaints made. The process should be documented and DEAS personnel, private case managers, and home health care providers should receive training on the new process.

DEAS management should continuously review information related to consumer complaints in an effort to identify issues of significance. This information may be used for program quality assurance efforts, monitoring, and planning.

The following chart describes the program flow of the complaint process, or the relationship between activities, outputs, and outcomes. The outputs and the outcomes are suggested measures management should track on an ongoing basis, which provide critical program quality assurance information.



Source: LBA analysis.

<u>Auditee Response:</u>

We concur that a formalized complaint process is needed for the HCBC-ECI program. DEAS has been in an intensive program development phase to strengthen quality assurance and controls, including improving communication with consumers and providers, of which a formal complaint gathering and tracking method is part. DEAS anticipates developing and implementing a process of gathering, storing and retrieving complaint information that will allow for the ability to generate regular management reports concerning the number and nature of complaints from consumers and providers, and that will allow this information to be tracked over time. Assuming that staff resources will remain constant, DEAS anticipates completing development of the process in SFY03, with training and implementation to be completed by the end of SFY04.

Observation No. 13

Improve Consumer Complaint Process

The DEAS does not implement the consumer complaint process in a uniform manner. Additionally, consumers receiving home and community-based services are not consistently informed of the process for making a complaint. DEAS field staff and private case managers routinely tell consumers to call them if any issues arise, but may not specifically address the issue of making a complaint. Private case management agencies did state they provide consumers with specific literature about their complaint processes, however, the DEAS could not provide evidence its field staff do this.

DEAS field staff and private case management personnel reported the majority of complaints are resolved informally. Consumers of mid-level care or nursing facilities have access to a formalized complaint process available through the LTC Ombudsman Program. The LTC Ombudsman Program, established pursuant to the OAA, is responsible for identifying, investigating, and resolving complaints made by or on behalf of residents of long-term care facilities. The LTC Ombudsman does not provide services to consumers receiving home and community-based services. Employing a formalized complaint process provides some assurance consumers will be treated in a similar manner.

A formalized complaint process supports the third goal of the New Hampshire State Plan on Aging, to "educate and empower seniors to advocate for themselves and assert their rights in pursuit of their health, safety and well-being." The lack of complaint literature and an established procedure for handling complaints may result in reluctance to complain about DEAS field staff or private case managers or the services they help to arrange as part of the consumers' POCs. Additionally, home-based care program quality assurance literature and DEAS management have suggested HCBC-ECI consumers may be hesitant to disclose concerns to DEAS field staff or private case managers because consumers view them as the 'service gatekeeper' and do not want to put their current living situation in jeopardy.

Recommendation:

We recommend DEAS management formalize the complaint process and provide training to DEAS field staff, private case management personnel, and home-based providers on the formalized complaint process. In formalizing the consumer complaint process, DEAS management should consider expanding access to the LTC Ombudsman program to consumers receiving home and community-based services.

Consumers should be consistently informed of the complaint process by DEAS field staff and private case managers. The DEAS should develop literature about the complaint process to be distributed by DEAS field staff and private case managers to all DEAS consumers. The literature should include information about consumer rights, an explanation of the complaint process, and contact information for making a complaint. Providing consumers with this type of documentation may help in the identification of issues warranting a complaint.

Auditee Response:

We concur that a formalized complaint process is needed to continue the program development work that has been ongoing for some time. It is DEAS' goal to ensure that all individuals are aware of their rights and of the choices available to them. An integral part of supporting independence and consumer direction is the ability of an individual to advocate for his or her own needs and desires. DEAS is redrafting the written communication that is given to new and current DEAS clients and this will include clear instruction on how a person can make a complaint to DEAS and what steps DEAS may then take to ensure the individual's satisfaction and well-being. When this written complaint process is ready for public distribution later in

2003, DEAS will ensure that case managers and providers receive training about the complaint process as well as an individual's right to register a complaint without adverse impact.

Observation No. 14

Improve State Registry

The DEAS does not maintain a registry with identifying information about individuals founded or substantiated in cases of abuse, neglect, or exploitation. Administrative rule He-E 701.51 defines the State registry as a database containing non-identifying demographic information on reports of abuse, neglect, self-neglect, and exploitation, received and investigated by the DEAS. Administrative rule He-E 704.11 states founded cases shall be expunged within one year, unless protective services are being provided. DEAS management stated "a non-identifiable approach to the registry was determined to be the most expedient way to meet the legal and administrative rule requirements." RSA 161-F:49 requires the establishment of "a state registry of abuse, neglect and exploitation reports…for the purpose of maintaining a record of information on each case of alleged abuse, neglect or exploitation reported." Per RSA 161-F:49, unfounded reports are expunged from the registry within a period of six months.

DEAS management reported using the statistical reports generated by the non-identifying information entered into the registry "to identify trends in adult protective services" for program monitoring and planning. While the collection of demographic information for planning and monitoring is important, ensuring providers administering care to consumers have not been part of a founded case of abuse, neglect, or exploitation is an important element in ensuring quality of care. A State registry may be used to screen prospective employees for home health agencies, consumers participating in consumer-directed care programs, and family and friends arranging home-based services privately. Additionally, a State registry may provide valuable historical information about individuals involved in investigations to social workers involved in adult protective service cases.

The HCBC-ECI waiver requires necessary safeguards to be taken to protect the health and welfare of service recipients. Without a State registry to screen prospective employees, there is nothing to prevent a founded perpetrator from providing direct care to consumers in the future. Additionally, a DEAS official has reported a concern about the lack of assurances in place to screen direct care personnels' histories.

Recommendation:

We recommend DEAS management establish additional safeguards to protect frail and dependent elderly and adults by establishing a State registry with identifying information. DEAS management should use a State registry to conduct checks on service providers for employers.

Additionally, to maintain more comprehensive historical information in founded adult protection cases, DEAS management should review its retention policy for founded cases and consider retaining them for longer than one year in the registry.

Auditee Response:

We concur. Although the current state registry meets statutory and administrative rule requirements, DEAS shares the concerns contained in this observation regarding the need to establish a state registry that identifies perpetrators of abuse, neglect and exploitation in order to protect frail and dependent elderly and adults.

DEAS has formed a workgroup to establish and draft the rules to govern such a registry as part of an effort to review, revise and re-write He-E 700, the Adult Protection Program Administrative Rules. There are many complex issues to resolve in the development process of a state registry that identifies individual perpetrators including, but not limited to, due process and civil liberty concerns, criteria for registry inclusion, notification to alleged perpetrators, public and professional access to the registry, maintenance responsibilities with respect to the registry, the length of time a finding remains part of the registry, whether remedial action by an individual should allow removal from the registry, and legislative requirements and concerns. The workgroup is also surveying other states that have such registries to take advantage of best practices. The development process will take place throughout the calendar year 2003 with implementation to follow as soon as possible.

DEAS agrees that improved protection of elderly and incapacitated adults is crucial. In the last legislative session DEAS played a leadership role in supporting the passage of HB 180 (Chapter 226, Laws of 2002), which established criminal penalties for the neglect of elderly, disabled, or impaired adults, as well as HB 463 (Chapter 36, Laws of 2002), which strengthened the Adult Protection law (RSA 161-F: 42-57).

Observation No. 15

Develop Formal Mechanism To Monitor 72-Hour Time Requirement For Adult Protective Services Investigations

The DEAS does not have a formal mechanism to ensure adult protective services (APS) investigations are initiated within 72 hours of receipt of a report. RSA 161-F:46 II requires an investigation be started within 72 hours following the receipt of an oral report that an incapacitated adult has been subjected to physical abuse, neglect, or exploitation or is living in hazardous conditions.

Neither DEAS management nor field staff indicated there is a centralized process in place to document the 72-hour time requirement. However, 19 of the 22 DEAS field staff interviewed stated all reports were initiated within the 72-hour time requirement. Additionally, DEAS management indicated the 72-hour time requirement is met, but cannot prove this via a report or other control mechanisms.

The lack of documentation results in a condition where there are no safeguards to ensure investigations are initiated in an appropriate timeframe, which could result in individuals remaining in potentially harmful situations for longer than necessary. Additionally, by not formally monitoring whether investigations are initiated timely management does not have an opportunity to identify if there are problems and a need for corrective action.

Recommendation:

We recommend DEAS management analyzes the different components of the APS investigation process and implement a method to ensure the 72-hour time requirement is met and documented.

Auditee Response:

We concur. The computer system DEAS uses for Adult Protective Services (APS), OPTIONS, does not have a data field to record when the 72 hour contact occurs. Although DEAS repeatedly finds through anecdotal reports and supervisory reviews that DEAS complies with the 72-hour requirement, there is not currently a formal mechanism to document that compliance.

Beginning on February 18, 2003, DEAS implemented a temporary interim resolution for this documentation problem for APS investigations in facility-based settings (nursing homes, group homes, residential facilities). To achieve this, DEAS has designated a specific text field in OPTIONS, which is utilized for recording the 72 hour requirement for investigations that occur in facilities. DEAS central office management will routinely run inquiry reports to monitor compliance with the 72-hour requirement. Training for District Office staff will be conducted in stages with the goal of July 1, 2003 for full implementation of this temporary fix in all District Offices for all APS investigations.

For a permanent resolution of this problem, DEAS is currently preparing the necessary computer program documentation to request a revision of OPTIONS to include a specified data field to be used to document start of each APS investigation. DEAS central office management will run routine data reports to track compliance with the 72-hour requirement. Assuming OPTIONS has adequate budgetary resources, DEAS estimates that the permanent resolution will be achieved with the planned Options systems change developed during SFY 2004 and released as part of a preplanned series of system upgrades.

Observation No. 16

Ensure Timely Adult Protective Services Investigations

APS investigations are not completed within the 45-day time requirement. A DEAS official stated a request for an investigative extension "must be in writing" and "extensions are rare and are usually the result of mitigating circumstances…" An OPTIONS report dated October 17, 2002 contained 307 open APS investigations of which 177 (58 percent) were past the 45-day report requirement. Additionally, 86 of the 177 (49 percent) APS cases were past due because they lacked a written summary or because the case workers were backlogged. Additionally, DEAS management acknowledged the 45-day time frame for completing an investigation is not consistently met.

DEAS administrative rule He-E 704.02 (b) states: "Protective investigations shall be completed within 45 calendar days of the date that the report was received."

The OPTIONS program tracks APS investigations based upon the report date entered. OPTIONS sets the investigation report due date 45 days from the day it is entered into OPTIONS.

Investigations which go beyond the 45-day time requirement do not ensure the timely protection of incapacitated adults. In addition, investigations not complying with He-E 704.02 (b) have the effect of extending the start date for the purge process of both founded and unfounded APS investigations as described in administrative rule He-E 704.11.

Recommendation:

We recommend DEAS management evaluate, develop, and implement a methodology, which would allow the investigations to be completed within the limitations of the administrative rules and provides protection and resolution to incapacitated adults and their associated APS reports.

Auditee Response:

DEAS concurs. Currently, the OPTIONS report contains fields for both the "report date" and the "completed date." When all investigative work and related initiation of services is completed, and final reports have been approved by the supervisor, then the completion date is entered into OPTIONS. Although the OPTIONS report may indicate that an Adult Protective Services (APS) investigation is not completed, this does not mean that the face-to-face investigation and the implementation of the remedial services has not been performed.

The reason that not all investigations are recorded by OPTIONS as complying with the 45-day "technical completion" requirement for APS investigations is complex. There has been a dramatic increase in the number of APS reports from about 1400/year in 2000, to about 1966 in 2002. In addition to this increase, existing DEAS field staff assumed responsibility for all APS investigations in nursing facilities and residential care facilities, a former responsibility of the Department of Health and Human Services (DHHS) Office of Ombudsman, Long Term Care Ombudsman Program, with no new staff. Over the past few years, in order to control caseload growth for district office social workers, as well as to foster the development of APS expertise, DEAS has been increasing the use of private case management providers to serve people participating in the HCBC-ECI program. Budget limitations, however, allow only about half of the HCBC-ECI caseload to be served by private case managers and, therefore, a significant amount of DEAS staff time is still associated with providing HCBC-ECI case management services in addition to attending to the growing number of APS reports. Further complicating this picture is the fact that a district office social worker vacancy cannot be filled due to the recent and ongoing hiring freeze.

Given the above, DEAS APS management currently prioritizes the operations of the APS social workers. This means that highest priority is given to performing face-to-face investigations to ensure the safety of alleged victims, and the next priority is given to the complex challenge of implementing remedial services that are necessary for protection purposes. The next priority is given to the necessary paper work to "technically complete" an investigation, unless that paper work is directly related to implementing remedial services.

DEAS is exploring the ability to change how the OPTIONS program records and reports data to distinguish between the completion of the investigation and the completion of the related paperwork.

Observation No. 17

Formalize Process Informing The Public Of Adult Protective Services

The DEAS has not implemented a formal or standardized process to educate consumers, caregivers, and the public of APS. This results in sporadic consumer, caregiver, and community education efforts. Interviews conducted with DEAS field staff and private case managers indicated the process of informing consumers of APS is not standardized. Additionally, DEAS field staff indicated they provide APS information to the public when opportunities arise, not as part of a formal or planned public education effort.

RSA 161-F:46 requires

> Any person, including, but not limited to, physicians, other health care professionals, social workers, clergy, and law enforcement officials, having reason to believe that any incapacitated adult protected under the provisions of this subdivision has been subjected to physical abuse, neglect, or exploitation or is living in hazardous conditions shall report or cause a report to be made.

Additionally, one objective of the State Plan on Aging is to "protect vulnerable elderly and incapacitated adults from abuse, neglect, self-neglect, and exploitation." Two strategies identified in the State plan to meet this objective are: "Provide education to the citizens of New Hampshire on issues and information relating to abuse, neglect, self-neglect, and exploitation" and "Continue outreach to health care, law enforcement, safety, and financial professions regarding mandatory reporting of adult abuse neglect, self-neglect, and exploitation." Furthermore, in its protocols for reviewing waiver programs, the CMS recommends the "Provision of information and training to provider agencies, direct care staff, case managers, waiver participants, caregivers, and family members/legal guardian (as appropriate) on the prevention, identification, and reporting of abuse, neglect and exploitation," as a quality enhancing activity related to the State's quality assurance program.

The result of not having a standardized and formal education mechanism in place to inform consumers and the general public of how and where to report abuses leaves incapacitated adults in a potentially unsafe situation. The lack of standardized and formal education mechanisms may be caused by the lack of policy and administrative rules requiring education of APS as part of the administrative responsibilities of operating the program. This lack of guidelines has resulted in ad hoc methods of APS education and information dissemination.

Recommendation:

We recommend DEAS management formalize and standardize the process for informing and educating consumers and the public on APS. DEAS management should consider a statewide education effort, which includes the use of the media and public service announcements.

Auditee Response:

We concur. DEAS acknowledges the need for and the value of an organized education plan to inform providers and the general public about Adult Protective Services. To date, two of the regularly published and distributed EDS provider quarterly bulletins have contained articles informing providers about the statutory requirement to report suspected abuse, neglect, or exploitation and emphasizing the importance of them being alert to possible signs that would lead to a report. DEAS also participated in a statewide radio call-in program on Adult Protective issues in 2002. In addition, DEAS is currently refining a draft of a public education pamphlet entitled, "Adult Protective Services." Finally, the Bureau of Community Services will be developing a comprehensive plan for public education about Adult Protective Services with planned implementation during SFY 2004.

DEAS has also been working in many different venues to promote and strengthen the rights of vulnerable adults. DEAS staff regularly speaks to groups about adult protection issues in order to educate providers, professional groups and ordinary citizens about the adult protection laws and reporting requirements. This may occur at the local level where a DEAS staff person speaks to a locally based group such as an Area Committee on Aging to inform members about the law, a staff meeting of a provider agency to educate staff about reporting requirements and the actions DEAS will take when a report is made, or to a professional group such as the New Hampshire Bankers Association to educate its members about their legal responsibilities to provide banking records.

DEAS also works proactively to strengthen the laws about adult protection. For example, DEAS worked with the New Hampshire Bankers Association to strengthen reporting requirements for financial institutions (Chapter 36, Laws of 2002). DEAS also took the lead along with a coalition of local law enforcement officials and the Attorney General's Office on an elderly criminal neglect bill (Chapter 226, Laws of 2002), which also passed the legislature last session. In addition, DEAS is working with the legislature during the current session on HB 461 to establish a taskforce to study financial exploitation and the causes thereof as well as the remedies and penalties that should apply when financial exploitation occurs. DEAS requested a new position as part of the budget process for the current and prospective biennium to focus on financial exploitation since this issue is occurring with greater frequency and requires focused expertise to properly investigate and prosecute.

3.5 Management Program Oversight

While DEAS management collects key program information for some programs, we found adequate information is not collected for other programs thereby limiting management oversight. An adequate quality assurance program provides management with timely information about the health and welfare of program recipients and program performance.

Observation No. 18

Strengthen Program Quality Assurance Controls

DEAS management could not provide key quality assurance information related to all its programs. DEAS management does not collect and analyze programmatic information related to consumers receiving timely and adequate services funded by the OAA, Social Services Block Grant (SSBG), and the HCBC-ECI program in addition to the related costs. DEAS management reported there is no mechanism in place to track the types of funds (i.e. OAA vs. SSBG) used to furnish services to each consumer, although there is a mechanism to track the HCBC-ECI services consumers receive. Therefore, the DEAS was unable to report on management information such as how many HCBC-ECI consumers also receive SSBG or OAA funding, the number of OAA consumers who receive SSBG funding, or the total average cost of consumers receiving services from more than one funding source. Furthermore, the DEAS could not report if individual consumers are receiving duplicate services from multiple funding sources.

Additionally, DEAS management provided anecdotal information that SSBG, OAA, and HCBC-ECI waiver providers were unable to meet consumer needs in a timely manner, but could not report specifically on which services had waiting lists, the length of wait, or how the failure to provide services in a timely manner affects consumers. DEAS management reported there is no waiting list to apply for HCBC-ECI services, however, the application process for HCBC-ECI takes approximately four to eight weeks.

The CMS issued protocols in December 2000 for the HCBC-ECI waiver noting "States have the first-line responsibility for quality assurance in the waiver programs" and states should be conducting front line monitoring of waiver activities. CMS determined the presence of a quality assurance system is a reasonable measure of a state's ability to protect health and welfare of consumers.

In the 1992 Request for Renewal of HCBC-ECI Medicaid Waiver, the State assures it will have in place "a formal system by which it ensures the health and welfare of the recipients, through monitoring of the quality control procedures…." Monitoring will "ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals."

Furthermore, 45 CFR 1321.7 (a) states "the State agency shall proactively carry out a wide range of functions related to…monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems…." Also stated under 45 CFR 1321.11 "policies developed by the State agency shall address the manner in which the State agency will monitor the performance of all programs and activities initiated under this part for quality and effectiveness."

Management is responsible for establishing effective controls to ensure program goals are met and include systems for measuring, reporting, and monitoring program performance. Further, controls over program operations include policies and procedures that management has implemented to reasonably ensure that a program meets its objectives.

Insufficient outcome information affects management's ability to monitor programs for: effective and efficient use of resources, consumer safety; quality of care, and program performance. Without information on program outcomes, management may not have the relevant information to make evidence-based decisions for future program direction.

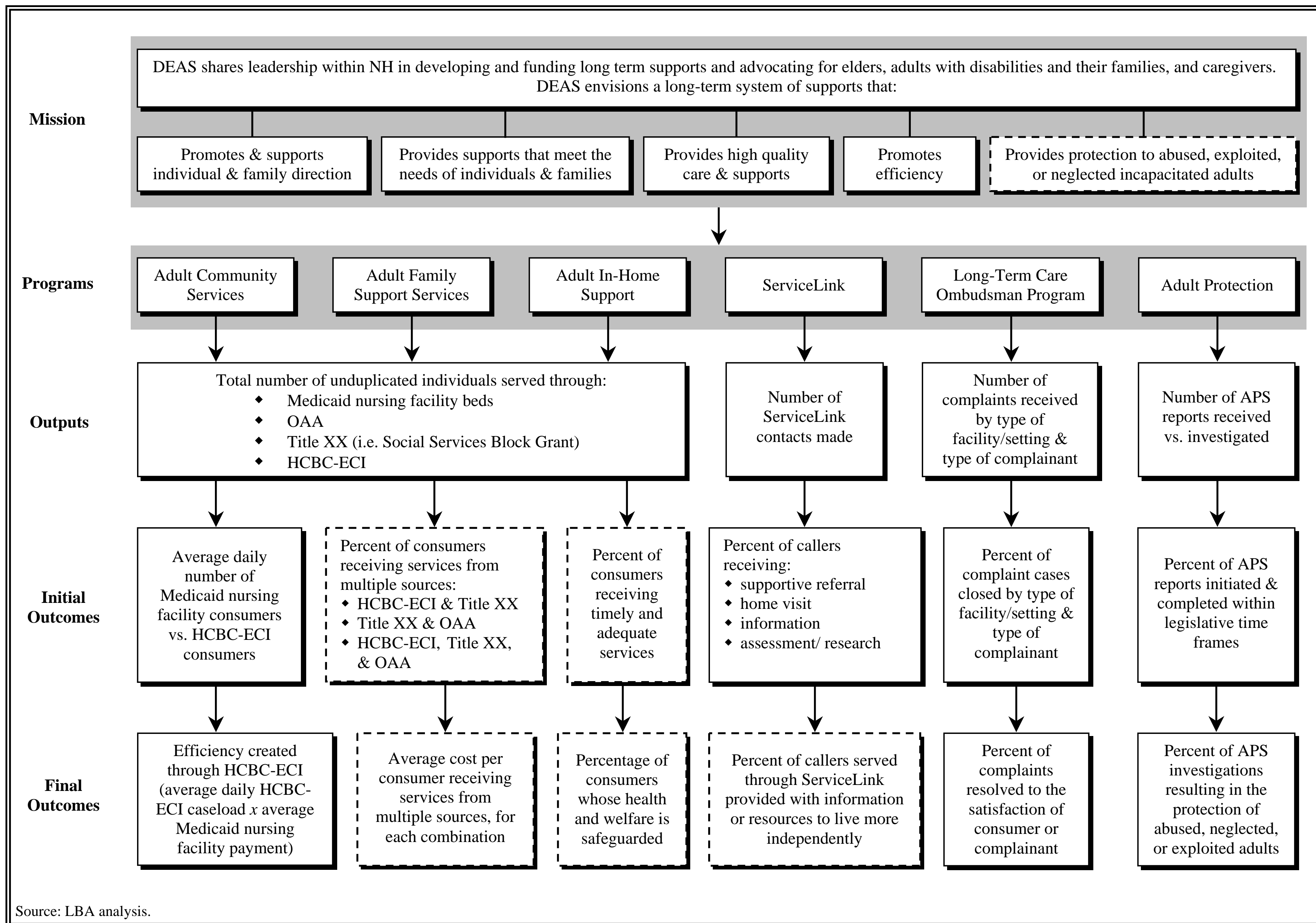
Recently, DEAS management began requiring impact reports from HCBC-ECI private case managers, highlighting consumers not receiving the services to safeguard their health and welfare. We note that while this is a good initiative for HCBC-ECI consumers, it does not address the health and welfare of SSBG or OAA consumers.

In 2001, the DEAS conducted three reviews, including file reviews of both DEAS and private case manager HCBC-ECI files, and a financial audit, providing management with some useful program performance information. DEAS management has reported they intend to continue conducting reviews, however, they are currently determining how to identify focus areas for future reviews.

Recommendation:

We recommend DEAS management strengthen its oversight and monitoring of its programs. Activities may include developing measures to ensure accurate and reliable data collection, establishing a quality assurance program, and increasing monitoring of contracts and service providers.

We recommend DEAS management work to identify key program outcome measures for all its programs. The following logic model is a graphic illustration categorizing organizational work to describe the DEAS' efforts to fulfill its mission through its programs. The model displays the theory, or the intended impact of the programs. The outcome information in the logic model corresponds to quality assurance information we expected DEAS management to provide in relation to its programs in our effort to determine if quality assurance controls were in place. The solid boxes represent program information DEAS management was able to provide and the dotted boxes represent program information DEAS management could not provide. An additional box was added to the mission statement to represent protection service efforts.



Source: LBA analysis.

<u>*Auditee Response:*</u>

We concur. As noted in the observation, DEAS has begun development of its oversight and monitoring capacity, and initial reviews within the HCBC-ECI program have occurred. As mentioned earlier (Observations Nos. 3, 5, and 6), DEAS is working with management of the MMIS to develop a case tracking system that would allow automation of support plans linked to payment authorization and claims data as well as to management reporting tools.

DEAS is completing its work to identify program outcome measures that are appropriate to the DEAS mission and vision. The suggestions made by the LBA are useful and will be reviewed for incorporation in DEAS' quality assurance work. DEAS will then develop a monitoring plan for the remainder of calendar 2003 to ensure the most comprehensive monitoring possible.

STATE OF NEW HAMPSHIRE
DIVISION OF ELDERLY AND ADULT SERVICES
HOME AND COMMUNITY-BASED CARE

OTHER ISSUES AND CONCERNS

In this section we present issues and concerns we encountered during our audit not developed into formal observations, yet we consider noteworthy. The Division of Elderly and Adult Services (DEAS) and the Legislature may consider these issues and concerns deserving of further study or action.

Documentation Of Consumer Contact Should Be Improved

DEAS management stated its field staff and private case managers are required to have face-to-face contact with Home and Community-Based Care for the Elderly and Chronically Ill consumers every other month and phone contact in the intervening months. Our file review indicated DEAS field staff and private case managers generally comply with this requirement. However, 15 percent of the files we reviewed lacked sufficient documentation indicating DEAS field staff or private case managers had regular consistent contact with consumers.

Through consistent and regular contact, DEAS field staff and private case managers ensure services are provided and observe any changes in a consumer's condition, amending a consumer's plan of care to reflect the supports needed to remain living independently in their home. Without this monitoring, a consumer's health and safety may be jeopardized causing a person to prematurely enter a nursing facility.

We suggest DEAS management ensure regular and consistent contact with consumers and appropriately document this contact.

ServiceLink Oversight Needs Improvement

The DEAS sets basic guidelines for ServiceLink and each site tailors them to reflect the values and philosophy of the community. ServiceLink personnel provide short-term supported referrals, assist consumers in making connections with needed services, and offer follow-up services. The DEAS, through the ServiceLink Program Manager, provides program planning and development, oversight of operations, marketing and communications, budgeting, contracting, monitoring, evaluating, reporting, and oversees the delivery of education and training supports for network partners.

Our interviews with ServiceLink directors identified several issues indicating the DEAS should review its oversight and monitoring of ServiceLink. These issues include: assisting consumers with short-term referrals beyond three months, the lack of a statewide database, collection and use of data, and the need for training and education beyond the ServiceLink directors.

We suggest DEAS management improve its oversight and monitoring of ServiceLink to allow for identifying trends and gaps in services, enabling them to make overall improvements to ServiceLink. We also suggest DEAS management enforce the contract provision limiting supported referrals to three months.

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CONCLUSION

Long-term care is a significant issue requiring attention now and into the future. Recognizing this, in 1997 the Legislature required the Department of Health and Human Services to develop a long-term care plan, *Shaping Tomorrow's Choices* (1998), and then through Chapter 388, Laws of 1998, required home and community-based service options be expanded and made changes to the financing of Medicaid funded long-term care services.

Generally, the DEAS has been successful in implementing the various components of Chapter 388, Laws of 1998. The law required long-term care information be made available throughout the State. The DEAS has successfully established ServiceLink, however work needs to continue, particularly with the Assessment and Counseling Program, to ensure consumers are informed about their long-term care choices.

We found while the DEAS has established some quality controls for home and community-based care, more work needs to be done. The DEAS needs to improve its controls to better protect the health and welfare of consumers using home and community-based services.

The increase in HCBC-ECI consumers and decrease in Medicaid nursing facility bed use suggests the DEAS has successfully promoted less costly service alternatives. However, as a result of level funding nursing facilities, the DEAS has been unable to fully reimburse nursing facilities under the acuity-based methodology resulting in cost containment.

Low provider rates have made it challenging to encourage more providers to join the long-term care workforce, particularly with mid-level care. Additionally, for existing providers it is often difficult to meet staffing needs, resulting in consumers not receiving all needed services and possibly impacting the quality of services received.

Therefore, while the State's long-term care expenditures have been contained, this is most likely due more to level funding nursing facilities and services not being provided to consumers, rather than changes made by Chapter 388, Laws of 1998.

Some successes have occurred as a result of Chapter 388, Laws of 1998, yet more work is needed to achieve the full results intended in the law. The DEAS and the Legislature should review Chapter 388, Laws of 1998, make appropriate adjustments, and devise an adequately funded long-term care plan to meet stated objectives. The DEAS should develop the infrastructure required for a quality assurance process allowing management to monitor and review the effectiveness of programs and make necessary changes to meet the demands of its consumers in a timely manner.

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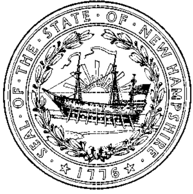
APPENDIX A

DEAS RESPONSE LETTER



STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF ELDERLY & ADULT SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4680 1-800-351-1888 Fax: 603-271-4643 TDD Access: 1-800-735-2964

Nicholas J. Vailas
Commissioner

Catherine A. Keane
Director

April 2, 2003

Catherine A. Provencher, CPA
Director of Audits
Audit Division
Office of Legislative Budget Assistant
State House, Room 102
107 North Main Street
Concord, NH 03301-4951

Dear Ms. Provencher:

Thank you for the opportunity to review and respond to the report regarding the Legislative Budget Assistant's performance audit of the Division of Elderly and Adult Services (DEAS).

The audit process has provided a valuable opportunity to review DEAS' work to reform the long term care support system. DEAS has been working since the passage of SB 409 (Chapter 388, laws of 1998) to provide cost effective care options that respond to and meet the needs of the seniors and adults with disabilities who live in New Hampshire. While DEAS' work has focused on the implementation of SB 409 and other laws, there are several DEAS achievements that were not required by law that have had a positive effect on both the service delivery system and the independence of the families served. These include the following:

1. DEAS actively reached out to residents throughout the state to better understand their needs and preferences and to provide needed education to help them maintain their independence.
   - A. DEAS conducted ten listening sessions and fifteen regional public meetings around the state to hear about the current long term care system from as many perspectives as possible.
   - B. DEAS conducted a series of personal interviews to begin review of the local service systems' ability to meet residents' long term support needs.

C. DEAS co-sponsored and organized the Annual Conference on Aging, to present information regarding maintaining one's health and independence.

2. DEAS established the first ever Vision Statement for the long term support system. This Statement applies not just to DEAS, but encompasses direct service providers as well as informal caregivers. The public, including providers, seniors and families, supported this Vision Statement.
3. The DEAS Mission Statement was amended to reflect what was learned through the public sessions, including greater support of individual independence.
4. DEAS successfully implemented two grants that support independence in the community: the Nursing Home Transition Grant and the Family Caregiver Support Grant. The Transition Grant supported the transfer of over 20 individuals who had been living in nursing facilities to community settings with greater independence. The Family Caregiver Support Grant provided short term support, such as respite care, to over 3000 families who are providing daily support to family members in place of institutional care.

Looking forward, DEAS and New Hampshire are at a unique point in their histories. Projections developed by the Office of State Planning from Year 2000 census data include an unprecedented growth in the number of residents over the age of 65 years in the next 18 years. By the year 2020, residents over the age of 65 will equal 21.7% of the total New Hampshire population. At the same time, workforce shortages and restricted resources are predicted to continue. Balancing the needs of the growing number of seniors with a limited workforce and limited resources will require continued work to rebalance the long term support system in favor of cost effective community based options as well as continued focus on efforts to educate the public about the need to comprehensively plan ahead, financially and otherwise, for their long term care needs. DEAS will continue to build on efficiencies and work with community partners to develop responses that meet the needs of seniors and adults with disabilities.

I appreciate the great deal of time and thoughtful attention that has been spent by the staff of the Office of the Legislative Budget Assistant in learning about the work of DEAS. DEAS staff has enjoyed working with them.

Sincerely,

Catherine A. Keane

APPENDIX B

SURVEY OF AGENCIES PROVIDING LONG-TERM CARE SERVICES

Notes:

- ***Responses are in bold.***
- ***Totals may not add up to 100 percent due to rounding.***
- ***"No," "NA," and blank responses are not included.***
- ***161 surveys were sent to providers on November 1, 2002; 108 to providers of Home and Community-Based Care for the Elderly and Chronically Ill (HCBC-ECI) services and 53 to those with social services contracts with the Division of Elderly and Adult Services (DEAS). Some providers are enrolled HCBC-ECI providers and social service contractors. The following is a breakdown of surveys received by December 11, 2002:***
  - ***Total undeliverable surveys 4***
  - ***Total returned surveys 119***
  - ***Total usable surveys 107***
- ***Of the 107 usable surveys:***
  - ***HCBC-ECI providers 71***
  - ***Social service contractors 18***
  - ***HCBC-ECI/social services 18***
- ***12 survey were excluded because:***
  - ***Six respondents from the private case management agencies were excluded because personnel from each agency were interviewed during the file review.***
  - ***Three agencies do not have direct contact with clients.***
  - ***One survey was sent back stating the agency closed.***
  - ***One agency no longer provides long-term care services.***
  - ***A nursing facility was excluded because none of the questions applied to them.***

The purpose of this survey is to obtain information from agencies providing long-term care services to the elderly and chronically ill adults in the community. Please note direct care personnel refers to anyone (paid staff or volunteers) who work directly with consumers.

1. What service(s) does your agency provide? *(Please check all that apply)*

107 individuals responding to this question provided a total of 387 responses. Percentages are calculated based on the number of individuals responding. Due to more than one response per individual, the percentages do not total 100 percent.

		<u>*Service Type*</u>
46	**(43%)**	Nursing
41	**(38%)**	Other (see below)
39	**(36%)**	Home Health Aide
38	**(36%)**	Homemaker
35	**(33%)**	Personal Care
34	**(32%)**	Respite Care
30	**(28%)**	Transportation
26	**(24%)**	Residential Care
20	**(19%)**	Nutrition – Congregate

19	**(18%)**	Nutrition – At Home
17	**(16%)**	Outreach
15	**(14%)**	Adult Companion Service
15	**(14%)**	Adult Medical Day Care
12	**(11%)**	Adult Group Day Care

41 individuals provided a total of 68 responses to Other services provided:

14	**(34%)**	Occupational, physical, and speech therapy
6	**(15%)**	Education/information and referral
6	**(15%)**	Therapy - bereavement, sudden death, or caregiver support/phone reassurance
5	**(12%)**	Care/case management/social work
4	**(10%)**	Community/outpatient clinics/community health screening/family health services
3	**(7%)**	Activities/recreation
3	**(7%)**	Assisted living
3	**(7%)**	Hospice care
3	**(7%)**	Social services/medical
2	**(5%)**	Chore/home repair/housekeeping
2	**(5%)**	Dental care
2	**(5%)**	Fitness and health maintenance
2	**(5%)**	In-home care program
2	**(5%)**	Meals-on-Wheels
2	**(5%)**	Skilled nursing care
1	**(2%)**	Congregate housing services
1	**(2%)**	Emergency response systems
1	**(2%)**	Foster grandparents program
1	**(2%)**	Nursing facility
1	**(2%)**	Psychiatric nursing care
1	**(2%)**	Rehabilitation services for blind and visually impaired
1	**(2%)**	Support services
1	**(2%)**	Volunteer services
1	**(2%)**	Wound specialist

2. On average, how many consumers does your agency serve each month? **Responses could not be categorized due to the variety of answers received.**

3. How many direct care staff are employed by your agency? **Responses could not be categorized due to the variety of answers received.**

4. Before direct care staff work with consumers does your agency: *(Check applicable boxes)*

   107 individuals responding to this question provided 225 responses. Percentages are calculated based on the number of individuals responding. Due to more than one response per individual, the percentage does not total 100 percent.

97	**(91%)**	Check references
77	**(72%)**	Perform criminal background checks
48	**(45%)**	Other
3	**(3%)**	Not done

48 individuals provided 77 responses to Other:

19	**(40%)**	Physical exam
16	**(33%)**	Department of Motor Vehicle record
12	**(25%)**	TB test
5	**(10%)**	Interview and written application
4	**(8%)**	Drivers license
4	**(8%)**	Drug testing
4	**(8%)**	Orientation
3	**(6%)**	Check with Board of Nursing
2	**(4%)**	Abuse registry check/sign statement if convicted of assault, abuse, or neglect
2	**(4%)**	Check license/certification
1	**(2%)**	Criminal checks as needed
1	**(2%)**	Check OIG website for Medicare sanctioning
1	**(2%)**	Classroom training
1	**(2%)**	Consumers encouraged to check references
1	**(2%)**	Credit record checked
1	**(2%)**	On the job training

5. Are any of your direct care staff required to be: *(Check applicable boxes)*

107 individuals responding to this question provided 142 responses. Percentages are calculated based on the number of individuals responding. Due to more than one response per individual, the percentages do not total 100 percent.

70	**(65%)**	Licensed
34	**(32%)**	Certified
38	**(36%)**	Not applicable *(Go to question #7)*

6. Are direct care personnel required to provide documentation of current licensure or certification?

Respondents: 80

74	**(93%)**	Yes
6	**(8%)**	No

7. How often does your agency provide training opportunities to direct care personnel?

Respondents: 104

49	**(47%)**	At least once a month
31	**(30%)**	4-6 times a year
10	**(10%)**	Twice a year
7	**(7%)**	Once a year
7	**(7%)**	Never

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8. How often does the Division of Elderly and Adult Services (DEAS) provide training opportunities to your agency's direct care providers?

Respondents: 97

2	**(2%)**	At least once a month
6	**(6%)**	4-6 times a year
4	**(4%)**	Twice a year
17	**(18%)**	Once a year
68	**(70%)**	Never

9. On average, once your agency receives a referral for services how long does it take for a consumer to receive services?

Respondents: 94

57	**(61%)**	Less than one week
21	**(22%)**	1 to 2 weeks
8	**(9%)**	3 to 4 weeks
8	**(9%)**	Over 4 weeks

14 individuals provided 17 additional comments

4	**(29%)**	Over 4 weeks for homemakers, companions, and adult in-home care
3	**(21%)**	Lack of resources (i.e., staff or rooms), do not accept some referrals
2	**(14%)**	Certain patients requiring "specialized" or "intensive" services; recruitment may be required
1	**(7%)**	Less than a week if insured or private pay
1	**(7%)**	If apply for HCBC-ECI can wait up to 3 months for processing and approval
1	**(7%)**	Contacted within 24 hours after phone referral
1	**(7%)**	Not taking new referrals
1	**(7%)**	Unless consumer knows someone at the DEAS
1	**(7%)**	Varies
1	**(7%)**	Daycare 1-2 weeks
1	**(7%)**	Certain geographic areas more challenging to fill; some areas no homemaker, in-home care and HCBC-ECI staff available/some receive partial service/number of applicants exceed funding limits

10. Does your agency have a waiting list for services?

Respondents: 104

39	**(38%)**	Yes
65	**(63%)**	No *(Go to question #12)*

19 individuals provided 29 additional comments

6	**(32%)**	How long on wait list depends upon request
5	**(26%)**	For homemakers
3	**(16%)**	Have people who are underserved/length depends on what client is willing to accept (i.e., partial coverage)
2	**(11%)**	Due to inadequate funding
2	**(11%)**	Do not have a wait list-fund raise whatever it takes/overserve contract by 152 daily
2	**(11%)**	Only for Title XX or Title III grants

1	**(5%)**	Wait list is due to application process
1	**(5%)**	Periodic wait lists when service demand increases and recruitment low
1	**(5%)**	Sometimes Licensed Nursing Assistants (LNA)
1	**(5%)**	Must wait for physician report
1	**(5%)**	First year have wait list
1	**(5%)**	Due to limited health care help in areas
1	**(5%)**	Certain geographic areas/clients may wait for months
1	**(5%)**	Average wait reflects large number of homemaker clients/can remain on list for months
1	**(5%)**	Clients requiring large blocks of time can be more lengthy-over 4 weeks

11. On average, how long does a consumer remain on a waiting list?

Respondents: 35

4	**(11%)**	Less than one week
7	**(20%)**	1 to 2 weeks
7	**(20%)**	3 to 4 weeks
17	**(49%)**	Over 4 weeks

12. Does your agency have sufficient direct care personnel to meet the demands for services?

Respondents: 99

76	**(77%)**	Yes
23	**(23%)**	No

23 individuals provided 24 additional comments.

11	**(48%)**	Currently/not always:demand for services rapidly growing as population ages and enrollment increases/sometimes difficult to meet times requested for visit
3	**(13%)**	Not enough LNAs, homemakers, or companions/only cover 70 percent of approved hours/continually recruiting for homemakers and LNAs
3	**(13%)**	Never enough staff; only take cases we can staff
1	**(4%)**	Need 2-3 more providers
1	**(4%)**	Due to inadequate funding
1	**(4%)**	Depends upon request
1	**(4%)**	There is an occasional struggle to meet needs when staffing is tight
1	**(4%)**	More and more elders living in the community desire 1:1 therapeutic counseling
1	**(4%)**	Mostly, as long as flex licensed staff into homemaking cases
1	**(4%)**	Need more volunteers

13. Are customers provided with, or read if appropriate, a copy of the client's bill of rights?

Respondents: 105

97	**(92%)**	Yes
1	**(1%)**	No
7	**(7%)**	Not Applicable

14. Are direct care personnel required to keep case notes on all home visits?

    Respondents: 82

68	**(83%)**	Yes
14	**(17%)**	No

15. If direct care personnel notice a change in a consumer's condition requiring a change in services what steps are taken to ensure the consumer receives the needed services?

    103 individuals provided a total of 257 responses: 145 responses pertained to notification, reporting, or meeting with individuals, 112 responses related to process or procedures.

		Notify, report, or meet with:
44	**(43%)**	Physician
25	**(24%)**	Supervisor/manager
25	**(24%)**	Case manager/social worker
23	**(22%)**	Primary nurse/Registered Nurse/Visiting Nurses Association (VNA)
20	**(19%)**	Family/caregiver
7	**(7%)**	Administrator/director
1	**(1%)**	Office personnel

		Process or procedures:
20	**(19%)**	Contact/refer to appropriate services/services changed or offered
17	**(17%)**	Obtain/implement new physician orders/revisit, implement new orders
13	**(13%)**	New or revised care plan developed and implemented
11	**(11%)**	Notify/communicate DEAS case worker/HCBC-ECI coordinator/authorization from case manager
10	**(10%)**	Discuss/follow-up with client/ensure services initiated
8	**(8%)**	New home assessment completed with or without DEAS depending on problem/assess situation; reassessment completed
7	**(7%)**	Speaks to or informs consumer
6	**(6%)**	Document changes/condition in client record
3	**(3%)**	Refers concern to appropriate state or area agency
3	**(3%)**	Refer to nursing facility or other provider if cannot safely provide services
2	**(2%)**	Refers to ServiceLink or other social service agency
2	**(2%)**	Nurse reviews plan of care
2	**(2%)**	Contacts referral source for response and follow-up
1	**(1%)**	Consumer encouraged to call Service Coordinator requesting any changes
1	**(1%)**	Work with payer
1	**(1%)**	Fill out appropriate paperwork
1	**(1%)**	Home health aide notes are reviewed
1	**(1%)**	Determine if can meet consumer's needs
1	**(1%)**	Is always dealt with
1	**(1%)**	When client no longer meets criteria recommends ALF with necessary staff
1	**(1%)**	Changes are reviewed within one week for effectiveness

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16. How are complaints from a consumer or their representative about direct care personnel handled?

102 individuals provided a total of 260 responses.

62	**(61%)**	Directed/reported to manager, supervisor, administrator, nursing manager, director
27	**(26%)**	Internal investigation/assessment of complaint
22	**(22%)**	Internal/formal process/procedure
17	**(17%)**	Depends on complaint: notify DEAS or DEAS case manager /refer to Ombudsman
15	**(15%)**	Plan of action/correction made/appropriate remedial action taken
14	**(14%)**	Meet with all concerned and talk it out/speak directly to complainant
12	**(12%)**	Written complaint/form received/encourage to complete
10	**(10%)**	Informs consumer of complaint process/contact information given-phone number or address
10	**(10%)**	Work with consumer until resolved/follow-up with client
7	**(7%)**	Resolved at CEO/President/Director level
7	**(7%)**	Report to Board of Governors/Directors
7	**(7%)**	Consumer provided with State/Ombudsman hotline number
6	**(6%)**	Handled/report to Executive Director
3	**(3%)**	Actions and process documented
3	**(3%)**	Complaints recorded in Quality Assurance Incident/Occurrence Report/log
2	**(2%)**	Consumer coached/trained on how to address concerns/right to hire, fire, etc.
2	**(2%)**	Encouraged residents to discuss with administrator/director/board of directors
2	**(2%)**	In cases of abuse or neglect notify: Adult Protective Services (APS), Ombudsman, and Board of Nursing
2	**(2%)**	Residents encouraged to contact Ombudsman or Department of Health and Human Services
2	**(2%)**	All complaints are addressed immediately
2	**(2%)**	Evaluate plan or follow-up
2	**(2%)**	Scheduling complaints handled by scheduling department/service coordinator
1	**(1%)**	Consumer provided with State Home Health Care Hotline
1	**(1%)**	Complaints given to wellness nurse (VNA)
1	**(1%)**	Statements taken/informal hearing/may lead to formal hearing
1	**(1%)**	Home health aides: resolved by primary nurse
1	**(1%)**	Complaints forwarded to Medicare Hotline
1	**(1%)**	Involvement of agency's ombudsman
1	**(1%)**	If involves legal matter contact local authorities
1	**(1%)**	Always followed through
1	**(1%)**	With care, confidentially, the consumer is always right
1	**(1%)**	Staff reassigned or may be placed on administrative leave
1	**(1%)**	If complaint about "fit" will change staff
1	**(1%)**	If not satisfied consumers encouraged reread information on how and where to contact Ombudsman
1	**(1%)**	If not resolved written complaint brought to Executive Director
1	**(1%)**	Other complaints dealt with directly
1	**(1%)**	Try to resolve any problems ahead of time
2	**(2%)**	Conducts customer satisfaction surveys
7	**(7%)**	No complaints/not been a problem

17. If direct care personnel suspect a consumer is being abused or neglected what action is taken?

103 individual provided 193 responses.

59	**(57%)**	Report/notify or file charges with DEAS/APS or State/State notified for follow-up
38	**(37%)**	Report/consult with supervisor/manager/administrator/director
14	**(14%)**	Call/notify Ombudsman
12	**(12%)**	Initiate investigation
10	**(10%)**	Report/notify to proper authorities/appropriate action taken
7	**(7%)**	Notify doctor
7	**(7%)**	Report to case manager/social worker
6	**(6%)**	Staff are encourage/require/trained to report it
5	**(5%)**	If necessary police notified
4	**(4%)**	Talk/meet with consumer, if appropriate
4	**(4%)**	Referred to appropriate organization/agency
3	**(3%)**	Actions and process documented
2	**(2%)**	Measures taken to protect consumer from active abuse
2	**(2%)**	Procedure that is legally prescribe/mandated/policy and procedure is followed
2	**(2%)**	Notify agency/office
1	**(1%)**	Consumers encouraged report to appropriate agency/posted in common room
1	**(1%)**	On-site police officer notified
1	**(1%)**	Initiate nurse visit
1	**(1%)**	Call social services
1	**(1%)**	Human rights investigation
1	**(1%)**	On-site visit often done
1	**(1%)**	Registered Nurse visits and evaluates situation
1	**(1%)**	If severe involve Bureau of Health Facilities
1	**(1%)**	Issue incorporated into plan of care
1	**(1%)**	If had that problem would reprimand and kept away from consumer
8	**(8%)**	NA-solely residential care/never happen/not an issue

18. How often does a supervisor accompany direct care staff on a home visit?

Respondents: 70

18	**(26%)**	Once a year
24	**(34%)**	2-4 times a year
16	**(23%)**	More than 5 times a year
12	**(17%)**	None

19. How often does agency staff meet with DEAS personnel?

Respondents: 92

14	**(15%)**	At least once a month
31	**(34%)**	4-6 times a year
11	**(12%)**	Twice a year
18	**(20%)**	Once a year
18	**(20%)**	Never

12 individuals provided 14 additional comments

7	**(58%)**	Not a regular event/as situation dictates/no set schedule
2	**(17%)**	Frequent phone contact
1	**(8%)**	If outsourced: every other month a physical visit
1	**(8%)**	Unless requested by the DEAS
1	**(8%)**	Private case manage calls residents once a month; tries to visit every other month
1	**(8%)**	Deal primarily with private case manager and other independent case managers
1	**(8%)**	District Office sends social worker to our facility at least once a week

20. In general, how long does it take to receive payment for services provided?

Respondents: 96

43	**(45%)**	Less than 30 days
44	**(46%)**	31-60 days
9	**(9%)**	Over 61 days

21. Please list or describe any additional comments or concerns you may have.

Respondents: 36

11 individuals had 16 comments about DEAS in general:

5	**(14%)**	The DEAS has been responsive/attentive to reported problems
1	**(3%)**	The DEAS never tells agency if consumer has a spend down
1	**(3%)**	Pleased with effort the DEAS puts into meeting growing population
1	**(3%)**	Would enjoy meeting with case workers quarterly for conferences
1	**(3%)**	Respect the limitation our agencies have in providing services to the clients
1	**(3%)**	Many DEAS clients have psychosocial issues that take a lot of time to resolve
1	**(3%)**	Most of work in development of Other Qualified Agency
1	**(3%)**	Still huge gaps in consumer directed personal care service the DEAS does not address
1	**(3%)**	Services are inequitably distributed
1	**(3%)**	Adversial relationship – the DEAS means to involve providers in policy decisions but does not/providers are undercut, invalidated, and worked around
1	**(3%)**	Great difficulty setting up payment because of misinformation from the DEAS which crashed our system
1	**(3%)**	Discouraging-APS receives far less funding to protect and respond to abuse and neglect/more funding initiatives are needed

4 individuals provided 6 comments about DEAS personnel:

3	**(8%)**	Heavy caseloads/concerned with how overwhelmed personnel seem to be lately/hiring freeze has increased workload
1	**(3%)**	DEAS personnel difficult to contact
1	**(3%)**	Cooperation, caring, and knowledge base of personnel for the most part is beyond reproach
1	**(3%)**	Good working relationship with DEAS case workers

28 individuals had 30 comments regarding payment or rates for services:

8	**(22%)**	Low Medicaid reimbursement rates/no yearly cost adjustment/worsen retention of good staff
4	**(11%)**	More small home/assisted living facilities would have more HCBC-ECI/Medicaid bed if rates were higher/less people on Medicaid in nursing homes

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4	**(11%)**	Residential care is grossly under-funded/could not remain open if only filled with HCBC-ECI residents-either refuse or mix with private pay and charge private substantially more to make up difference/lose $300-$400 per month on each HCBC-ECI resident
3	**(8%)**	Need an efficient payment method/electronic billing/nothing but problems with billing: are either misfiled, input incorrectly or lost
1	**(3%)**	Nice if Medicare could be used to defray expenses
1	**(3%)**	Like to see small homes exempt from portions of red tape/should not be held to same standards as large facility
1	**(3%)**	Increasing number of caregivers without respite service lead to caregiver burnout and premature placement/need consistent respite funding if they are to continue or risk their own health
1	**(3%)**	Some in nursing facilities do not need that level of care but there are no other options
1	**(3%)**	Nursing service could provide clients with filling of mediplanners not covered by Medicaid unless client has skilled nursing home visits/would save State money and provide much needed service
1	**(3%)**	Requests and referrals exceed Title XX contract by 25 percent/have staff to meet demand but refuse new client/even cut number of hours of service to existing clients
1	**(3%)**	RSA 126:DEAS has not adjusted rates for 4 years nor have submitted annual reports
1	**(3%)**	Huge unmet need and lack of funding for elderly dental services
1	**(3%)**	HCBC-ECI has allowed our residential care facility to continue as a business/over half residents are on the program/could not survive without funding
1	**(3%)**	Very little assistance from local mental health center
1	**(3%)**	Electronic Data Systems has been a God-send/most clients are HCBC-ECI and funding them properly has made such a difference

4 individuals had 8 comments pertaining to the HCBC-ECI application process:

4	**(11%)**	Need electronic application process/length of time it takes to get a client approved for state benefits-sometimes up to 6 months
1	**(3%)**	Better to link approval process for Supplemental Security Income with approval for Medicaid
1	**(3%)**	A lot of families do not understand the process
1	**(3%)**	Cannot move a person into residential care until all the paperwork and level of care has been met
1	**(3%)**	Shortage of direct care staff

3 individuals provided 8 comments about private case managers:

2	**(6%)**	Concern over many of outsourced cases/difficult to get a hold of case manger/ often not able to answer questions as quickly and effectively as DEAS/does not follow-up on problems or additional needs/significant change in quality of communication
2	**(6%)**	Spend a lot of time handling issues that should be handled by case manager
1	**(3%)**	Have seen significant turnover in outsourced case managers-is very disruptive to quality care and continuity
1	**(3%)**	Notice a significant increase in APS putting responsibility back to DEAS social worker
1	**(3%)**	Outsourced case managers often do not know whether a client is assigned to them; by the time it is clarified the client has experienced disruption in care planning
1	**(3%)**	This program needs a second look before it is expanded

APPENDIX C

TELEPHONE SURVEY OF SERVICELINK DIRECTORS

Notes:

- ***Responses are in bold.***
- ***Parenthetical numbers indicate total number of similar responses.***
- ***13 Directors were surveyed.***

I would like to start off by asking you some general questions about your ServiceLink site.

1. In your opinion, what is the mission or purpose of ServiceLink?
   - **To link seniors, adults with disabilities, their families or caregivers to services or supports. (9)**
   - **Keep seniors in their homes for as long as possible. (3)**
   - **Provide public education through traditional and non-traditional means. (3)**
   - **Information and referral service. (2)**
   - **Provide supportive information.**
   - **Meet the intermediate needs of the caller.**
   - **A proactive safety net for seniors and the disabled.**
   - **Advocate for the consumer.**
   - **Provide crisis training.**
   - **Regional planning – identifying needs and how to meet them.**

2. What are the hours of operation of your site?

   Generally 8:00 a.m. – 5:00 p.m. Monday thru Friday; evenings and weekends by appointment.

3. What happens if a person calls you during non-business hours?

   Calls are answered either by an answering service or voice mail. (13)

4. How many satellite offices are there? **Ranges between 1-11**

5. Who staffs the satellite offices?

   1 Volunteers **6** Paid staff **6** Staff and volunteers

The next set of questions relate to the database or information your site has on the services available to those who call.

6. How does your site maintain a list of available services?

   5 Computerized database
   8 Paper based database
   4 Other: **Experience (2); Information and Referral (I&R) available on computer; Access Healthline; online research (2); flyers from programs & other resource guides**

   - **Developing a database. (3)**
   - **Developing a website.**
   - **Creating a resource book.**

7. How does your site obtain current information on available State and community services?

 13 DEAS
 11 Providers of services
 12 Researching information for callers
 10 Through networking – when "marketing" ServiceLink
 7 Other: **Meet with county social workers (2); call providers every year to update information (2); Advisory Board; consumers call; human service group meetings; education; outreach**

This next section concerns calls received.

8. On average, how many calls does your site receive each month?

- **45**
- **50**
- **60-85**
- **60-100**
- **62**
- **65**
- **85 (2)**
- **90**
- **100 (2)**
- **100-120**
- **131**

- **A gray area because located in the Senior Center calls come in on different lines; some are referred to ServiceLink.**
- **The numbers don't tell the whole story; a caller will request information on one thing but finds out the caller needs more help. The more support needed the more complex the case.**

9. How are calls logged?

 11 Manually – ***contact/in-take sheet***
 2 Computerized
 ______ Other:______________________________

- **Manually take information then enter data into a database. (4)**

10. What types of information are collected from callers?

- **Collect demographic data and information required by the DEAS. (13)**
- **Will collect more detailed information such as income to help in determining eligibility for programs. (3)**
- **One site uses "canned" software to collect detail information about a caller.**
- **A caller does not have to give any information, only tells as much as they want to. The elderly tend to be afraid to release a lot of information.**

APPENDIX C

11. How do you use this information?
    - **Monthly reports to the DEAS. (8)**
    - **Report to Advisory Board. (4)**
    - **To date the information has not really been used. (3)**
    - **Report to the Regional Quality Committee who review the statistics.**
    - **Information is given to the Area Agency on Aging.**
    - **Would like to use data more.**
    - **Some of the information sits there.**
    - **Started tracking towns where callers are from and their top needs.**
    - **Data shows where the biggest bang for the buck is achieved.**
    - **Identify work done with other providers and gaps in services.**
    - **Helps in answering what are the biggest questions and cost savings to the State; how many were helped by volunteer agencies and how many were referred back to the State (5 were referred back to the State).**
    - **Report numbers on their website. In July there were 47 hits and 28 database searches.**

12. For those calls requiring follow-up, in general, how long will it take for ServiceLink personnel to get back to a caller?

    __**13**__ 1-3 days
    _____ 4-6 days
    _____ Longer than a week

    - **Time may vary on the follow-up calls, depending on a callers needs. (5)**
    - **If they don't have the information that day they will at least call them back and tell the caller they are working on it. (3)**
    - **Calls are logged in IRIS; staff enter a call back date. IRIS will alert the staff to follow-up. This is used when a caller is given information to ensure they have made the appropriate linkage.**

13. If staff receive a call they believe may be a case of abuse or neglect, how is it handled?
    - **Contact the DEAS district office or state office. (13)**

14. In general, how satisfied are you with the toll free phone system?

    __**5**__ Very Satisfied
    __**7**__ Satisfied
    ______ Dissatisfied
    ______ Very Dissatisfied
    __**1**__ **Would not categorize**

    - **Not always easy to transfer calls. (3)**
    - **866 is not recognized as a toll free number. (2)**
    - **A lot of people do not want or like to use the toll free number. Has to explain calls will be answered locally that calls are transferred to the local ServiceLink office. (2)**
    - **Is a hard number to remember. (2)**

- **People who live in bordering towns will be transferred to another county. Believes this is because the first three digits of the phone numbers are the prefix for the other counties. (2)**
- **Complaints about the phone system have been made but it is still not always working correctly.**
- **They had problems with the system in spring; it took longer to fix than would have liked.**

The next section is to obtain information about linkages.

15. On average, how many linkages are made each month?
    - **50-60**
    - **80-100**
    - **100 (3)**
    - **100-120 (2)**
    - **100-150**
    - **110-130**
    - **150-200**
    - **180**
    - **197**
    - **Not sure**

16. On average, how many linkages does a caller require?
    - **1-2**
    - **1-3 (7)**
    - **1-4**
    - **2**
    - **3**
    - **3-4**
    - **4**
    - **A person may call about one thing but after talking with them find out they need other services. (3)**

17. On average how long will staff/volunteers work with a person in establishing linkages?

__**2**__ Less than a week
__**9**__ 2 to 4 weeks
__**1**__ 2 to 3 months
______ Over 3 months
__**1**__ **Did not answer – runs the full gamut. About 30 percent of callers have a one category question and are helped immediately. About 50 percent of callers' questions require a week to research and make the linkage. The rest may take anywhere from 1 week to 3 months. Supportive referrals are more complex.**

- **If they have been working with a caller for over 3 months she will look at it and see if something more is needed like case management.**

- **Have been working with a person for 4 months. After 6 months the person is referred to the DEAS; they do not do case management**
- **Some work is ongoing. Some may take a year or more.**
- **Stay with a person until they do not want or need them any longer.**
- **Callers they have been working with for six or seven months are noteworthy; try to get an agency to pick them up.**

18. What activities are involved in making linkages?

13 Researching information
13 Calling providers
13 Arranging meetings between callers and providers
13 Attending meetings between the caller and provider – ***if requested***
13 Assisting in filling out applications
13 Coordinating services – ***to a small degree (2); not in case mgt sense***
9 Other: **Education; advocacy (2); explain services (2); arrange transportation; provide transportation; collect and mail information; as much as they can; strategize with local groups; translation**

- **Concord, Nashua, and Manchester have the best concentration of providers.**

19. Are home visits conducted by:

13 Paid staff
1 Volunteers

20. Why would personnel conduct a home or site visit?

Reasons for Conducting a Visit

- **A person is physically unable to get to the office. (5)**
- **If a situation is too complex or there is too much information for over the phone. (3)**
- **Families or caller may request a visit. (3)**
- **When a caller does not feel comfortable meeting at a site or if does not have a phone.**
- **More often than not it is because there is a gathering of adult children who live out of State and are having a family meeting to plan or discuss options. This type of situation is increasing.**
- **To bring food or a free cell phone.**

What is Done During a Visit

- **Determine/assessment of person's needs. (9)**
- **A social service assessment.**
- **Not a clinical assessment. If a person has health issues she refers them to a doctor or visiting nurse.**
- **May go to a home to help a person fill out an application for fuel assistance but may find out more services are needed i.e., there is no food in the home.**
- **Uses a computerized questionnaire program called Wired Wizard that has detail questions such as income or services being receiving. Once completed a list of services the person is potentially eligible for is shown along with contact information. The person can call the agencies or if they sign a release she will make the calls.**

Number of Home Visits

As a follow-up Directors were asked on average, how many home visits do they conduct each month:

- **2 (2)**
- **2-3**
- **3**
- **3-4 (2)**
- **6**
- **10-15**
- **15-25**
- **25**
- **Not many (2)**
- **Not asked**

Miscellaneous Comments

- **In general, if person already has someone coming in such as a county social worker then it is not appropriate to go in.**
- **Some sites do an awful lot of home visits and does not know why they are doing them.**
- **They have a low threshold when it comes to conducting home visits. Each site is different.**

The next section deals with your outreach/marketing efforts.

21. What types of outreach/marketing activities do you conduct?

13 Presentations to local groups
10 Newspapers
8 Radio/TV
13 Brochure
12 Other: **Flyers (3); magnets (2); education (4); things that do not cost much; signs; church bulletins (2); newsletters; bookmarkers; offer training to local groups; resource guide for caregivers; sit on committees; outreach**
______ None

22. How would you rate the effectiveness of your outreach efforts?

3 Very effective
7 Effective
2 Somewhat effective
______ Not effective
1 See Bullet

- **Has not been in position long enough to answer.**
- **Marketing is a weakness; it is hard to find the time to do. (3)**
- **Waiting for the statewide package that will be available in December. It will standardize ServiceLink marketing so everyone is on the same page. (2)**

- **Efforts are becoming more effective each month.**
- **It is a huge county; outreach is done well in some parts and not well in others.**
- **They have done a good job with providers and a decent job with seniors but there is a lot of room for growth. Need to work on the disabled population.**

The next set of questions is about your volunteer program.

23. How many volunteers do you currently have?

- **1**
- **2 (2)**
- **4**
- **13 (3) – 8 are Advisory Committee members**
- **15 (3) – includes Board members; recruited on their own**
- **20**
- **40 – includes regional planners**
- **100 – includes senior center and 12 long distance transportation volunteers**

24. How many volunteers would you like to have?

- **1**
- **2 (2)**
- **3**
- **5**
- **17**
- **20**
- **25 (2) – transportation needs a lot of volunteers**
- **45**
- **100 – a reasonable number; would be a pool of agencies sharing volunteers**
- **20 hours/week**
- **A few more**

25. Before volunteers can participate in ServiceLink are:

__**12**__ References checked
__**12**__ Criminal background check performed?

- **Check driving records. (4)**

26. How would you rate your volunteer recruitment program?

__**2**__ Very satisfied
__**4**__ Satisfied
__**3**__ Somewhat satisfied
__**2**__ Dissatisfied
__**2**__ See Bullets

- **Would not categorize.**
- **Cannot answer the question; has not been in position long enough. Are struggling to get the volunteer program off the ground.**

27. What, if any, areas of the volunteer program would like to improve?
    - **Would like a volunteer coordinator. (4)**
    - **Ensure they are set up to bring in volunteers; a matter of how to best use volunteers. (4)**
    - **More support or interest by the other coordinators for they could help each other; provide ideas and exchange information. (2)**
    - **Have ServiceLink specific volunteers so could grow the hubs. (2)**
    - **Need to have volunteer management – the ability to train and provide oversight.**
    - **Risk management issues need to be evaluated.**
    - **ServiceLink first envisioned a more integrated role for volunteers but this has not happened.**
    - **The fiscal agent has the infrastructure but as a network it seems the volunteer aspect has been pulled back.**
    - **The efforts have been tremendous but ServiceLink is in direct competition with other organizations; the volunteer pool is small while the need is great.**
    - **Will not recruit unless have a specific job; have service descriptions for volunteer position. Similar to hiring paid staff.**
    - **Grow the volunteer program.**
    - **Expand relations with businesses and the community.**
    - **Would like to see a friendly visit program.**
    - **Could get more volunteers from the smaller communities. This goes along with increasing ServiceLink's presence in the smaller communities.**
    - **Does not have the time to recruit volunteers.**

The next set of questions is about training.

28. What, if any, are the training requirements for paid staff?
    - **Orientation. (5)**
    - **No requirement. (5)**
    - **Encouraged to attend training. (3)**
    - **Is a training requirement but does not know what is it. (2)**
    - **Trained by social workers.**
    - **Trains everyone when staff first start. There could be improvements.**
    - **Alliance of I&R Systems training – by next year all staff are expected to be certified.**

29. What, if any, are the training requirements for volunteers?
    - **Orientation. (9)**
    - **Are encourage to attend training sessions. (4)**
    - **No requirement. (3)**
    - **Required 2-4 hours of training/year.**
    - **Training from volunteer coordinator.**
    - **Trained in answering the phone.**
    - **Policies and procedures are reviewed and receive on the job training.**

30. What, if any, types of training programs does DEAS conduct?

- **Monthly Directors meetings. (6)**
- **Health related issues: Alzheimer's training, West Nile virus. (2)**
- **They do a great job with the Directors but wish they would bring it around to the local levels.**
- **Has been told DEAS is training Directors.**
- **Earlier on issues like quality assurance.**
- **Around administration policy and issues.**
- **In service legal training.**
- **Recruitment of volunteers for volunteer coordinators.**
- **List of training opportunities are made available through district offices.**
- **Per request.**

This last set of questions relate to the overall performance of ServiceLink.

31. How would you rate the success of your ServiceLink site?

__**10**__ Very successful
__**3**__ Successful
______ Somewhat successful
______ Not successful

32. How do you measure the success of your ServiceLink site?

- **Quality assurance/customer satisfaction survey. (7)**
- **Number of calls. (5)**
- **Number of referrals from doctors, agencies, or providers. (4)**
- **Number of repeat callers. (3)**
- **Number of linkages. (3)**
- **Does good work for people; cannot help everyone but if able to help one then doing a good job. (2)**
- **Relations with other agencies and providers. (2)**
- **Databases within IRIS are used to measure success.**
- **Identify the differences they have made to consumers with the information and connections they provide.**
- **Number of providers calling for information.**
- **The level of participation in the regional planning process.**
- **Having and meeting stated goals.**
- **Being well received by the community.**
- **If ServiceLink is successful then nursing home admissions or length of stay will decrease but this is hard to measure. With the increasing population and if nursing home beds are kept frozen, if there is no waiting list for beds it would mean something is happening like people are going to nursing homes late in the disease process. It may take five years to see this.**

APPENDIX C

33. Overall, what improvements would you like to see with the ServiceLink program?

- **More paid or bigger staff. (7)**
- **A standardized statewide marketing effort (4)**
- **Would like to have a system or statewide database in which all the sites enter data and everyone is collecting the same data. Currently, everyone collects different types of information. It seems everyone is spinning their wheels going in different directions. (4)**
- **More resources. As the program grows it will not have the resources to provider quality services. At what point is service compromised because of the volume of calls?**
- **If increased marketing then would not be able to handle all the calls.**
- **Can do more in terms of marketing but would lead to increase calls. Do not have the staff to handle increase and maintain quality of service.**
- **Hit a place where if they were out there more (marketing) they could not respond to the volume and intensity of calls. An increase of one position would allow for some growing room and allow pursuit of other activities.**
- **Does very little marketing for fear will not be able to meet increased demand. Do not have the infrastructure to grow.**
- **Efforts are consistent with service; never markets more then they can handle. Currently capacity is being pushed.**
- **ServiceLink sites need to work together more; collaborating more. Each site is recreating the wheel.**
- **Better communicate to the public about the good work they are doing.**
- **Would like to see ServiceLink expand.**
- **Increase training.**
- **Increase public educational offerings.**
- **Professional overview of customer satisfaction survey design and implementation. The current survey is not a statistically sound document.**
- **Continue cooperating with the community and playing an integral part in meeting and identifying the needs of the community.**

34. Do you have any questions or comments?

- **Provides more services then giving out phone numbers.**
- **Envisions it growing to be the central access point to services.**
- **It can be and is becoming a way to provide information to people not yet in the system.**
- **This is a new concept for the DEAS with working in partnership with the community instead of being contracted by the DEAS.**