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Institute For Health, Law and Ethics

Toward a Community Support System For the Elderly

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This study was supported by a grant from the State of New Hampshire Health Care Transition Fund

June, 1998

Chapter 2: Executive Summary

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Introduction

The goal of this study is to assist the State of New Hampshire and its elder citizens as they address the critical challenges and opportunities which face the State of New Hampshire in adopting and implementing a community-based long term care policy for the elders of the state.

National Best Practices and Innovative Trends

Chapter Three presents the findings of a national best practices survey which highlights some of the best community-based elder care programs from the rest of the country. These programs can serve as potential models for the State of New Hampshire to emulate or build upon in developing its own system of community-based care. Taken together, these programs also identify some of the innovative trends in supporting elders in the community.

A nationwide nominations process was used to identify successful programs in supporting frail elders in their communities. Based on pre-established criteria, seventeen programs from fifteen different states were studied extensively using a standardized interview format. In Chapter 2, each of the programs are discussed at length. The national best practices survey highlights innovations and improvements in three distinct areas:

1. The development of a range of new community-based residential care models including assisted living, adult family care and enhanced congregate care. In the National Best Practices Survey, these programs are represented by the Supported Residential Living Program located in Maricopa County, Arizona, a very successful and innovative Medicaid reimbursable, autonomy-focused assisted living program; Adult Family Living in Connecticut, a well designed but little used foster care model; and the Congregate Housing Services Program of Maryland, a leader in the original development and ongoing improvement of congregate care. At the core of these new community-based residential care programs is the understanding that arranging for the housing and especially the supported housing needs of elders is critical to prolonging many frail elders' ability to remain in the community. Medicaid nursing home care includes reimbursement for room and board but Medicaid's community-based programs do not. Creative supported housing programs are starting to use Medicaid funds to cover the service components of their programs.

The successful new programs in this area provide the safe setting many frail elders need, but they do not adopt safety as their primary principle. Rather, they promote quality of life through independence, choice and autonomy. A person participating in Arizona's Supportive Residential Living (SRL) program or Maryland's CHS program has a fairly unlimited amount of freedom in daily activities. To the extent they are able, participants in these programs are free to

utilize the services they choose, and can come and go as they like. Participants in foster care programs may be more limited in these areas because of the inherent structures that are in place when trying to accommodate the needs and schedules of a number of people--in this case a family. The tradeoff in these situations is that the elder gets companionship and emotional support, something that may be lacking in the more "independent" residential programs. Both programs serve a very specific, narrowly defined population; adults that can self-direct their care and who require some services, but for one reason or another are not able to remain in their own homes. Both alternatives can be less expensive than nursing home placement, although not more so than similar services provided in the home.

In both the Arizona and the Maryland programs, the apartments are generally located in facilities with other residents who do not receive services. A benefit to this is that if the non-participants do eventually require services, they can "age in place" by accessing the program's supports without having to relocate.

2. The development of informal, non-professional caregiver programs which are designed to support family caregivers or increase the availability of informal caregivers by providing additional funding for these purposes, enhancing the flexibility in the use of existing funds, or expanding the use of volunteers. All of the programs that follow this trend start with the recognition that informal and family caregivers provide the lion's share of support to frail elders and that they are essential in enabling these elders to remain in the community. Furthermore, informal caregivers provide support in extremely cost effective ways.

In the National Best Practices Survey, a direct family support program is best exemplified by the Family Caregiver Support Program of Pennsylvania which provides limited financial reimbursement for out of pocket expenses, case management support and counseling support to in-home family caregivers of frail elders. Two volunteer based programs are included in the study. The Grace Hill Neighborhood Center provides a neighborhood-based service bank system in St. Louis, Missouri which allows volunteers to accumulate service credits that they can cash in for volunteer services when they have unmet needs. In contrast, Project Dana, is run out of a variety of different Buddhist Temples and Christian Churches in Hawaii and is particularly effective in serving elders from a diverse group of cultures and countries of origin. Finally, the Qualified Service Provider Program exemplifies a non-professional, consumer-directed personal care attendant model that has been extremely effective in North vast rural areas where formal care giving is difficult to arrange. Under this program, family members may be hired by the elder as qualified service providers and thus paid to provide care.[\[1\]](#)

3. The development of programs designed to enhance flexibility, efficiency and integration in the delivery of formal services and the expenditure of long term care funds. At the center of these programs is a desire to maximize the effective and efficient use of resources by allowing for flexibility and removing or navigating around obstacles such as onerous provider regulations, limitations on covered services, and duplicative or non-existent case management. There are numerous strategies, which are not mutually exclusive, to accomplishing this goal, including:

a. Integration of financing through capitation.

Under this approach, funds are paid to a provider of services on a flat fee basis, typically based on the level of the elder's needs, in exchange for providing a set of services that meet those needs. The provider and the elder are thus freed from the burden of fee for service reimbursement and its limitations regarding types of services which are eligible for reimbursement. The wider the array of funding sources available to the provider of services or network of providers, the greater the range of both responsibility and flexibility the provider has in meeting the elder's needs.[\[2\]](#)

Providence Elderplace, a Program for All Inclusive Services (PACE) site in Washington State, exemplifies flexibility through capitation. Elderplace receives a capitated payment from both Medicare and Medicaid. The program is responsible for all of the elder's acute and long term care needs but it has absolute flexibility in how to meet those needs. Another version of flexibility through capitation, but one limited to long term care, is the Supported Residential Living Program in Maricopa County, Arizona. The program receives a flat monthly fee, the amount of which varies according to the elder's acuity level, and is responsible for all of the elder's long term care support and service needs. It is free to develop and alter the specifics of the elder's care plan so that it best responds to his or her current needs. Florida's Channeling Program also utilizes a capitated managed care model for home based long term care services. There, the program coordinates services for \$24 a month per consumer and uses up to \$554 a month per client to sub-contract with other providers for needed services.

b. Integration of financing through consumer-directed approaches such as "cash and counseling" or "voucher" programs.

This approach is similar to capitation, but it provides flexibility and the purchasing power to arrange for long term care services directly to the elder rather than to the provider or network. The elder can then "purchase" the services or supports she desires. A common and often preferred model of long term care in a number of European countries, including Germany, it is growing in the United States. To be eligible for Medicaid reimbursement, these type of programs must use vouchers for services rather than dollars. Typically, in the US, these programs allow consumers of long term care services to arrange for their own personal care attendants.[\[3\]](#) An example of this type of program, is the North Dakota Qualified Service Provider Program discussed in the National Best Practices Survey.

c. Integration of service delivery through integrated networks, care coordination and integrated access to services and information.

The integration of the delivery of services is a central component to supporting elders in the community with the desired level of flexibility and responsiveness to their needs. On a day to day level, the process of accessing and obtaining services is how the elder consumer experiences the formal care system and will determine that system's ability to support the elder. Thus, programs which attempt to integrate services are among the most common innovations seen today. Integration can occur at three different levels; full integration of services, care coordination, and information and referral.[\[4\]](#) The National Best Practices Survey includes programs that are successful in each of these areas.

Florida's Channeling Project and the Options for Long Term Care Program of Colorado offer a "single entry point" information and referral concept to make accessing services easier for clients. Both of these programs contract with their states for Medicaid funds and perform case management services for clients. The Channeling Program provides case management to coordinate 19 different home and community-based services, with over 60 subcontracted providers.

In South Carolina, a unique approach to integrating services is demonstrated in the Neighborcare Program of the Council on Aging of the Midlands. Neighborcare utilizes a neighborhood-based approach to accessing and coordinating area services. It reduces the duplication of services by communicating with other agencies and coordinating services, and by using neighborhood-based care teams that include a care manager, a van driver, and a nurse.

Probably the best example of a totally integrated program is Providence Elderplace, a PACE model in Seattle, Washington, operated by the Sisters of Providence. Elderplace incorporates all medical, pharmacy, dental, and case management services under one umbrella. The program provides all primary medical and specialist care, home health and related services, utilizing a team approach to work with the client to develop a care plan. PACE programs have been successful throughout the United States, with one significant drawback being that the program participants are frequently unable to continue utilizing their regular physicians. In several instances, the Washington model made exceptions and worked with participants to allow them to continue seeing their own physicians, making them, in essence, part of the care team. The PACE philosophy of promoting participant involvement and decision making, and its "one stop shopping" model of health care make it a particularly impressive program. Unfortunately, the PACE model is an urban model for high cost users of services. It is less effective for rural settings or frail elders who do not have significant medical needs.

d. Integrated service delivery and increased flexibility in services available through the use of state-funded "sister" programs to fill the gaps in

the Medicaid Home and Community-Based Waiver Programs.

In order to ensure the availability of care plans which can provide a full range of covered services and the flexibility to maximize effective, efficient and creative community care, states are developing state funded programs that have great flexibility in how the funds can be used. These "sister" programs are utilized as a supplemental source of funds to arrange for care that can not be covered under the traditional and more restrictive Medicaid Home and Community-Based Waiver Program. While these programs utilize state general funds, they allow Medicaid Waivers to be used as effectively as possible. States that utilize this "sistering" approach believe that in the long run the additional dollars which provide flexibility to develop workable care plans are worth the investment because they reduce the financial liability associated with higher cost nursing home care.

The most renowned of these types of programs is the Wisconsin's Community Options Program, which was not included in the National Best Practices Survey, because it was not nominated. Within the survey, North Dakota's Qualified Service Provider Program uses both Medicaid and State funded streams of funds in order to allow increased flexibility for family members and others to participate in the program. Pennsylvania's Family Caregiver Support Program is also a state-funded program which provides monetary reimbursement to family caregivers of elders who receive formal services through the Medicaid Home and Community-Based Waiver Program. By doing so, the elder can remain in the community longer and save the state the higher cost of nursing home care.

Another approach used to leverage the effectiveness of state dollars is the use of sliding scale or cost share programs. These type of innovations extend the purchasing power of an elder's private funds by providing a state subsidy for services on a sliding fee basis. Typically, the goal of these programs is to make less intensive services available to at risk elders prior to their eligibility for Medicaid. In this way, states can attempt to extend the period of time that elder will not need or qualify for more expensive and intensive Medicaid services. The Florida Senior Resource Alliance Cost Share Program discussed in the survey is an example of this approach.

e. Expanded use of personal care attendants either by exempting them from the regulation of a state's nurse practice act or by expanding a nurse's ability to appropriately delegate functions to personal care attendants.[\[5\]](#)

In an attempt to maximize flexibility and efficiency in using available long term care resources, states have increased utilization of personal care attendants (PCAs) to do a wide range of long term care tasks which were previously reserved for licensed nurses or nursing assistants. Typically, the use of PCAs has increased in three ways; as employees of supported housing programs, home health agencies, or consumers of long term care. In residential settings, PCAs are either exempted from the state nurse practice act or more likely take advantage of more expansive authority of nurses to delegate in those states. As home health agency employees they tend to receive delegation from nurses empowered with broader authority to delegate. As a direct employee of a consumer of long term care services, the PCA, who often must obtain certification through training and/or a background check, is considered an extension of the consumer and specifically exempted from regulation under the nurse practice act. In the National Best Practices Survey, the program that best exemplifies the trend toward increase use of PCAs is the North Dakota Qualified Service Provider Program. In addition, as described in the survey, the State of Texas significantly broadened the authority of nurses to delegate and its Community-Based Alternatives Program includes the use of PCAs as employees of home health agencies.

A full discussion of all the programs contained in the National Best Practices Survey is contained in Chapter Three.

The Perspective of the National Experts

Chapter Four contains selected proceedings from a conference on innovations in community-based long term care for elders that the Institute for Health Law and Ethics hosted in Concord, New Hampshire on October 16, 1997. In the included selections, three national experts on the topic, Dr. Robyn Stone, former Acting Assistant Secretary of Aging in the Clinton Administration, Trish Riley, Executive Director of the National Academy for State Health Policy, and Professor Walter Leutz of the Brandeis Institute for Health Policy, provide their perspectives on the status of innovation in community-based long term care for elders. In addition to discussing current innovative trends, some of the experts express the belief that the extent of innovation to date has been somewhat questionable, but that the current trends in managed care and federal-state relations provide a window of opportunity for states to experiment with and improve their long term care systems.

The conference proceedings also explore the currently popular concept of integration, stressing the need for more clarity than currently exists in defining the specific goals of any integration initiative. For example, is the goal of a specific initiative to integrate the acute health care system with the long term care system or is it simply trying to integrate all available long term care services? The conference seemed to indicate that the existence of a well developed and integrated community-based long term care system is a prerequisite for successfully integrating long term care with the acute health care system because without it, the medical system dominates leaving insufficient resources for needed long term care supports and systems. The type of integration being pursued must also be more clearly defined. For example, is the goal of a specific initiative to integrate financing streams, service delivery systems, state administrative structures and/or the populations to be served (e.g. DD and Elderly)? Since it is not feasible to achieve all these ends, it is critical to acknowledge the limits of any integration initiative and to be clear as to the specific goals desired. Only in this way can the initiative be critically evaluated and improved.

NH's Developmental Disabilities Model of Community-Based Care

Turning from the national perspective, Chapter Five analyzes the history and key elements of the State's community-based care system for the developmentally disabled. That system is renowned as one of the best community-based care systems in the country, if not the world, for those with developmental disabilities. In designing and implementing an improved community-based care system for frail elders, many important lessons can be learned from studying the successes of the developmentally disabled (DD) system in the State.

The successful evolution of that system followed a major shift of funding away from institutions and to community-based models of care. This shift of funding reflected a political shift of alliances by state policy makers away from institutions, nursing homes, unions and hospitals, and toward the individuals and families the system is intended to serve. The shift in funding resulted in a significant investment in development of community services by creating and funding development of area agencies.[\[6\]](#) However, the funding alone does not account for the success of the DD system. Rather, the centrality of the fundamental tenets of inclusion, individualized supports and individualized service plans are responsible.

The primacy of a philosophical imperative to support individuals in the community with individually tailored care plans has led to a series of important innovations, including (a) an individual planning process and needs assessment with focus on quality of life while incorporating the individual's dreams and hopes; (b) the use of interdisciplinary teams to develop the individualized care plans which include and increasingly rely upon individual consumers and their friends and family; (c) a shift in thinking regarding the meaning of community supports away from correcting deficiencies and toward pursuing interests, relationships and preferences; (d) the flexible use of public funds to develop innovative support arrangements in order to meet specific individualized needs and aspirations;[\[7\]](#) (e) the provision of individualized, non-congregate, residential supports and living options; (f) the investment in service staff development by providing training on the value of inclusion, individual needs and service plans, quality of life goals, and creative community-based problem solving; (g) a shift in support-staff's role from simply providing services to include building bridges between the consumers and

the community; (h) expanded access and use of adaptive equipment;[\[8\]](#) and (i) the use of case managers who serve as community liaisons, provide direct support and coordinate available resources.[\[9\]](#)

In addition to these systemic advances, the evolution of the DD model benefited and continues to benefit from the primary roles played by the families of those with developmental disabilities. These families have advocated at the state level in a collective and politically powerful voice. As a result, the central role of these families as primary caregivers is acknowledged, respected and supported. For example, the law requires the creation of regional family support councils (FSCs), comprised of 10-12 family members, who together with paid family support coordinators monitor needed innovations to the system and provide flexible funding to families based on individual need from funds allotted solely for this purpose. FSCs serve as a feedback loop to effect statewide policy changes and to teach and learn from families themselves. The chairs of each of the 12 FSCs which comprise the State Family Support Council meet monthly with the New Hampshire Division of Developmental Disabilities Family Support Coordinator to plan, inform the state of current issues and needs, and learn from one another about effective council functioning. By establishing Family Support Councils to guide and advise family support efforts, a collaborative learning relationship developed in which the service system learned more about the ways that families solved their own problems and families became more knowledgeable about support options and the scope of problems that other families have faced. The success of the DD system is due in part to the significant reliance placed upon service users and their families in all aspects of planning, governance and quality assurance.

Transferability of the DD model to Elders

Chapter Six examines the transferability of New Hampshire's DD model of care to an elder population. It identifies and discusses some important differences between elders and individuals with DD which affect transferability. These include differences in attitude toward services and service providers, phases of life and desires for integration in society, expected prognosis and functional ability, relationship to family and community and developing quality-of-life outcome measures. The chapter further explores significant social, philosophical and political differences which also affect the transferability of the DD model to an elder population.

The transferability analysis also points out some legal issues that affect transferability, most notably the absence of a legal mandate to de-institutionalize the elder system as existed in the DD system. Nevertheless, the federal statutory and regulatory structure which governs the DD Medicaid waiver also governs the state's Elderly and Chronically Ill Medicaid waiver program. Thus, while there is no legal mandate, there is also no federal legal barrier to developing a DD-like model of community care for elders in New Hampshire. In pursuing such a course of action, the state should be sensitive to the differences that exist between the two populations and modify the DD approach to accommodate the elderly. It appears that the most significant barriers to transferability of the DD-like model to the elderly are political and societal. Entrenched and powerful entities, including the nursing home, home health and nursing industries have substantial vested interests in the status quo. Furthermore, society tends to have a bias toward maximizing frail elders' safety rather than their quality of life. Finally, many policy makers are concerned about the additional costs of providing a DD-like model of care for elders. Yet, as discussed in the introduction and further established in the case studies, these fears appear to be misplaced.

Case Studies of Elders At Risk of Nursing Home Placement

Chapter Seven presents the results of a series of in-depth case studies of New Hampshire elders at risk of nursing home placement. The case studies were conducted in order to explore the specific applicability of the community alternatives presented in the national best practices survey and the DD model, as well as to compare the costs of these models to nursing home care. After identifying twelve geographically dispersed elders at risk of nursing home placement, we conducted a series of intensive interviews which focused on their conditions, needs and current care plans. Following the initial interviews, we developed a series of individualized community care plans for each person as alternatives to nursing home placements. These care plan alternatives were modeled on specific programs in the national best practices survey and the existing DD system.[\[10\]](#) These alternative models were then presented to the elders and their care givers to determine which, if any, were preferred over nursing home care and whether they would meet the elder's needs. The cost of the preferred model of care for each participant was calculated and compared to the cost of nursing home placement.

Of the ten participants who completed the case studies,[\[11\]](#) five preferred the DD model of care, four preferred the assisted living model of care,[\[12\]](#) and one preferred the consumer-directed, personal care attendant program. The average monthly cost of the preferred model of care was \$1,773, compared to \$3,398 for a Medicaid nursing home bed. The case studies clearly establish the preference among frail elders for DD, assisted living and consumer-directed personal care attendant models of care as well as the cost efficiencies of these choices over a nursing home placement.

Lessons and Recommendations

Chapter Eight describes a set of important lessons learned regarding the development of successful community-based care systems and provides a series of specific recommendations to the State of New Hampshire in order to develop a coherent, comprehensive and effective community support system for the elderly.

In studying successful community-based long term care programs, we have identified a number of important lessons that should be considered as one embarks on reforming the elder care system:

1. Improvements should be responsive to the direct needs of the elders in a specific locality as defined and described by the elders themselves. In other words, the proposed changes should be responsive to the specific community, cultural and resource needs of a targeted area.
2. An active and powerful elder leadership and lobby is necessary not only to assist in designing the reform efforts but, most importantly, to create the political will to implement those changes in the face of many interest groups, especially providers, who are vested in the status quo.
3. It is important that improvements to the system be based on philosophical underpinnings or a vision which serves as the driving force for the reform efforts. While the philosophical underpinning has differed in different places, ranging from a belief in increased consumer choice, quality of life being paramount, or the need for coordinated service systems, it is the philosophical basis which guides change over time and which motivates elder involvement.
4. The goals of the system change need to be well formulated, prioritized and articulated. Only in this manner can action steps be developed and evaluated.
5. Improvements to the system have often been incremental, but based on a more global plan that embodies an underlying philosophical basis.
6. Successful transformation from an institutional long term care paradigm to a community-based model requires a significant investment of funds to develop the infrastructure, resources, programs and information systems to create real community options for elders. Merely allowing elders to spend their "long term care allotment" in the community does not provide sufficient support and opportunities to ensure the transformation of the system. Often, to avoid the potential harm of a gap in service to a vulnerable population, investment in the creation of the new system needs to occur while the old system is still serving most of those receiving services. However, as the transition progresses, the infrastructure investment by states can increasingly be covered by the traditional streams of service dollars such as Medicaid.
7. For states that define their system change goals to include cessation in the growth of nursing home utilization, it is critical to target community services directly to individuals likely to enter nursing homes.. This can be accomplished by providing easy access to comprehensive community services for those

applying for nursing home care and those being discharged from hospitals or rehabilitation centers.

8. Assumptions about diversion of nursing home utilization and resulting cost savings need to be realistic. A state should not expect to cut significant numbers of nursing home beds. Only one state has cut the raw numbers of nursing home beds through its community-based transition.^[13] Most of the successful states have prevented growth in nursing home utilization by encouraging the use of less expensive, and often preferred, home and community-based care to meet the increased demands of their growing population of frail elders. By overestimating cost savings from nursing home reductions, the implementation plan will have insufficient resources to ensure the successful development of the community-based system.

Below are our specific recommendations or "action plan" for the State of New Hampshire to develop a coherent, comprehensive and effective community support system for the elderly. These recommendations are based on the totality of our research and are explained in greater detail in Chapter Eight.

A. Develop a statewide network of regional community-based support agencies to be the single entry point and independent care coordinators for all community-based long term care services for elders and which can ensure needed wrap around services such as transportation;^[14]

B. Develop consumer and caregiver support councils to ensure regional systems that are responsive to the community's needs;

C. Amend the Medicaid Waiver to permit a wider array of flexible benefits, including bundled service packages, consumer directed vouchers, and personal care attendant services;

D. Develop an array of local community-based residential options that allow for "aging in place" and consumer-direction, by amending the Medicaid Waiver accordingly, adopting appropriate assisted living regulations and by working with funding institutions, such as the New Hampshire Housing Finance Authority to invest in initiatives to develop these residential options;

E. Increase monetary and systemic support for families and informal caregivers by expanding respite opportunities under the Medicaid Waiver, permitting limited reimbursement for care provided by family caregivers who reduce employment to provide care, developing support opportunities through the regional consumer support agencies and enacting a limited state-funded caregiver support program to reimburse family for out of pocket expenses which prevent institutionalization;

F. Use Proportionate Share dollars to fund the creation of an infrastructure (community support agencies and innovative support programs) sufficient to give the new community-based system a fair chance to succeed;

G. Adjust state and county portion of Medicaid costs for nursing home and home and community-based care so as to eliminate any financial incentive on the state to place elders in nursing homes;

H. Amend New Hampshire's Nurse Practice Act and regulations to permit increased utilization of personal care attendants and nurse delegation in the provision of home care;

I. Require community-based home health providers who accept Medicaid reimbursement to provide Medicaid home and community-based care waiver services to any qualified individual in the provider's catchment area;

J. Eliminate the disparity in the financial eligibility criteria for Medicaid home and community-based care and nursing home care, which currently forces individuals into higher cost nursing home care;

K. Develop strong elder organizations in the state in order to ensure the needed leadership to plan ongoing reform and to create support for implementing the needed changes; and

L. Expand existing capacity in the home care and community support industries so that they can meet the growing demand for such services by investing in training, economic development and by ensuring competitive compensation for direct care providers.

Conclusion

These recommendations, if followed, could serve as an implementation plan for a community-based long term care system that will prepare the state for the challenge of the anticipated boom in its older citizens over the next twenty to twenty-five years.^[15] They address many of the problems with the state's current community-based care system for the elderly, as well as the identified barriers to improving that system.^[16] The recommendations incorporate components of successful programs from both the National Best Practices Survey^[17] and the New Hampshire Developmental Service System.^[18] A system of community-care based on these recommendations will be more responsive than the existing system to the needs and stated desires of New Hampshire's elderly population and their families. According to the experience of other states,^[19] as well as the case studies of New Hampshire elders,^[20] a community-based long term care system for the elderly which follows these recommendations should also result in cost-savings to the state.

^[11] Paying family members for the provision of home care services through Medicaid is legally complex and difficult to implement. Attached as Appendix III is a detailed memorandum on the topic.

^[2] Typically, the integration of funding into a capitated payment results in the provider or network developing an integrated services delivery system. Note, however, that the integration of services can also be accomplished without formally integrating funding streams. This is typically done through coordination and integrated care management (see c, below).

^[3] These programs are legally complex and difficult to implement. Attached as Appendix IV is a detailed memorandum on fiscal models for consumer-directed personal care services.

^[4] See comments of Walter Luetz, in Chapter 3.

^[5] A detailed memorandum that addresses the complex legal issues associated with the nurse practice act and nurse delegation both in New Hampshire and other states is attached as Appendix II.

^[6] While area agencies were developed using state funding, they were created by law as private non-profits whose boards of directors must consist of at least one-third consumers or their family members.

^[7] This is achieved by paying the DD area agencies on a contract basis to provide needed services, similar to a capitated approach, rather than reimbursing them on a fee for service basis for eligible services.

^[8] This has been achieved through ample funding for equipment, statewide technical assistance to assist individuals with what equipment and funding is

available, assistance with training and information and the development of a program to recycle used adaptive equipment

[\[9\]](#)Case managers typically have light case loads of up to thirty individuals so that they are able to effectively fill these roles.

[\[10\]](#) The alternative models presented included programs based on the Adult Family Living program from Connecticut, the Pennsylvania Family Caregiver Support Program, Missouri's Neighbor Helping Neighbor Program, a PACE program from Washington State, a consumer-directed personal care attendant approach based on the North Dakota Qualified Service Provider Program, Supported Residential Living/assisted living based on an Arizona model and a DD model of care as developed by an area agency for DD.

[\[11\]](#)Two participants died prior to the follow up interview.

[\[12\]](#) Of the four, two preferred residential programs geared specifically to individuals with Alzheimer's

[\[13\]](#)Oregon by 8.6 percent over a 13 year period.

[\[14\]](#)Model legislation for the development of such a network is included in Appendix I.

[\[15\]](#) See Introduction, Chapter 1.

[\[16\]](#) See Appendix V for a summary of consumer and provider identified barriers and problems.

[\[17\]](#) See Chapter 3.

[\[18\]](#) See Chapters 5 and 6.

[\[19\]](#) See discussion in Chapter 1.

[\[20\]](#) See Chapter 7.

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Last modified April 6, 1999.