



New Hampshire State Plan on Aging

*Advancing the state's efforts in understanding,
serving, supporting and celebrating older
individuals across the state*

October 1, 2023 – September 30, 2027

FINAL DRAFT

NH Department of Health and Human Services
State of New Hampshire



*Improving the Lives of Older Adults and People with Disabilities
Through Services, Research, and Education*

September 19, 2023

The Honorable
Governor Christopher T. Sununu
107 North Main Street
Concord, NH 03301

Dear Governor Sununu:

I am pleased to inform you that the New Hampshire State Plan on Aging under the Older Americans Act for October 1, 2023 through September 30, 2027 has been approved.

The State Plan outlines significant activities that will serve as a guide for New Hampshire's aging service network during the next four years. Of particular note is your commitment to developing and implementing a comprehensive, coordinated, statewide system of long-term services and supports (LTSS) with prioritization of person-centered care (PCC).

I appreciate your commitment and dedication to ensure the continuity of quality services for older adults in New Hampshire and am delighted to see that the Bureau of Elderly & Adult Services continues to serve as an effective and visible advocate for older adults and family caregivers at a state level.

The Administration for Community Living looks forward to working with you and the Bureau of Elderly & Adult Services in the implementation of the State Plan. If you have questions or concerns, please do not hesitate to contact Jennifer Throwe, Regional Administrator, at (617) 565-1158. I value your efforts toward improving the lives of older persons in New Hampshire.

Sincerely,

Alison Barkoff
Senior official performing the duties of the
Administrator and the Assistant Secretary for Aging.

Cc: Edwin Walker, Deputy Assistant Secretary for Aging
Amy Wiatr-Rodriguez, Director, Center for Regional Operations
Alice Kelsey, Deputy Director, Administration on Aging
Jennifer Throwe, Regional Administrator

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Message from the Bureau Chief

I am pleased to present New Hampshire's 2024-2027 State Plan on Aging. This State Plan serves as a roadmap to ensure advancement of the state's efforts in understanding, serving, supporting and celebrating older individuals across the state. This State Plan was developed by the New Hampshire Bureau of Elderly & Adult Services (BEAS) with input from the State Commission on Aging and numerous aging network stakeholders.

The Administration for Community Living (ACL), an operating division of the U.S. Department of Health and Human Services, is the federal agency responsible for administering the Older Americans Act (OAA). Federal priorities articulated by ACL, and combined with the State's priorities informed New Hampshire's aging network, create the framework for the State Plan.

The State Plan marks an opportunity to reframe how we view and approach aging and the healthy aging process. It gives us a chance to thoughtfully assess, and where needed, change our strategies as an aging network. It prompts us to rethink our approach to policymaking, service delivery, and investment decisions. At a time when our workforce is significantly constrained and our efforts to respond to the COVID-19 pandemic and future health threats are evolving, the need to act has never been more urgent.

The goals, objectives and strategies outlined in the State Plan reflect our commitment and dedication to our vision for New Hampshire to be a great place live as we age. One strategy the Bureau will explore in the first year of the State Plan will be to consider changing the name for the Bureau of Elderly & Adult Services (BEAS) to one that both reflects its ongoing commitment to understanding, serving, supporting, and celebrating older people and acknowledges the fact that names matter.

Research suggests using inclusive language of aging - as all of us are aging every day - creates a greater willingness by people to support policies and programs we all need to thrive at every age. Unfortunately, evidence suggests words like "elderly" can evoke negative stereotypes and images of frailty, dependence, uselessness, and burden.

As a leader within our state that strives to create a more balanced perspective, a name change that removes the word "elderly" from its title enables the Department to model language that acknowledges the many contributions that older people bring to society.

BEAS is honored and pleased to present the 2024 – 2027 New Hampshire State Plan on Aging. This State Plan addresses the opportunity to align, change and strengthen the work of BEAS within the service delivery system across the state, as well as the opportunity to transform how we collaborate with others to accomplish these goals. This State Plan will serve as a roadmap to address BEAS' continuing planning efforts and strategies to further advance NH's system of care for healthy aging in New Hampshire.

Sincerely,



Wendi Aultman, Bureau Chief





New Hampshire State Commission on Aging

June 27, 2023

Dear Colleagues,

I am pleased to endorse on behalf of the New Hampshire State Commission on Aging, New Hampshire's 2024-2027 State Plan on Aging. This comprehensive and actionable State Plan outlines approaches to improve Older American's Act and related services in New Hampshire. It will help create more opportunities for Granite Staters to maximize their health and well-being as they age. Older Americans Act services makes it possible for older adults, their families, caregivers, and persons with disabilities to have the autonomy of choice to age in place, living safely in their homes in our communities longer.

This State Plan was developed by the New Hampshire Department of Health and Human Services, Bureau of Aging and Adult Services with input from the New Hampshire State Commission on Aging, the New Hampshire Alliance for Healthy Aging, and numerous aging network stakeholders. The plan was guided by public input gathered through surveys and listening sessions. The plan is also influenced by the five federal priorities established by the Administration for Community Living (ACL) to whom each state submits their plan on aging to receive Older Americans Act funding to implement Older American's Act services. The five priorities are to: 1) advance equity 2) build caregiver infrastructure 3) expand access to home and community-based services 4) COVID-19 Pandemic recovery activities, and 5) support Older Americans Act Core Programs.

Our experiences since the onset of the COVID-19 pandemic have exposed both the strengths and weaknesses of the status quo. Themes emerging from the community data gathering in advance of developing this plan were different from previous years, with concerns for safety, access to health care, and increased experiences of social isolation being voiced. Our aging services workforce has never been more constrained. These are just a few of the signs of change that require all of us to rethink our approach to policymaking, service delivery, and investment decisions. The pandemic also exposed the fortitude of older adults and of the organizations that serve them, and the willingness of all people to come together to work on solutions.

I ask aging network partners—public and private; state and local; policy makers and advocates; past, current, and future—to maintain their commitment to older Granite Staters and caregivers by acting on this State Plan. While I ask for your commitment, I pledge the Commission on Aging's continued and renewed dedication to the priorities established herein and towards continued development and support of innovative programs and policy reforms. I am confident that, with thoughtful, aligned execution of this plan, and ongoing efforts towards continuous improvement, New Hampshire will become the best place to age in the nation.

Sincerely,

Susan Ruka, RN, PhD

Chair

New Hampshire State Commission on Aging

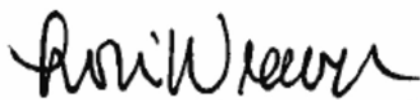
4th Floor Dolloff Building ♦ 117 Pleasant Street ♦ Concord, NH 03301 ♦ 603-271-0527



Verification of Intent

The State Plan on Aging is hereby submitted for the State of New Hampshire for the period of October 1, 2023 through September 30, 2027. Included are all assurances and plans to be implemented by the New Hampshire Department of Health and Human Services, Bureau of Elderly & Adult Services (BEAS), under provisions of the Older Americans Act of 1965 as amended. BEAS has the responsibility and authority to develop and administer the State Plan on Aging in accordance with all requirements of the Older Americans Act and is primarily responsible for the development of the comprehensive and coordinated services for older people of New Hampshire.

The State Plan on Aging for Federal Fiscal Years 2023 - 2027 hereby submitted has been developed in accordance with all federal statutory and regulatory requirements.



Commissioner - NH DHHS



Date



Chair – NH Legislative State Commission on Aging

6/27/2023

Date



Governor – State of New Hampshire



Date



Executive Summary

The New Hampshire Bureau of Elderly & Adult Services (BEAS) is designated by the NH Legislature as the State's Unit on Aging, under the Older American's Act (OAA) of 1965, as amended. Under this designation, BEAS has the responsibility, authority and opportunity to develop and administer the State Plan on Aging (SPOA) in accordance with all requirements of the OAA. The State Plan marks an opportunity to reframe how we view and approach aging and the healthy aging process. It gives us a chance to thoughtfully assess, and where needed, change our strategies as an aging network. It prompts us to rethink our approach to policymaking, service delivery, and investment decisions. All of which BEAS is dedicated to.

BEAS operates within the NH Department of Health and Human Services (DHHS), whose mission is "*to join communities and families in providing opportunities for citizens to achieve health and independence.*" Aligned with this mission, BEAS is responsible for the development of comprehensive and coordinated services for older adults, ages 60 and older, and adults with disabilities, who are 18 years old or older. Per OAA, BEAS prioritizes these services to those individuals with greatest economic and social needs, and to NH's most vulnerable older adults.

BEAS works with federal, state and local agencies, service providers, the private, volunteer and business sectors and constituent groups to collectively plan and coordinate a person-centered service delivery system. Contracting and collaborating with these entities helps the Bureau to develop, coordinate and deliver needed services to eligible older adults and adults with disabilities.

The population of older people in NH is growing and changing rapidly. The aging service delivery system across NH is working hard to respond to and plan for these changes. By the year 2030, it is estimated that over one-third of NH's population will be over 65 years of age. The increasing number and percentage of older people in the state presents significant challenges and opportunities for State leadership, service providers, community organizers and the aging population to *come together* to address these issues.

One of the most important ways that NH is serving and supporting older adults is through the SPOA. The SPOA is developed every four years, and is a federal requirement under the OAA. In order for NH to receive OAA funds to serve and support older people across the state, BEAS must complete a SPOA, which includes program overviews, public input, federal assurances, state planning reports, goals and objectives, and a proposed annual budget for each of the four years. It is a plan to guide how the State of NH will deliver the core foundation OAA programs to older people in NH.

BEAS began a planning process by inviting a diverse group of statewide leaders from our Governor appointed, State Commission on Aging and our partners at the Alliance for Healthy Aging to *come together* and serve on a SPOA Planning Committee. The goal of the SPOA Committee was to "develop a four-year plan that helps to guide our state's efforts in understanding, serving, supporting and celebrating older adults across the state."

The SPOA Committee worked closely with the BEAS Executive Team and the State Commission on Aging (NHCOA) on the development of a 34-question survey, and the coordination of 10 listening sessions; 5 listening sessions were conducted in the communities across the state and 5 listening session were held virtually. This outreach campaign engaged over 1,135 individuals from a broad array of people in the community older adults, caregivers and family members across New Hampshire – all helping to inform the development of the SPOA.



Our partner at the Alliance for Health Aging helped us distill the large amount of feedback gathered from the survey and listening sessions. The feedback garnered from the community listening sessions was correlated and summarized by BEAS staff and the UNH Institute on Disability and Center on Aging and Community Living. The SPOA Survey and Listening Session Analyses provided critical information that was used to guide the development of the SPOA. BEAS also encourages service providers and community agencies to use this information in their own local efforts to better understand, serve, support and celebrate aging in NH.

The four-year SPOA period is October 1, 2023 through September 30, 2027, and represents an annual budget of approximately \$23 million in support of programs that deliver services and supports to tens of thousands of older people, caregivers and family members across the Granite State.

Since the writing of the last SPOA in the spring of 2019, a great deal of collaboration and work has been accomplished; all in support of serving and supporting older adults in NH.

- Eight (8) months after finalizing our SPOA in 2019, NH and our entire country was faced with the Covid-19 Pandemic and the declaration of a Public Health Emergency both on the federal and state level, which required BEAS to work closely with its service providers in order to quickly adjust service provisions in a way that promoted the safety and well-being of our communities.
- Brought NH Aging Community together with NH Council on Developmental Disabilities. In doing this, it was discovered that they are working on many of the same initiatives and goals. From there, the Executive Director of the NH Council for Developmental Disabilities has joined NH Alliance for Healthy Aging and actively participated on Sub-Committee.
- Prior to the Covid-19 pandemic, the Chronic Disease/Pain Self-Management Network began work to connect and develop a partnership with NH's Managed Care organizations to work with them regarding our Self-Management Programs. During the pandemic that work had halted, but is now beginning to work towards that goal. Also since then, BEAS has connected Chronic Disease/Pain Self-Management Train the Trainer Network with NH Center for Independent Living (CILS) Network. Chronic Pain/Disease Self-Management Network Master Trainers conducted a Train the Trainer of CIL's staff in order to provide Self-Care workshops through their Health and Wellness networks & events.
- Solidified a working partnership between DHHS' Division of Public Health Services (DPHS) and Falls Prevention Awareness Network, where they are working together on Tai Ji for Arthritis with the local YMCAs. Currently, plans are in motion for that program to move into senior centers as part of their regular exercise programs.
- As an active member of NH Falls Prevention Taskforce, BEAS has connected with Refugee populations in Manchester, NH through the Victory Women of Vision, which is a 501(c)(3) nonprofit dedicated to helping immigrants and refugees resettle in their new homes in NH. The Taskforce Master Trainers conducted a "train the trainer" training for refugees 60+ years of age.
- NH has a robust network of community-based organizations that integrate their efforts on the community level. These organizations bring tremendous strengths, resources and experience to bear



on the issues presented by our growing population of older persons.

- BEAS launched an Expanded Personal Emergency System (PERS) Program, which in addition to personal emergency repose system, program offers other assistive equipment required for folks to be safe in their home including hearing and vision assistive equipment.
- In promotion of aging in place, BEAS launched a statewide Home Modification and Repairs Program (pilot). The pilot program started in December of 2022 and it was quite clear from the beginning that the need in NH is great. BEAS is now in the process to identify and secure funding for this program to continue beyond the current contract, as the need is only increasing as the housing crisis continues and our population ages.
- BEAS have staff participate in “Project Visibility” training, which is focused on creating inclusive communities for LGBTQ+ older adults. BEAS has encouraged our ServiceLink contractors to display inclusive signage as a way to be culturally responsive service providers or community members. BEAS recognizes that because they fear discrimination, neglect and even violence, LGBTQ+ seniors are five (5) times less likely to access services (Boulder County Area Agency of Aging).
- BEAS has started a connection with the NH Ryan White CARE Program. The Ryan White CARE Program provides a network of medical care, as well as, providing support for identified needs for people living with HIV. The goal of this partnership is to enhance our efforts to bring our Chronic Disease & Self-Management Evidenced-Based programs to our older adult HIV/AIDS population in NH.
- An ongoing BEAS priority is to ensure that the state’s system of care for long-term services and supports has the capacity and flexibility to meet the needs of older people, caregivers and family members. BEAS is making continuous progress, while working to keep pace with effective approaches to align quality, comprehensive, holistic, integrated, and cost-effective services for older people and older people with disabilities.

Inclusive Space



This space
RESPECTS
all aspects of people including age, gender, race,
ethnicity, religion/no religion, national origin,
language, education, marital status, body size,
political affiliation/philosophy, sexual orientation,
gender identity-expression or variance,
physical and mental ability, social-economic status,
genetic information and HIV and veteran status

As BEAS works to strengthen leadership, partnerships, and service delivery, there is recognition that some State policies and cultural ideas about aging are outdated within NH’s government structure. It is also important to note that the funding received from ACL has not kept pace with the significant older adult population shifts taking place in NH. The lack of needed funding is creating significant challenges and barriers for BEAS, service providers and community organizations in providing needed services and supports for older adults in NH. Notably, our state continues to rank amongst the lowest for states in the percentage of Medicaid dollars invested in home and community-based supports. While NH has one of the fastest growing number of older adults in the country, we are nearly last in offering a balanced system of care. Moving forward, BEAS looks forward to partnering with NH and federal leadership in tackling these issues.



Despite funding challenges, BEAS, service providers and community organizations have continued to provide the core foundation programs of the OAA to older people, caregivers and their families. In addition to providing these core programs, BEAS, in partnership with the SPOA Committee, SCOA and ACL, has identified the following additional “sustainment and improvement” goals within this State Plan:

1. Support older people to stay active and healthy;
2. Promote person-centered thinking and practices;
3. Ensure the rights, safety, independence and dignity of older people and prevent their abuse, neglect and exploitation; and
4. Advance age-friendly communities.

NH’s core foundation programs of the OAA, along with the goals identified above, will address the following outcomes:

- *Older people and their family members looking for long-term supports and services will be able to access help, guidance, support and choice.*
- *Older people, caregivers and families will have access to person-centered care and planning regardless of where they access the service system.*
- *Family caregivers of older people will be informed, and have the supports they need.*
- *Older people will have reduced risk of abuse, neglect or exploitation, and live in safety and dignity.*
- *Older people will have greater resources and supports to reduce the risk of loneliness and isolation.*
- *Older people will be educated and informed regarding Medicare and its options, helping to reduce fraud, errors and abuse.*
- *Older people, caregivers and families will be better educated and informed regarding emergency preparedness and planning.*
- *Services and supports for older people, caregivers and families will be inclusive of all diverse populations, and will serve all populations with respect and dignity.*

BEAS is honored and pleased to present the 2024 – 2027 New Hampshire State Plan on Aging. This State Plan addresses the opportunity to align, change and strengthen the work of BEAS within the service delivery system across the state, as well as the opportunity to transform how we collaborate with others to accomplish these goals. This State Plan will serve as a roadmap to address BEAS’ continuing planning efforts and strategies to further advance NH’s system of community based long-term care services.



New Hampshire's Landscape and Environment

New Hampshire (NH) covers 8,968 sq. miles, 90% defined as rural. In 2020, NH had approximately 1,377,530 residents, with 509,527 (or 37%) living in rural areas. In 2019, NH's median age was 43, and 19% of the population (~248K people) were 65 or older, making it the 3rd oldest state in the nation, after a 43% growth in older adults between 2008 and 2018. In 2016, NH's Office of Energy and Planning estimated that by 2040, 33% of residents will be 65 or older.

Demographers at the University of New Hampshire (UNH) believe this population shift is primarily driven by large cohorts of "Baby Boomers" (~389,000 residents) who reached their 50s and 60s by 2015. However, this shift in the population age structure is not occurring evenly; the more rural counties of northern and central NH have a more significant proportion of residents aged 65 or older than other regions. Residents of NH's rural communities are more likely to be uninsured, of low-income, older, or disabled, than non-rural residents.

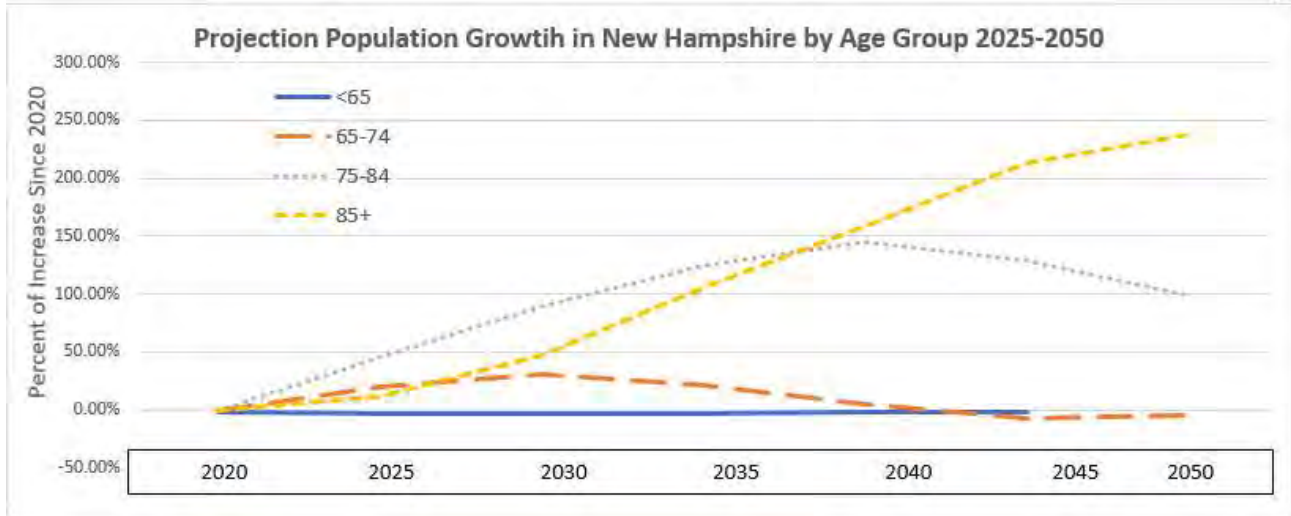
One important consideration is that the number of older adults will increase rapidly in the next two decades. In 2019, the two large baby boom cohorts in their 50s (207,000 residents) and the two in their 60s (189,000 residents) represented nearly 30 percent of New Hampshire's population. These cohorts were larger than the population age 70-79 in 2019. Although mortality and migration will modestly diminish these baby boom cohorts over the next few years, the vast majority will celebrate their 70th birthdays in New Hampshire. As a result, the state's older population will more than double over the next 20 years.

As NH ages, it grows more racially and ethnically diverse, heralding the need for programs and services to become more culturally and linguistically appropriate. In a 2015 report, the NH Center for Public Policy Studies estimated that among the state's 1.3 million residents, approximately 75,000 were foreign-born. In 2018, while 90.5% of the state's population was non-Hispanic white, nearly 10% came from communities of color. The current State Plan on Aging (SPOA) notes that 12% of people of color are 60 years of age and older; these residents have incomes below the poverty level. Furthermore, the overall population is living longer, including individuals that identify as LGBTQ. The Williams Institute at UCLA estimates that 4.7% of adults in NH are LGBTQ, suggesting that between 4 and 5% of NH's older adults are also LGBTQ. Moreover, the rates of Alzheimer's disease and other dementias and the rates of disability among older adults are increasing. In NH, the percentage of adults impacted by Alzheimer's disease is expected to rise by 33% between 2018 and 2025 to 32,000 people.



Projection Population Growth in New Hampshire, by Age Group, 2020-2050

Data Report: 2023 NH Department of Business and Economic Affairs - Office of Planning & Development



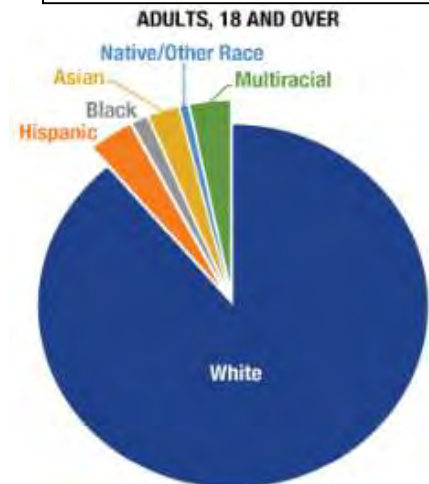
The population of the New Hampshire is projected to reach 1,501,909 by the year 2050. This projection represents an increase of just over 124,000 or 9.0 percent from the 2020 Census population count of 1,377,533. In 2030, the state population is projected to be 1,473,285, and in 2040 the population is projected to increase to 1,511,770, followed by a decline to 2050.

Increasing Diversity

Data from the 2020 Census show that New Hampshire is 87 percent non-Hispanic white, making it the state with the fourth-highest share of white residents nationwide. Minority residents now represent 12.8 percent of the state's population compared to 7.5 percent (101,400) in 2010. Though the minority population grew, a substantial majority of the state's population remains non-Hispanic White. In all, 87.2 percent of state residents (1,200,600) reported to the Census Bureau that they were White alone and not of Hispanic origin on the 2020 Census. This is 14,400 fewer than in 2010.

Hispanics are the largest minority population in New Hampshire with 59,500 residents, or 4.3 percent of the population. The non-Hispanic Asian population is 35,600 (2.6 percent), and non-Hispanic Blacks number 18,700 (1.4 percent). These groups each had significant population gains between 2010 and 2020. The largest population gain was among multiracial non-Hispanic residents, who at 54,600, now represent 4 percent of the state. The population reporting that they were Native American or of "some other race" also increased; together, these two groups now represent 0.6 percent of the state's population.

New Hampshire Population by Age, Race, and Hispanic Origin, 2020



New Hampshire Healthy Aging Data Report 2019

WHERE YOU LIVE MATTERS

About 37% of NH's population lives in rural areas. Older people in rural areas often have greater needs – and less access to the services needed to diagnose, treat acute illness and manage chronic disease.



Cities had the:

- ↓ lowest disability rates
- ↑ highest serious & complex chronic disease rates



Towns had the:

- ↓ lowest serious & complex chronic disease rates
- ↑ highest disability rates



Rural communities had the:

- ↓ lowest indolent chronic conditions rates (which progress slowly and cause little pain)
- ↑ high serious & complex chronic disease rates

Healthy Aging Data Report

The NH Healthy Aging Data Report of 2019 continues to be the lead source for the examination of the health of older people in NH, with detailed profiles for 244 cities and towns, plus maps to understand healthy aging trends and disparities throughout the state. NH has a growing population of older people, with over 20% of residents aged 60 or older. How we age is influenced by where we live, how we work, the health care we receive, and our experiences of daily living. NH is the 3rd healthiest state for older people in the country—but not for everyone. There are disparities by zip code and gender. All Granite Stators should have the opportunity to access a wide range of choices to promote good health, dignity and independence as we age. Prepared by researchers at the University of Massachusetts, Boston and funded by the Tufts Health Plan Foundation, this report provides information to assist cities and towns in making positive changes to adjust to the aging population. The data in this report can also inform community and state-level decisions about economic development, public health, housing development and transportation. The NH Healthy Aging Data Report 2019 and future reports created by Healthy Aging Data Reports will continue to help BEAS to advance its goals, objectives and strategies as it plans for an aging population, which is scheduled to be updated by early 2024.



BEAS Organizational Structure and Service Delivery

The Bureau of Elderly & Adult Services (BEAS), NH Department of Health and Human Services (DHHS)

The Division of Long Term Supports and Services (DLTSS) was established in the fall of 2017 and aligns a number of services and programs with shared goals of enhancing and integrating the services available to older people and others. These realigned programs include: the Bureau of Elderly & Adult Services, the Bureau of Developmental Services and the Bureau of Family Centered Services.

BEAS' Central Office is located in the DHHS Central Administration building in Concord. The Central Office is responsible for administrative functions, program and policy development, contract development and monitoring, budget development and financial planning. BEAS also includes District Offices, located in each of NH's ten counties. These BEAS District Offices are located within the larger DHHS District Offices, ensuring that BEAS programs have a local presence, partnerships are established in local communities, and services are delivered locally.

BEAS contracts with a variety of service providers and vendors to develop, coordinate and deliver services to eligible older adults and adults with disabilities. The programs and initiatives described below constitute an integrated and collaborative framework for community-based services in NH.

The ServiceLink Aging and Disability Resource Center and NHCarePath. ServiceLink is a program of BEAS, known throughout the community as the ServiceLink Network. There is at least one ServiceLink location in each of NH's ten counties, covering the state, totaling thirteen offices. Each ServiceLink is a fully functioning Aging and Disability Resource Center (ADRC) and serves as a BEAS/DHHS No Wrong Door full service access partner, known as NHCarePath. ServiceLink helps individuals access and make connections to long-term services and supports, family caregiver information and supports, explore options, and understand and Medicare and Medicaid. ServiceLink also administers programs and services such as Information Referral and Assistance, Options Counseling, NH Family Caregiver Program, State Health Insurance Assistance Program (SHIP), and Senior Medicare Patrol (SMP).

NHCarePath builds on the ServiceLink functions, while serving as the State's full service access partner. NHCarePath integrates locally based community partners to work collaboratively to ensure individuals receive guidance, support, and choice, and to ensure a consistent experience for individuals seeking assistance. Multiple statewide partners work together as part of NHCarePath, including the NH DHHS, ServiceLink Network, Area Agencies offering developmental services, and Community Mental Health Centers.

Adult Protective Services (APS) - provides social work assessments, case management services and investigations of alleged abuse, neglect, self-neglect, and/or exploitation of a vulnerable adult, or perpetrator-based abuse under the NH Protective Services Adult Law, RSA 161-F: 42. These services are provided by a professional staff of over 60 employees in a Central Intake Unit, State Registry Unit, and eleven District Offices statewide.

The Office of the Long-Term Care Ombudsman (OLTCO) - represents the interests and concerns of older adults residing in NH's long-term care facilities; and represents and advocates on their behalf. OLTCO is administratively attached to DHHS under the Office of the Commissioner. The OLTCO is programmatically independent of it and mandated by both State law (RSA 161-F: 10-19) and federal law (42 U.S.C. 3058g).



Community Based Program Administration Unit - supports the DLTS in overseeing the development and implementation of long-term services and supports (LTSS) programming, policies, and procedures in part, related to OAA funding, Medicaid funded LTSS, and other public funds directed to DLTS. The Community Based Program Unit develops Long Term Care Policy, monitors operational activities, and explores opportunities for funding and partnerships that support and inform improvements and future planning efforts.

Choices for Independence and Nursing Facility Program Administration Unit - is responsible for determining clinical eligibility for Medicaid-funded nursing home care, and home and community-based services provided through the 1915(c) Home and Community Based Choices for Independence (CFI) waiver. BEAS and the Bureau of Family Assistance (BFA) have an integrated team that processes and administers the Medicaid Long-Term Care (LTC) eligibility and services.

Information Technology (IT) Unit: - supports the Options information system utilized by over 240 users, to manage the BEAS social worker caseload, the Adult Protection Program and the State Registry. Social Service authorizations and provider payments related to the Social Services Block Grant and Older Americans Act services are processed in Options. Client case information and service authorizations for the CFI waiver are managed in DHHS' New Heights System, and supported by the unit.

Money Follows the Person Unit - The Money Follows the Person (MFP) Demonstration supports state strategies to rebalance LTSS systems from institutional to community-based care. The goals of the demonstration are to increase the use of home and community-based services (HCBS) and reduce the use of institutional services, eliminate barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to enable Medicaid-eligible individuals to receive support, strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions, and put procedures in place to provide quality assurance and improve HCBS.

Independent Providers - BEAS contracts with independent service providers in providing a variety of community and long-term supports to adults ages 60 and older and to adults with disabilities between the ages of 18 and 59.



State Plan on Aging Development

As part of the development of the State Plan on Aging 2024-2027, the Bureau Elderly & Adult Services (BEAS), NH Department of Health and Human Services (DHHS), in partnership with the NH State Commission on Aging (SCOA) and the NH Alliance for Healthy Aging (NH AHA) held 10 community listening sessions, as outlined below, to hear what older adults think about what is working and what is not working in the community as it relates to aging.

To increase access, efforts were made to hold both in-person and virtual listening sessions. In-person sessions were held in different regions across the state and in local settings where older adults congregate (i.e., senior centers, community centers). Virtual listening sessions utilized a widely known software platform (i.e., Zoom) and hosted both computer and phone-in options. Virtual sessions were held at varying times to accommodate stakeholder schedules. Participation in the listening sessions varied across a wide range of stakeholders and included older adults and their families, service providers, aging researchers, policy makers, state employees, and others. Combined, the 10 sessions included 180 stakeholders.

The discussion and feedback from these sessions focused around five major questions. Throughout the sessions, several recurrent successes and concerns were shared as summarized below.

- What is working well in your community as it relates to aging?
- What is not working well in your community as it relates to aging?
- How can NH better serve and support its aging population today and in the future?
- What do you need to continue living in your home as you get older?
- What can we do to reduce isolation for older adults in NH?

As a starting point, BEAS invited representatives of the NH Alliance for Healthy Aging (NHAHA), a statewide coalition of greater than 480 stakeholders focused on the health and well-being of older people in NH, and the NH Commission on Aging (NHCOA), established to advise the governor and the general court on policy and planning related to aging, to come together and serve on the State Plan on Aging (SPOA) Planning Committee. This SPOA Committee representation allowed for input from both statewide initiatives with the goal to develop a four-year plan that aligns with and can be supported by both initiatives.



In their role as backbone to the NH Alliance for Healthy Aging, the University of New Hampshire Center on Aging and Community Living provided analysis of the survey.

Data collection began on December 8, 2022 and concluded on February 24, 2023. The survey was promoted across the state by BEAS, NHAHA, and NHCOA as well as by their respective partners, through flyer (electronic and paper) distribution, social media, and email. BEAS also issued press releases announcing the survey and listening sessions as well as provided information on their website (<https://www.dhhs.nh.gov/programs-services/adult-aging-care/new-hampshire-state-plan-aging>). All partial survey responses were included for survey analysis with a total of 955 individuals answering at least one question, and 755 individuals completing the survey in its entirety.



New Hampshire State Plan on Aging

2024-2027 –Goals, Objectives & Strategies

This plan’s goals and objectives are influenced by 5 federal priorities established by the Administration on Community Living (ACL):

- Advancing Equity
- Building a Caregiver Infrastructure
- Expanding Access to Home and Community Based Services
- Recovering from the COVID 19 Pandemic
- Supporting Older Americans Act Core Programs

Goals

1. Advance age-friendly communities;
2. Ensure the rights, safety, independence and dignity of older people and prevent their abuse, neglect and exploitation;
3. Support older people to stay active and healthy; and
4. Advance equity and person centered thinking and practices.

Goal 1: Advance age-friendly communities:

Objective 1.1 - Support transportation options that connect older adults to healthcare, daily activities and community involvement.

Strategies:

- Explore and review current transportation funding, programs, and infrastructure within BEAS, DHHS, NH Department of Transportation (DOT), service providers, State, regional and local agencies.
- Collaborate with the State Commission on Aging, State Coordinating Council (SCC), Regional Coordinating Council (RCC), NH Alliance for Healthy Aging (NH AHA), Regional Planning Commissions (RPCs), NH State Library, Regional Coordination Councils, places of worship, ServiceLink, YMCAs, American Association of Retired Persons (AARP), and other adult-related organizations to strengthen transportation access, options and supports.
- Enhance outreach, education and transportation service delivery by funding and supporting mobility management strategies within Regional Coordination Councils throughout the state.
- Formalize a partnership between DHHS, NH DOT and NH 211 to ensure that 211’s database of providers is updated and capable of more easily assisting users, callers or website users seeking transportation services.
- Recommend to DHHS that a BEAS staff person represent DHHS and BEAS on the State Coordination Council for Community Transportation (per RSA 239-B), working towards a successful coordination of transportation services.
- Work with regional Mobility Managers to support the enhancement of NH’s Volunteer Driver program.

Objective 1.2 - Encourage the promotion and development of different affordable housing options for older adults and those who care for them.



Strategies:

- Partner with the State Commission on Aging and other community organizations in exploring diverse housing policies and programs that allow older adults unique and affordable housing options.
- Encourage the development of Home Share networks (such as the Home Share Program being developed at the Gibson Center in North Conway).
- Partner with the Bureau of Housing Services (BHS), Division for Behavioral Health and NH DHHS to strengthen collaboration between BEAS and BHS, ensuring that a focus on older adults and older adults with disabilities is included in programming, services and supports.
- Explore opportunities to share resources and strengthen collaboration with the NH Housing Finance Authority, local Housing Authorities and the NH's Council on Housing Stability.

Objective 1.3 - *Reduce loneliness and isolation by improving opportunities for social connectedness for people who are aging.*

Strategies:

- Support leadership engagement within the network of aging services to ensure that training, technical assistance and informational needs including those related to diversity and inclusion are identified within planning and service areas.
- Collaborate and partner with the DHHS' Office of Health Equity and other state and local organizations serving diverse populations to better inform the service network of inclusion issues; share network resources to reach out to diverse populations where they live and connect with others on services available.
- Work with local and national partners to develop strategies to address loneliness and isolation and provide engagement opportunities throughout NH.
- Collaborate with state technology programs and providers to advance technology solutions that can play an important role in minimizing social isolation.
- Educate Meals on Wheels providers on isolation/loneliness in order to have this network of providers share information on programs/services that might help to reduce isolation/loneliness.
- Improve adequate internet and technology access to allow for virtual engagement through telehealth, online web platforms, and other technologies.
- Improve coordination between Operation ABLE and their Senior Community Service Employment Program (SCSEP) and other OAA programs by leveraging the aging network to promote SCSEP and professional growth opportunities such computer classes, local community college and technical education programming in order to better utilize the mature worker population to expand workforce and promote social connectedness.

Objective 1.4 – *Encourage and support progress towards improving community conditions for older Granite Staters.*

Strategies:

- Educate service providers, State Agencies, community groups, older adults and the general public regarding the increasing number of older adults who live alone, including possible risk factors of isolation. Use the NH Healthy Aging Data Report as a resource in providing this education.



- Explore opportunities to strengthen supports (for individuals who are isolated) with the NH Community Action Programs, NH Coalition of Aging Services (NCOA), NH Council on Churches and other community organizations.
- Explore and support opportunities to increase access to broadband internet connectivity statewide.
- Explore opportunities to improve capacity to support intergenerational approaches to serving older adults with YMCAs, town recreation departments, NH State Library and other community stakeholders.
- Partner with Senior Centers across NH in the development of new ideas to strengthen participation at senior centers, using the NCOA resources to modernize senior centers, re-establishing a senior center/senior programming professional network within New Hampshire.
- Collaborate with the NH DHHS Office of Health Equity to strengthen language/communication access for those individuals with hearing loss or hearing challenges and limited English proficiency.
- Expand BEAS Personal Emergency Response services to include assistive technology tools and resources.
- Partner with the State Commission on Aging and the Bureau of Mental Health Services on exploring opportunities to better align the State Plan on Aging and the 10-Year Mental Health Plan, with a goal of strengthening services and supports to older adults throughout NH.
- Partner with the NH DHHS Bureau of Mental Health Services on applying to the National Council on Aging to receive approval of the Referral, Education, Assistance and Prevention (REAP) program as an evidence-based program that in turn would be eligible for funding under Title IIID.
- Establish evaluation methods to show effectiveness of the Grab-n-Go (home-delivered meal service option) and Restaurant Voucher Program (congregate meal service option) in expanding and maintaining participation and supporting socialization of older adults.
- Collaborate with NH's Alzheimer Association to promote awareness, early detection of and strategies to reduce social isolation concerns for older adults statewide.

Objective 1.5 - Prioritizing investments and opportunities that will advance age friendly communities.

Strategies:

- Explore system change options that assist people who are dually eligible for both Medicare and Medicaid.
- Working with the Division of Program Quality and Integrity, improve the Medicaid provider outreach and enrollment process and develop a user-friendly provider enrollment manual.
- Identify improvement opportunities to integrate means to address social determinants of health into the health services and supports someone is receiving.
- Identify national best practices, review recommendations for implementation, and develop a plan for amending policy and administrative rules.
- Participate in workforce improvement initiatives, through greater collaboration with workforce projects and partnerships across the state.
- Explore opportunities to improve capacity for other community-based services, such as Adult Day Health Programs.
- Collaborate with the NH Commission on Aging in the development of a NH Multi-Sector Plan on Aging in order to help align priorities and develop other strategies that are not addressed by the NH State Plan on Aging.



Performance Measures:

- Continue to work towards adding all transportation resources to the 2-1-1 database by the end of year one, and annually update the database each following year.
- Volunteer driver programs will have increased the geographies served in New Hampshire using July 2023 as a baseline.
- Will reestablish a NH Association of Senior Centers or a similar provider association.
- Continue to partner with NH Alliance for Healthy Aging to continue to promote older adult initiatives in NH.
- Establish a baseline for the number of older adults and older adults with disabilities who access transportation, by the end of year one.
- Increase the number of older adults and older adults with disabilities who access transportation by the end of year two.
- Increase the number of service providers enrolled to provide Medicaid funded LTSS by the end of year one.
- Publish a provider manual for Medicaid Community Based LTSS by the end of year two.

Goal 2: Ensure the rights, safety, independence, and dignity of older people and prevent their abuse, neglect and exploitation:

***Objective 2.1** - Change the Name of the Bureau of Elderly and Adult Services in efforts to counter ageism and elevate awareness of ageism.*

Strategies:

- Continue to work with Department Senior Leadership to finalize the name change for the Bureau.
- Develop an outreach and communication plan to broadcast the new name of the Bureau.
- Identify resources to implement the name change to educational and programmatic materials related to the Bureau.
- In year two (2), implement the outreach and communication plan.

***Objective 2.2** - Strengthen Adult protection through greater awareness, collaboration, and response.*

Strategies:

- Provide training and technical assistance to law enforcement officials and service providers with a goal of increasing awareness of adult abuse, including what to look for and how to respond.
- Attend and support Elder Wrap meetings across the State, partnering with service providers and community groups to share resources and identify solutions for “hard to resolve, at risk” older adult situations.
- Strengthen the efficiency and delivery of services by participating in the LEAN process for the data management system within our Options system.
- Partner with the Bureau of Developmental Services in exploring opportunities to integrate reports for adult protective reports with reports from developmental services.
- Strengthen outreach to those who come into contact with older people on a daily or regular basis, including mail carriers, bank clerks, hairdressers, healthcare workers, senior center staff and volunteers, as well as those individuals who are on the front line.



Objective 2.3 - *Serve as an effective advocate for nursing home, assisted living and residential hospice care residents.*

Strategies:

- Provide education and support to the certified long-term care ombudsmen volunteers and volunteer candidates, including relevant topics such as Person Centered Care (PCC), and culturally effective care.
- Provide education and consultation to residents, staff members, resident’s family members and other individuals on issues affecting residents in long-term care facilities.
- Support residential empowerment and family support through assisting in the development and technical support of resident and family councils.

Objective 2.4 - *Promote prevention efforts to protect vulnerable older adults against financial exploitation.*

Strategies:

- Partner with NH Legal Assistance, NH Department of Justice, Office of Attorney’s General, AARP, Senior Medicare Patrol, Law Enforcement and others in providing education and resources regarding financial exploitation.
- Collaborate with the NH DHHS Public Information Office and statewide media partners in providing greater awareness of financial exploitation, and recommendations on how to prevent financial exploitation.
- Continue to support collaboration between Adult Protective Services and the NH Department of Justice, Office of Attorney General.

Objective 2.5 - *Partner with the NH Department of Public Health Services (DPHS) Emergency Preparedness, Response and Recovery, ServiceLink Network, Regional Public Health Network and other community organizations in strengthening emergency services and preparedness.*

Strategies:

- Support the identification of up to five possible regional disaster shelters that provide accessibility, capacity, public transportation, and other needed criteria as outlined by the American Red Cross.
- Support the development of Shelter Assessment Teams comprised of representatives (at a minimum) from: the shelter facility, American Red Cross, local first responders, and DHHS Emergency Preparedness, response and Recovery officials.
- Support shelter operations training that includes: communication access, assistance animal considerations, discharge planning, and personal preparedness unique to the older people and disabled population within the community.
- Collaborate with the DPHS’ Bureau of Emergency Preparedness, Response and Recovery, ServiceLink Network, Regional Public Health Network, older adult volunteer groups (such as Senior Corps), and other community members in the promotion and support of trainings.
- Expand our information/educational resource outreach to include “StayConnectedNH” and New Hampshire FAST, whose mission is to increase public awareness of financial exploitation and Protecting our State’s vulnerable populations.



Objective 2.6 - Promote Advance Directives and End of Life Care planning.

Strategies:

- Partner with the Foundation for Healthy Communities and the NH Home Care, Hospice and Palliative Care Alliance, as well as other community organizations in identifying opportunities to better integrate End of Life planning in BEAS programs and services.
- Explore and promote educational opportunities regarding Advance Directives as part of PCC, including but not limited to, how to access support for Advance Directives and understanding the rules the govern end of life care.
- Collaborate with the Foundation for Healthy Communities, NH Home Care, Hospice and Palliative Care Alliance and ServiceLink to assess the knowledge and abilities of NH individuals and/or organizations to help facilitate discussions with individuals regarding advance care planning discussions.

Objective 2.7 - Elevate awareness of ageism, while promoting the reframing of aging.

Strategies:

- Align program work and messaging with the vision and work of the NH Alliance for Healthy Aging.
- Use Reframing Aging language across BEAS program areas and projects - starting with this SPOA.
- Educate and partner with the NH DHHS Public Information Office on using Reframing Aging language in communications, messaging and media to support healthy aging in NH.

Goal #2 - Performance Measures:

- Increase the number of educational and training sessions to nursing home and assisted living facility staff by 10% each year, beginning at the end of year two.
- Increase the number of organized family councils within nursing homes by 10% each year, beginning at the end of year two.
- Coordinate two meetings per year with the NH Healthcare Decisions Coalition, NH Foundation for Healthy Communities and other community organizations as needed to identify opportunities to better integrate End of Life planning in BEAS programs and services, beginning at the end of year one.
- Increase the number of educational presentations given to service providers and community groups regarding adult protection by 5% each year, beginning at the end of year one.
- Increase outreach, trainings and support to communities regarding emergency preparedness and planning, beginning at the end of year one.
- Increase the number of financial exploitation trainings each year, beginning at the end of year one.
- Ensure that BEAS staff (as part of staff orientation) are exposed to Reframing Aging tools, as well as participate in trainings.
- Participate in Ageism Awareness events (trainings/conference workshops) at least 4 times per year.

Goal 3: Support older people to stay active and healthy and strengthen Older American Act core programs:

Objective 3.1 - Promote greater awareness and understanding of services and programs across the state.



Strategies:

- Collaborate with the NH State Library, NH Council on Churches, Senior Centers, Parks and Recreation/Community Centers, YMCAs, health clubs, and other community organizations frequented by older adults in promoting the ServiceLink Aging and Disability Resource Centers, OAA core programs & services, and other state and federal programs.
- Promote greater awareness, education and resource sharing through continued updates to the ServiceLink and NHCarePath database of services on both websites, as well as, the NH DHHS website.
- Hold monthly meetings of the ServiceLink leadership staff, ensuring consistency in services, protocols and practices, while focusing on person-centered care, care transition services, and community collaboration.
- Collaborate with NH DHHS Division of Public Health Services (DPHS), Bureau of Family Assistance (BFA) and Division of Administrative Services (DAS) nutrition programs through the Food and Nutrition Security Inter/Intra Agency Workgroup that was established during the Covid-19 Public Health Emergency to improve program awareness, expand participation and improve nutrition security.
- Partner with the DPHS to strengthen screening for fall-related Traumatic Brain Injury (TBI) and the services and programs to support individuals who are experiencing TBI.
- Collaborate with the Office of Health Equity in order to maintain and improve appropriate utilization of communication access.
- Develop marketing and outreach plans for NH's Aging & Disability Resource Center network (ServiceLink).
- Include performance data on Older Americans Act funded services in the design of the Systems of Care for Healthy Aging data dashboard.
- Explore the adoption of screening tools to identify health factors, including immunization status, dementia, fall-related TBI, and suicide.

Objective 3.2 - Reduce hunger, malnutrition risk and social isolation by strengthening food and nutrition security and social supports for older adults through home-delivered meals, congregate meals and supplemental foods.

Strategies:

- Promote access to nutritious food and opportunities for physical activity that support healthy aging.
- Continue to work with Meals on Wheels New Hampshire, Division of Public Health Services (DPHS) and the Bureau of Family Assistance (BFA) in reviewing the population health statistics to better identify gaps and opportunities for strengthening outreach and expanding nutrition programs.
- Partner with the Meals on Wheels New Hampshire (MOWNH), NH Community Action Programs and DPHS in exploring opportunities to increase meal participation for older adults with greatest economic and social needs, including a focus on low-income older adults, low-income minority older individuals, older adults with limited English proficiency, and older adults residing in rural areas.
- Partner with Meals on Wheels New Hampshire, and ServiceLink in the development of new ideas to better define and promote senior centers and community centers, including possible rebranding of senior centers and meals sites, and broadening outreach to diverse populations.



- Collaborate with the MOWNH, DPHS and ServiceLink in the development of creative and broad promotion/programming of home-delivered meals, congregate meal sites and supplemental food programs. Messages will promote benefits such as door-to-door transit to Congregate Dining Programs, local farmer's markets (for fresh fruits and vegetables), and opportunities to reduce isolation and improve access to information.
- Coordinate with DPHS, Meals on Wheels New Hampshire to continue to strengthen assessment and reassessment tools, and procedures to ensure priority is given to target population under Title III and outlined in SPOA.
- Leverage Adult Protective Service Workers to expand malnutrition risk and food insecurity screening and referrals by providing training, resources, consultation, and collaborating with MOWNH for tool development and universal application.
- Continue to partner with the DPHS by maintaining a working relationship with other state programs that support nutrition, food insecurity and healthy aging across NH.

Objective 3.3 - Support the work of the No Wrong Door (NWD) System of Access for LTSS to strengthen integration and outcomes in providing guidance and support to older adults in NH.

Strategies:

- Meet at least quarterly with NWD/NHCarePath partners, including Community Mental Health Centers, Area Agencies (who serve individuals with developmental disabilities), DHHS District Office Teams, ServiceLink, hospitals, local Delivery Networks, VA staff and other key stakeholders to: review data collection capacity, create data teams, identify information system gaps, and develop methodology.
- Work with NWD Grant recipient to strengthen the NWD Governance structure in New Hampshire
- Use the NWD Governance Grant Plan as a guide in the development of strategies to strengthen our NWD Governance structure, to include the identification of meaningful outcomes and improvement of the NWD System.
- Ensure that all work includes a focus on Person-Centered Options Counseling and the Person-Centered Options Counseling Certification plan, process and assessment.
- Leverage NH DHHS Care Coordination and Closed Looped Referral Systems, and improve functionality of the NHEASY system to support streamlining eligibility and connections to long-term care supports and services.
- Provide education and training to ServiceLink (ADRC) staff related to understanding fall-related Traumatic Brain Injury (TBI) and the services and programs to support individuals who experiencing TBI.

Objective 3.4 - Promote greater awareness and education of Alzheimer's disease, including the promotion of the Alzheimer's disease and Related Dementia (ADRD) Respite Grant.

Strategies

- Support the Alzheimer's Association, ServiceLink and the NH Family Caregiver Support Program in promoting health campaigns with healthcare professionals, community groups and the general public to increase understanding and awareness of early warning signs of Alzheimer's and other dementia, including the promotion of the ADRD Respite Grant.
- Partner with the Commission on Aging, the Health and Human Services Oversight Subcommittee on Alzheimer's and other related dementia, the NH Medical Society, and the Alzheimer's Association to develop a public awareness campaign on brain health, Alzheimer's disease, and



related dementias (ADRD), and incorporate the campaign into NH DHHS's existing, relevant public health outreach programs on an ongoing basis.

- Regularly collect data on Alzheimer's disease, cognitive decline, and care giving through the Behavioral Risk Factor Surveillance System and other surveys, using the results to effect systems change.

Objective 3.5 - Promote greater understanding of Medicare and its programs.

Strategies

- Support the continued integration and collaboration between Medicare and ServiceLink staff and volunteers (located in ServiceLink offices) – in strengthening awareness and promotion of Medicare options, Medicare related financial assistance, and Medicare fraud, errors and abuse.
- Support the State Health Insurance Information Program (SHIP) as they provide group outreach and customized individual contacts by providing quarterly education and training events along with guidance and resources on a consistent basis.
- Support the Senior Medicare Patrol (SMP) Counselors to recruit, train, and maintain volunteers and staff on informing Medicare consumers on how to protect personal health information, detect payment errors, and report questionable Medicare billing concerns by providing quarterly education and training events along with guidance and resources on a consistent basis.
- Increase screening for Medicare financial assistance programs, Preventive Services, and understanding of Medicare Part D options by providing quarterly education and training events along with guidance and resources on a consistent basis.

Objective 3.6 - Promote self-management of chronic disease and falls prevention.

Strategies:

- Continue to partner with the Northern and Southern NH Area Health Education Centers and the Division of Public Health Services (DPHS) on the promotion of the NH Chronic Disease Self-Management Program.
- Partner with the DPHS to strengthen screening for fall-related Traumatic Brain Injury (TBI) and the services and programs to support individuals who experiencing TBI.
- Identify and create a plan for promotion of self-management of chronic disease and falls prevention by braiding funding between BEAS and DPHS.
- Ensure BEAS has a presence and is actively engaged in New Hampshire's Falls Risk Task Force.
- Continue to partner with MOWNH and the Division for Public Health Services on the promotion of self-management of chronic diseases and falls prevention to individuals receiving home delivered meals.
- Advance equity by providing Falls Prevention programming to refugee populations throughout NH.
- Collaborate with the State Independent Living Network to conduct Train the Trainer programs with Chronic Disease Self-Management staff to provide Self-Care workshops through their Health and Wellness Events.
- Collaborate with UNH Cooperative Extension to leverage and align with evidence-based training they provide in communities across the state.
- Develop performance measures on evidence-based programs to include in the System of Care for Healthy Aging performance dashboard.



Objective 3.7 - Support the development and implementation of comprehensive, coordinated, statewide system of LTSS that is responsive to the needs and preferences of older individuals and their family caregivers.

Strategies:

- Increase the percent of Medicaid spending on LTSS that is for Home and community-based waiver services.
- Build upon existing infrastructure to establish a comprehensive and coordinated system of care to ensure that older adults and adults with disabilities have access to and timely delivery of supports and services and to ensure that they have a meaningful range of options.
- Expanding the availability of less costly home and community-based services.
- Implementing an expedited application process to access Medicaid funded home and community based services.
- Conduct a participant experience survey for individuals access LTSS Choice for Independence Medicaid Waiver Program
- Conduct a Home and Community Based Services (HCBS) system assessment, gap analysis, and recommendations, by looking at a range of demographic and diversity data, long term services and supports (LTSS) utilization, needs and workforce capacity.
- Improve access to care for the LGBTQ+ community and elevate inclusivity within BEAS staff and partnering agencies by promoting training and educational opportunities by leveraging LGBT and HIV Resources, and the National Resource Center on LGBT Aging.

Goal #3 – Performance Measures:

- Increase by 5% the number of outreach events for ServiceLink and NHCarePath each year, beginning at the end of year two.
- Conduct state and county based outreach to introduce the SPOA and establish a SPOA “score card” to communicate progress of the State Plan, beginning in year one and taking place each following year.
- Update information on all agencies that provide OAA services in both ServiceLink and NHCarePath websites by end of year one, with annual updates for every following year.
- Increase by 3% the number of group outreach events and individual contacts for Medicare programs each year.
- Establish baseline number of individuals served in home-delivered meals and congregate meals by end of first year and monitor/evaluate annually.
- Maintain or increase the number of individuals who participate in home-delivered meals or congregate meals, by the end of year two and each following year.
- Achieve outcome measures for the NWD Governance grant, per the grant work plan and grant proposal.
- Increase the number of outreach events to promote the ADRD program, beginning at the end of year one.
- Continue to develop Master trainers for the Chronic Disease Self-Management Program, beginning at the end of year two.



Goal 4: Advance equity and person centered thinking and practices:

Objective 4.1 - Partner with contractors, service providers and community organizations in support of equitable Person Centered Care (PCC).

Strategies

- Develop standardized language for use in all service plans, in-take assessments, grants, policy documents, media and other communication.
- Require contract agencies to demonstrate person-centered elements in intake assessments and service plans.
- Encourage partnerships with the NH Hospital Association, the NH Medical Society, the NH Home Care, Hospice and Palliative Care Alliance, the NH Health Care Association, NAMI NH and the Citizens Health Initiative at UNH to advance Person Centered Care and Counseling.

Objective 4.2 - Promote the importance of equitable PCC among older people and their families.

Strategies

- Partner with the DHHS Public Information Office, ServiceLink Network, NHCarePath Partners, and other community-based organizations in promoting the importance and benefits of PCC.
- Explore the challenges of workforce shortages and turnover, including how these challenges impact the success of PCC. Include possible solutions on how to address these issues.
- Collaborate with the State Commission on Aging to promote Equitable PCC within their Newsletter, "Aging Matters".

Objective 4.3 - Promote awareness and increase support to family caregivers, including the promotion of Person-Centered Care

Strategies

- Collaborate with the NH Alliance for Healthy Aging on the promotion of a Caregiver Self-Identification tool kit for caregivers and employers, including education and promotion regarding person-centered care.
- Develop strategies with community-based organizations to support making businesses more Caregiver friendly.
- In partnership with the ServiceLink Network, collaborate with the NH State Library, NH Association of Counties, doctor's offices, places of worship, home care organizations and other medical centers on delivering six outreach events per year to promote the five elements of the NH Family Caregiver Support Program. Include education and promotion regarding person-centered care.
- Partner with ServiceLink staff/sites that excel in caregiving programs to help train, educate and mentor new caregiver program specialists across the state. Include education and promotion regarding person-centered care.
- Partner with Tailored Caregiver Assessment And Referral (TCARE, Inc.), an evidence based & trauma informed family assessment tool, to provide fifteen (15) licenses to BEAS to utilize within our ADRC network to support building tailored action plans, tech-enabled insights, comprehensive resources, and family care protection products to assure that every family member can continue the lifestyle they've earned in the face of change. Two (2) of these licenses will provide direct access to TCARE and Translate the TCARE platform functionality into other non-English TCARE standard languages, which shall include but is not limited to: Spanish, French and/or Arabic.



Objective 4.4 - Enhance training and certification of Person-Centered Options Counselors (PCOC) in Person Centered Counseling.

Strategies

- Develop and implement a continuous quality improvement process as outlined in NH's PCOC Certification Plan, providing ongoing support to the plan, partners and process.
- Reinstigate in-person Person Centered Counseling training for all BEAS staff
- Establish quality improvement and evaluation methods to show effectiveness of PCOC in preventing and/or postponing institutionalization.
- Recruit and train PCOC mentors to support new staff through the PCOC certification process.
- Develop strategies to retain certified PCOC staff.

Goal #4 - Performance Measures:

- Complete a Person Centered Counseling Toolkit that includes a standardized definition, elements, approach and practices for Person Centered Counseling by the end of year one.
- Increase the number of caregivers receiving services through the NH Family Caregiver Support Program (NHFCS) by 3 percent each year, beginning at the end of year one.
- Coordinate six outreach events across the state, promoting the NHFCS, each year.
- Ensure 100% of all ServiceLink staff are fully trained in PCC within one year of hire.

State Plan on Aging Desired Outcomes

- Older people and their family members looking for long-term supports and services will be able to access help, guidance, support and choice.
- Older people, caregivers and families will have access to person-centered care and planning regardless of where they access the service system.
- Family caregivers of older people will be informed, and have the supports they need.
- Older people will have reduced risk of abuse, neglect or exploitation, and live in safety and dignity.
- Older people will have greater resources and supports to reduce the risk of loneliness and isolation.
- Older people will be educated and informed regarding Medicare and its options, helping to reduce fraud, errors and abuse.
- Older people, families and caregivers will be better educated and informed regarding emergency preparedness and planning.
- Services and supports for older people, caregivers and their families will be inclusive of all diverse populations, and will serve all populations with respect and dignity.



State Plan Quality Management

BEAS will assure the quality of the strategies of this State Plan through comprehensive evaluation activities and quality management practices to guide system and service improvements where needed. These activities include:

- **Tracking progress on State Plan outcomes;**
- **Tracking State Plan implementation;**
- **Collecting information through the Aging Network reporting and updates; and,**
- **Additional data collection and remediation activities.**

To assess progress toward State Plan goals BEAS will evaluate state-level performance for state objectives and strategies. In addition to the activities described, BEAS will continue its existing quality management initiatives which include an array of person-centered home and community-based services efforts and compliance monitoring of contractors and enrolled providers to strengthen assessments and oversight responsibilities.

Older Americans Act Services

BEAS conducts on-site monitoring consisting of site visits, service provision observation of providers, and desk reviews of data and reports received from providers. For Title III service providers, extensive and detailed quarterly reports are submitted to BEAS. Reporting elements include client data, service expenses and revenues, and client satisfaction survey elements. Providers maintain systems for tracking, resolving and reporting client complains/concerns, and must ensure equal access to quality services by providing culturally and linguistically appropriate services as needed.

BEAS provides quality oversight via monitoring visits by DHHS staff. Random selections of records are pulled to assure timely and appropriate options counseling and service provision through review of assessments, plans of care, goals, strategies, needs, and follow up as needs change. Great care is taken to ensure that the participants and/or family caregivers have input into the plan, such that opportunities for choice/flexibility are emphasized in the options counseling and decision support process.

Medicaid Funded LTSS

NH DHHS employs staff specifically designated to oversee the performance of operational and administrative functions. Designated staff work in partnership with the DHHS Office of Improvement and Integrity and Office of Quality Assurance and Improvement to assess the qualifications of and performance of non-state entities.

Methods used to assess performance include oversight and monitoring of Medicaid Provider agreements, annual contract review, licensing and certification reviews and quality assurance activities such as record reviews and performance reviews of provider agencies according to the performance measures included in contracts and as part of the Choices for Independence (CFI) waiver.

ServiceLink Aging and Disability Resource Centers (ADRC) and Consumer Satisfaction

ServiceLink develops and implements locally based Quality Assurance and Continuous Improvement Plans to ensure that all services are of high quality, person-centered services, and provided and sustained



throughout the geographic service area and services produce measurable results. ServiceLink continuously evaluates and improves their service provision to individuals, families and organizations in the community.

ServiceLink also ensures implementation of formal complaint and grievance policies, and maintains a system for tracking, resolving, and reporting client complaints regarding its services, processes, procedures, and staff. Any grievances filed are available to DHHS upon request.

ServiceLink's Quality Assurance and Continuous Improvement Plan utilizes formal processes for receiving input and feedback from individuals and their families on the operations, services, and on-going development. Processes include using a standardized satisfaction survey and procedures for measuring consumer satisfaction and outcome measures related to the visibility, trust, ease of access, responsiveness, efficiency and effectiveness.

Sentinel Event

NH DHHS requires all enrolled CFI Waiver providers to comply with its Sentinel Event Reporting process and NH Adult Protective Services reporting requirements. Reporting sentinel events under the provisions of this policy does not replace the mandatory reporting requirements of RSA 161-F: 42-57 with regard to abuse, neglect, self-neglect, or exploitation. Therefore, depending on the incident, a report made on behalf of a CFI Waiver participant may be made under both requirements.

The DHHS Sentinel Event Policy is part of a comprehensive quality assurance program and establishes the reporting and review requirements of sentinel events involving individuals served by DHHS. Statutory authority for reviews of sentinel events is set forth in NH RSA 126-A:4, IV. NH DHHS Sentinel Event Reporting Process: <http://www.dhhs.nh.gov/dcbcs/sentinel.htm>

Case Review and Consultation Committee

When an Adult Protective Services Worker or CFI Case Manager are struggling to remediate complex client issues, a case review is requested. The function of the Case Review and Consultation Committee is to assist BEAS staff and case managers in delivering safe and person-centered services to at-risk* service recipients through information sharing and creative problem solving.

**Risk is defined as the possibility of harm to a service recipient, that when realized, results in loss, injury, disease or death. Someone who is at-risk is in a circumstance or condition where his or her health, safety or welfare is threatened.*

Interagency Integration Team

The Interagency Integration Team facilitates monthly collaborative meetings with representatives from the Bureaus of Elderly & Adult Services, Developmental Services, Drug and Alcohol Services, Housing Supports, Children's Behavioral Health, Office of Medicaid Services, Quality Improvement, and Mental Health Services to review cases in which an individual needs services from multiple service delivery systems. These collaborative meetings allow representatives from each bureau to review complicated situations on a case-by-case basis, and determine potential barriers exist and identify pathways to meet the individual's needs within the multiple service delivery systems. The Interagency Integration Team identifies policy changes that are needed on a larger scale to ensure that service delivery and quality oversight are occurring for people with multiple needs.



All information on individuals receiving Title III services and programs administered by the department or a provider shall be kept confidential, and only persons involved in administering Title III services and programs shall review an individual's information, unless the individual signs an authorization to release the information to another person or organization.

Office of the Long-Term Care Ombudsman

OLTCO conducts data collection through OmbudsManager, a web-based case management software system that complies with the National Ombudsman Reporting System and ACL requirements. The system generates data reports, tracks consultations, facility visits and education and training activities. OLTCO will work with the Local Area Network for Excellence (LANE) to focus on national quality benchmarks related to performance and medical goals obtained through individualized, person centered and person directed approaches.



New Hampshire

State Plan on Aging 2024-2027

Appendix

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Attachment A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES

Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title— . . .

(2) The State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—...

(5) in the case of a State specified in subsection (b)(5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the



and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

- (1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,
- (2) a numerical statement of the actual funding formula to be used,
- (3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and
- (4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;



(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the of each focal point so

(4) (A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;



(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts

will
on (i) identify individuals eligible for assistance under this Act, with special

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—



(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for



providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;



(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—



(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and are

(B) an analysis of how such change may affect such individuals, including with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English

(C) an analysis of how the programs, policies, and services provided by such area can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in planning and service area is expected to affect the need for supportive

(3) An area agency on aging, in cooperation with government officials, State agencies, organizations, or local entities, may make recommendations to government officials in planning and service area and the State, on actions determined by the area agency to build capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation;

(L) assistive technology devices and services; and

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.



(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

- (i) providing notice of an action to withhold funds;
- (ii) providing documentation of the need for such action; and
-) at the request of the area agency on aging, conducting a public concerning the

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90

(g) Nothing in this Act shall restrict an area agency on aging from providing services provided or authorized by this Act, including through—

(1) contracts with health care payers;

(3) other arrangements with entities or individuals that increase the availability of home community-based services and



Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000...

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular



low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8) (A) The plan shall provide that no supportive services, nutrition services, or in-services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount



expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

- (i) public education to identify and prevent abuse of older individuals;
- (ii) receipt of reports of abuse of older individuals;



(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and



(vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27) (A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State’s statewide service delivery model, for any anticipated change in



the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;



(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order...



Signature and Title of Authorized Official

June 1, 2023

Date



Attachment B

INFORMATION REQUIREMENTS

I. Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Response:

The Bureau of Elderly & Adult Services (BEAS) will meet this requirement with assurances included administrative rules and in contracts with service providers to serve those with the greatest economic and social need as part of their scope of work. Targeted individuals include those who are low income, living in rural areas, are in frail physical or mental health, older minority, and are at risk of institutionalization without the services. BEAS currently achieves this requirement through our contract funding formulas, which uses US Census data to help identified communities throughout NH that has the highest social & economic needs, to ensure we are distributing our funding to service providers in those identified areas of our State. Also, to ensure that targeting criteria is met, home delivered meals and services provided in the home are limited to individuals who meet the criteria by completing required documentation that establishes eligibility of Title III Services. BEAS further monitors targeting compliance by the conduction of both on-site and desk reviews of contracted agencies.

II. Section 306(a)(6)(I)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

Response:

BEAS will meet this requirement with assurances included in contracts with service providers which will specify, to the extent feasible, coordinate with BEAS to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals. BEAS will monitor contract performance and various portions of related assurances by providing contractors with tools to measure how measure is achieved.

III. Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Response:

- 1) The DHHS has an emergency call list and the BEAS senior leadership are included on that list. If a situation developed requiring after hour assistance by the BEAS, all senior leadership have state-issued cell phones and could be available, depending on what their role would be.



- 2) It is recommended that all BEAS staff sign up to receive NH DHHS Alerts to be notified of emergencies/disasters.
- 3) During State Emergency Operations Center (SEOC) activation, the BEAS Chief will provide a situational summary to the Emergency Support Function/Recovery Support Function (ESF 8/RSF 3) desk Coordinator for Public Health and Medical Services/Health and Social Services Recovery regarding any impact on older adult programs and services. If needed, the DHHS Emergency Services Unit (ESU) Director or designee would be available to facilitate a planning call for BEAS senior leadership pertaining to older adult population mission response.
- 4) The BEAS Chief will provide the DHHS Public Information Officer with specific information pertaining to community programs/services provided by DHHS and BEAS that may be impacted by the emergency/disaster.
- 5) BEAS and State emergency officials will develop frequently asked questions pertaining to BEAS' community programs/services during disaster and recovery as needed for distribution to BEAS partners.

IV. Section 307(a)(2)

The plan shall provide that the State agency will —...

(B) *specify a minimum proportion* of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

Response:

- a) Access & Assistance Services – NH uses 60% of the total IIIB award for this.
- b) In Home Services – NH uses 38% of the total IIIB award for this.
- c) Legal – NH uses 2% of the total IIIB award for this.

V. Section 307(a)(3)

The plan shall—

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

Response:

BEAS will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

New Hampshire (NH) covers 8,968 sq. miles, 90% defined as rural. In 2020, NH had approximately 1,377,530 residents, with 509,527 (or 37%) living in rural areas. In 2019, NH's median age was 43, and 19% of the population (~248K people) were 65 or older, making it the 3rd oldest state in the nation, after a 43% growth in older adults between 2008 and 2018. In 2016, NH's Office of Energy and Planning estimated that by 2040, 33% of residents will be 65 or older.

Demographers at the University of New Hampshire (UNH) believe this population shift is primarily driven by large cohorts of "Baby Boomers" (~389,000 residents) who reached their 50s and 60s by 2015. However, this shift in the population age structure is not occurring evenly; the



more rural counties of northern and central NH have a more significant proportion of residents aged 65 or older than other regions. Residents of NH's rural communities are more likely to be uninsured, of low-income, older, or disabled, than non-rural residents.

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and*

Response:

See Attachment C, page 60. With 90% of NH's land area defined as rural (as described above), BEAS assures focus on ensuring those in rural areas have access to these services.

(iii) *describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

Response:

BEAS obligates OAA funds to contracted providers who target older people in NH in the greatest social and economic need with a focus on ensuring those in rural areas have access to these services. With NH's northern and rural counties projected to experience the highest growth percentages, BEAS and its contracted partners are continuously seeking to maximize OAA funds to meet the needs of rural areas, collaborating with other state agencies, community partners, and volunteers to ensure access despite the rural landscape and dispersed population.

VI. Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*

Response:

NH covers 8,968 square miles. In 2020, NH had approximately 1,377,530 residents, with 509,527 (or 37%) living in rural areas. In 2019, NH's median age was 43, and 19% of the population (~248K people) were 65 or older, making it the 3rd oldest state in the nation, after a 43% growth in older adults between 2008 and 2018. Concord is the state capital. The state's largest cities are Manchester, Nashua and Concord. Over 60% of NH's population lives in a rural area of the state. Contracted providers are required to prioritize those in greatest economic and social need, including those living in rural areas.

VII. Section 307(a)(14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and*

(B) *describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.*

Response:

As NH ages, it grows more racially and ethnically diverse, heralding the need for programs and services to become more culturally and linguistically appropriate. In a 2015 report, the NH Center for Public Policy Studies estimated that among the state's 1.3 million residents, approximately 75,000 were foreign-born. In 2018, while 90.5% of the state's population was non-Hispanic white, nearly 10% came from communities of color. Furthermore, the overall



population is living longer, including individuals that identify as LGBTQ. The Williams Institute at UCLA estimates that 4.7% of adults in NH are LGBTQ, suggesting that between 4 and 5% of NH's older adults are also LGBTQ. Moreover, the rates of Alzheimer's disease and other dementias and the rates of disability among older adults are increasing. In NH, the percentage of adults impacted by Alzheimer's disease is expected to rise by 33% between 2018 and 2025 to 32,000 people.

BEAS coordinates with the DHHS Office of Health Equity to support the provision of culturally and linguistically appropriate services to NH's residents by DHHS as well as to maintain communication with racial, ethnic and other medically underserved populations to create partnerships to enhance the overall health of the communities by developing combined opportunities and resources to address health disparities.

Service providers contracted by BEAS are required to provide culturally and linguistically appropriate services to older people and persons with disabilities. BEAS collaborates with the DHHS Office of Health Equity (OHE), which advances equitable access to effective, quality programs and services, with a particular focus on racial, ethnic, language, and gender/sexual minorities, and individuals with disabilities.

Racial, ethnic, and language diversity is greatest in the more urban and southern cities and towns in NH. In the southern District Offices of DHHS, professional interpreters are available to assist individuals with limited English proficiency in accessing services and applying for public assistance such as Supplemental Nutritional Assistance Program (SNAP) or Medicaid. While NH has no federally recognized Native American tribes, NH has a strong community of Indigenous people, most notably the Abenaki people. NH's Intertribal Native American Council helps to improve access to services for older Native American individuals.

VIII. Section 307(a)(21)

The plan shall —

...

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, *and specify the ways in which the State agency intends to implement the activities.*

Response:

NH has no federally recognized Native American tribes. Administratively attached to the NH Department of Cultural Resources, the Commission on Native American Affairs recognizes the historic and cultural contributions of Native Americans to NH. Their mission is to promote and strengthen Native American heritage and further the needs of NH's Native American community through state policy and programs. BEAS has made its resources available to the Commission and remain available to provide information, technical assistance and/or support. BEAS will meet this requirement through the state plan goals, objectives, and strategies to pursue activities in partnership with the NH Intertribal Native American Council to increase access by older individuals who are Native Americans to all aging programs and benefits provided by BEAS.

IX. Section 307(a)(27)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.



(B) Such assessment may include—

- (i) the projected change in the number of older individuals in the State;
- (ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
- (iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
- (iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Response:

BEAS assures that a system assessment and gap analysis will be conducted during the 10-year period following the fiscal year for which the plan is submitted. BEAS assures that it will include all requirements in Section (B) above.

BEAS will lead a system assessment and gap analysis that looks at a range of demographic data, including race, ethnicity, age, and gender at the state and county levels. The team will study LTSS utilization trends among older adults and older adults with physical disabilities. BEAS will examine state and county trends and compare urban, suburban, and rural communities. BEAS will also look at the diversity of people served and how they reflect the state's population.

X. Section 307(a)(28)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Response:

BEAS will meet this assurance by ensuring a continued partnership with the NH DHHS Emergency Services Unit, ServiceLink Network, Regional Public Health Network and other community organizations in strengthening emergency services and preparedness. BEAS will:

- 1) Support the identification of up to five possible regional disaster shelters that provide accessibility, capacity, public transportation, and other needed criteria as outlined by the American Red Cross.
- 2) Support the development of Shelter Assessment Teams comprised of representatives (at a minimum) from: the shelter facility, American Red Cross, local first responders, and DHHS Emergency Services Unit officials.
- 3) Support shelter operations training that includes: communication access, assistance animal considerations, discharge planning, and personal preparedness unique to the older people and disabled population within the community.
- 4) Collaborate with the NH DHHS Emergency Services Unit, ServiceLink Network, Regional Public Health Network, older adult volunteer groups (such as Senior Corps), and other community members in the promotion and support of trainings.

XI. Section 307(a)(29)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.



Response:

- 1) In keeping with U.S. Homeland Security guidance, the National Response Framework and the National Recovery Framework, State and local level emergency response and recovery is structured into support functions. These support functions provide a framework for activating capabilities best able to address the needs of disaster impacted and recovery of jurisdictions.
- 2) At the State Emergency Operations Center (SEOC), there are assigned Emergency Support Function (ESF)/Recovery Support Function (RSF) desks where the jurisdictional requests are coordinated. The ESF 8/RSF 3 desk is responsible for Public Health and Medical Services/Health and Social Services Recovery response both during and after disasters, with recognition of older adults and persons with disabilities and others with access and functional needs, etc.
- 3) The ESF 8/RSF 3 Coordinator, in conjunction with the State's Homeland Security and Emergency Management (HSEM) Director, has resources to coordinate and network with partners to address health and medical issues as they relate to older adult emergency planning.
- 4) In the event of a major disaster, some older adult community programs and residential care facilities may require evacuation to a general population shelter. The SEOC ESF 6 desk Coordinator is responsible for Mass Care, Housing, and Human Services. The ESF 6 desk Coordinator may be asked to assist the ESF8/RSF3 desk Coordinator as needed for older adult care response and recovery activities.
- 5) Most emergencies and special events start and end at the local level and are handled by local emergency management officials, and during public health emergencies with assistance from Public Health Network Coordinators, in conjunction with police, fire, and emergency personnel.
- 6) The state is divided into 13 Regional Public Health Networks (RPHNs). The purpose of the RPHNs is to integrate multiple public health initiatives and services into a common network of community stakeholders. The RPHNs serve every community in the state.
- 7) As of early 2016, each RPHN has established a Public Health Advisory Council (PHAC). The role of the PHAC is to advise the Regional Public Health Network partners by identifying regional public health priorities based on assessments of community health; guiding the implementation of programs, practices and policies that are evidence-informed to improve health outcomes; and advancing the coordination of services among partners. Additionally, the PHAC structure is intended to build on and, when feasible, blend existing local leadership and coordinating groups working on various public health issues. This work began with substance misuse prevention, public health emergency preparedness and has now extended its advisory and coordinating role over a much broader range of public health issues and services based on regional priorities and capacity.
- 8) As of early 2018 the State has established a healthcare coalition with representation from long-term care facilities, DHHS Health Facilities Licensing and Certification Unit, homecare organizations (including VNA), urgent care clinics, etc.
- 9) In 2018 the Granite State Health Care Coalition (HCC) was developed. This coalition is a network of health care, public health and safety organizations brought together to enhance the state's ability to prepare for, respond to and recover from events impacting NH. This is accomplished by bridging the gaps between partners, providing situational awareness, training and education and sharing best practices and lessons learned. Emergencies typically affect the whole community, not just a single facility. Membership in the HCC is voluntary. Outreach has begun to all the credentialed and licensed health care facilities in



the state as well as to various health care and agencies/organizations.

XII. Section 705(a) ELIGIBILITY —

In order to be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307— . . .*

(1) *a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).*

(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—

(1) *an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;*

Response:

BEAS staff includes a Legal Assistance Developer designated by DHHS' Legal Services Unit. The Legal Assistance Developer provides assistance, guidance and direction in the development of BEAS' policies, procedures, administrative rules and legislation. In addition, the Legal Assistance Developer provides technical assistance to BEAS' program areas to facilitate resolution of client service questions and concerns, and provides State leadership in developing legal assistance programs for older individuals throughout the State.

NH Legal Assistance (NHLA) is a statewide nonprofit law firm that represents low-income and aging clients in civil cases that impact their basic needs. Since 1975, NHLA, through its Senior Law Project (SLP), has been collaborating with BEAS and providing legal services to NH's older residents pursuant to Title III-B of the Older Americans Act. For over 40 years, NHLA's SLP has been the primary voice for the aging population in NH's legal and legislative arenas. The designated BEAS Legal Developer provides oversight to our contract with NHLA.

BEAS carries out the legal requirements of the Protective Services to Adults Law under Adult Protection Services (APS). The purpose of the law, which is civil and not criminal, is to provide protection for vulnerable adults who are age 18 and older, determined to be abused, neglected, exploited, or are self-neglecting. An adult protective services unit receives and investigates reports involving incapacitated/vulnerable adults who live independently or live in or are participating in homes/programs administered by or affiliated with the DHHS Bureaus of Mental Health Services and Developmental Services. The APS unit is also responsible to receive and investigate reports involving vulnerable adults who are suspected to have been abused, neglected or exploited in their own homes by individuals that provide care, or while receiving care in a community, general or specialized hospital, rehabilitation center or other treatment center.

In NH, adults are legally competent unless they are under guardianship. If there has been an activated DPOA, we work with that individual. In the absence of an activated Durable Power of Attorney (DPOA), APS would consider whether a guardianship needs to be in place. If so, APS would work with the family or other individual/s to help them with that process. According to the APS statute, if all other remedies are exhausted, we may seek to have a guardian appointed by the probate court.

In addition, the Office of the Long-Term Care Ombudsman (OLTCO) is responsible to receive initial reports involving vulnerable adults who are residents of nursing homes or assisted living



facilities. The OLTCO is administratively attached to the Office of the Commissioner at DHHS. The OLTCO does not have management responsibility for, or operate under the supervision of an individual with management responsibility for adult protective services.

(2) *an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;*

Response:

BEAS will support the provision of at least one public hearing a year to gather input from the public on Office of Long Term Care Ombudsman operations. In addition, BEAS leverages the legislative Commission on Aging who meet regularly and are open to the public and comments from the public are welcome as part of the agenda. BEAS has a state seat on the Commission. The Bureau Chief provides this representation.

(3) *an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;*

Response:

BEAS Assures this through trained and certified Community Resource Specialists in Aging and Disabilities and State Certified Person Centered Options Counselors following the No Wrong Door/ADRC model, staff inform all clients of their rights when receiving services and provide information to clients about how to address issues related to their rights and benefits, including coordinated referrals to Adult Protective Services, NH Legal Assistance, Attorney General's office consumer assistance program, and the Long-Term Care Ombudsman.

(4) *an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;*

Response:

BEAS assures that it will use funds made available under this subtitle for Adult Protective Services, the State's Long Term Care Ombudsman Program, and to contract with New Hampshire Legal Assistance supported with Title VII. BEAS will not supplant any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in this chapter.

(5) *an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);*

Response:

NH does not have local Ombudsman entities under section 712(a)(5) separate from the State Long Term Care Ombudsman.

(6) *an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—*

Response:

NH does not have local Ombudsman entities under section 712(a)(5) separate from the State



Long Term Care Ombudsman.

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-public education to identify and prevent elder abuse;

(i) public education to identify and prevent elder

Response:

BEAS Adult Protective Services provides training to staff internal to DHHS, community based providers and other community groups statewide including but not limited to local law enforcement, senior centers, social service agencies, congregate meal sites, libraries, caregiver groups, new staff orientations, and statewide conferences. They review applicable laws and policies, such as reporting requirements for mandated reporting requirements for mandated reporters, and show what is expected when someone suspects a vulnerable adult is at risk.

(ii) receipt of reports of elder abuse;

Response:

He-E 701.04 Protective Investigation Requirements.

(a) The department shall conduct a protective investigation on each report received, except as described in (b), (c), or (d) below.

(b) The department shall not conduct or complete a protective investigation when any of the following apply:

(1) The alleged victim does not fall under the reporting requirement described in RSA 161-F:46;

(2) The allegation(s) is determined not to meet any of the definitions of abuse, neglect, exploitation, or self-neglect contained in RSA 161-F:43;

(3) When the alleged victim cannot be located and the department determines that an interview with the alleged victim is necessary to conduct the investigation;

(4) When the alleged victim no longer resides in New Hampshire and adult protective staff has referred or attempted to refer the report to appropriate adult protective services or law enforcement;

(5) When the investigator has made multiple attempts to interview the alleged victim and the alleged victim:

a. Declines to be interviewed;

b. Does not display any indications of having suffered cognitive decline; and

c. Is not in imminent danger;

(6) When the alleged victim cannot be reached for interview and the investigator has:

a. Made at least 3 attempts to contact the alleged victim by phone;

b. Made 3 unannounced home visits to attempt to contact the alleged victim; and

c. Contacted or attempted to contact anyone the investigator suspects may have knowledge of the alleged victim's whereabouts;

(7) When the report involves an incident or situation of abuse, neglect, or exploitation that allegedly occurred one or more years ago, and there is no current contact with the alleged perpetrator;

(8) When the report does not include sufficient information to allow an investigation to be conducted under RSA 161-F:42-57;

(9) When the alleged perpetrator dies prior to the initiation of the investigation, or after the investigation has been initiated, but before it is completed;

(10) When another DHHS bureau has been or will be conducting an investigation because the alleged perpetrator is living in a certified or licensed facility or residence at the time of the alleged incident;



(11) When the report is determined to be frivolous or without factual basis as described in RSA 161-F:46, III;

(12) For reports of self-neglect when the alleged victim is in or enters into a hospice program and is compliant with a hospice treatment plan; or

(13) When the alleged victim and the alleged perpetrator are both residents of a licensed or certified facility after the report and adult protective staff has referred the report to the appropriate licensing entity.

(c) When the report is criminal in nature, and a criminal investigation will be or has been conducted by law enforcement, the department shall not conduct or complete an investigation unless one or more of the following apply:

(1) The alleged perpetrator is registry eligible;

(2) The investigator has determined that the alleged victim is in need of protective services; or

(3) The alleged perpetrator has ongoing contact with the alleged victim.

(d) When the alleged victim has died, the department shall not conduct or complete an investigation when any of the following apply:

(1) When a report is self-neglect;

(2) When the alleged perpetrator is not registry eligible; or

(3) When the alleged victim has not been interviewed and BEAS determines that an interview with the alleged victim is necessary to the investigation.

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

Response:

The APS investigator will discuss with the alleged victim and/or their legal representative appropriate protective services. Except where protective services are court ordered, the investigator works to implement protective services agreed to by the victim. Victims with decisional capacity can choose to decline all services. Some services that can be offered are:

- Referrals to service providers, including case management, guardianship services, mental health and developmental services, law enforcement, and health care.
- Securing change of representative payee.
- Petitioning for removal of a court-appointed guardian.
- Notifying and filing a misuse of funds report with the Social Security Administration.
- Alerting financial institutions of misappropriation of funds.
- Assisting the client to close/change banking or other accounts.
- Intervening in cases of identity theft.
- Petitioning for guardianship.
- Filing for temporary restraining orders and relief from abuse orders.

In addition, the State Health Insurance Assistance Program, the Senior Medicare Patrol program and New Hampshire's designated contracts for the aging and disability resource network members are committed to providing information and assistance to individuals to access benefits and exercise their rights. BEAS also have staff who assist older adults in identifying and accessing services and benefits for which they are eligible.

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

Response:



See above list of possible referrals. The Adult Protective Service Worker (APSW) completes a Law Enforcement Referral Form when a protective report has been received by APS, and the APSW and the APS Supervisor have determined that the report warrants referral to the Attorney General's office or to another law enforcement agency.

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

Response:

1. When an Alleged Victim Refuses APS Assistance: If an alleged victim refuses the assistance of APS and, the Investigator shall, at a minimum:
 - a. Document steps taken to assess the alleged victim's capacity to consent or refuse;
 - b. Offer protective services, referrals and safety planning to the alleged victim, and document;

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

- (i) if all parties to such complaint consent in writing to the release of such information;*
- (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or*
- (iii) upon court order.*

Response:

He-E 701.21 Who May Receive Information.

(a) When the investigation is in process, information which has been obtained, or which is in the process of being obtained, shall be released to the following, but only that information which is necessary for the receiving entity to carry out its statutory or regulatory mandates or service provision:

- (1) The department of justice, other law enforcement officials, or a court;
- (2) The health facilities administration, when the investigation involves an alleged victim residing in a facility overseen by the health facilities administration, except that the reporter's name shall not be released;
- (3) The bureau of behavioral health, when the investigation involves an alleged victim who receives services from a community mental health program or resides at a facility overseen by the bureau of behavioral health, except that the reporter's name shall not be released;
- (4) New Hampshire hospital or Glencliff home when the alleged victim who resides at the facility, except that the reporter's name shall not be released;
- (5) The bureau of developmental services, when the investigation involves an alleged victim who resides in a facility or participates in a program overseen by the bureau of developmental services, except that the reporter's name shall not be released;
- (6) The office of the state long-term care ombudsman, when the investigation involves an alleged victim residing in a licensed nursing facility, licensed assisted living facility, licensed residential care facility, or licensed supported residential care facility, except that the reporter's name shall not be released;
- (7) The board of nursing, when the investigation involves a victim who is alleged to have been abused, neglected, or exploited by an individual licensed by the board, except that the reporter's name shall not be released; and



(8) Agencies or individuals who provide services to the alleged victim, except that the reporter's name shall not be released.

(b) When the investigation is completed, and a determination has been made, information shall be released, if requested, to the following agencies and individuals who request it, in accordance with the provisions specified below:

(1) To the victim and the victim's guardian, if any, or, if the victim is deceased, the executor or administrator of the victim's will, a copy of the protective investigation summary, except that the reporter's name shall not be released;

(2) To the perpetrator and the perpetrator's guardian if any, a copy of the protective investigation summary, but only when a founded determination has been made, except that the reporter's name shall not be released;

(3) To the department of justice, a court-appointed attorney for the proposed ward or ward, or any other law enforcement officials, a copy of the protective investigation summary or any other requested information, including the reporter's name if requested;

(4) To a court, a copy of the protective investigation summary or any other requested information, including the reporter's name if requested;

(5) To the board of nursing and the health facilities administration, a copy of the investigation summary, but only when a founded determination has been made, except that the reporter's name shall not be released;

(6) To the bureau of behavioral health and the bureau of developmental services, only that information that is needed by those bureaus to carry out their statutory mandates, except that the reporter's name shall not be released;

(7) To agencies or individuals who are, who were, or who will be, participants in providing services to the victim, only that information needed to provide services, except that the reporter's name shall not be released;

(8) To a family member or another individual who is petitioning for the appointment of a guardian for a victim, only that information related to the petition for guardianship except that the reporter's name shall not be released; and

(9) To employers as provided in RSA 161-F:49, VII, a copy of the protective investigation summary, except that the name of the reporter, the last name of the victim and the last name of any individual cited in the summary shall not be released.

(c) When a disposition has been used, information shall be released, if requested, to:

(1) The alleged victim and the alleged victim's guardian, if any, or, if the alleged victim is deceased, the executor or administrator of the alleged victim's will, if the alleged victim was contacted or interviewed, except that the reporter's name shall not be released;

(2) The alleged perpetrator and the alleged perpetrator's guardian, if any, provided that the alleged perpetrator was contacted or interviewed, except that the reporter's name shall not be released; and

(3) The department of justice, other law enforcement officials, a court-appointed attorney for the proposed ward or ward, or a court, including the reporter's name, if requested.



Attachment C

State Unit on Aging, Single Planning and Service Area Funding

Resource Allocation Introduction

Resource Allocation Plan

As a designated Single Planning and Service Area, NH does not utilize an intrastate funding formula for its Older Americans Act (OAA)-related funding. The total amount of OAA funding received for allocation to service providers is determined by the federal government. The attached budget sheets show actual expenditures for services provided through OAA funding for State Fiscal Years 2020, 2021 and 2022, and projected funding for 2023 and 2024.

BEAS manages approximately 67 contracts that deliver a variety of services. Contracts are procured by the Department and are approved by the Governor and Executive Council. Most contracts are effective for two consecutive state fiscal years (July through June) with annualized renewal options.

The contracts contain funding allocations based on the type of service to be provided, scope of work to be accomplished and county and/or geographic area to be served. The funding allocations within the State of funds received under OAA are based on County/geographical allocations awarded in the prior procurement period and a proportionate share of older individuals in the County/geographical area using 2020 United States Census data and projected population growth in New Hampshire outlined by Age Groups, 2015-2050 (AARP Report: 2018 Across the States Profiles of Long Term Services and Supports) and the County's population 60 years and older.

Nutrition Services Incentive Program (NSIP):

In NH, the NSIP award acts as a 100% pass-through supplement to the contracted nutrition providers' "standard" meals reimbursement rate. It is paid after the service has been delivered. It is disbursed on a monthly basis using each nutrition providers' individual month's actual Title III-eligible meals served, which contracted vendors for Title III-C nutrition services provide in a monthly report to the SUA.

Any NSIP funds left over for that Federal Fiscal Year ending in September is paid out to the providers proportionally based on their yearly Title III-eligible meals served, as none of that remaining funding can be used for any other purpose.

The NSIP reimbursement rate is generally set in July, and is usually a conservative estimate of the total award divided by the number of meals anticipated to be served, without going over.

We have found that our providers prefer a lower monthly NSIP rate if it means that they will receive a monthly NSIP payment for the whole year – as opposed to having a high NSIP rate, but running through the grant quicker than 12 months.



| Service | SFY 2020 Actual Dollars Expended | | | | | |
|--|----------------------------------|-----------|-----------|-----|-----------|------------|
| | General | Fed Other | III | VII | XX | Totals |
| Adult Community Services | | | | | | |
| Adult Group Day Care | 142,685 | | 64,393 | | 117,437 | 324,516 |
| Congregate Meals | 864,342 | | 865,204 | | | 1,729,547 |
| Misc Services (Note 1) | 74,671 | | 4,580 | | 52,663 | 131,914 |
| Transportation | 721,912 | | 752,133 | | | 1,474,045 |
| Total Adult Community Services | 1,803,611 | 0 | 1,686,311 | 0 | 170,100 | 3,660,021 |
| In-Home Support | | | | | | |
| In-Home Care | 1,999,999 | | 186,824 | | 2,719,762 | 4,906,585 |
| Emergency Support | 36,101 | | 36,101 | | | 72,202 |
| Home-Delivered Meals | 2,139,954 | 1,200,000 | 3,892,149 | | 1,730,725 | 8,962,828 |
| Home Health Aide | 70,700 | | 70,700 | | | 141,399 |
| Total In-Home Support | 4,246,754 | 1,200,000 | 4,185,773 | 0 | 4,450,487 | 14,083,014 |
| Family Support | | | | | | |
| Alzheimer's Disease Support Program | 283,467 | | | | | 283,467 |
| NH Family Caregiver Support Program | 203,989 | | 612,620 | | | 816,609 |
| Total Family Support | 487,455 | 0 | 612,620 | 0 | 0 | 1,100,076 |
| Aging Information Resource System | | | | | | |
| NH Servicelink Network | 1,451,792 | 1,049,772 | | | 92,817 | 2,594,381 |
| Health Insurance Counseling | 0 | 305,373 | | | | 305,373 |
| Senior Medicare Patrol Project | 48,542 | 192,957 | | | | 241,499 |
| Medicare Improvements for Patients and Providers Act | 0 | 82,000 | | | | 82,000 |
| Health Promotion | | | 92,651 | | | 92,651 |
| Enhanced ADRC / No Wrong Door | 0 | 0 | | | | 0 |
| Total Aging Information Resource | 1,500,334 | 1,630,102 | 92,651 | 0 | 92,817 | 3,315,904 |
| Adult Protective Services | | | | | | |
| Long Term Care Ombudsman | 28 | | | 125 | | 153 |
| Legal Services (formerly part of Misc Services) | 73,121 | | 73,121 | | | 146,241 |
| Total APS | 73,149 | 0 | 73,121 | 125 | 0 | 146,395 |
| Grand Totals | 8,111,304 | 2,830,101 | 6,650,476 | 125 | 4,713,404 | 22,305,409 |
| | | | | | | 22,305,409 |
| Note 1: Miscellaneous Services include: Community Elder Support Svs, Nursing, Health Screening, Vision, Respite and Guardianship. | | | | | | |



| Service | SFY 2021 Actual Dollars Expended | | | | | |
|---|----------------------------------|-----------|-----------|-----|-----------|------------|
| | General | Fed Other | III | VII | XX | Totals |
| Adult Community Services | | | | | | |
| Adult Group Day Care | 105,777 | | 44,670 | | 43,704 | 194,151 |
| Congregate Meals | 519,180 | | 519,633 | | | 1,038,813 |
| Misc Services (Note 1) | 56,406 | | 7,953 | | 50,148 | 114,507 |
| Transportation | 428,164 | | 446,082 | | | 874,246 |
| Total Adult Community Services | 1,109,527 | 0 | 1,018,338 | 0 | 93,852 | 2,221,717 |
| In-Home Support | | | | | | |
| In-Home Care | 1,915,769 | 70,356 | 331,509 | | 2,936,304 | 5,253,937 |
| Emergency Support | 32,347 | | 32,347 | | | 64,694 |
| Home-Delivered Meals | 1,925,687 | 2,327,592 | 3,349,472 | | 1,592,629 | 9,195,381 |
| Home Health Aide | 68,696 | | 68,696 | | | 137,392 |
| Total In-Home Support | 3,942,499 | 2,397,949 | 3,782,024 | 0 | 4,528,933 | 14,651,404 |
| Family Support | | | | | | |
| Alzheimer's Disease Support Program | 179,419 | | | | | 179,419 |
| NH Family Caregiver Support Program | 93,030 | 279,206 | 728,202 | | | 1,100,438 |
| Total Family Support | 221,376 | 279,206 | 664,811 | 0 | 0 | 1,165,393 |
| Aging Information Resource System | | | | | | |
| NH ServiceLink Network | 1,373,859 | 1,017,613 | | | 83,672 | 2,475,144 |
| Health Insurance Counseling | 0 | 235,956 | | | | 235,956 |
| Senior Medicare Patrol Project | 44,514 | 171,677 | | | | 216,192 |
| Medicare Improvements for Patients and Providers Act | 0 | 77,499 | | | | 77,499 |
| Health Promotion | | | 102,974 | | | 102,974 |
| Enhanced ADRC / No Wrong Door | 0 | 0 | | | | 0 |
| Total Aging Information Resource | 1,418,373 | 1,502,745 | 102,974 | 0 | 83,672 | 3,107,764 |
| Adult Protective Services | | | | | | |
| Long Term Care Ombudsman | 0 | | | 158 | | 158 |
| Legal Services (formerly part of Misc Services) | 73,150 | | 73,150 | | | 146,300 |
| Total APS | 73,150 | 0 | 73,150 | 158 | 0 | 146,458 |
| Grand Totals | 6,764,925 | 4,179,900 | 5,641,297 | 158 | 4,706,458 | 21,292,736 |
| | | | | | | 21,292,736 |
| Note 1: Miscellaneous Services include: Community Elder Support Svcs, Nursing, Health Screening, Vision, Respite and Guardianship. | | | | | | |



| Service | SFY 2022 Actual Dollars Expended | | | | | Totals |
|--|----------------------------------|-----------|-----------|-----|-----------|------------|
| | General | Fed Other | III | VII | XX | |
| Adult Community Services | | | | | | |
| Adult Group Day Care | 141,600 | | 97,680 | | 65,880 | 305,160 |
| Congregate Meals | 741,201 | | 741,944 | | | 1,483,145 |
| Misc Services (Note 1) | 73,314 | | 8,970 | | 78,126 | 160,410 |
| Transportation | 652,249 | | 679,519 | | | 1,331,768 |
| Total Adult Community Services | 1,608,364 | 0 | 1,528,113 | 0 | 144,006 | 3,280,483 |
| In-Home Support | | | | | | |
| In-Home Care | 240,685 | 97,767 | 189,594 | | 2,618,604 | 3,146,649 |
| Emergency Support | 22,385 | | 32,345 | | | 54,729 |
| Home-Delivered Meals | 2,987,734 | 51,575 | 2,827,552 | | 1,656,785 | 7,523,646 |
| Home Health Aide | 72,096 | | 72,096 | | | 144,192 |
| Total In-Home Support | 3,322,899 | 149,342 | 3,121,587 | 0 | 4,275,389 | 10,869,216 |
| Family Support | | | | | | |
| Alzheimer's Disease Support Program | 252,579 | | | | | 252,579 |
| NH Family Caregiver Support Program | 225,441 | 191,232 | 677,079 | | | 1,093,752 |
| Total Family Support | 478,020 | 191,232 | 677,079 | 0 | 0 | 1,346,331 |
| Aging Information Resource System | | | | | | |
| NH ServiceLink Network | 1,519,064 | 1,130,389 | | | 91,578 | 2,741,031 |
| Health Insurance Counseling | 0 | 271,061 | | | | 271,061 |
| Senior Medicare Patrol Project | 50,769 | 197,531 | | | | 248,300 |
| Medicare Improvements for Patients and Providers Act | 0 | 82,069 | | | | 82,069 |
| Health Promotion | | | 98,678 | | | 98,678 |
| Enhanced ADRC / No Wrong Door | 0 | 0 | | | | 0 |
| Total Aging Information Resource | 1,569,833 | 1,681,049 | 98,678 | 0 | 91,578 | 3,441,138 |
| Adult Protective Services | | | | | | |
| Long Term Care Ombudsman | 0 | | | 225 | | 225 |
| Legal Services (formerly part of Misc Services) | 73,150 | | 73,150 | | | 146,300 |
| Total APS | 73,150 | 0 | 73,150 | 225 | 0 | 146,525 |
| Grand Totals | 7,052,265 | 2,021,623 | 5,498,606 | 225 | 4,510,973 | 19,083,693 |
| | | | | | | 19,083,693 |

Note 1: Miscellaneous Services include: Community Elder Support Svcs, Nursing, Health Screening, Vision, Respite and Guardianship.



| Service | SFY 2023 Based on Contracts | | | | | Totals |
|--|-----------------------------|------------------|------------------|----------|------------------|-------------------|
| | General | Fed Other | III | VII | XX | |
| Adult Community Services | | | | | | |
| Adult Group Day Care | 89,480 | | 164,531 | | 260,820 | 514,832 |
| Congregate Meals | 310,274 | 781,934 | 1,758,208 | | | 2,850,416 |
| Misc Services (Note 1) | 119,469 | | 112,350 | | 78,028 | 309,847 |
| Transportation | 978,680 | | 730,571 | | | 1,709,250 |
| Total Adult Community Services | 1,497,903 | 781,934 | 2,765,660 | 0 | 338,848 | 5,384,345 |
| | | | | | | 0 |
| In-Home Support | | | | | | 0 |
| In-Home Care | 2,336,904 | 40,000 | 520,245 | | 3,243,733 | 6,140,882 |
| Emergency Support | 17,637 | | 17,637 | | | 35,274 |
| Home-Delivered Meals | 2,331,449 | 1,316,810 | 3,570,659 | | 1,711,844 | 8,930,762 |
| Home Health Aide | 41,996 | | 125,989 | | | 167,985 |
| Total In-Home Support | 4,727,986 | 1,356,810 | 4,234,529 | 0 | 4,955,578 | 15,274,903 |
| | | | | | | |
| Family Support | | | | | | |
| Alzheimer's Disease Support Program | 302,507 | | | | | 302,507 |
| NH Family Caregiver Support Program | 230,712 | | 752,137 | | | 982,849 |
| Total Family Support | 533,219 | 0 | 752,137 | 0 | 0 | 1,285,356 |
| | | | | | | |
| Aging Information Resource System | | | | | | |
| NH ServiceLink Network | 1,298,470 | 916,439 | | | 90,491 | 2,305,400 |
| Health Insurance Counseling | | 219,190 | | | | 219,190 |
| Senior Medicare Patrol Project | | 249,633 | | | | 249,633 |
| Medicare Improvements for Patients and Providers Act | | 126,562 | | | | 126,562 |
| Health Promotion | | | 66,974 | | | 66,974 |
| Enhanced ADRC / No Wrong Door | | 0 | | | | 0 |
| Total Aging Information Resource | 1,298,470 | 1,511,824 | 66,974 | 0 | 90,491 | 2,967,759 |
| | | | | | | |
| Adult Protective Services | | | | | | |
| Long Term Care Ombudsman | 0 | | | 0 | | 0 |
| Legal Services (formerly part of Misc Services) | 9,144 | | 27,431 | | | 36,575 |
| Total APS | 9,144 | 0 | 27,431 | 0 | 0 | 36,575 |
| | | | | | | |
| Grand Totals | 8,066,722 | 3,650,568 | 7,846,731 | 0 | 5,384,917 | 24,948,938 |
| | | | | | | 24,948,938 |
| Note 1: Miscellaneous Services include: Community Elder Support Svs, Nursing, Health Screening, Vision, Respite and Guardianship. | | | | | | |





NH Department of Health and Human Services DHHS Overview*

Office of the
Commissioner

Population Health

Division of Public Health

- Population Health & Community Services
- Infectious Disease Control
- Public Health Protection
- Laboratory Services
- Public Health Statistics and Information
- Public Health Systems, Policy & Performance
- Emergency Services Unit
- State Epidemiologist

Office of Health Equity

Division of Medicaid Services

- Clinical Operations
- Medicaid Policy
- Dental Services
- Health Care Reform
- Managed Care

DHHS 24/7 Facilities

- New Hampshire Hospital
- Glenclyff Home for the Elderly
- Sununu Youth Services Center
- Hampstead Hospital

2023

* Overview represents DHHS program areas, functions, and business entities, not necessarily reporting structures.

Human Services & Behavioral Health

Division of Economic & Housing Stability

- Family Assistance
- Employment Supports
- Housing Supports
- Child Support Services
- Child Development & Head Start Collaboration

Division for Behavioral Health

- Mental Health
- Drug & Alcohol Services
- Children's Mental Health

Division of Long Term Supports & Services

- Adult Protection Services
- Elderly & Adult Services
- Developmental Services
- Family Centered Services
- Community Based Military Programs

Division for Children, Youth & Families

- Field Services
- Family, Community & Program Support
- Professional & Strategic Development
- Evaluation, Analytics & Reporting
- Sununu Youth Services Center

Operations

Division of Program Quality and Integrity

- Program Quality
- Program Integrity

Bureau of Human Resource Management

- Organizational Development & Training Services

Bureau of Information Services

- Data Management
- Data Warehouse
- Information Security
- Medicaid Management Information System
- DHHS Systems Oversight
- Linkage to DoIT
- Project Management and LEAN

Bureau of Facilities Maintenance & Office Services

- HHS Facilities & State Office
- Safety & Wellness
- Office Services
- Oversight – Institutional Services

Communications Bureau

- Public Information Office

Employee Assistance Program



Brief Overviews of Older Americans Act Core Programs, and Other BEAS Support Programs and Partners

Adult Day Health Programs

Adult Day Health Programs offer provide a coordinated program of professional and compassionate services for adults in a community setting. Services are designed to provide social and some health services to adults who need supervised care in a safe place outside the home during the day. They also afford caregivers respite from the demanding responsibilities of caregiving. Adult day health programs generally operate during normal business hours five days a week. Some programs offer services in the evenings and on weekends. The following are some general services that are offered by most adult day centers:

- Social Activities
- Transportation
- Meals & Snacks
- Personal Care
- Therapeutic Activities

There are currently 15 Adult Day Health Programs in the State (4,600 nationally), consisting of a total licensed capacity of 773 persons per day. Thirty percent (30%) of these programs are located in Hillsborough County, 25% in Rockingham County, and 12% in Merrimack, Carrol and Cheshire counties. Three counties in the state are not represented with an Adult Day program. The number of Adult Day programs in the state has decreased 30% in the past 24 years, despite the growth in the population of older adults. Most programs cited low Medicaid reimbursement rates and/or low census as closure causes.

Adult Protective Services

NH's Adult Protective Services (APS) Program serves individuals who are vulnerable adults aged 18 and older. State legislation (RSA 161-F: 42-57) provides statutory authority for the program and mandates all adults to report alleged instances of abuse, neglect, or exploitation involving the target population.

The Adult Protection Program has a central intake unit for receiving reports. The responsibility for investigating adult protective reports is shared among the District Offices. Callers are connected to the central intake unit through a statewide toll-free number and the report is routed to the appropriate District Office.

Reports are investigated concerning individuals who live in their own homes or with others. BEAS coordinates a variety of services and supports to individuals at risk of abuse, neglect, self-neglect and/or financial exploitation. The primary goal is to prevent further abuse, neglect and/or exploitation and to identify services and supports that may be needed to help the individual remain in the community.

NH Adult Protective Services continues to work collaboratively with law enforcement, the Circuit Court Probate Division, Area Agencies (who serve individuals with developmental disabilities), the Office of the Long Term Care Ombudsman (OLTCO), and the Bureau of Health Facilities Administration (BHFA). When APS receives a report that is criminal in nature, notification is sent to the NH Attorney General's Office as well as to local law enforcement. When APS receives a report that involves an alleged perpetrator that is also a guardian, the probate court is notified and kept informed. When APS receives a report on an individual served by developmental services, the Bureau of Developmental Services is notified. When APS receives a report regarding an individual living in a certified or licensed residence/facility, OLTCO



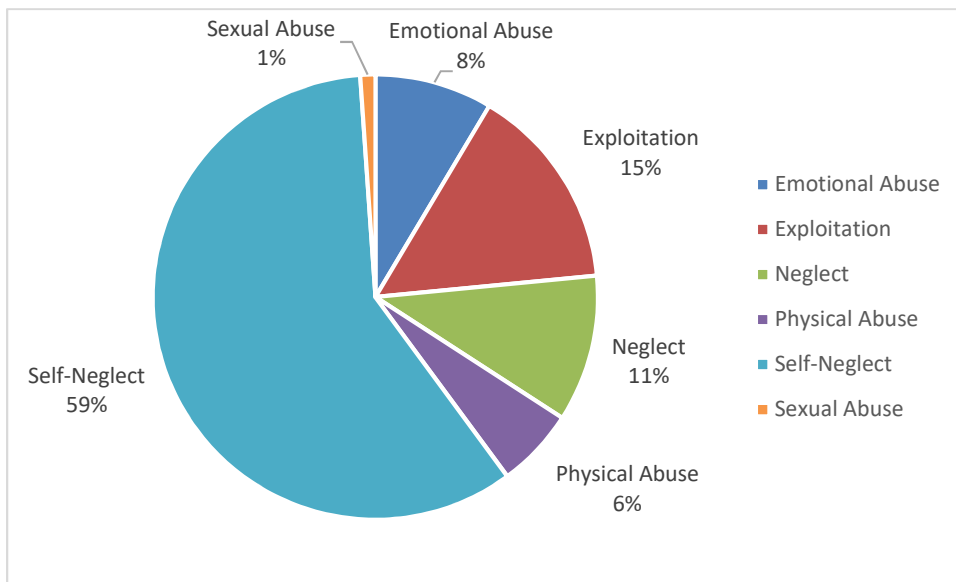
and BHFA are notified. Whenever possible, every effort is made to do joint investigations to reduce the number of times a client and others need to be interviewed.

APS continues to rely heavily on its local partners to help remediate abuse and neglect. In 2022, APS conducted 22 speaking engagements to local agencies such as town fire departments, local police departments, senior companion programs, local medical providers, home-delivered meals' agencies, local mental health providers, and several nursing facilities.

Representatives from APS continue to attend local Elder Wrap meetings, which are made up of key community organizations and partners. The mission of Elder Wrap groups is to provide guidance and lend resources to difficult situations in which a client's health and safety are at risk.

Fiscal Year: 07/01/2021 – 06/30/2022

Representing 4,042 Investigations



Alzheimer's disease and Related Disorders Respite Program

Approximately 25,000 individuals are living with ADRD in NH. The ADRD Respite Program is an integral part of the caregiver support structure in NH, and is a legislatively mandated and state general-funded program for caregivers of individuals with ADRD. By embedding the ADRD Respite Program and NH Family Caregiver Support Program within the ServiceLink structure, caregivers have access to the same counseling and support services. When respite funds are needed, ServiceLink can authorize utilization of the funding stream that is appropriate for the caregiver's situation. Through this program, BEAS serves an average of 280 people per year with respite.

At several SPOA listening sessions, concerns were shared regarding the need to strengthen education and resources for healthcare professionals, family members and the general public regarding Alzheimer's disease. Representatives from the Alzheimer's Association attended many SPOA listening sessions, and are working with BEAS to increase and strengthen education and outreach.





CENTER ON AGING AND
COMMUNITY LIVING

Center on Aging and Community Living

The Center on Aging and Community Living (CACL) is a collaboration between The Institute on Disability (IOD) and The Institute for Health Policy and Practice (IHPP) at The University of New Hampshire (UNH). These two institutes have been actively engaged in projects related to aging and long-term care for many years. Jointly, the IOD and IHPP provide ongoing support to BEAS, the ServiceLink Network, and various other community partners in the aging network, in designing, implementing, and evaluating systems change initiatives. In light of these efforts and the need to assure that the State will benefit from an integrated center for applied research, evaluation, and training on issues related to aging and long-term care, the CACL was established to coordinate the work of both institutes, maximizing the resources available, and providing optimal benefit to the State of NH. For additional information, visit the [CACL website](#).

Choices for Independence (CFI) Program

Many long-term care recipients and potential recipients prefer to be cared for at home or in other settings less acute than a nursing facility. The option to receive care in a home and community based setting is enabled via Choices for Independence - a 1915(c) Medicaid Waiver that allows a person who meets the criteria for nursing home level of care to receive their care in a setting that is not a nursing home. It provides those eligible for Medicaid nursing facility services the opportunity to choose more appropriate, less costly services and home and community-based care. Through the CFI Waiver program, participants receive coverage of a wide range of services that help them live independently and actively participate in their communities. In this way, the State intends to serve this increasing Medicaid eligible population more appropriately and more economically.

Over the last decade, the CFI Waiver program has grown. In 2012, 3,671 people were enrolled in the CFI Waiver program, and DHHS spent \$51,568,536 on participants' CFI Waiver services. In 2022, 4,478 people participated in the CFI Waiver program, and DHHS expended \$81,520,687 on services provided to people enrolled in the CFI Waiver program. Currently, at any given time, roughly 3,800 individuals are enrolled as CFI Waiver participants. Eight case management agencies provide comprehensive care planning and a network of more than 200 enrolled providers enable the delivery of services.

The goal of the program is to both allow people to receive the care they need in a setting they chose and allow for a cost effective model of care. Services can include Personal Care, Non-Medical Transportation and Participant Directed options. In July of 2022, service refinements were made and several new services were introduced.

DHHS takes seriously its responsibility to ensure that a service provider network sufficient to serve all CFI Waiver participants' needs exists. There is a workforce challenge in NH; this is not unique to CFI that limits the pool of workers available to deliver CFI Waiver services. In 2023, DHHS requested that the legislature amend state law to expand the pool of workers by allowing guardians of, and individuals with power of attorney for CFI Waiver participants to deliver CFI Waiver services.

Over the last three years, DHHS increased CFI Waiver service fee schedule rates by between 11.2 percent and 22.2 percent, and secured approval from CMS to further increase these rates each biennium to account for medical inflation. DHHS is currently seeking from the legislature an additional 3 percent increase for all CFI Waiver service rates and additional targeted increases to critical CFI services.



In addition, specialized rates have been piloted and policy is being developed to support program participants and providers in enabling services for people with specialized needs.

Effective January 1, 2024, DHHS will be fully launching provider “electronic visit verification” in alignment with the 2016 21st Century Cures Act for all CFI Waiver personal care, home health aide, and skilled nursing services. Using real-time technology, electronic visit verification will allow DHHS and case managers to confirm that a personal care, home health aide, or skilled nursing service has been provided and it will document in an electronic record specific information about the service, including the date of the service, the time the service began and ended, and the location of the service. DHHS is currently providing EVV training to providers who will be required to use EVV, offering grants to provider agencies to cover the cost of obtaining technology to implement EVV, and pilot testing EVV through a “soft launch”. It is expected that full implementation will be July 2024.

Chronic Disease Self-Management Programs and Healthy Aging Partnerships

BEAS is a member of DHHS’ Division of Public Health Services (DPHS) Falls Risk/Injury Reduction Task Force. The task force collaborates with the Dartmouth Center for Injury Prevention, hospital community health programs and senior centers to support a variety of evidence-based falls prevention programs focused on balance, strength training, and awareness.

The Chronic Disease Self-Management Program (CDSMP) and Powerful Tools for Caregivers Evidence-Based Programs are coordinated through a partnership between BEAS, ServiceLink, DPHS, Northern and Southern Area Health Education Centers, Master trainers and leaders, Dartmouth Center for Injury Prevention, senior centers and hospital community health programs. This evidence-based program partnership supports the training of new leaders for both programs, stipends to support sites to offer the programs, and participant recruitment support and ongoing participant data collection and analysis of patient activation measures.

The CDSMP Program began in 2009 when NH collaborated with Vermont to offer a CDSMP training for Master Trainers. Eleven Master trainers completed the program. NH obtained a grant from the Administration on Aging (AoA) in 2010. We trained 55 participants in Year 1, 191 in Year 2, and 394 in Year 3. We continued CDSM programming, serving 1,145 people between 2013 and 2017. Programming has varied over the years offering between 5 and 30 programs per year. NH currently has 4 active CDSM Master Trainers and 12 active workshop leaders. In 2022, BEAS connected the Chronic Disease/Pain Self-management train the trainer network with our NH Center for Independent Living staff to provide Self-Care workshops through their Health and Wellness events.

BEAS has also participated in the development of DPHS’ Heart Disease and Stroke Prevention Plan 2015-2020. DPHS’ Heart Disease and Stroke Prevention Program and Million Hearts Campaign is also collaborating with BEAS and a BEAS-contracted nutrition provider on a technical assistance grant to pilot sodium reduction strategies in the preparation of congregate and home-delivered meals.

Prior to the pandemic Chronic Disease/Pain Self-Management Network had attempted to connect and develop a partnership with NH’s Managed Care Organizations (MCOs) to work with them around our Chronic Disease Self-Management Programs. The pandemic derailed those efforts, but we are happy to report that this work has recent began again.



Grandparents Raising Grandchildren

Another component of the NH Family Caregiver Support Program (NHFCSP) is to support grandparents who are at least 55 years old and who are raising their grandchildren. In 2020, an estimated 12,000 grandparents were raising their grandchildren in NH. While counseling and support are the main focus of the program, the respite and supplemental funding are very helpful to grandparents who find themselves facing retirement and parenting for the second time around. The ServiceLink Network is able to work with grand families, assisting them in finding resources to keep their families safe and healthy. ServiceLink continues to provide outreach across the state to make partners aware that they offer these services to grand families.

The NHFCSP also supports the Annual Statewide Caregiver's Conference that provides educational sessions, addresses compassion fatigue and introduces relaxation techniques to caregivers in attendance. During the PHE the annual conferences was successfully held virtually.

Home Care Services

Home Care Services are provided to eligible individuals living in the community through licensed contracted home health agencies. BEAS contracts for both non-medical home care and home health care. Services provided are a critical component to supporting individuals in their homes.

Non-medical home care includes assistance with personal care, help with preparing meals, and help with taking care of one's home. Services include: meal preparation, laundry, light housework, bathing, dressing, eating, help getting to and from the bathroom, transportation, help with walking and medication reminders.

Home health care is medical in nature. A prescription or prior authorization from a doctor may be required to obtain the services provided by healthcare professionals such as registered nurses, licensed practical nurses, and physical, occupational, and speech-language therapists. Home health care may also be described as clinical care and skilled care. Home health agencies provide the following services: administration of medication (including IVs and injections), monitoring vital signs, wound care, assistance with recovery from illness or injury, physical therapy, occupational therapy, speech-language therapy, monitoring of medical equipment and expertise in specific medical conditions (such as Alzheimer's disease or dementia).

Legal Services

Legal Services are a vital component of the state's elder justice system. An ever-increasing number of older adults are falling victim to financial exploitation, which can leave them both homeless and penniless. They also face challenges including illegal evictions, improper denial of benefits, abusive partners and challenges at long-term care facilities. Without access to an attorney to help them protect their legal rights, older adults are forced to navigate the legal system on their own, with potentially dire consequences. Legal advocacy can make the difference in obtaining or preserving the basic building blocks of a stable life.

NH Legal Assistance (NHLA) is a statewide nonprofit law firm that represents low-income and aging clients in civil cases that impact their basic needs. Since 1975, NHLA, through its Senior Law Project (SLP), has been providing legal services to New Hampshire's older residents pursuant to Title III-B of the Older Americans Act. For over 40 years, NHLA's SLP has been the primary voice for the aging population in New Hampshire's legal and legislative arenas.

BEAS provides funding for the SLP and the entry point for legal advice and referrals 603 Legal Aid to assist adults ages 60 and older, and works closely with NHLA on an ongoing basis. Services are targeted



toward the most economically and socially disadvantaged older adults. The SLP assists consumers with concerns that include financial exploitation, consumer protection/debt collection, public and private housing, family problems, food stamps and other public assistance benefits, and utility shut-offs. It also assists with civil nursing home and assisted living/residential care facility problems. Legal services include legal advice, brief services and extended representation by attorneys and paralegals. The Project has the capacity to serve individuals who are housebound and/or isolated. In addition to providing direct representation to senior citizens in state and federal court and before a multitude of administrative agencies, SLP advocates provide community education to senior citizen groups, elder rights advocates and service providers. The SLP also engages in systemic advocacy to support laws and rules that benefit large groups of seniors.

Medicaid Nursing Home Rate Setting

BEAS is responsible for Medicaid nursing home rate setting policy. BEAS partners with the Division of Medicaid Rate Setting Unit to calculate acuity-based rates twice per year using data from Medicaid Cost Reports filed by the facilities and acuity data provided for each nursing home resident.

Medicare Programs

BEAS receives discretionary grants from the Administration for Community Living for the provision of the NH State Health Insurance Assistance Program (SHIP), the Senior Medicare Patrol (SMP) Program, and the Medicare for Patients and Providers Act (MIPPA). These critical programs are delivered through the ServiceLink Network and are guided and monitored by BEAS. ServiceLink staff members receive extensive and ongoing training in order to serve as SHIP, SMP and MIPPA counselors.

The SHIP program provides highly trained counselors to provide information, education, counseling and assistance relating to the procurement of adequate and appropriate health insurance coverage for Medicare. Key Medicare topics are Medicare coverage, prescription drug benefit, supplemental plans, and Medicare Advantage Plans. The SHIP is operated in accordance with the SHIP Standard Operating Guidance developed and approved by CMS. Timely reporting to the SHIP Tracking and Reporting System (STARS) database of all the Medicare related contacts aggregates the SHIP activity for the state. In 2022, the SHIP counselors worked with over 8,495 individual Medicare beneficiaries in their home or at a ServiceLink office, and provided over 106 outreach events around the State. These outreach events included Medicare workshops, enrollment events, brochure distribution, print advertising, cable TV messaging, and wellness fairs with education and assistance provided to an estimated 161,664 individuals.

The SMP program fosters program visibility and consistency to enhance the capability to identify and refer instances of potential health care fraud, errors and abuse through collaborations with service providers and education through outreach and individual contacts. The SMP conducts timely reporting to the SMP Information and Reporting System (SIRS) database that meets the requirements of the Office of the Inspector General (OIG). A key component of the program is volunteer participation. Each ServiceLink program recruits, trains and supports volunteers who assist consumers in navigating medically related payment and billing issues for Medicare beneficiaries.



Performance Measures submitted for the 2022 OIG report are provided below:

| | Total |
|---|----------|
| 1) Number of active SMP team members | 36 |
| 2) Number of SMP team member hours | 2,091.88 |
| 3) Number of group outreach and education events | 108 |
| 4) Estimated number of people reached through group outreach and education events | 1,254 |
| 5) Number of individual interactions with, or on behalf of, a beneficiary | 3,449 |

The MIPPA program provides tools for the SHIP counselor to provide awareness, education, screening, and application assistance for the MIPPA mission. This includes financial assistance for Medicare costs known as the Medicare Savings Program (MSP), information about no-cost preventative services, and information around Part D Medicare in rural areas. Timely reporting to the MIPPA tracking system embedded in the STARS forms captures the MIPPA work in the state. Hundreds of older people in NH were screened for eligibility of a Medicare cost savings program and over 1,143 Medicare beneficiaries were assisted with applying for a Medicare Savings Program in 2022.

Money Follows the Person

Money Follows the Person (MFP), formerly known in NH as the NH Community Passport Program (CPP), was established in 2007 through funding from the Centers for Medicare and Medicaid. The overarching goal of the MFP program is to support and incentivize states to increase capacity to transition individuals from institutional settings to community based settings. Financial savings and gains from operating the program were then re-directed towards efforts to rebalance the state’s long term care system so that individuals have meaningful choices of where they live and receive services. BEAS completed its last CPP transition in March of 2016. Since that time New Hampshire, implemented strategies to sustain and support transitions from institutional settings back to community by creating training and tools to support individuals and providers who are exploring transition. In addition, BEAS added services and supports to its Choices for Independence Waiver that were successfully utilized in CPP to sustain transition efforts, including transitional case management and Community Transition services.

NH received CMS approval and funding for a demonstration grant award to restart the MFP program in late 2022. BEAS is currently in the process of developing the Operational Protocol for the MFP program which will outline the new array of services and supports that NH will implement to build upon the success of CPP and further expand access to home and community based services. BEAS is developing the Operational Protocol with input from various stakeholders and anticipates submission to CMS on or before December 31, 2023.





NH Alliance for Healthy Aging

The NH Alliance for Healthy Aging (AHA) is a statewide coalition of stakeholders focused on the health and well-being of older adults in NH. AHA works to promote its shared vision to create communities in New Hampshire that advance culture, policies and services which support older adults and their families. Their goal is to raise our collective voice in support of the aging population in New Hampshire, promoting a strong, stable infrastructure for advocating for older adults in our state. AHA has participation of over 350 stakeholders statewide, representing many organizations within New Hampshire. BEAS has several staff involved and supporting NH AHA efforts. This partnership will help to advance our State Plan on Aging.

NH Family Caregiver Support Program

The NH Family Caregiver Support Program (NHFCSP) is embedded in the ServiceLink Network. The majority of long-term care in the home is provided by family caregivers, and NH has made significant investments to develop and expand a coordinated infrastructure to support family caregivers, providing the ongoing information and tools needed by caregivers to continue their important role. ServiceLink staff attain specific training and competencies in order to support family caregivers.

In addition to the counseling and support provided, caregivers may also receive small grants to support their access to respite care and supplemental services. Many NH caregivers report that having access to a caregiver specialist is the most critical benefit of the program.

The strongest asset of the program is the flexibility in designing individual service plans using a person centered planning model so that caregivers can decide what they need most in their caregiving situation. Each caregiver also completes a spending plan so they know how they want to use any grant funds they receive. BEAS contracts with Gateways Community Services to perform human resource and financial management service functions. Gateways also processes and pays the bills for the approved respite and supplemental services and issues monthly statements to both caregivers and ServiceLink to help monitor spending. NH has an estimated 170,000 caregivers, and the NHFCSP serves about 500 grantee caregivers each year. One of the goals of the program is to continually identify caregivers and offer them the support they need.

Recently, NH has begun using an evidenced-based caregiver assessment which helps identify the risk of burnout and placement. This is important because it assists in the development of a care plan that will aid in prolonging the caregiver ability to provide care to their family member in the community for longer as they will stay healthier, mentally and physically stronger for longer. In addition, we have added Trualta, an education platform for caregiver, providing caregivers education on a wide variety of topics from dementia care, to caring for grandchildren, to self-care. This education program is self-paced. Therefore, Caregivers are able to participate when they are able. Trualta also includes an online community feature, which includes online support groups and webinars.



NH Legislative State Commission on Aging

In July of 2019, The Governor and the NH State Legislature approved the establishment of a State Commission on Aging (SCOA). The SCOA includes two (2) members of the House of Representatives (appointed by the speaker of the house) and one (1) member of the senate (appointed by the president of the senate). Also, the SCOA includes Commissioners from the Department of Health & Human Services, Department of Labor, Department of Employment, Department of Safety, Department of Transportation, the Attorney General, The Executive Director of the New Hampshire Housing Finance Authority and the Long-Term Care Ombudsman, or their designees. In addition, the SCOA includes fifteen (15) members of the public, including at least one member from each county, including representatives of the business community, health care, technology and innovation, municipal leaders, the aging network, advocacy organizations, caregivers, and direct service providers focused on the older adult population, and are appointed by the governor. The SCOA has also hired an Executive Director who facilitates SCOA meetings and other duties as the Commission may require.

The members appointed serve 2-year terms; provided that initially such members shall serve staggered terms and no such member shall serve more than two (2) consecutive terms. When thirteen (13) members are present for a Commission meeting then that shall constitute a quorum. The SCOA makes recommendations for consideration by the policy leaders within New Hampshire. The primary goal for the SCOA is to ensure that all individuals in New Hampshire have the opportunity to thrive as we age and continue to make valuable contributions to our families, communities, and state.

Nursing Homes

New Hampshire nursing homes play a vital role in the Long Term Services and Supports (LTSS) continuum of care. There are currently seventy-four nursing homes in the state, which provide care to an increasingly acute population. In order to be admitted into a nursing home, an individual must have been deemed to have a medical need under the Preadmission Screening and Resident Review (PASSR II) process. This screening process is designed to ensure an individual receives the needed LTSS services in the most appropriate care setting. Nursing homes face many challenges in meeting the care needs of their residents. They operate in the second most regulated industry in the United States, facing ongoing regulatory pressures from the federal government and at times, additional regulatory challenges from the New Hampshire state legislature; face a healthcare workforce challenge which is threatening the ability of some homes to remain in the continuum of care due to a lack of staff; and face ongoing changes to reimbursement models, both at the federal level of government and at the state level of government which threatens the financial sustainability of providers and ultimately, their ability to attract and retain qualified care givers to meet the care needs of our residents.

Of the seventy-four nursing homes in the state, eleven of these homes are operated by the ten New Hampshire counties, and comprise roughly twenty-five percent of the total number of nursing home beds in the state. County nursing homes are part of the New Hampshire Association of Counties (NHAC), which represents the interests of county government in New Hampshire. In New Hampshire, a significant portion of the state Medicaid program, including nursing facility services and certain long-term care services and supports (LTSS), is financed by county taxes. New Hampshire counties play a critical role in the financing of all LTSS services. For the majority of LTSS services county governments provide the state share of Medicaid costs, which is matched by federal spending at a 50% rate.



Nutrition – Congregate Meals and Home Delivered Meals

Congregate and home-delivered meals are a core program of the Older Americans Act and provide critical nutrition services and social supports to older adults across New Hampshire. Through a statewide network of delivery systems, nutritious and affordable meals are delivered to over 15,000 homes in the State each year, totaling over 1.8M home-delivered meals.

Despite many obstacles such as the various New England weather conditions and vast distances between client homes in rural areas, the nutrition agencies manage the challenging task of delivering thousands of home-delivered meals. The daily check-in by the driver provides essential human contact for many individuals who otherwise might not see another person all day. The home-delivered meals are often the first service accessed by older adults and one of the important services that helps older adult remain in their home and community. Nutrition providers follow-up on thousands of issues and concerns made apparent through the daily check-in, some of which require reports of suspected elder abuse and self-neglect or provide information and referral for additional community resources.

Historically, the Congregate Dining Program provides meals to 17,000 older adults annually. With that being said, NH has seen a significant decrease in congregate dining since the Covid-19 pandemic. These meals offer nutritious and affordable food, provide opportunities to socialize with other older adults, and support access to information and education on nutrition, health, community resources and older adult issues. Most of BEAS' meals providers are transportation providers as well, and provide door-to-door transit enabling older, isolated adults to participate in the Congregate Dining Programs. Also, NH has develop a new congregate dining program called the Restaurant Voucher Program, which was designed to expand congregate dining opportunities and increase opportunities for socialization.

Additionally, all nutrition agencies promote healthy aging through basic preventative health screenings, exercise programs for the body and mind, and volunteer opportunities that keep older adults connected to their communities. Also, when providing nutrition services, contracted vendors ensure that they allow for cultural considerations/preferences are available for clients who have those requests and, when necessary, provide medically tailored meals for clients with unique nutritional needs.

The agencies that provide these services are integral members of the elder network in the state, the region, and nationally. These agencies raise an average of 30% of their annual budgets in order to meet the current and growing need.

Office of the Long-Term Care Ombudsman (OLTCO)

The Long-Term Care Ombudsman receives, services, investigates and resolves complaints or problems concerning residents of long-term health care facilities. The OLTCO recruits, trains, certifies and provides ongoing support and training to program volunteers who support the work of the professional OLTCO staff in identifying and resolving complaints or problems experienced by long-term care residents in nursing homes, assisted living facilities and residential hospice care facilities.

The OLTCO, including professional long-term care ombudsmen and volunteers, advocates on behalf of either individual residents or groups of residents. OLTCO also provides information to residents, family members and staff members at the designated facilities regarding long-term care services and supports, including transition assistance options for nursing home residents who express a desire to explore transitioning to the community.



Complaints are received from various sources, and information about the complainant (reporter) is only released with the resident's or complainant's permission. Complaints received by OLTCO are sometimes referred to other agencies for resolution. For example, a report that, in addition to care complaints and rights complaints, also contains allegations of abuse, neglect, self-neglect and financial exploitation, is referred to the APS Program. Depending on individual client circumstances, referrals may also be made to Medicaid Client Services, the NH Board of Nursing, ServiceLink and to DHHS Bureau of Health Facilities Administration. Referrals may also include NH Legal Assistance, the Disability Rights Center and law enforcement.

Referral, Education, Assistance and Prevention (REAP) Program

REAP is a long standing and unique evidence-based service model. REAP began in 1992 with a Robert Wood Johnson grant obtained by New Hampshire Housing, and expanded the program in 2003 through a partnership with NH's Community Mental Health Centers (CMHC) leveraging evidence based tools and practices. Counselors are located in each of the 10 CMHCs. REAP offers free and confidential, home-based counseling statewide to adults age 60 and older and to family members or caregivers with concerns about an older adult. Counseling is offered on a wide range of personal concerns: grief and loss, the use of alcohol or drugs, medication safety, housing and mental health concerns and more.

REAP counselors reach out to older adults where they live in the community, and are trained to address the unique needs and concerns of older adults. They help over 2,000 individuals every year stay healthy and independent. REAP counselors also offer group educational sessions in senior housing and other places where older adults gather, and provide technical assistance to professionals who serve older adults. REAP is supported by New Hampshire Housing and other areas in the NH Department of Health and Human Services: the Bureau of Mental Health Services, and the Bureau of Drug and Alcohol Services.

Senior Centers

There are 65 senior centers across New Hampshire. While not funded through BEAS (with the exception of sites that provide congregate or BEAS supported evidenced-based programs), the NH Association of Senior Centers and its membership throughout the state are important, longstanding community partners with BEAS, and provide a vital service to our aging communities. Of the 65 senior centers in NH, 23 of these centers are members of the NH Association of Senior Centers, and work to support and strengthen the statewide network of senior centers and senior program professionals. The Association also works to elevate the awareness, value and appreciation of Senior Centers and Senior Programs throughout the state.

ServiceLink Aging and Disability Resource Center

The ServiceLink Aging and Disability Resource Center (ADRC) is a program of the Bureau of Elderly & Adult Services at the NH Department of Health and Human Services. BEAS developed and implemented the statewide Aging and Disability Resource Center (ADRC) system, known as the ServiceLink Network, in 2003. This comprehensive network includes at least one ServiceLink location in each of NH's ten counties. There are 8 contracts around the state, operating 13 offices. Each ServiceLink is a fully functioning ADRC; ServiceLink is also the BEAS/DHHS No Wrong Door Full Service Access Partners, known as NHCarePath. BEAS contracts with independent 501(c) (3) entities that act as fiscal agents for the ServiceLink Network.

In fiscal year 2022, ServiceLink served over 38,880 unduplicated individuals, partnering with numerous community organizations across the state in providing guidance, support, and choice for individuals of all ages, income levels and abilities.



ServiceLink administers the following programs:

- *Assistive Technology equipment demonstrations and loans;*
- *Full Service Access Partner for the BEAS/DHHS No Wrong Door System also known as NHCarePath;*
- *Information Referral and Assistance;*
- *NHCarePath;*
- *NH Family Caregiver Program;*
- *Outreach and Education;*
- *Person Centered Options Counseling;*
- *Senior Medicare Patrol (SMP);*
- *State Health Insurance Assistance Program (SHIP);*
- *Streamlined access to publically funded programs; and*
- *Veterans Directed Home and Community Based Services Program.*

Serving Adults with Disabilities

Under the recently established Division of Long Term Services and Supports, BEAS is aligned with the Bureau of Developmental Services (BDS), and the Bureau of Family Centered Services. BEAS works collaboratively with all bureaus, and has identified significant alignment opportunities to strengthen supports between programs and services to support all individuals across the aging community.

BEAS and BDS recognize the overlap of aging and disability, and are working together to strengthen and align this work. BDS offers individuals with developmental disabilities and acquired brain disorders a wide range of supports and services within their own communities, and is comprised of a main office in Concord and 10 designated non-profit Area Agencies. In partnership with the Area Agencies, supports include:

- Service coordination;
- Day and vocational services;
- Personal care services;
- Community support services;
- Early Supports and Services and Early Intervention;
- Assistive technology services; and
- Specialty services and flexible family supports including respite services and environmental modifications.

BDS has made great strides with its population, identifying risk and destabilization with its implementation and on-going training of the Health Risk Screening Tool (HRST); a tool that can be used throughout the aging population. The Bureau also supports the Disabilities and Public Health Project in helping to promote and maximize health, prevent chronic disease, improve emergency preparedness and promote access for people with disabilities and the older population at large. In 2019, BEAS assigned the BEAS Program Manager of the Chronic Disease Self-Management Program to serve on the NH Council on Disabilities, strengthening supports to chronic disease self-management across both populations.



There are also multiple opportunities for older adults within the state to provide homes, daily care, and transportation for the aging disabled. Adult caregivers are aging in place, simultaneously providing care to individuals with developmental disabilities. The adult caregivers are administering medication, and performing needed medical tasks under the guidance of nurses trained to oversee this aging population.

System of Care for Long-Term Supports & Services

July, 2023, the NH Legislature, Senate and Governor approved a biennium budget for SFY24 & SFY25 that includes an investment in NH's long-term care system of care. The system of care referenced in the budget bill is meant to streamline access to long-term care supports and Services, and not intended to expand eligibility for Medicaid or any home and community-based Medicaid waiver programs. This budget will also expand staff capacity and support staff education & training coordination within NH's ADRC network. In addition, expanding family caregiver supports and services.

Title XX Programs (Social Services Block Grant)

BEAS also receives a portion of DHHS' Title XX funding, for which an individual must demonstrate a service need and meet financial eligibility requirements. Title XX services are available to adults with chronic illnesses or disabilities between the ages of 18-59 and older adults aged 60 and older. Title XX services include Adult Day Services, Homemaker and In-Home Services, Home-Delivered Meals and Essential Services (emergency supports). Some of BEAS' service providers receive both Titles III and XX funding, but cannot bill both sources at the same time. This enables service providers to bill for services under Title III or XX, depending on a participant's circumstances. Title XX service providers may charge a participant a co-payment toward the cost of services and must maintain a sliding fee scale to accommodate individuals' ability to pay.

Transportation

Transportation continues to be identified as a top concern and need during our 2023 SPOA Listening Sessions, and it has been a priority for older adults and adults with disabilities for many years in NH. Transportation is provided for eligible older adults to help them continue to live in their home and community. Trips are provided on an on-demand and/or fixed-route basis. Many of the BEAS funded nutrition providers also provide transportation. Vehicle, licensing and operational standards are established by the NH Department of Safety and federal Department of Transportation regulations. BEAS funded transportation providers are members of the NH Community Transportation Regional Coordinating Councils (RCC's), which is comprised of local transportation providers, human service agencies, funding organizations, consumers, and regional planning commission staff. The RCC's identify opportunities for coordination between service providers, and provide guidance and updates to the State Transportation Coordinating Council.

Because of the importance of transportation to NH's older adults and adults with disabilities, additional information is provided below regarding the State Coordinating Council (SCC)/Regional Coordinating Councils (RCCs):

With the passage of RSA 239-B in 2007, the NH State legislature established the State Coordinating Council (SCC) for Community Transportation in NH with the goal of reducing duplication, increasing the availability of service, and making scarce resources go further as the need for transportation increases with an aging and growing population. Represented on the Council are the state departments of Health and Human Services, Transportation, and Education as well as the Governor's Commission on Disability, transit providers, regional planning commissions, and various advocates.

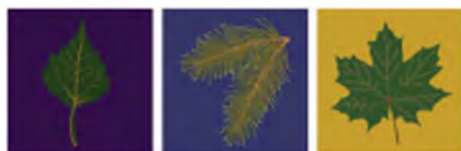


Subsequent to the establishment of the SCC, a network of nine (9) community transportation regions was established. Each region has a Regional Coordinating Council (RCC) that works to develop information that is helpful to transportation service users, identify opportunities for coordination between service providers, and advise the SCC as to the state of coordination in the region. NHDOT contracts with a lead agency within each region to implement regionally prioritized projects. The lead agency in turn subcontracts with multiple types of transit providers within its region to provide a variety of transportation options to meet the needs of different populations. The RCCs' comprehensive system is comprised of bus and van transportation, volunteer driver networks, private operators of public transportation (e.g., taxis), and transportation that supports riders with mobility challenges.

A similarity between NHDOT and BEAS exists in that both receive funding to support transportation for specialized populations. BEAS receives Health and Human Services Title IIIB funding to provide transportation for older adults, whereas NHDOT receives Federal Transit Administration (FTA) Section 5310 Program funding to provide transportation for older adults and individuals with disabilities.

NHDOT sets approximately 55% of this FTA Section 5310 funding aside for agencies such as senior centers and adult day centers to purchase capital (i.e., vehicles) used for this purpose. These agencies apply directly to NHDOT's statewide grant/project solicitation, with letters of support from the affected RCC(s) being a requirement of the application to ensure that the receiving agencies are committed to participating in the regionally coordinated model.

The balance of NHDOT's FTA Section 5310 funding is allocated to each region via the respective lead agencies. The funding is generally used for mobility management activities and/or operating assistance. NHDOT utilizes NH census information and comprehensive funding formulas in its calculations to allocate funding to each region. This enables NHDOT to allocate funding to align with the current needs of the RCC's population. In addition, NHDOT collects financial and performance data from the RCCs, as required both by the FTA as well as NHDOT. NHDOT receives data and information supplied from each RCC, which helps to ensure that the allocated transportation funding is meeting the needs of clients. BEAS historically has captured basic transportation information, including the number of riders and number of trips provided.



Tri-State Collaborative on Aging

In 2014, the NH Endowment for Health, the state's largest health foundation, commenced an inaugural five-year strategic focus and planning period to support aging in NH. The initial engagement included Maine and Vermont, due to the similarities between the three states and, most importantly, the three states have the three fastest-growing older populations in the country. This initial work provided the foundation for these three states to launch the Tri-State Collaborative on Aging, a thriving, multi-sector collaborative that is helping to build strong communities that support healthy aging through shared learning and collaborative partnerships in Maine, NH and Vermont. The Collaborative offers a community network, a learning collaborative, webinars, tools, and regional gatherings that focus on all



aspects of healthy aging across the region. For more information, please see:
<https://agefriendly.community/>

Veteran Directed Care

The ServiceLink Network are recognized as champions in serving and supporting NH veterans and their families, and share a positive and collaborative partnership with the Veterans Administration (VA), as well as with other military partners. There are over 100,000 veterans in NH, and over 50% of these veterans are over 65 years of age. Just over 30,000 veterans receive care at the VA, and the majority of veterans and their families' access services and care in the community.

ServiceLink collaborates with the Manchester VA Medical Center (NH) and the White River Junction VA Medical Center (Vermont) in delivering Veteran Directed Care (VDC). VDC is for veterans who need skilled services, case management, and assistance with activities of daily living (e.g., bathing and getting dressed) or instrumental activities of daily living (e.g., fixing meals and taking medicines). The VA determines the eligibility and monthly budget for the program, and ServiceLink assists in identifying and securing needed supports and services. This program operates state-wide and serves over 100 of NH's most vulnerable and isolated veterans each year. ServiceLink staff are trained in military culture every year to help strengthen understanding and supports to veterans and their families.



New Hampshire State Plan on Aging Survey and Listening Session Summary



Bureau of Elderly & Adult Services
NH Department of Health and Human Services

In partnership with the NH State Plan on Aging Planning Committee
and the NH Legislative State Committee on Aging



2023 State Plan on Aging

Survey & Listening Sessions Summary

Prepared by: The New Hampshire Alliance for Healthy Aging

The New Hampshire Department of Health and Human Services (DHHS), Bureau of Elderly & Adult Services (BEAS) is designated by the NH Legislature as the State's Agency on Aging. Under this designation, BEAS is given the authority to develop and administer the State Plan on Aging (SPOA) in accordance with all requirements of the Older American's Act (OAA) of 1965, as amended. The SPOA is required by the federal Administration for Community Living (ACL) for NH to receive federal funding for Older Americans Act programs. As a starting point, BEAS invited representatives of the NH Alliance for Healthy Aging (NHAHA), a statewide coalition of greater than 480 stakeholders focused on the health and well-being of older people in NH, and the NH Commission on Aging (NHCOA), established to advise the governor and the general court on policy and planning related to aging, to come together and serve on the State Plan on Aging (SPOA) Planning Committee. This SPOA Committee representation allowed for input from both statewide initiatives with the goal to develop a four-year plan that aligns with and can be supported by both initiatives.

In their role as backbone support to the NH Alliance for Healthy Aging, the University of New Hampshire Center on Aging and Community Living provided analysis of the survey and listening sessions held to gather input from stakeholders into the priorities and goals of State Plan on Aging.

SPOA Survey and Quantitative Results

Methodology

Developing the Survey and Data Collection

To develop the survey, the SPOA Committee began by reviewing the previous SPOA survey. The previous survey included evidence-based research questions and extensive input from the BEAS Executive Team, NH Legislative State Committee on Aging, and outside community groups. To address potential gaps in data collection from the previous survey, input from stakeholder experts was solicited. For example, the NH Alliance for Healthy Aging Transportation Strategic Priority Workgroup, which includes a range of transit experts, provided recommendations related to understanding transportation needs.

The survey was available online through Qualtrics, a survey platform, and on paper. Paper surveys were available at SPOA listening sessions and other community spaces such as senior centers. Paper surveys were collected and sent to analysts for input. Both online and paper-based surveys were available in multiple languages, including Arabic, English, French, Greek, Kinyarwanda, Nepali, Portuguese, Spanish, Swahili, and Vietnamese.

Data collection began on December 8, 2022 and concluded on February 24, 2023. The survey was promoted across the state by BEAS, NHAHA, and NHCOA as well as by their respective partners, through flyer (electronic and paper) distribution, social media, and email. BEAS also issued press releases announcing the survey and listening sessions as well as provided information on their website



(<https://www.dhhs.nh.gov/programs-services/adult-aging-care/new-hampshire-state-plan-aging>). All partial survey responses were included for survey analysis with a total of 955 individuals answering at least one question, and 755 individuals completing the survey in its entirety.

Data Analysis

Data was analyzed using Microsoft Excel, Qualtrics, and SPSS. No statistical analysis was performed.

The survey included 28 multiple choice questions and 6 Likert scale questions for a total of 34 question. Importantly, some survey questions include the option “*check all that apply*”. To adequately represent the importance of these response item, analysts calculated percentages using the following formula:

$$\frac{\text{Number of respondents who indicated response item}}{\text{Total number of respondents who answered question}}$$

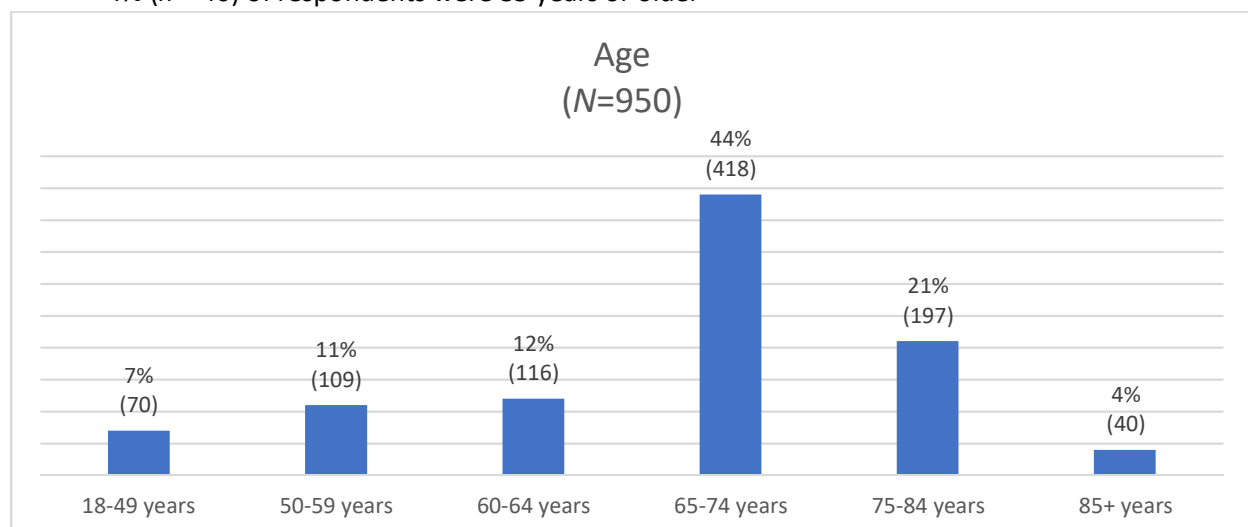
Therefore, percentages may not equal 100% and for “*check all that apply*” questions, response categories can be viewed as a percentage of those who chose the response compared to those who did not choose the response. Likert scale questions were ranked as follows 1 = not sure/doesn’t apply, 2 = not important/low need, 3 = moderate importance/need, 4 = very important/high need. Therefore, higher mean values equate to higher importance/higher need.

Results

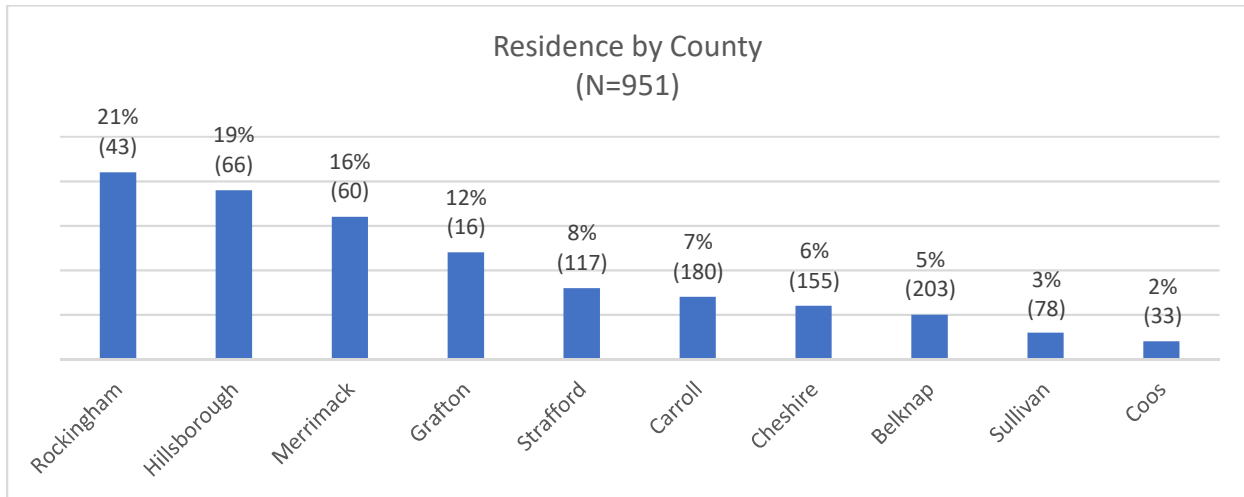
Section 1: Demographic Information

Age. A total of 950 respondents indicated their age from a select range in years (18-49 years, 50-59 years, 60-64 years, 65-74 years, 75-84 years, and 85+ years).

- 44% ($n = 418$) of respondents were between the ages of 65–74
- 21% ($n = 197$) of respondents were between the ages 75-84
- 12% ($n = 116$) of respondents were between the ages of 60 -64
- 11% ($n = 109$) of respondents were between the ages 50-59
- 7% ($n = 70$) of respondents were between the ages of 18 and 49
- 4% ($n = 40$) of respondents were 85 years or older



Residence. 951 respondents identified their county of residence. The county with the most respondents was Rockingham (21%, $n = 203$), followed closely by Hillsborough County (19%, $n = 180$). The county with the least respondents was Coös (2%, $n = 16$) preceded by Sullivan County (3%, $n = 33$).



Race and Ethnicity.

- Of the 936 respondents, about 1% ($n = 9$) of respondents indicated that they were of Hispanic, Latino/a, or Spanish origin, while 99% ($n = 927$) were not of Hispanic, Latino/a, or Spanish origin.
- Of the 937 respondents that identified their race, 1.3% ($n = 12$) identified as American Indian or Alaska Native, 1.7% ($n = 11$) identified as Asian, 0.7% ($n = 7$) identified as Black or African American, 0.2% ($n = 2$) identified as Native Hawaiian or Pacific Islander, and 98% ($n = 919$) identified as White.

Ability to speak English. Most respondents indicated that they speak English very well (96%, $n = 911$) or well (3%, $n = 32$). About 0.1% ($n = 1$) of respondents indicated that they do not speak English well and 0.4% ($n = 4$) indicated that they do not speak English at all and completed the survey with translation assistance.

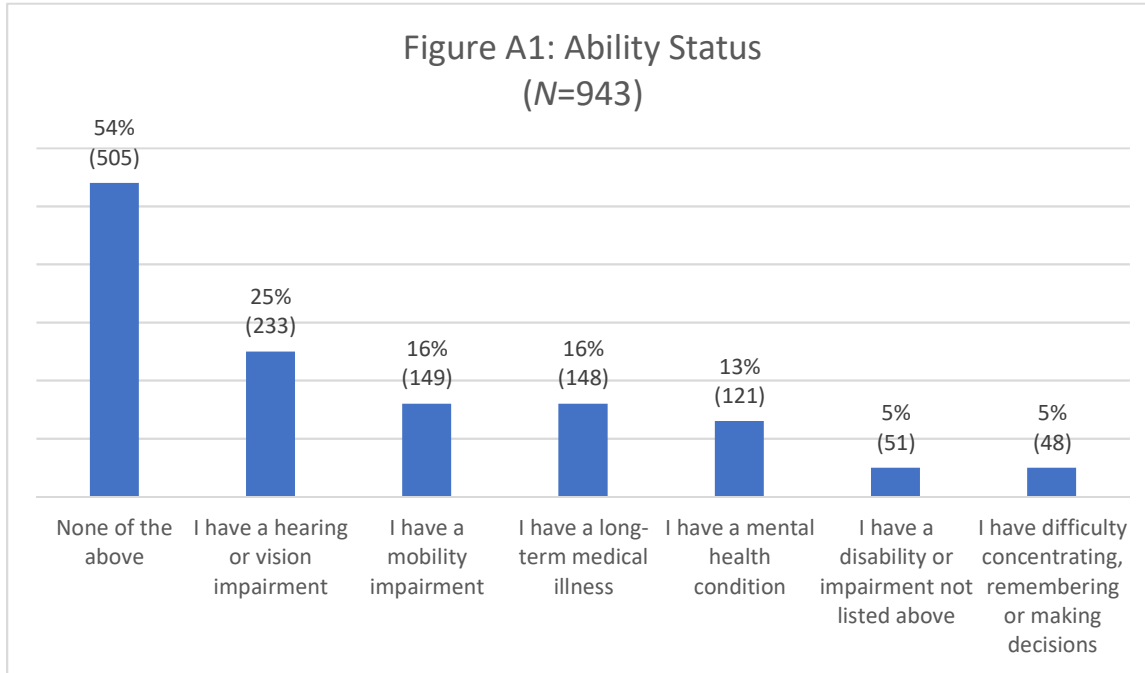
Sexual Orientation and Gender Identity.

- A total of 943 respondents identified their sexual orientation. Most respondents identified as heterosexual (87%, $n = 825$), with 2% ($n = 20$) identifying as bisexual, 3% ($n = 26$) identifying as lesbian or gay, and 1% ($n = 11$) as other.
- For gender identity, 949 respondents answered with about 84% ($n = 794$) identifying as female, 14% ($n = 136$) as male, 0.11% ($n = 1$) as transgender, 0.42% ($n = 4$) as non-binary, and 1% ($n = 14$) preferred not to disclose.

Ability Status. This question asked about a range of physical and cognitive impairments and/or disabilities that respondents may experience. Of the 943 respondents who answered, about 54% ($n = 505$) indicated that they did not have any impairments. About 25% ($n = 233$) of respondents indicated



that they have a hearing or vision impairment while 16% ($n = 149$) indicated that they have a mobility



Difficulty with Activities. Respondents indicated if they had difficulty with activities of daily living including dressing/bathing, running errands alone, and managing finances. Of the 90 respondents who answered this question, 47% ($n = 61$) had difficulty doing errands alone, 35% ($n = 45$) had difficulty managing finances, and 19% ($n = 25$) had difficulty dressing or bathing.

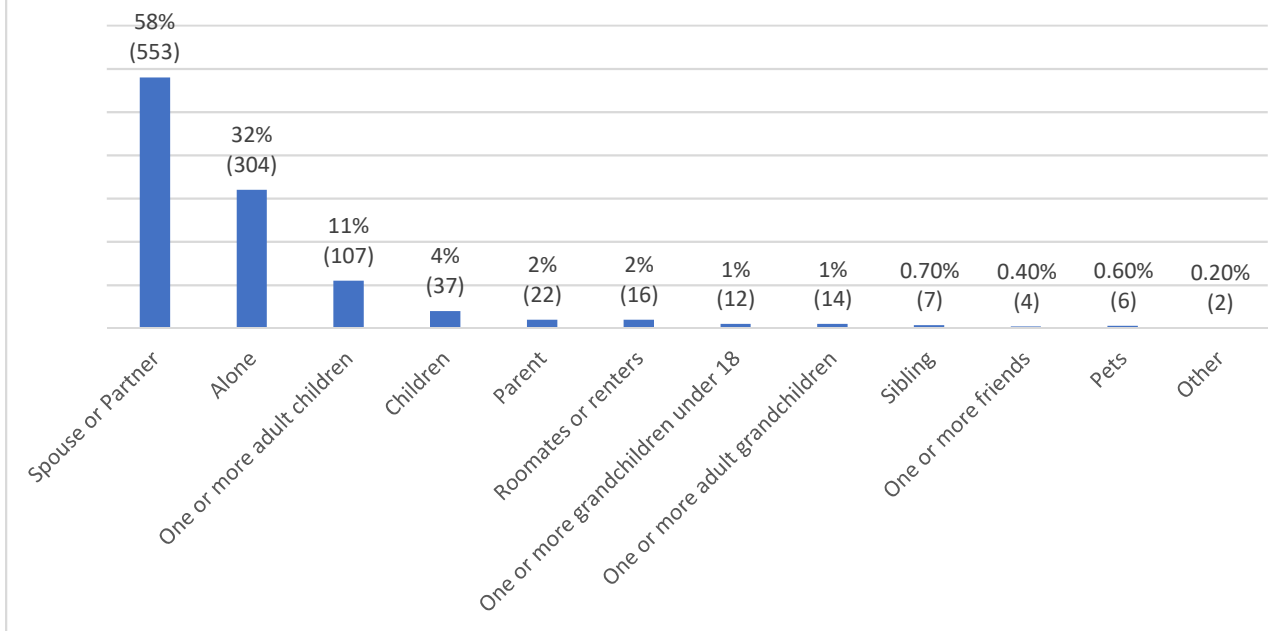
Employment Status. Of the 945 respondents that answered this question, almost half indicated they are retired (56%, $n = 525$), 26% ($n = 243$) are working full-time, 16% ($n = 152$) are working part-time, and 12% ($n=116$) are volunteers.

| Employment Status | % | N |
|--------------------------------------|------|-----|
| Retired | 47% | 525 |
| Working full-time | 22% | 243 |
| Working-part-time | 14% | 152 |
| Volunteer | 10% | 116 |
| Unable to work | 4% | 41 |
| Homemaker | 2% | 27 |
| Out of work and looking for work | 1% | 12 |
| Working and looking for more work | 0.5% | 6 |
| Out of work and not looking for work | 0.3% | 3 |

Household Size. Of the 947 respondents who answered this question with more than half (58%, $n = 551$) indicated they live with a spouse or partner, about 32% ($n = 302$) live alone, and about 11% ($n = 104$) live with one or more adult children. Other responses included living with a nephew ($n = 1$) and prefer not to say ($n = 1$).



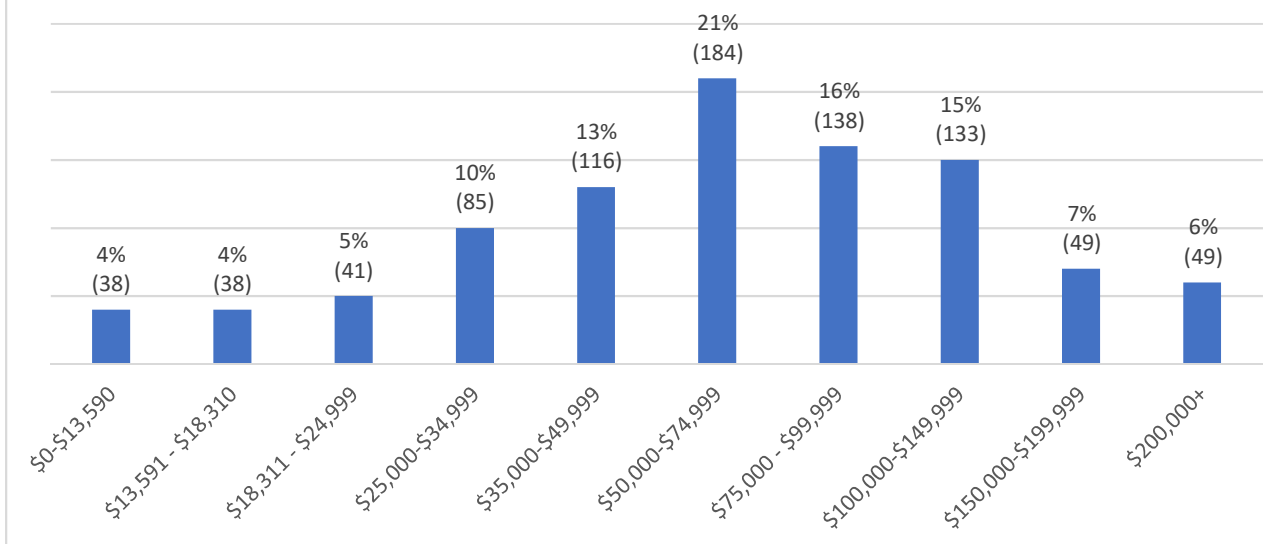
Figure A2: Household Size
(N = 947)



Education level. 945 respondents provided their level of education. About 40% ($n = 375$) indicated that they had a graduate or professional degree, 31% ($n = 294$) have a bachelor’s degree, 11% ($n = 105$) have some college, 9% ($n = 88$) have an associates degree, 7% ($n = 66$) have a high school degree or GED, and 2% ($n = 17$) have no high school diploma or equivalent.

Income level. 881 respondents provided income based on predetermined ranges. This sample shows a normal distribution for income with fewer people having low and high incomes.

Figure A3: Income
(N = 881)



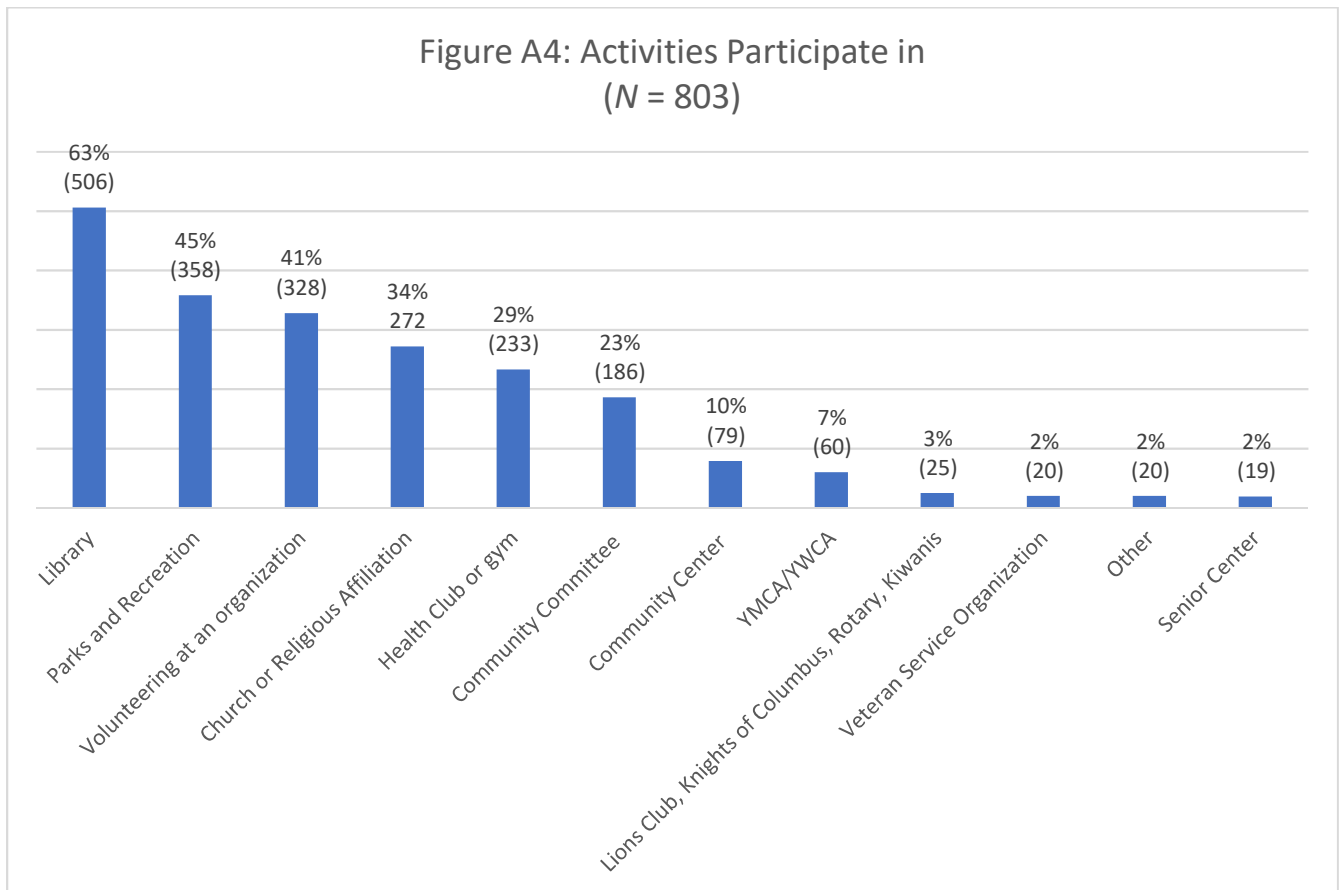
Active Duty. Of those who answered this question ($N = 937$), most respondents (93%, $n = 871$) had not served in the U.S. Armed Forces in the regular military, National Guard, or military reserves.

Section 2: Activities Participated in

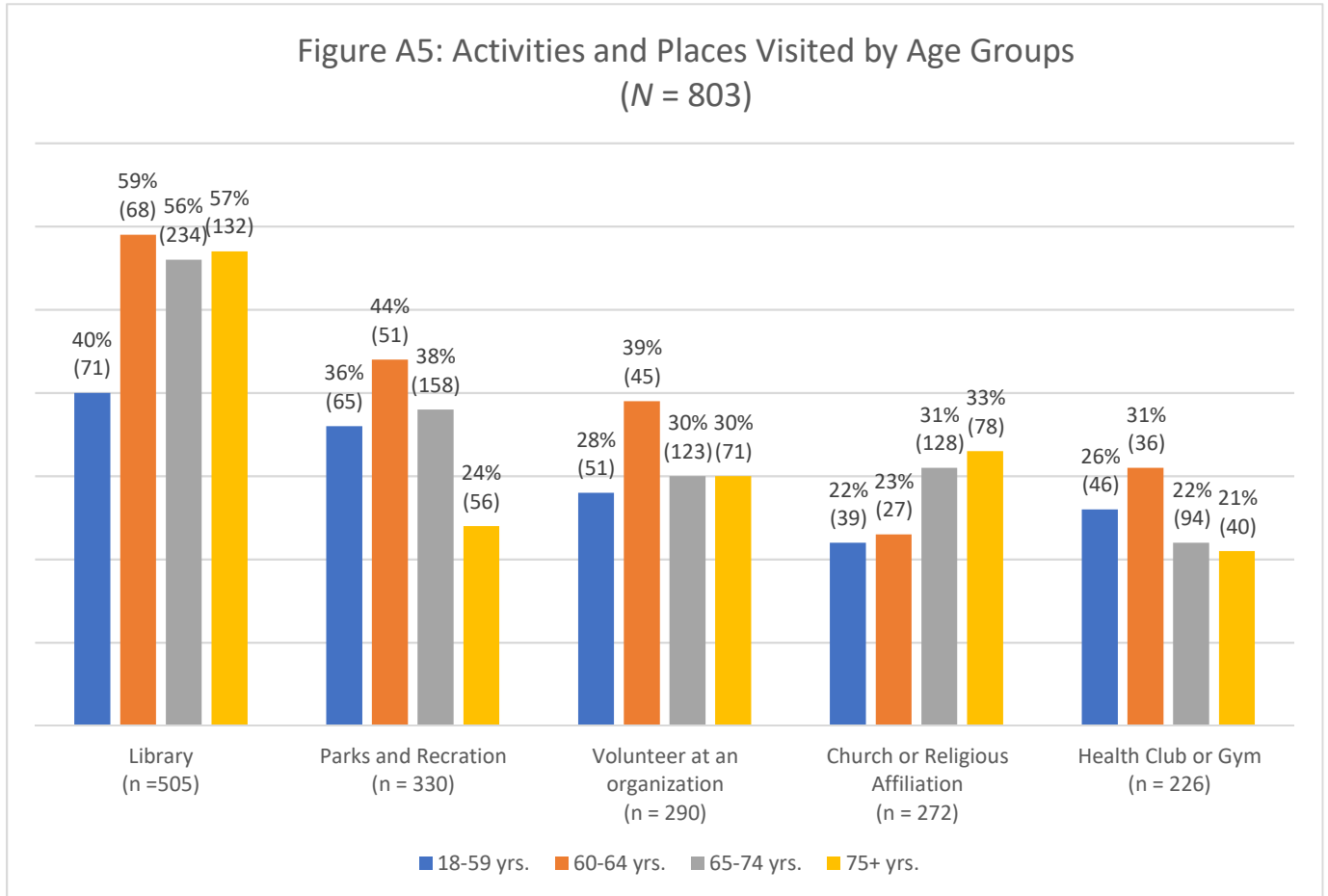
Places Visited and Activities Conducted. 803 respondents answered the question “*What places do you visit or activities do you engage in? Check all that apply.*” This question included an “other” box which allowed respondents to type in the types of activities they engaged in or places they frequent. Many written responses were duplicative of available prompts and were recoded to be included in the original prompts.

The most frequented responses included library (63%, $n = 506$ parks and recreation department (45%, $n = 358$), and volunteering at an organization (41%, $n = 328$). The least responses were about 7% ($n = 60$) of respondents participated in YMCA/YWCA, 3% ($n = 25$) in the Lions Club/Mason’s Knights of Columbus/Rotary/Kiwanis, and 2% ($n = 20$) in a veteran’s organization.

Two themes emerged from the “other” write-in box that warranted their own category. Specifically, 19 respondents (2%) indicated that they engage with their senior center. About 1% ($n = 10$) of respondents indicated that they do not engage in any activities or visit any locations outside of their home with some respondents citing that they are bed bound or unable to drive. Other write-in comments (2%, $n = 20$) included travel, caregivers groups and support groups, educational classes and teaching such as OLLI, and spending time with friends and family.



Places Visited and Activities Conducted Across Age Groups. The five most popular places visited and activities conducted (i.e., libraries, parks and recreation, volunteer at an organization, church or religious affiliation, and health club or gym) is depicted visually across age ranges of 18 – 59 years, 60 – 64 years, 65 – 74 years, and 75+ years. Respondents aged 18 – 59 years are the most engaged with libraries (40%, $n = 71$) and the least engaged with churches or religious affiliations (22%, $n = 39$). About 44% ($n = 51$) of respondents aged 60 – 64 years engaged with parks and recreation and about 39% ($n = 45$) volunteer at an organization. About 38% ($n = 158$) of respondents aged 65 – 74 years old engage with parks and recreation and about 22% ($n = 94$) utilize a health club or gym. About 33% ($n = 78$) of respondents aged 75 years or older engage with churches or religious affiliations.



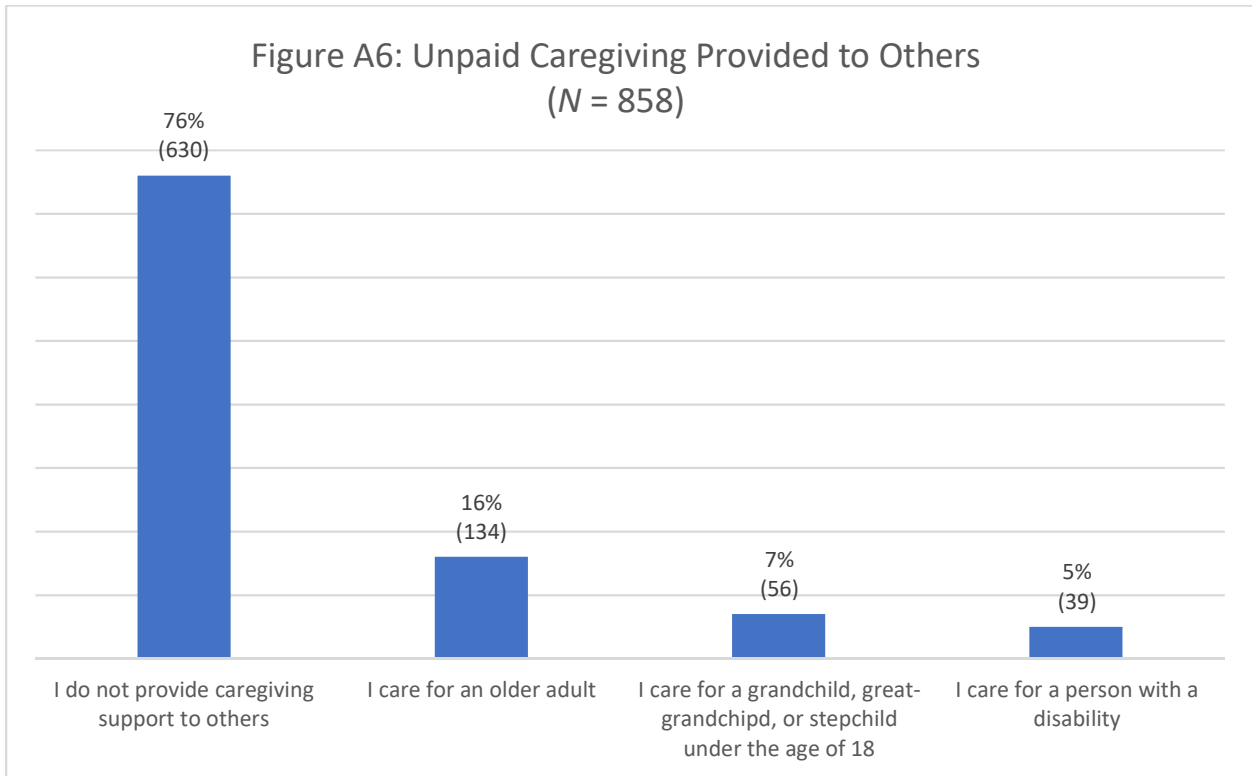
Senior Center Participation. Respondents ($N = 813$) were asked if they visited their local senior center. Data shows that little over half (56%, $n = 456$) indicated that they are not interested in visiting their local senior center. Conversely, 22% ($n = 182$) of respondents indicated that a senior center does not exist in their community, and 6% ($n = 52$) of respondents indicated that they would like to but are unable to visit a senior center due to difficulties getting there. About 7% ($n = 61$) indicated that they visit their local senior at least once a month and another 7% ($n = 62$) of respondents visit at least twice a month.



Table B1: Senior Center Participation.

| | % | N |
|---|-----|-----|
| No, I am not interested | 56% | 456 |
| No, there is no Senior Center in my community | 22% | 182 |
| Yes, at least twice monthly | 7% | 62 |
| Yes, at least one month | 7% | 61 |
| No, I would like to, but I have difficulty getting to the Senior Center | 6% | 52 |

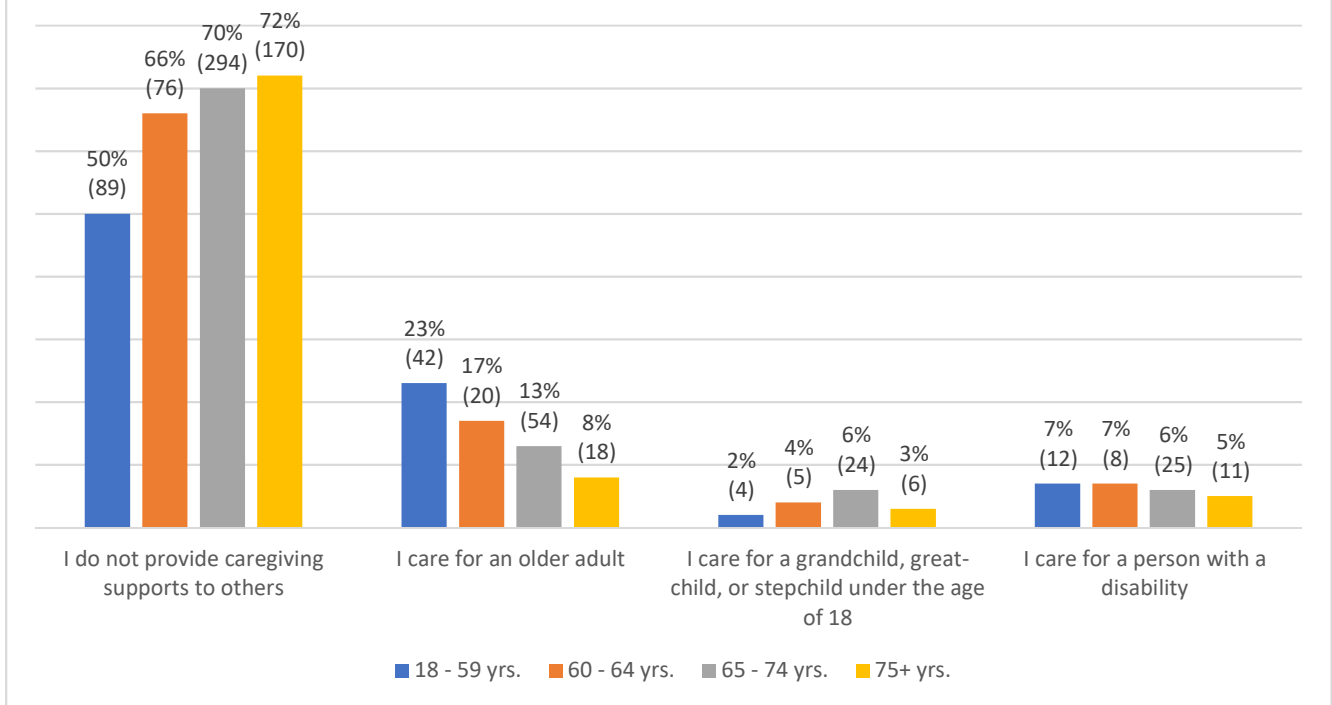
Caregiving. Of the 832 respondents who answered the question “Do you provide unpaid caregiving support weekly for any of the below individuals? Check all that apply” most respondents (76%, $n = 630$) indicated that they do not provide caregiving supports to others. About 16% ($n = 134$) of respondents indicated that they care for an older adult, 7% ($n = 56$) care for a person with a disability, and 5% ($n = 39$) care for a grandchild/great-grandchild/stepchild under the age of 18.



Caregiving Across Age Groups. The chart below visualizes age ranges of respondents across caregiving support. As indicated above, most respondents ($n = 630$) do not provide caregiving supports across all age ranges. For those ages 18 – 59 years old, data shows that about 23% ($n = 42$) care for an older adult and about 7% ($n = 12$) care for a person with a disability. For those aged 60 – 64 years about 17% ($n = 20$) care for an older adult and about 4% ($n = 5$) care for a child under age 18. About 13% ($n = 54$) of respondents aged 65 – 74 years old care for an older adult and about 6% ($n = 25$) care for a person with a disability. For respondents aged 75+ about 8% ($n = 18$) care for an older adult and about 3% ($n = 6$) care for a child.



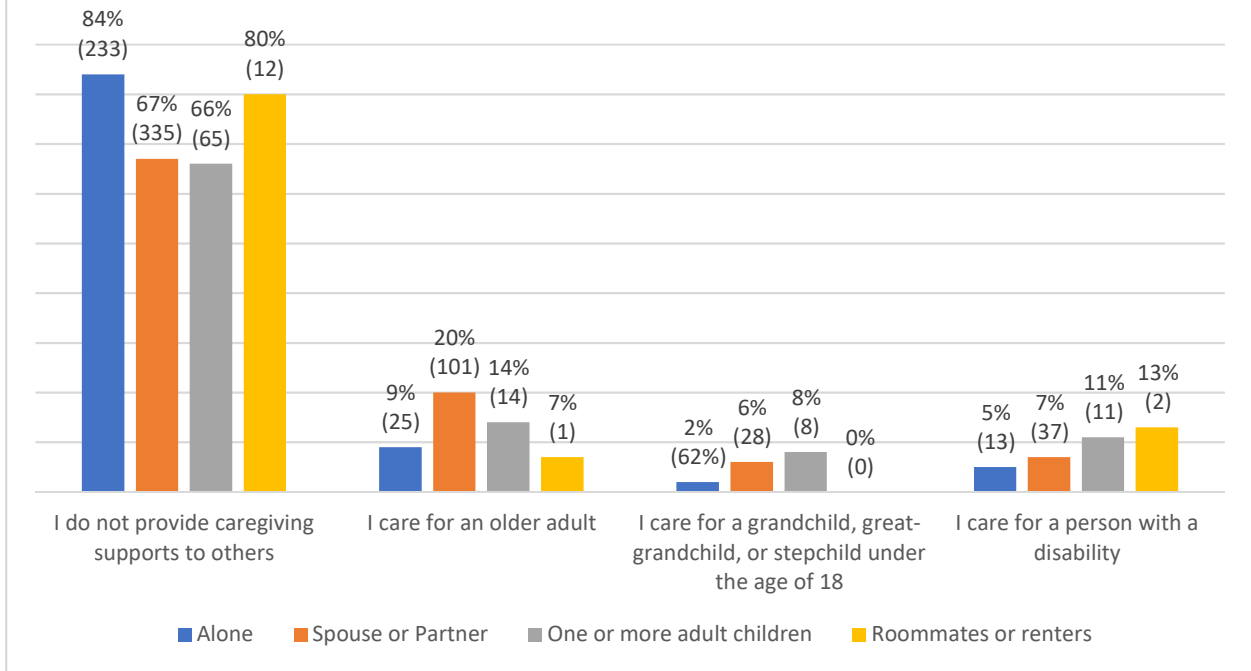
Figure A7: Age Ranges Across Caregiving Support
(N = 858)



Caregiving Across Living Arrangements. As discussed, most respondents do not provide caregiving support to others (n = 630), however, that varied by living arrangement. Specifically, about 80% (n = 12) of respondents living with roommates or renters and 84% (n = 233) of respondents living alone did not provide caregiving supports while 67% (n = 335) of those living with a spouse or partner and 66% (n = 65) of those living with adult children did not provide caregiving supports. Related to caregiving for an older adult, the largest group was those living with a spouse or partner (20%), then respondents living with adult children (14%), followed by those living alone (9%), and lastly those living with roommates/renters (7%). The smallest caregiving supports were provided to grandchildren, great-grandchildren or stepchildren under the age of 18 with the largest group being those living with adult children (8%, n = 8) followed by about 6% (n = 28) of those living with a spouse or partner. Lastly, about 5% (n = 13) of those who live alone provide supports to a person with a disability and about 13% (n = 2) of those who live with roommates/renters provide support for a person with a disability.



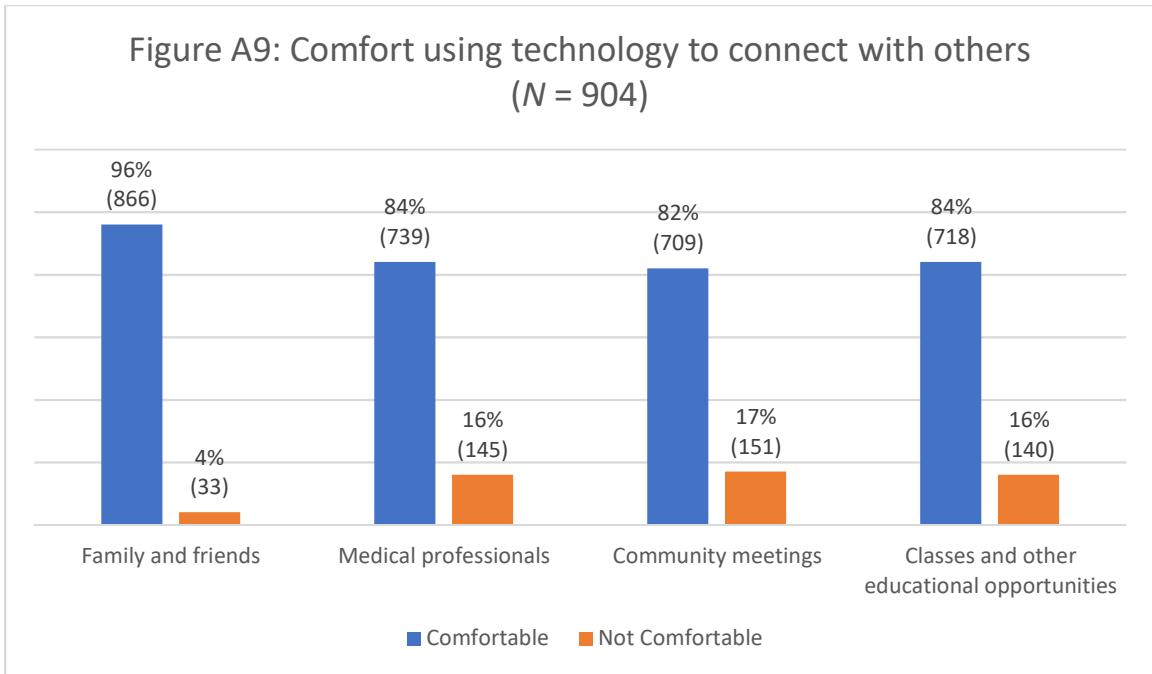
Figure A8: Living Arrangement Across Caregiving Support
(N = 858)



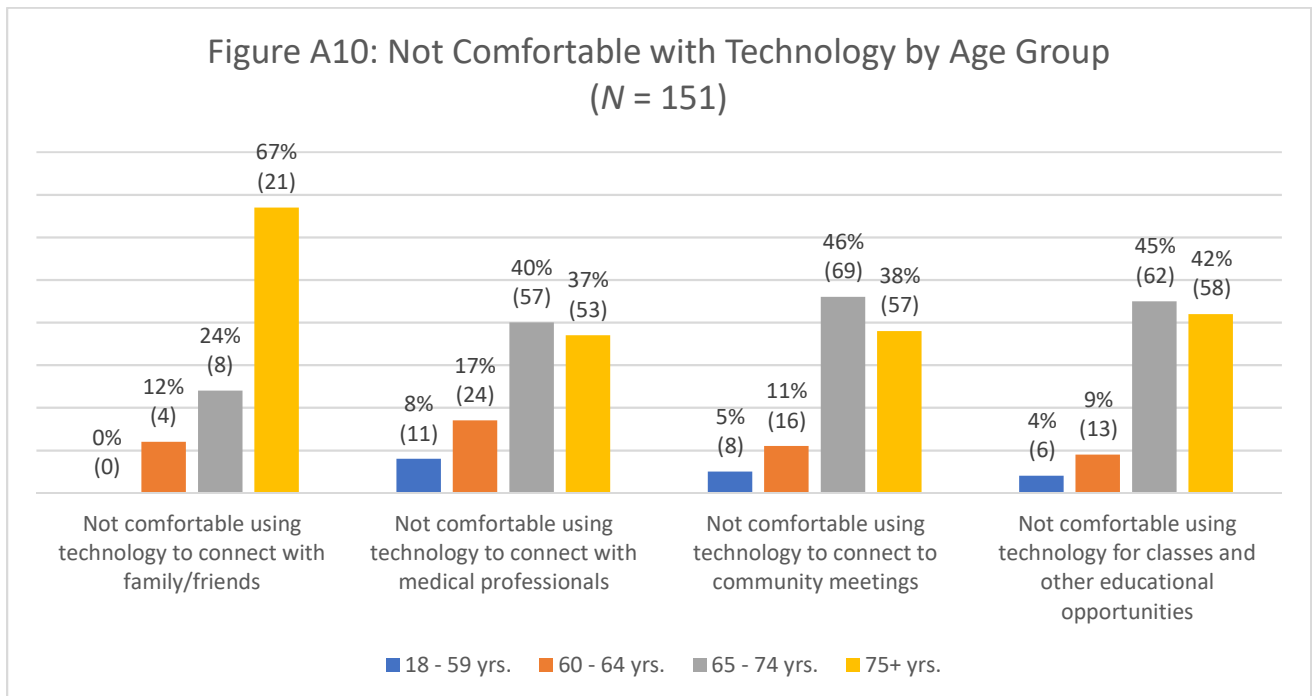
Caregiving Top Needs. Respondents who identified as caregivers were asked “What are your top needs as a caregiver? Check all that apply.” Of the 182 respondents, 43% (n = 78) identified the need for respite, 41% (n = 74) indicated the need for information and referral, and 34% (n = 61) identified transportation assistance as a need. About 26% (n = 47) identified education about loved one’s diagnoses and care requirements as a need, 24% (n = 44) indicated a need for support groups, 17% (n = 31) identified funding for clothing, incontinence supplies, food, home modifications or other items as a need, and 14% (n = 26) identified funds for prescription deductibles and co-pays as a need. Lastly, 26% (n = 48) identified ‘other’ needs via a write-in response. However, 5 responses were recoded to be included in the provided values, for example, a respondent wrote “coordinated respite care with family members” which was included in respite scale point. Therefore, a total of 43 responses were thematically coded and include increased health care workers, specifically in-home health workers (n = 15), emotional support to reduce loneliness for loved one (n = 5), adult day centers (n = 2), and affordable housing (n = 3). About 7 respondents indicated that no assistance was needed, and 11 respondents indicated specific requests such as dental insurance, professional legal assistance, and feeling appreciated.

Comfort with Technology. Respondents (N = 904) indicated their level of comfort with technology to connect with others. Most indicated that they are comfortable using technology to connect with family and friends (96%, n = 866), medical professionals (84%, n = 739), classes and other educational opportunities (84%, n = 718), and community meetings (82%, n = 709).





Comfort with Technology Across Age Groups. The chart below shows only respondents who indicated that they are not comfortable using technology to connect with family/friends, medical professionals, community meetings, and classes and other educational opportunities. Specifically, about 67% (n = 21) of respondents who are not comfortable using technology to connect with family and friends are 75 years or older. About 40% (n = 57) of respondents who are not comfortable using technology to connect with medical professionals are between the ages of 65 – 74 years. Similarly, about 46% (n = 69) of respondents who are not comfortable using technology to connect to community meetings are between the ages of 65 – 74 years old.



Section 3: Food and Nutrition

Participation in Food Assistance Programs. Respondents were asked: “Do you participate in any of the following food assistance programs or get food assistance from family or friends? Check all that apply.” Of the 844 respondents that responded, 90% ($n = 760$) indicated that they do not participate in any food assistance programs. About 4% ($n = 35$) of respondents indicated that they receive food from a community food pantry, 3% ($n = 25$) receive SNAP benefits or from another government sponsored food source, 3% ($n = 22$) receive food from family and/or neighbors, 2% ($n = 17$) receive food from Meals on Wheels, 1% ($n = 8$) eat meals at a community organization, 1% ($n = 6$) receive food from a religious organization, and 1% ($n = 9$) are unsure.

Amount of Food Assistance Needed. Respondents indicated how often they needed food assistance. Of the 865 respondents, about 92% ($n = 796$) indicated that they did not need assistance, 5% ($n = 45$) indicated a few times a month, 1% ($n = 12$) indicated a few times a week, and 1% ($n = 12$) indicated daily.

Why Lack of Engagement in Food Assistance. Respondents ($N = 810$) were asked to check all the reasons they did not receive food assistance. Almost three-quarters (71%, $n = 686$) indicated they do not need food assistance. About 14% ($n = 132$) do not think they are eligible for food assistance programs, 5% ($n = 39$) did not want to ask for help with food assistance, and 2% ($n = 23$) do not know how or where to apply for assistance.

Table B2: Reason for not receiving food assistance.

| | % | N |
|---|-----|-----|
| Do not need it | 85% | 686 |
| Do not think they are eligible for food assistance programs | 16% | 132 |
| Do not like asking for help | 5% | 39 |
| Do not know how or where to apply for assistance | 3% | 23 |
| Unaware of food assistance programs | 3% | 22 |
| On a restrictive diet | 2% | 19 |
| Do not want to provide personal information | 2% | 16 |
| Would not receive enough assistance | 2% | 15 |
| Do not think food would be any good | 2% | 15 |
| Need assistance filling out application | 1% | 5 |

Section 4: Transportation

How Travel Needs Are Met. Respondents ($N = 869$) indicated how they travel to meet their daily needs. The majority of respondents (93%, $n = 811$) drive their personal or family vehicle, 11% ($n = 92$) rely on friends or family to drive them, 10% ($n = 83$) walk, 4% ($n = 32$) use public transit or community transportation, 3% ($n = 29$) ride a bike, 2% ($n = 14$) use private transit such as Uber/Lyft, and 1% ($n = 9$) use a volunteer driver program.

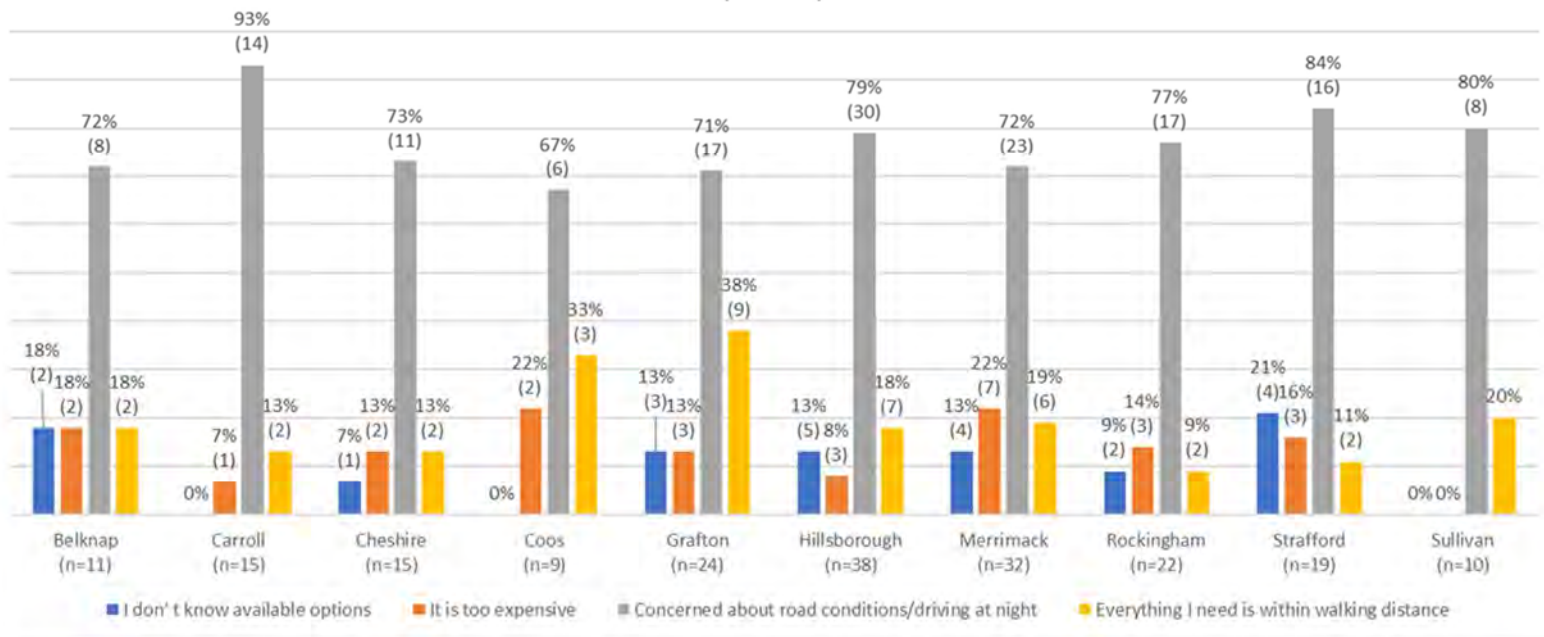
Difficulties in Leaving Home. Respondents ($N = 196$) were asked “If you find it difficult to get around and/or rarely leave your home, please check all the reasons that apply.” About 77%, ($n = 151$) cited concern about driving at night or in bad weather, 21% ($n = 41$) cited physical limitations, and 19% ($n = 38$) indicated that nowhere they need to go is within walking or biking distance from their home. About 13%



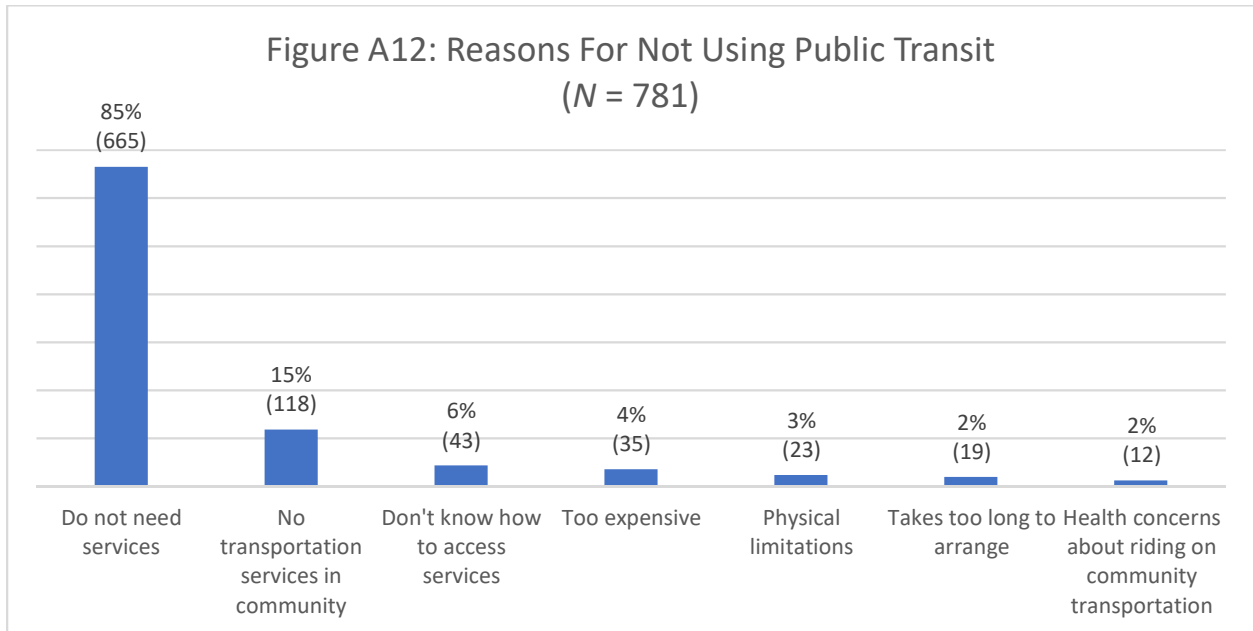
(n = 26) indicated it is too expensive to pay for a ride, 11% (n = 21) indicated that they were unsure what transportation services are available, 10% (n = 19) don't drive and don't have friends or family that can drive them, 9% (n = 18) indicated they don't need to go out because they can do everything online.

Difficulties in Leaving Home Across Counties. The chart below demonstrates county level responses to the difficulties respondents identified in getting around or why they rarely leave their home (N=196). As discussed previously, and across all counties, concerns about road conditions/driving at night is the largest reason for why respondents have difficulties leaving home. For respondents living in Carroll, Coös, Grafton, Hillsborough, and Sullivan Counties the second largest reason they did not leave home was because everything they needed is within walking distance. Conversely, respondents living in Merrimack and Rockingham indicated that cost was the second biggest reason for why they did not leave home. For residents living in Strafford County being aware of available transportation options is a barrier to leaving home.

Figure A11: Reasons for Difficulties Leaving Home by County (N=196)



Reasons For Not Using Transportation Services. Respondents ($N = 781$) were asked “If you haven’t used public transit, volunteer driver services, or other community transportation, why not? Check all that apply”. Most respondents (85%, $n = 665$) indicated that they do not need services because they drive. About 15% ($n = 118$) indicated that there are no transportation services in my community that go where they need and about 6% ($n = 43$) stated that they do not know how to access transportation services.

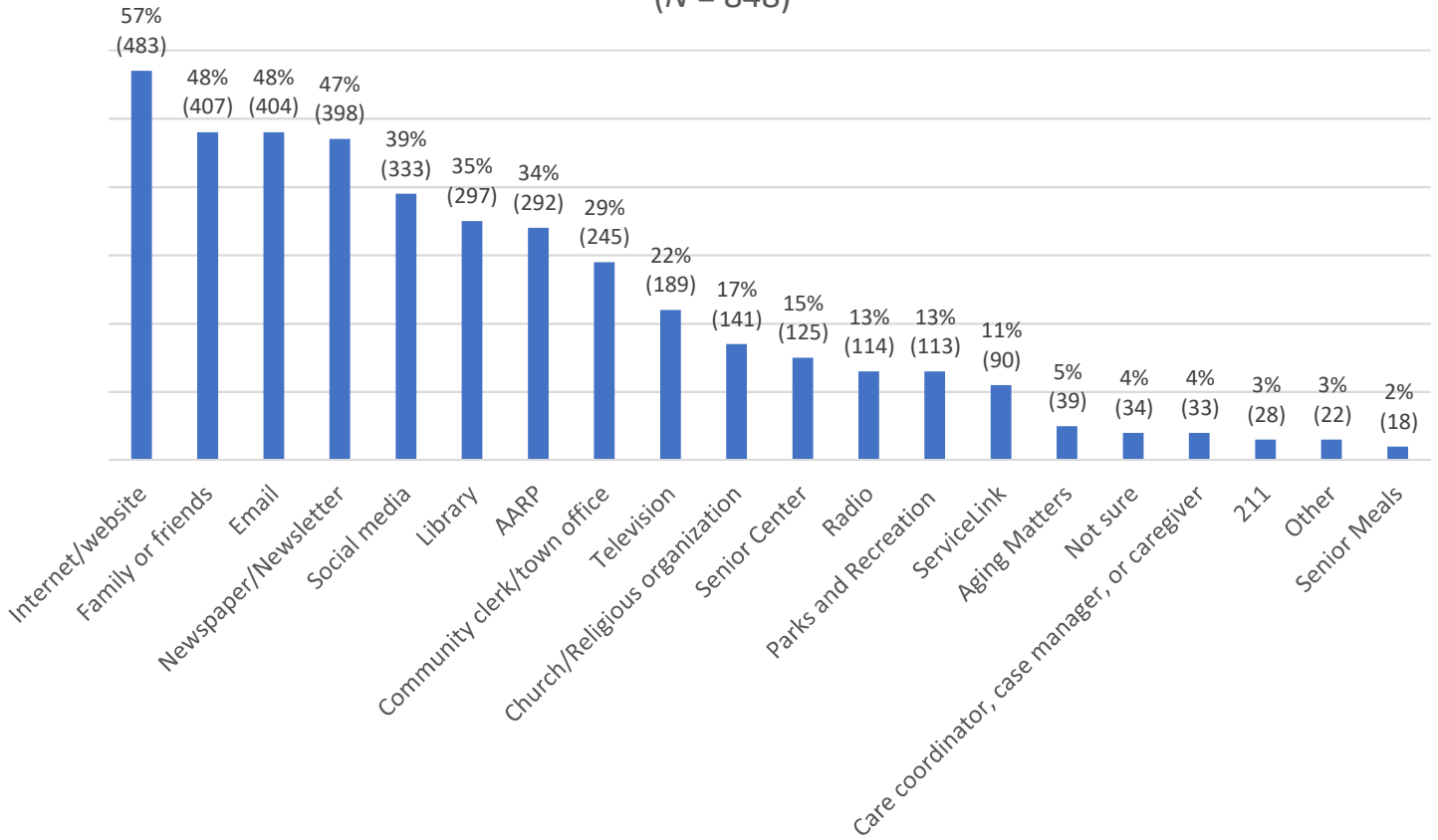


Section 5: Information and Referral

Finding Information About Community Services. Respondents ($N = 848$) answered the question “How do you get information about community services? Check all that apply”. More than half (57%, $n = 483$) of respondents indicated that they use the internet/websites to attain information. Similarly, about 48% ($n = 407$) relied on family and friends, 48% ($n = 404$) relied on email, and 47% ($n = 398$) relied on newspapers/newsletters for information. More than one-third (39%, $n = 333$) use social media to get information. Some sources were not used prevalently, such as care coordinators/case manager/caregiver (4%, $n = 33$), 2-1-1 (3%, $n = 28$), and senior meals (2%, $n = 18$). A total of 43 respondents wrote in “other” sources, however, 21 responses were recoded to be included in provided values. For example, a respondent wrote “Google” which was included in internet/website scale point. Therefore, a total of 22 ‘other options’ were thematically coded and include attaining information from community organizations and entities ($n = 7$), through housing (i.e., bulletin board in complex, $n = 4$) or through employment ($n = 3$). Other responses also included no interest or need for gathering information about resources ($n = 4$) and 4 respondents indicated that they work in the community service field.



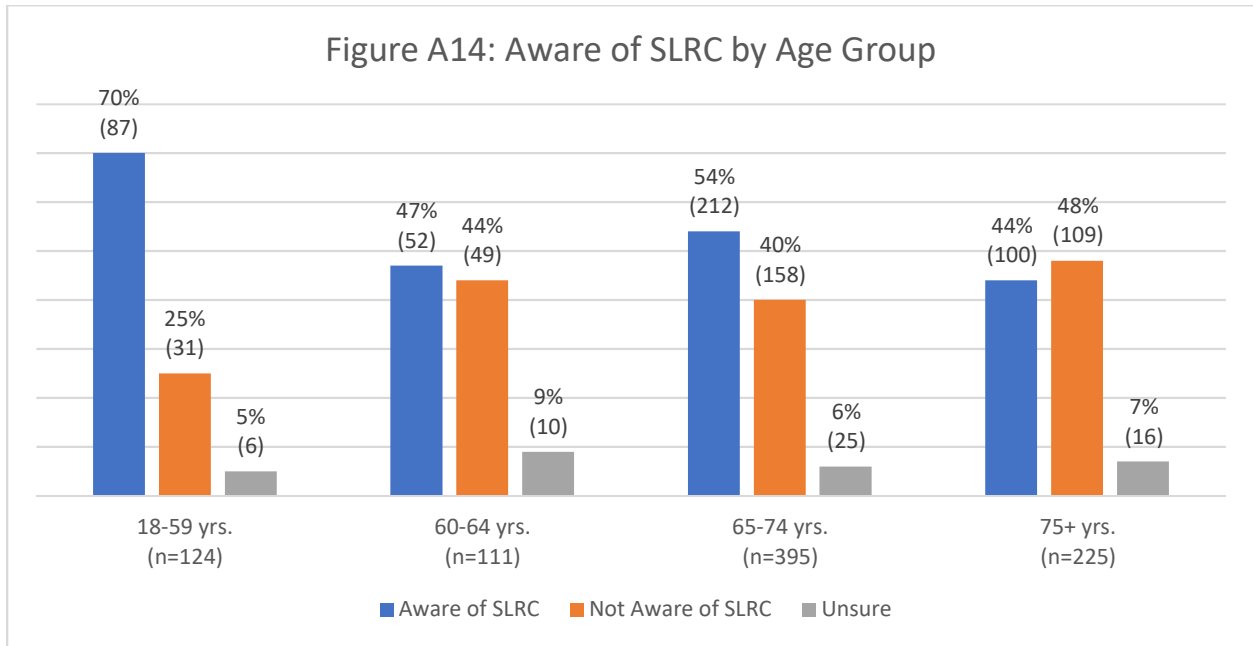
Figure A13: Information about Community Services
(N = 848)



Awareness of SLRC. Respondents (N = 856) indicated if they are aware of ServiceLink (SLRC; New Hampshire Aging and Disability Resource Center). A little more than half (51%, n = 452) indicated they are aware of SLRC, about 41% (n = 347) indicated they are not aware of SLRC, and 7% (n = 57) indicated they are not sure.



Awareness of SLRC across Age Groups. The chart below depicts level of ServiceLink awareness based on age. Within the category of 18-59 years, about 70% ($n = 87$) of respondents are aware of SLRC. For those ages 60-64, there is an almost even split between those who are aware of SLRC (47%, $n = 52$) and those who are not aware of SLRC (44%, $n = 49$). About 54% ($n = 212$) of respondents in the age group of 65-74 are aware of SLRC. For respondents who are 75+ years data shows that more respondents (48%, $n = 109$) are *not* aware of SLRC than those who *are* aware (44%, $n = 100$).



SLRC Support. More specifically, respondents ($N = 763$) were asked “How has ServiceLink assisted you in the last year? Check all that apply.” About 90% of respondents indicated they had not heard of SLRC (39%, $n = 294$) or had not used SLRC (51%, $n = 387$). Of services provided by SLRC, the most popular responses included Medicare benefit counseling ($n = 74$), Medicaid information or support ($n = 25$) and caregiving help ($n = 24$).

Section 6: Living in Community

Importance of Concerns to Age in Community. Respondents ($N = 802$) were asked “Please rate the importance of the following based on how much they impact your ability to age in your community.” Scale points were ranked as 1 = not sure/doesn’t apply, 2 = not important, 3 = moderately important, 4 = very important, therefore, higher mean values equate to higher importance. The table below provides counts and percentages for each scale point, and the mean and standard deviation are provided. Each item is ranked based on the highest mean.

Results show that maintaining physical health ($M = 3.87$, $SD = 0.4$), access to healthcare ($M = 3.86$, $SD = 0.5$), and financial security ($M = 3.79$, $SD = 0.6$) were the most important to respondents for their ability to age in their community. Depression ($M = 2.85$, $SD = 1.2$), support for caregivers ($M = 2.85$, $SD = 1.3$), and respite care ($M = 2.58$, $SD = 1.3$) were rated as the least important for the ability to age at home.



Table B3: Rate the Importance of the following based on how much they impact your ability to age in your community.

| Item | Response Categories | | | | M(SD) |
|--|---------------------|---------------|----------------------|----------------|------------|
| | Not sure/NA | Not important | Moderately important | Very important | |
| Maintaining physical health (n = 774) | 0.9% (7) | 0.7% (5) | 8.5% (66) | 89.92% (696) | 3.87 (0.4) |
| Access to healthcare (n=791) | 2.0% (16) | 1.4% (11) | 4.9% (39) | 92.7% (725) | 3.86 (0.5) |
| Financial security (n = 786) | 3.1% (24) | 2.0% (16) | 7.6% (60) | 87.3% (686) | 3.79 (0.6) |
| Safety during emergencies such as power outages, snowstorms, or floods (n = 768) | 3.1% (24) | 4.6% (35) | 24.4% (187) | 68.0% (522) | 3.57 (0.7) |
| Fuel costs (n = 768) | 4.0% (31) | 4.6% (35) | 29.3% (225) | 62.1% (477) | 3.49 (0.8) |
| Transportation (n = 758) | 6.7% (51) | 7.1% (54) | 26.1% (198) | 60.0% (455) | 3.39 (0.9) |
| Affordable and accessible housing (n = 756) | 13.0% (97) | 12.9% (96) | 17.0% (127) | 57.2% (427) | 3.33 (1.0) |
| Availability of in-home long-term services and supports (n = 745) | 12.6% (94) | 7.0% (52) | 20.7% (154) | 59.7% (445) | 3.28 (1.0) |
| Access to information about long-term services and supports (n = 745) | 11.0% (81) | 7.0% (52) | 20.7% (154) | 59.7% (445) | 3.27 (1.0) |
| Quality long-term care options (n = 751) | 13.3% (100) | 6.8% (51) | 23.4% (176) | 56.5% (424) | 3.23 (1.1) |
| Having enough food to eat (n = 747) | 13.0% (97) | 12.9% (96) | 17.0% (127) | 57.2 (427) | 3.18 (1.1) |
| Assisted Living facilities (n = 744) | 18.4% (137) | 10.8% (80) | 30.2% (225) | 40.6% (302) | 2.93 (1.1) |
| Memory loss (n = 745) | 23.4% (174) | 9.9% (74) | 20.5% (153) | 46.2% (344) | 2.90 (1.2) |
| Depression (n = 730) | 22.5% (164) | 12.6% (92) | 22.9% (167) | 42.1% (307) | 2.85 (1.2) |
| Support for caregivers (n = 746) | 26.1% (195) | 9.1% (68) | 18.1% (135) | 46.7% (348) | 2.85 (1.3) |
| Respite care (n = 720) | 32.2% (232) | 13.5% (97) | 18.6% (134) | 35.7% (257) | 2.58 (1.3) |

Importance of Concerns to Age in Community Across Age Groups. Results below show levels of importance across the top five issues that respondents identified about their ability to age in their communities across age ranges. As above, issues are ranked based on the highest mean. Results show that *maintaining physical health* was more important for respondents aged 60-64 years (91%), 65-74 years (91%), and 75+ years (92%) when compared to respondents aged 18-59 (82%). Most age groups placed high importance on *access to healthcare*. Related to *financial security*, about 92% of respondents ages 60-64 years identified this as very important, while only 83% of those 75+ years old thought financial security was very important. Data indicates that *safety during emergencies* was the most important to respondents ages 18-59 years (74%), while 30% of respondents ages 60-64 and 26% of



respondents ages 65-74 ranked safety during emergencies as moderately important. *Fuel costs* related to moderate and high importance were similar across all age groups.

Table B4: Rate the Importance of the following based on how much they impact your ability to age in your community across age groups.

| | | 18-59 yrs. | 60-64 yrs. | 65-74 yrs. | 75+yrs. |
|--|------------------------|------------|------------|------------|-----------|
| Maintaining physical health (n=774, M=3.87) | Not sure/doesn't apply | 1% (1) | 1% (1) | 1% (4) | 0.5% (1) |
| | Not important | 1% (1) | 0% (0) | 0.3% (1) | 1% (2) |
| | Moderately important | 16% (17) | 8% (8) | 8% (28) | 7% (13) |
| | Very important | 82% (88) | 91% (92) | 91% (332) | 92% (183) |
| Access to healthcare (n=791, M=3.86) | Not sure/doesn't apply | 2% (2) | 2% (2) | 2% (6) | 3% (6) |
| | Not important | 3% (3) | 1% (1) | 1% (4) | 1% (3) |
| | Moderately important | 2% (2) | 5% (5) | 6% (21) | 5% (11) |
| | Very important | 94% (103) | 92% (93) | 92% (344) | 90% (184) |
| Financial security (n=786, M=3.79) | Not sure/doesn't apply | 2% (2) | 2% (2) | 3% (11) | 5% (9) |
| | Not important | 2% (2) | 2% (2) | 2% (6) | 3% (6) |
| | Moderately important | 7% (8) | 4% (4) | 8% (29) | 10% (19) |
| | Very important | 89% (98) | 92% (93) | 88% (330) | 83% (164) |
| Safety during emergencies such as power outages, snowstorms, or floods (n = 768, M=3.57) | Not sure/doesn't apply | 1% (1) | 1% (1) | 4% (13) | 2% (9) |
| | Not important | 8% (8) | 0% (0) | 5% (17) | 5% (10) |
| | Moderately important | 18% (19) | 30% (30) | 26% (94) | 22% (43) |
| | Very important | 74% (78) | 69% (69) | 66% (242) | 68% (134) |
| Fuel Costs (n=768, M=3.49) | Not sure/doesn't apply | 2% (2) | 1% (1) | 5% (18) | 5% (10) |
| | Not important | 6% (6) | 5% (5) | 4% (13) | 6% (11) |
| | Moderately important | 29% (31) | 30% (30) | 32% (117) | 25% (47) |
| | Very important | 64% (69) | 64 (64%) | 60% (219) | 65% (124) |

Importance of Concerns to Age in Community Across Counties. Results show variation across each New Hampshire County and the level of importance ranked across the top five issues respondents identified about their ability to age in their communities.

- *Maintaining physical health* received the most important ranks from respondents living in Grafton (95%) and Strafford (95%) counties, while only about 80% of respondents living in Coös and 82% of Belknap respondents identified maintaining physical health as very important.



- Most counties identified *access to care* as very important, especially Coös with 100% of respondents identifying accessing care as very important, conversely, Belknap had the lowest rate with 77% citing access to care as very important.
- Results show that 94% of respondents living in Grafton, 92% of respondents living in Merrimack, and 92% of respondents living in Sullivan counties ranked *financial security* as very important. Fewer respondents living in Belknap (77%), Carroll (77%), and Sullivan (78%) rated financial security as very important.
- *Safety during emergencies* was rated the highest (85%) by respondents living in Coös whereas 30% of Sullivan and 29% of Carroll county respondents were more likely to indicate that safety during emergencies was moderately important.
- *Fuel costs* were very important to respondents living in Coös with 93% indicating high importance. Most other counties showed about 2/3 of respondents indicating very important, about a quarter indicating moderately important, and about a tenth indicating not important or not sure.



Table B5: Rate the Importance of the following based on how much they impact your ability to age in your community across Counties

| | | Belknap | Carroll | Cheshire | Coös | Grafton | Hillsborough | Merrimack | Rockingham | Strafford | Sullivan |
|---|------------------------|----------------|----------------|-----------------|-------------|----------------|---------------------|------------------|-------------------|------------------|-----------------|
| Maintaining physical health (n=774, M=3.87) | Not sure/doesn't apply | 3% | 0% | 2% | 0% | 1% | 0% | 0% | 2% | 0% | 0% |
| | Not important | 0% | 2% | 0% | 0% | 1% | 0% | 1% | 1% | 0% | 0% |
| | Moderately important | 15% | 7% | 10% | 20% | 3% | 8% | 10% | 9% | 5% | 19% |
| | Very important | 82% | 91% | 88% | 80% | 95% | 92% | 90% | 88% | 95% | 82% |
| Access to healthcare (n=791, M=3.86) | Not sure/doesn't apply | 9% | 2% | 2% | 0% | 1% | 1% | 2% | 3% | 3% | 0% |
| | Not important | 0% | 4% | 0% | 0% | 0% | 3% | 1% | 2% | 0% | 4% |
| | Moderately important | 15% | 4% | 4% | 0% | 5% | 5% | 5% | 5% | 5% | 0% |
| | Very important | 77% | 91% | 94% | 100% | 94% | 91% | 93% | 90% | 92% | 96% |
| Financial security (n=786, M=3.79) | Not sure/doesn't apply | 12% | 4% | 4% | 0% | 2% | 2% | 2% | 4% | 2% | 0% |
| | Not important | 0% | 7% | 2% | 0% | 2% | 3% | 1% | 2% | 0% | 4% |
| | Moderately important | 12% | 11% | 8% | 14% | 2% | 8% | 5% | 8% | 6% | 19% |
| | Very important | 77% | 77% | 86% | 86% | 94% | 87% | 92% | 86% | 92% | 78% |
| Safety during emergencies such as power outages, snowstorms, or floods (n = 768, M=3.57) | Not sure/doesn't apply | 10% | 0% | 8% | 0% | 3% | 2% | 3% | 4% | 2% | 0% |
| | Not important | 3% | 9% | 6% | 0% | 5% | 4% | 3% | 4% | 3% | 15% |
| | Moderately important | 19% | 29% | 17% | 15% | 20% | 27% | 31% | 22% | 20% | 30% |
| | Very important | 68% | 62% | 69% | 85% | 71% | 67% | 63% | 71% | 76% | 56% |
| Fuel Costs (n=768, M=3.49) | Not sure/doesn't apply | 9% | 4% | 15% | 0% | 3% | 2% | 6% | 3% | 2% | 0% |
| | Not important | 3% | 9% | 6% | 7% | 4% | 4% | 4% | 4% | 7% | 4% |
| | Moderately important | 21% | 24% | 27% | 0% | 36% | 32% | 29% | 31% | 27% | 26% |
| | Very important | 67% | 64% | 52% | 93% | 57% | 62% | 61% | 62% | 65% | 70% |



Need for Services. Respondents ($N = 801$) were asked to “Rate your need for the following services.” Scale points were ranked as 1 = not sure/doesn’t apply, 2 = low need, 3 = moderately need, 4 = high need, therefore, higher mean values equate to higher need. The table below provides counts and percentages for each scale point, and the mean and standard deviation are provided. Each item is ranked based on the highest mean.

Results show that stable internet ($M = 3.19$, $SD = 1.1$), social activities ($M = 2.60$, $SD = 1.1$), and oral health services ($M = 2.35$, $SD = 1.1$) were the highest needed services. In-home health services ($M = 1.62$, $SD = 0.8$), adult day programs ($M = 1.61$, $SD = 0.8$), and veteran’s benefits ($M = 1.61$, $SD = 0.9$) were overall rated as the least needed.

Table B6: Rate the need for the following services.

| Item | Response Categories | | | | M(SD) |
|--|---------------------|-------------|---------------|-------------|------------|
| | Not sure/NA | Low need | Moderate Need | High Need | |
| Stable internet (broadband/high-speed) ($n = 760$) | 13.3% (101) | 13.2% (100) | 15.3% (116) | 58.3% (443) | 3.19 (1.1) |
| Social activities ($n = 763$) | 21.9% (167) | 21.8% (166) | 30.9% (236) | 25.4% (194) | 2.60 (1.1) |
| Oral health services ($n = 758$) | 30.1% (228) | 28.2% (214) | 18.5% (140) | 23.2% (176) | 2.35 (1.1) |
| Information and referral services such as SLRC ($n = 764$) | 30.2% (231) | 27.2% (208) | 23.2% (177) | 19.4% (148) | 2.32 (1.1) |
| Help in dealing with vision or hearing loss ($n = 765$) | 32.2% (246) | 28.1% (215) | 20.1% (154) | 19.6% (150) | 2.27 (1.1) |
| Affordable housing ($n = 752$) | 35.5% (267) | 28.3% (213) | 12.1% (91) | 24.1% (181) | 2.25 (1.2) |
| Yard work, trash removal or snow shoveling ($n = 784$) | 31.1% (244) | 31.8% (249) | 21.9% (172) | 15.2% (119) | 2.21 (1.0) |
| Breast and cervical cancer screening program ($n = 742$) | 34.4% (255) | 30.9% (229) | 16.7% (124) | 18.1% (134) | 2.18 (1.1) |
| Senior Center ($n = 767$) | 31.7% (243) | 39.8% (305) | 17.1% (131) | 11.5% (88) | 2.08 (1.0) |
| Transportation ($n = 275$) | 36.6% (275) | 37.4% (281) | 12.6% (95) | 13.4% (101) | 2.03 (1.0) |
| Legal assistance ($n = 754$) | 36.6% (276) | 38.3% (289) | 16.5% (124) | 8.6% (65) | 1.97 (0.9) |
| Financial assistance ($n = 752$) | 40.3% (303) | 38.2% (287) | 11.4% (86) | 10.1% (76) | 1.91 (1.0) |
| Home modification support ($n = 753$) | 41.0% (309) | 36.9% (278) | 14.9% (112) | 7.2% (54) | 1.88 (0.9) |
| Help with household chores ($n = 787$) | 42.2% (332) | 40.5% (319) | 10.2% (80) | 7.1% (56) | 1.82 (0.9) |
| Food assistance such as Senior Congregate Meals, Meals on Wheels, Commodity Supplemental Foods, and/or food pantry ($n = 767$) | 48.4% (371) | 40.3% (309) | 5.6% (43) | 5.7% (44) | 1.69 (0.8) |



| | | | | | |
|--------------------------------------|-------------|-------------|-----------|-----------|------------|
| In-home health services (n = 775) | 50.6% (392) | 41.4% (321) | 3.4% (26) | 4.6% (36) | 1.62 (0.8) |
| Adult day program (n = 746) | 52.4% (391) | 38.5% (287) | 5.0% (37) | 4.2% (31) | 1.61 (0.8) |
| Veteran's benefits (n = 742) | 61.7% (458) | 24.8% (184) | 4.5% (33) | 9.0% (67) | 1.61 (0.9) |

Need for Services by Age. Results show the need for services across the top five issues that respondents identified across age groups. As above, the needs with the highest need are ranked first.

- **Stable internet.** Results show that almost half of all age groups identified stable internet as a high need. About 67% of respondents aged 75 years and older identified stable internet as a high need while 45% of those ages 18-59 identified this as a high need. Interestingly, about 24% of respondents between the ages of 18 and 59 indicated not sure or doesn't apply.
- **Social Activities.** About a third of respondents ages 60-64, a third ages 65-74, and a third of over the age of 75 identified a moderate need for social activities. Comparatively, about a third of respondents aged 18 to 59 indicated not sure or doesn't apply.
- **Oral Health Services.** About 27% of respondents ages 60-64 identified a high need for oral health services while about 29% of respondents over the age of 75 indicated not sure or doesn't apply.
- **Information and referral services.** About 24% of respondents over the age of 75 indicate a high need for information and referral services while about 42% of respondents ages 18 to 59 indicated that they were not sure or doesn't apply.
- **Help in dealing with vision or hearing loss.** About 32% of respondents ages 60-64 years of age indicated that help in dealing with vision or hearing loss is a low need while about 26% of those over the age of 75 identified it as a high need.

Table B7: Rate the need for the following services by age.

| | | 18-59 yrs. | 60-64 yrs. | 65-74 yrs. | 75+yrs. |
|--|------------------------|------------|------------|------------|-----------|
| Stable internet (broadband/high-speed) (n = 760, M = 3.19) | Not sure/doesn't apply | 24% (26) | 13% (13) | 13% (46) | 8% (16) |
| | Low need | 16% (17) | 12% (12) | 14% (50) | 10% (20) |
| | Moderate need | 15% (16) | 19% (19) | 15% (54) | 14% (27) |
| | High need | 45% (48) | 56% (55) | 58% (211) | 67% (129) |
| Social activities (n = 763, M = 2.60) | Not sure/doesn't apply | 32% (34) | 21% (21) | 21% (75) | 18% (35) |
| | Low need | 25% (26) | 21% (21) | 23% (84) | 31% (61) |
| | Moderate need | 20% (21) | 35% (35) | 32% (118) | 31% (59) |
| | High need | 24% (25) | 22% (22) | 24% (88) | 19% (37) |
| Oral health services (n = 758, M = 2.35) | Not sure/doesn't apply | 38% (41) | 29% (29) | 28% (103) | 29% (55) |
| | Low need | 24% (26) | 29% (29) | 29% (105) | 28% (53) |
| | Moderate need | 12% (13) | 14% (14) | 22% (80) | 18% (33) |
| | High need | 25% (27) | 27% (27) | 21% (75) | 25% (47) |
| Information and referral services such as SLRC (n = 764, M = 2.32) | Not sure/doesn't apply | 42% (45) | 31% (36) | 23% (95) | 29% (55) |
| | Low need | 28% (30) | 22% (25) | 25% (106) | 24% (46) |
| | Moderate need | 11% (12) | 17% (20) | 24% (100) | 23% (45) |
| | High need | 19% (21) | 16% (18) | 15% (63) | 24% (46) |



| | | | | | |
|---|------------------------|----------|----------|-----------|----------|
| Help in dealing with vision or hearing loss (n = 765, M = 2.27) | Not sure/doesn't apply | 46% (50) | 34% (34) | 32% (117) | 24% (45) |
| | Low need | 28% (30) | 32% (32) | 29% (106) | 24% (46) |
| | Moderate need | 8% (9) | 13% (13) | 23% (83) | 26% (49) |
| | High need | 18% (19) | 21% (21) | 17% (62) | 26% (48) |

Need for Services by County. Results show differences across each New Hampshire County and the level of need across the top five services respondents identified.

- **Stable internet** was ranked as the highest need across all the counties. Specifically, 78% of respondents living in Belknap and 73% of respondents living in Sullivan counties identified it as a high need. About 18% of respondents living in Cheshire and 16% of respondents living in Strafford identified stable internet as a low need.
- **Social activities.** Respondents living in Sullivan (37%) and Carroll (29%) rated social activities as a high need. About a third of respondents living in Hillsborough (36%), Coös (36%), and Strafford (35%) counties identified social activities as a moderate need. Further, 7% of respondents living in Coös and 7% of respondents living in Sullivan counties identified social activities as a low need.
- **Oral Health services.** About 8% of respondents living in Coös County identified oral health services as a high need while about 29% of Merrimack respondents identified oral health services as a high need.
- **Information and Referral services.** Several respondents from various counties indicated a lower need (i.e., Belknap, Carroll, Coös) for information and referral services when compared to other counties (i.e., Rockingham, Merrimack, and Hillsborough).
- **Help in Dealing with vision or hearing loss.** Many respondents across many counties indicated not sure or doesn't apply to this particular concern. Respondents from Cheshire (26%) and Strafford (26%) identified this is a high need while about 30% of respondents living in Hillsborough and 31% living in Rockingham identified this as a low need.



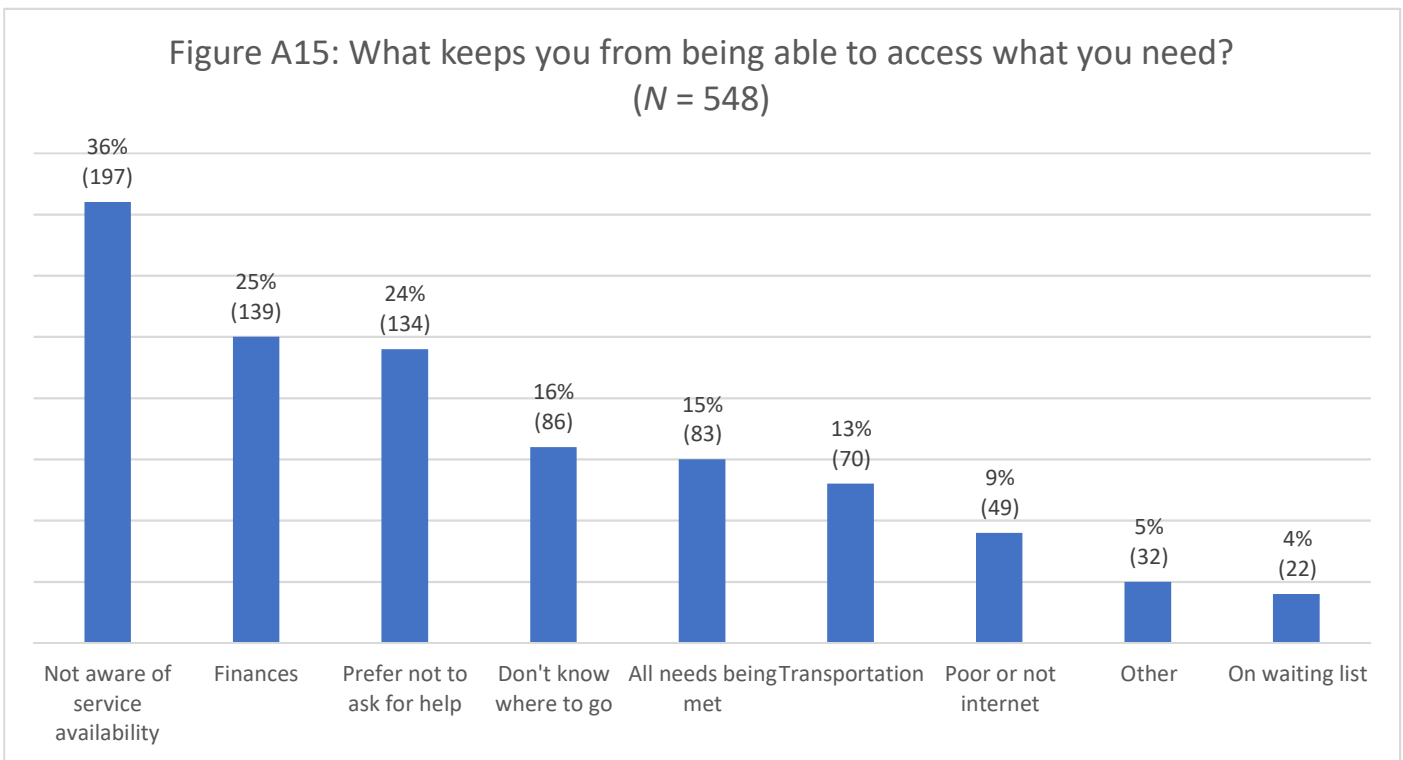
Table B8: Rate the need for the following services by County.

| | | Belknap | Carroll | Cheshire | Coös | Grafton | Hillsborough | Merrimack | Rockingham | Strafford | Sullivan |
|--|------------------------|----------------|----------------|-----------------|-------------|----------------|---------------------|------------------|-------------------|------------------|-----------------|
| Stable internet (broadband/high-speed) (n = 760, M = 3.19) | Not sure/doesn't apply | 3% | 13% | 12% | 14% | 17% | 14% | 14% | 15% | 8% | 8% |
| | Low need | 6% | 13% | 18% | 14% | 13% | 15% | 14% | 12% | 16% | 4% |
| | Moderate need | 13% | 19% | 14% | 29% | 14% | 13% | 11% | 19% | 18% | 15% |
| | High need | 78% | 56% | 56% | 43% | 56% | 59% | 61% | 54% | 57% | 73% |
| Social activities (n = 763, M = 2.60) | Not sure/doesn't apply | 30% | 26% | 21% | 36% | 23% | 20% | 25% | 21% | 18% | 3% |
| | Low need | 27% | 18% | 25% | 7% | 24% | 20% | 22% | 26% | 18% | 7% |
| | Moderate need | 27% | 27% | 29% | 36% | 27% | 36% | 32% | 26% | 35% | 52% |
| | High need | 18% | 29% | 25% | 21% | 25% | 25% | 22% | 27% | 28% | 37% |
| Oral health services (n = 758, M = 2.35) | Not sure/doesn't apply | 30% | 28% | 24% | 15% | 35% | 31% | 31% | 33% | 25% | 27% |
| | Low need | 36% | 39% | 24% | 23% | 26% | 27% | 25% | 30% | 30% | 23% |
| | Moderate need | 9% | 18% | 28% | 54% | 25% | 18% | 16% | 17% | 13% | 19% |
| | High need | 24% | 16% | 24% | 8% | 15% | 24% | 29% | 20% | 33% | 31% |
| Information and referral services such as SLRC (n = 764, M = 2.32) | Not sure/doesn't apply | 21% | 24% | 16% | 36% | 31% | 32% | 34% | 33% | 32% | 33% |
| | Low need | 46% | 33% | 32% | 36% | 30% | 25% | 21% | 25% | 29% | 22% |
| | Moderate need | 18% | 26% | 38% | 7% | 31% | 21% | 22% | 19% | 18% | 26% |
| | High need | 15% | 17% | 14% | 21% | 9% | 22% | 23% | 24% | 21% | 19% |
| Help in dealing with vision or hearing loss (n = 765, M = 2.27) | Not sure/doesn't apply | 41% | 40% | 22% | 39% | 36% | 31% | 37% | 28% | 24% | 35% |
| | Low need | 27% | 25% | 24% | 8% | 32% | 30% | 25% | 31% | 31% | 19% |
| | Moderate need | 21% | 25% | 28% | 31% | 17% | 15% | 17% | 22% | 19% | 35% |
| | High need | 12% | 11% | 26% | 23% | 14% | 24% | 21% | 20% | 26% | 12% |



Barriers to Addressing Needs. Respondents ($N = 548$) were asked “What keeps you from being able to access what you need? Check all that apply”. About one-third of respondents (36%, $n = 197$) indicated that they are not aware of service availability and 25% ($n = 139$) indicated that finances keep them from being able to access what they need. Transportation accounted for about 13% ($n = 70$) of respondents not being able to access what they need while 9% ($n = 49$) cited poor or unstable internet. A total of 125 respondents wrote in “other” inabilities to being able to access needs. A major theme in this category was “no needs at this time/all needs being met” ($n = 83$) and was included as a larger category in the chart below. Thirteen (13) responses were recoded and included in provided values, for example, a respondent wrote “transportation services are difficult to negotiate” which was included in the existing transportation scale point. Therefore, a total of 32 ‘other options’ were thematically coded and include more activities and services needed ($n = 6$), accessing community resources and assistance ($n = 5$), visual, hearing and mobility impairments ($n = 4$), housing ($n = 3$), and fear of COVID ($n = 3$). Other options include through housing (i.e., bulletin board in complex, $n = 4$) or through employment ($n = 3$). About 11 respondents included individualized needs such as “finding a typewriter”, “neighborhood harassment”, and “working full time”.

Figure A15: What keeps you from being able to access what you need?
($N = 548$)



Barriers to Addressing Needs by Age. The chart displays respondents who answered the question “What keeps you from being able to access what you need? Check all that apply” across varying age groups. It is important to note that because respondents were allowed to check off more than one response, percentages will not equal 100%. Each need is discussed below.

- **Transportation.** The largest group to identify transportation as a barrier was those over the age of 75 with about 17% of respondents indicating that transportation was a challenge when accessing

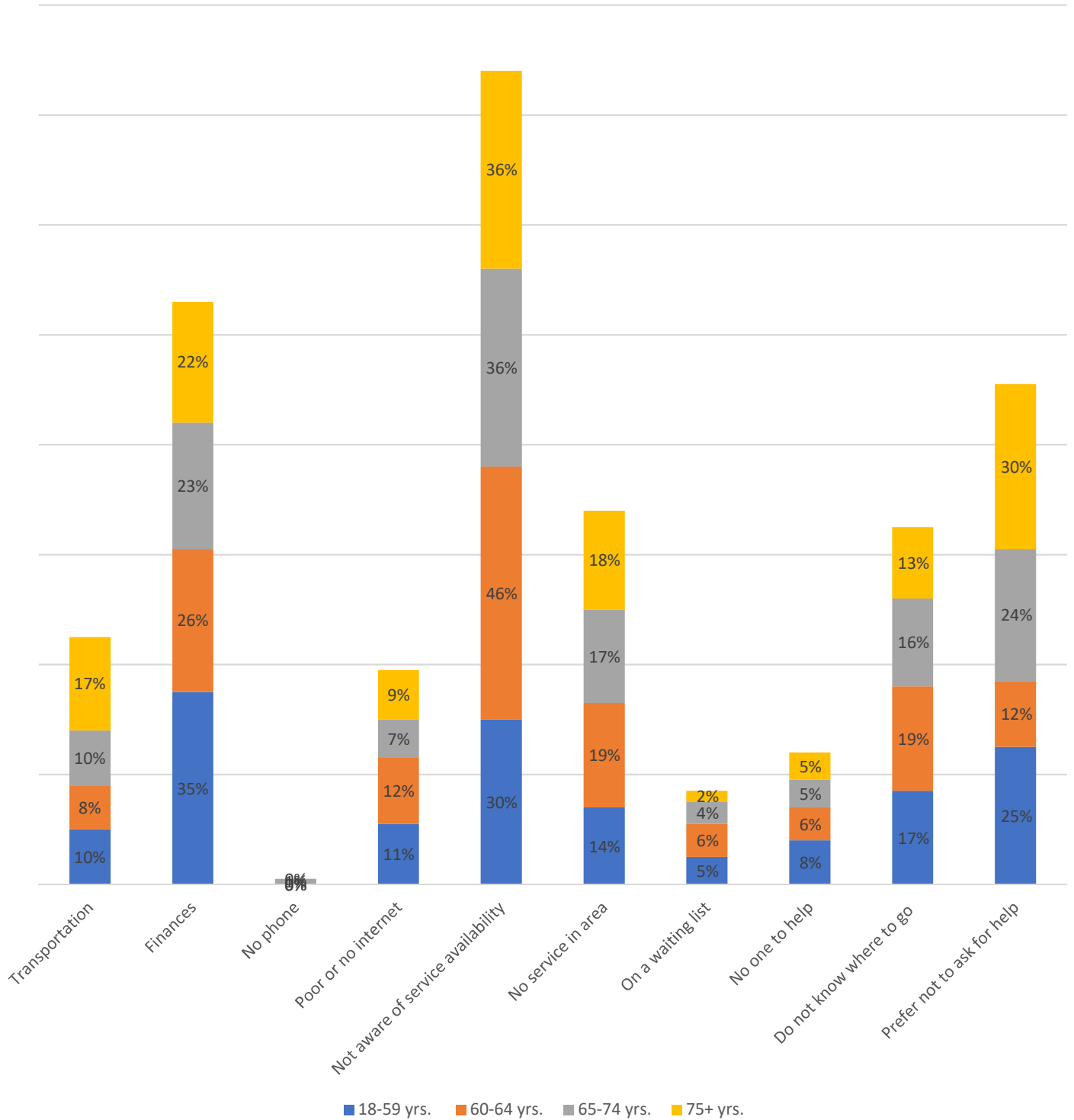


what they need. The smallest group to identify transportation as a barrier was those aged 60-64 years (8%).

- **Finances.** About 35% of those ages 18 to 59 identified finances as a barrier to accessing what they need while only about a quarter of the other age groups identified finances as a barrier.
- **No Phone.** Less than 1% of *all* respondents identified no phone as a barrier to accessing what they need.
- **Poor or no internet.** There is very little variation across poor or no internet as a barrier to accessing what is needed across age groups.
- **Awareness of service availability.** About 46% of respondents ages 60-64 years identified awareness of service availability as a barrier to accessing what they need while 36% of respondents ages 65-74 and 36% of respondents 75 years and older identified this as a barrier.
- **No service in area.** About 19% of respondents ages 60-64 identified no service in their area as a barrier and 14% of respondents ages 18 to 59 identified this as a barrier.
- **On a waiting list.** Fewer respondents identified being on a waiting list as a barrier to accessing what they need. The largest age group to identify being on a waiting list as a barrier was respondents age 60-64 (6%) and the smallest were respondents over the age of 75 (2%).
- **No one to help.** Fewer respondents identified no one to help as a barrier to accessing what they need. The largest group to identify no one to help as a barrier to accessing their needs were respondents from the ages of 18 to 59 (8%).
- **Do not know where to go.** About 19% of respondents ages 60 to 64 identified not knowing where to go as a barrier to accessing what they need, comparatively, 13% of respondents over the age of 75 identified not knowing where to go as a barrier.
- **Prefer not to ask for help.** About 30% of respondents over the age of 75 selected prefer not to ask for help as a barrier to accessing what they need while 25% of respondents ages 18 to 59, 24% of respondents ages 65-74, and 12% of respondents ages 60 to 64 identified this as a barrier.
- Across age groups, finances were identified by respondents ages 18 to 59 as the largest barrier to accessing what they need (35%). For respondents aged 60 to 64 (46%), 65 to 74 (36%), and over the age of 75 (36%) not being aware of service availability was the largest barrier to accessing what they need.



Figure A16: Barriers to Accessing Needs by Age
(N=548)



Barriers to Addressing Needs by County. The chart below displays respondents who answered the question “*What keeps you from being able to access what you need? Check all that apply*” across each county. It is important to note that because respondents were allowed to check off more than one response, percentages will not equal 100%. Each county is discussed below.

- **Belknap.** The largest barriers identified to being able to access what is needed include awareness of service availability (36%) and prefer not to ask for help (32%). Fewer responses were selected for barriers such as no phone (0%) and on a waiting list (4%).
- **Carroll.** The largest barriers identified to be able to access what is needed include awareness of service availability (33%) and finances (28%). Fewer respondents chose on a waiting list (7%) and do not know where to go (7%) as barriers.
- **Cheshire.** The most respondents living in Cheshire county chose prefer not to ask for help (28%) and finances (20%) as barriers to accessing what they need. Fewer respondents living in Cheshire county chose transportation (10%) and no one to help (10%) as barriers.
- **Coös.** The largest barriers identified in Coös County include finances (55%) and lack of awareness of service availability (55%). About 36% of respondents also indicated a lack of service availability and 9% indicated no phone as barriers.
- **Grafton.** About 27% of respondents living in Grafton County identified no service in area and 27% indicated prefer not to ask for help as barriers. Fewer respondents living in Grafton county indicated no one to help (4%) and on a waiting list (3%) as barriers.
- **Hillsborough.** The largest barriers identified in Hillsborough County include lack of awareness of service availability (44%), prefer not to ask for help (27%), and finances (25%). Fewer responses included not knowing where to go (14%) and transportation (13%) as barriers.
- **Merrimack.** The largest barriers identified to being able to access what is needed include finances (31%) and prefer not to ask for help (27%). Fewer responses were selected for barriers with no one to help (7%) poor or no internet (6%).
- **Rockingham.** The most respondents living in Rockingham chose lack of awareness of service availability (38%) and prefer not to ask for help (22%) as barriers to accessing what they need. Fewer chose poor or no internet (3%) and transportation (7%) as barriers.
- **Strafford.** About 56% of respondents living in Strafford County identified a lack of awareness of service availability in their area and 40% indicated finances as barriers. Fewer respondents living in Strafford County indicated no one to help (2%) and on a waiting list (4%) as barriers.
- **Sullivan.** The largest barriers identified to being able to access what is needed include lack of awareness of service availability (45%), finances (35%), and do not know where to go (30%). Fewer responses were selected for barriers such as no phone (0%) and on a waiting list (5%).



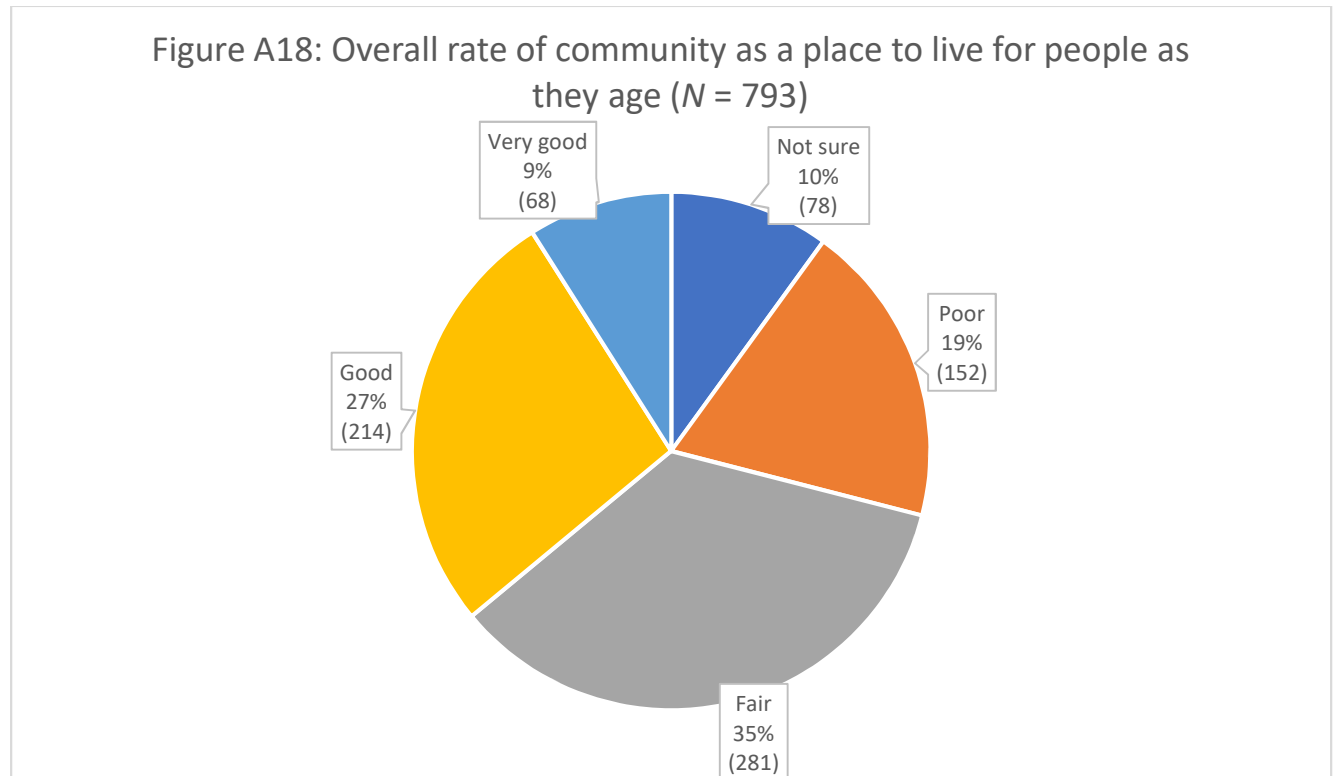
Figure A17: Barriers to Accessing Needs by County
(N = 548)



Financial Concerns. A total of 791 respondents answered the question “In the past 12 months, have you had to skip paying for a basic need (such as food, medication, heat, or housing) because of financial concerns? Check all that apply”. Most respondents (91%, $n = 717$) indicated that they did not skip paying for basic needs due to financial concerns. About 5% ($n = 36$) were unable to pay for medical care including medications, 4% ($n = 29$) were unable to pay for food, 3% ($n = 24$) were unable to pay for heat, 3% ($n = 21$) were unable to pay for transportation including insurance and vehicle maintenance, 3% ($n = 20$) were unable to pay for electricity, 2% ($n = 16$) were unable to pay for internet, 1% ($n = 11$) were unable to pay taxes, and 1% ($n = 10$) were unable to pay for housing.

Section 7: Meeting Your Needs

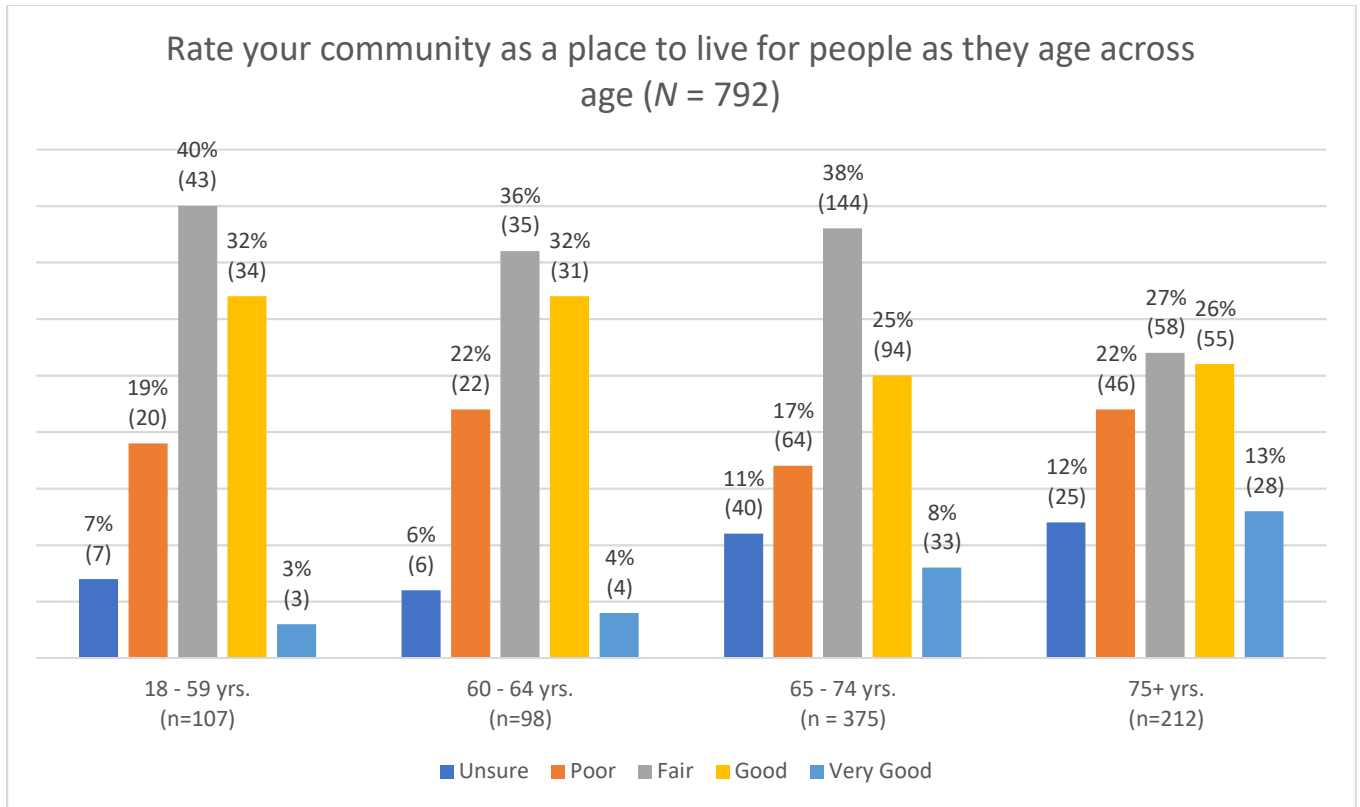
Overall Rating of Community as Place to Age. Respondents ($N = 793$) answered the following question “Thinking about your future needs, how would you rate your community as a place to live for people as they age?” A little more than one-third of respondents (35%, $n = 281$) indicated “fair” while about a quarter (27%, $n = 214$) indicated good. About 19% ($n = 152$) cited poor, 10% ($n = 78$) indicated not sure, and 9% ($n = 68$) indicated very good.



Overall Rating of Community as Place to Age Across Age Groups. The graph above depicts respondent’s thoughts to the question “Thinking about your future needs, how would you rate your community as a place to live for people as they age?” across age groups. For respondents ages 18 to 59 years, 40% ($n = 43$) indicated that as a place to age their community is fair, while 3% ($n = 3$) indicated that their community is a very good place to age. Comparatively, for respondents ages 60 to 64 years old, about 32% ($n = 31$) indicated that their community is a good place to age while about 22% ($n = 22$) indicated that it is a poor place to age. About 11% ($n = 40$) of respondents ages 65 – 74 indicated that they are unsure about their community as a place for people to age, and 38% ($n = 144$) indicated that



their community is a fair place to age. For respondents over the age of 75 about 26% ($n = 55$) indicated that their community is a good place to age and 13% ($n = 28$) indicated that their community is a very good place to age. Across all the age groups, “fair” and “good” indicators received the highest number of responses followed by fair, unsure, and very good.



Importance of Future Issues. Respondents ($N = 795$) were asked to “As you look to the future, please rate the importance of the below”. Scale points were ranked as 1 = not sure/doesn’t apply, 2 = low importance, 3 = moderately important, 4 = high importance, therefore, higher mean values equate to higher importance. The table below provides counts and percentages for each scale point, and the mean and standard deviation are provided. Each item is ranked based on the highest mean.

Results show that feeling safe in my own home ($M = 3.84, SD = 0.5$), feeling safe in my community ($M = 3.83, SD = 0.4$), and affordable health insurance ($M = 3.82, SD = 0.5$) were the most important services to respondents when thinking about the future. Retrofitting my home so essential rooms are accessible ($M = 3.06, SD = 1.0$), finding someone to help me in my home ($M = 3.05, SD = 1.0$), and finding an assisted living or nursing home ($M = 2.84, SD = 1.1$) were rated overall as the least important to respondents when thinking about the future.



Table B9: Looking to the future, rate the importance of the following

| Item | Response Categories | | | | M(SD) |
|--|---------------------|---------------|----------------------|----------------|------------|
| | Not sure/NA | Not important | Moderately important | Very important | |
| Feeling safe in my own home (n = 787) | 0.6% (5) | 2.0% (16) | 9.5% (75) | 87.8% (691) | 3.85 (0.5) |
| Feeling safe in my community (n = 786) | 0.4% (3) | 1.0% (8) | 13.5% (106) | 85.1% (669) | 3.83 (0.4) |
| Affordable health insurance (n = 772) | 1.0% (8) | 3.8% (29) | 7.5% (58) | 87.7% (677) | 3.82 (0.5) |
| Having medical services nearby (n = 770) | 1.0% (8) | 0.7% (5) | 15.6% (120) | 82.7% (637) | 3.80 (0.5) |
| Having safe walkways and roads (n = 770) | 1.2% (9) | 2.3% (18) | 14.4 (111) | 82.1% (632) | 3.78 (0.5) |
| Financial security (n = 769) | 3.4% (26) | 7.4% (57) | 11.4% (88) | 77.8% (598) | 3.64 (0.8) |
| Affordable housing (n = 760) | 7.0% (53) | 10.3% (78) | 16.7% (127) | 66.1% (502) | 3.42 (0.9) |
| Having recreation and social engagement opportunities (n = 768) | 3.9% (30) | 6.8% (52) | 33.6% (258) | 55.7% (428) | 3.41 (0.8) |
| Having family nearby (n = 764) | 4.2% (32) | 10.1% (77) | 29.7% (227) | 56.0% (428) | 3.38 (0.8) |
| Easy and affordable access to public transportation (n = 766) | 6.0% (46) | 9.3% (71) | 33.7% (258) | 51.0% (391) | 3.30 (0.9) |
| Having senior centers within my community (n = 771) | 7.1% (55) | 10.0% (77) | 35.3% (272) | 47.6% (367) | 3.23 (0.9) |
| Public transportation (n = 757) | 6.6% (50) | 13.9% (105) | 36.2% (274) | 43.3% (328) | 3.16 (0.9) |
| Retrofitting my home so essential rooms are accessible (n = 760) | 10.9% (83) | 16.5% (125) | 28.6% (217) | 44.1% (335) | 3.06 (1.0) |
| Finding someone to help me in my home (n = 766) | 11.8% (90) | 14.9% (114) | 30.2% (231) | 43.2% (331) | 3.05 (1.0) |
| Finding an assisted living facility or nursing home (n = 755) | 16.0% (121) | 19.5% (147) | 28.6% (216) | 35.9% (271) | 2.84 (1.1) |



Importance of Future Issues Across Age. These results show levels of importance across the top five issues that respondents identified looking towards their future across age groups. As above, issues are ranked based on the highest mean. Results show that *feeling safe in my own home* was more important for respondents aged 18 to 59 years (94%) and 60-74 years (90%) when compared to respondents over the age of 75 (84%). About 91% of respondents ages 18 to 59 placed high importance on *feeling safe in their communities* while about 83% of respondents ages 60 to 64 and 83% of respondents over the age of 75 rated feeling safe in community as very important. The majority (95%) of respondents between the ages of 60 – 64 indicated that *affordable health insurance* is very important, similarly respondents between the ages of 18 – 59 (92%) this as very important. About 82% of respondents 75 years and older rated affordable health insurance as very important and 7% rated it as not important. Data indicates that *having medical services nearby* was very important to respondents ages 75 years and older (86%). *Having safe walkways and roads* was most important to respondents aged 18 to 59 (85%) while 78% of respondents aged 60 to 64 rated safe walkways and roads as very important.

Table B10: Looking to the future, rate the importance of the following by age category.

| | | 18-59 yrs. | 60-64 yrs. | 65-74 yrs. | 75+yrs. |
|--|------------------------|------------|------------|------------|-----------|
| Feeling safe in my own home (n=787, M=3.85) | Not sure/doesn't apply | 1% (1) | 0% (0) | 1% (2) | 1% (2) |
| | Not important | 1% (1) | 2% (2) | 2% (7) | 3% (6) |
| | Moderately important | 4% (4) | 8% (8) | 10% (37) | 12% (26) |
| | Very important | 94% (100) | 90% (89) | 88% (325) | 84% (176) |
| Feeling safe in my community (n=786, M=3.83) | Not sure/doesn't apply | 0% (0) | 0% (0) | 0% (0) | 1% (3) |
| | Not important | 2% (2) | 1% (1) | 1% (4) | 1% (1) |
| | Moderately important | 7% (8) | 16% (16) | 14% (50) | 15% (32) |
| | Very important | 91% (96) | 83% (82) | 85% (317) | 83% (173) |
| Affordable health insurance (n=772, M=3.82) | Not sure/doesn't apply | 1% (1) | 0% (0) | 2% (6) | 1% (1) |
| | Not important | 0% (0) | 1% (1) | 4% (13) | 7% (15) |
| | Moderately important | 7% (7) | 4% (4) | 7% (27) | 10% (20) |
| | Very important | 92% (96) | 95% (94) | 87% (319) | 82% (167) |
| Having medical services nearby (n = 770, M=3.78) | Not sure/doesn't apply | 2% (2) | 1% (1) | 1% (3) | 1% (2) |
| | Not important | 1% (1) | 1% (1) | 1% (2) | 1% (1) |
| | Moderately important | 15% (16) | 17% (17) | 17% (62) | 12% (25) |
| | Very important | 82% (87) | 81% (80) | 81% (294) | 86% (175) |
| Having safe walkways and roads (n=770, M=3.78) | Not sure/doesn't apply | 2% (2) | 1% (1) | 1% (1) | 2% (5) |
| | Not important | 3% (3) | 2% (2) | 1% (5) | 4% (8) |
| | Moderately important | 10% (10) | 19% (18) | 15% (55) | 14% (28) |
| | Very important | 85% (87) | 78% (76) | 83% (304) | 80% (164) |



Importance of Future Issues Across County. Results show differences across each New Hampshire County and levels of importance across the top five issues that respondents identified looking towards their future.

- **Feeling safe in my own home.** All Coös respondents (100%) indicated that feeling safe in their own homes is very important for future aging, while 90% of Merrimack and 90% of Rockingham respondents also indicated that feeling safe is very important. About 15% of Cheshire respondents indicated that feeling safe in their own home was moderately important. All counties had few response rates for “not important” with Belknap, Carroll, Coös, and Sullivan counties having 0 residents who indicated that feeling safe in their own home was not important.
- **Feeling safe in my community.** Respondents living in Coös (100%), Belknap (91%), and Rockingham (90%) identified feeling safe in my community as very important. About 26% of respondents living in Cheshire and 19% of respondents living in Sullivan Counties indicated that feeling safe in their communities is moderately important.
- **Affordable health insurance.** About 94% of respondents living in Cheshire and 93% of respondents living in Sullivan County identified affordable health insurance as an issue in future aging. About 9% of respondents living in Belknap and 8% of respondents living in Grafton County identified affordable health insurance as not important.
- **Having Medical Services Nearby.** A majority of respondents from Cheshire (88%), Merrimack (88%), and Strafford (88%) Counties indicated that having medical services nearby is very important for future aging when compared to only 67% of Belknap and 76% of Hillsborough County respondents who indicated that having medical services nearby is very important.
- **Having safe walkways and roads.** About 93% of Coös and 90% of Cheshire respondents indicated that having safe walkways and roads is very important. Comparatively, about 21% of Carroll and 17% of Grafton respondents indicated that having safe walkways and roads is moderately important.
- Below, each county is provided and the highest ranking issue that was identified looking towards the future
 - **Belknap:** Feeling safe in my community (91%)
 - **Carroll:** Feeling safe in my own home (87%)
 - **Cheshire:** Affordable health insurance (94%)
 - **Coös:** Feeling safe in my own home (100%) and Feeling safe in my community (100%)
 - **Grafton:** Having medical services nearby (86%)
 - **Hillsborough:** Affordable health insurance (91%)
 - **Merrimack:** Feeling safe in my own home (90%) and Affordable health insurance (90%)
 - **Rockingham:** Feeling safe in my own home (90%) and Feeling safe in my community (90%)
 - **Strafford:** Feeling safe in my own home (88%) and Having medical services nearby (88%)
 - **Sullivan:** Affordable health insurance (93%)



Table B11 Importance of future needs by County

| | | Belknap | Carroll | Cheshire | Coös | Grafton | Hillsborough | Merrimack | Rockingham | Strafford | Sullivan |
|--|------------------------|----------------|----------------|-----------------|-------------|----------------|---------------------|------------------|-------------------|------------------|-----------------|
| Feeling safe in my own home (<i>n</i> =787, <i>M</i> =3.85) | Not sure/doesn't apply | 0% | 2% | 0% | 0% | 2% | 1% | 0% | 1% | 0% | 0% |
| | Not important | 0% | 0% | 4% | 0% | 2% | 2% | 2% | 2% | 2% | 0% |
| | Moderately important | 12% | 11% | 15% | 0% | 12% | 9% | 8% | 7% | 11% | 12% |
| | Very important | 88% | 87% | 81% | 100% | 84% | 88% | 90% | 90% | 88% | 88% |
| Feeling safe in my community (<i>n</i> =786, <i>M</i> =3.83) | Not sure/doesn't apply | 0% | 0% | 0% | 0% | 2% | 1% | 0% | 0% | 0% | 0% |
| | Not important | 0% | 2% | 2% | 0% | 1% | 0% | 1% | 2% | 2% | 0% |
| | Moderately important | 9% | 15% | 26% | 0% | 17% | 13% | 13% | 8% | 15% | 19% |
| | Very important | 91% | 84% | 73% | 100% | 80% | 87% | 86% | 90% | 83% | 81% |
| Affordable health insurance (<i>n</i> =772, <i>M</i> =3.82) | Not sure/doesn't apply | 3% | 0% | 0% | 0% | 1% | 1% | 1% | 2% | 0% | 4% |
| | Not important | 9% | 4% | 2% | 0% | 8% | 3% | 4% | 2% | 4% | 0% |
| | Moderately important | 9% | 17% | 4% | 7% | 7% | 6% | 6% | 9% | 10% | 4% |
| | Very important | 79% | 80% | 94% | 93% | 84% | 91% | 90% | 88% | 86% | 93% |
| Having medical services nearby (<i>n</i> = 770, <i>M</i> =3.78) | Not sure/doesn't apply | 0% | 2% | 0% | 0% | 2% | 1% | 1% | 2% | 0% | 0% |
| | Not important | 0% | 0% | 0% | 0% | 2% | 1% | 2% | 0% | 0% | 0% |
| | Moderately important | 33% | 19% | 12% | 13% | 10% | 23% | 9% | 16% | 12% | 16% |
| | Very important | 67% | 80% | 88% | 87% | 86% | 76% | 88% | 82% | 88% | 84% |
| Having safe walkways and roads (<i>n</i> =770, <i>M</i> =3.78) | Not sure/doesn't apply | 3% | 2% | 0% | 0% | 2% | 0% | 2% | 2% | 0% | 0% |
| | Not important | 0% | 4% | 0% | 0% | 3% | 3% | 5% | 1% | 2% | 0% |
| | Moderately important | 12% | 21% | 10% | 7% | 17% | 13% | 13% | 15% | 14% | 15% |
| | Very important | 85% | 74% | 90% | 93% | 78% | 84% | 81% | 82% | 84% | 85% |



SPOA Listening Sessions and Qualitative Results

As part of the development of the State plan on Aging 2019-2023, the Bureau of Elderly & Adult Services (BEAS), NH Department of Health and Human Services (DHHS), in partnership with the NH State Plan on Aging (SPOA) Planning Committee held 10 community listening sessions, as outlined below, to hear what older adults think about what is working and what is not working in the community as it relates to aging.

| Location | Date | Number of Attendees |
|------------------------------|------------------|---------------------|
| North Conway | January 17, 2023 | 6 |
| Virtual (9:00 am – 11:00 am) | January 18, 2023 | 16 |
| Virtual (3:00 pm – 5:00 pm) | January 18, 2023 | 9 |
| Berlin | January 19, 2023 | 30 |
| Keene | January 25, 2023 | 10 |
| Concord | January 26, 2023 | 15 |
| Virtual | January 27, 2023 | 24 |
| Virtual | January 30, 2023 | 25 |
| Virtual | February 1, 2023 | 22 |
| Manchester | February 2, 2023 | 28 |

To increase access, efforts were made to hold both in-person and virtual listening sessions. In-person sessions were held in different regions across the state and in local settings where older adults congregate (i.e., senior centers, community centers). Virtual listening sessions utilized a widely known software platform (i.e., Zoom) and hosted both computer and phone-in options. Virtual sessions were held at varying times to accommodate stakeholder schedules. Participation in the listening sessions varied across a wide range of stakeholders and included older adults and their families, service providers, aging researchers, policy makers, state employees, and others. Combined, the 10 sessions included a total of 185 stakeholders.

Sessions were facilitated by Wendi Aultman, Bureau Chief, Bureau of Elderly & Adult Services (BEAS), DHHS and Thom O’Connor, Home and Community Based Services Administrator, BEAS, DHHS. Key BEAS program management staff and local District Office staff attended each session. NH Alliance for Healthy Aging staff and State Commission on Aging members attended each listening session.

The discussion and feedback from these sessions focused around five major questions. Throughout the sessions several recurrent successes and concerns were shared as summarized below.

Question 1: What is working well in your community as it relates to aging?

- **Senior Centers**
 - Help distribute information and resources to older adults and are “vital [to] supporting older adults to remain healthy and active in their communities.”
 - Address isolation and loneliness by having a calendar of events.
 - During the pandemic, senior centers supported older adults through grab and go meals, phone calls, online programming, and serving as vaccination sites.
- **ServiceLink (SLRC)**
 - Breadth and availability of services SLRC provides to older adults.



- Some SLRC offices are co-located within other organizations (i.e., Senior Center, public health network) making it easy for clients to access.
- One respondent felt they could “trust” SLRC to help them navigate Medicare.
- **State and Local Government Programs**
 - Meals on Wheels.
 - State programs including the NH Referral Education Assistance and Prevention Program (REAP) and the No Wrong Door/NH Care Path team.
 - Local government such as Cheshire County are investing in home modification programs and local police department activities including wellness checks.
- **Community Organizations and Local Initiatives.**
 - Local initiatives such as community nursing programs (i.e., Community Nurse Connect, Tamworth Community Nurses), local groups that provide resources, education, and connection (i.e., Sanbornton Connects), Dinner Bells program (i.e., church that provides meals) and others (i.e., Ossipee Concerned Citizens, Monadnock Broadband Initiative).
 - Agencies providing care in the home such as respite care, palliative care, and hospice.
 - Other organizations such as libraries and recreational activities (i.e., pickleball, ski resorts).
 - Communities and initiatives are working across the state to develop a strong collaborative to strengthen the aging network.
- **Transportation**
 - Some transportation is working well, specifically, some communities have a bus (i.e., town of Atkinson, Easter Seals) that is available for rides, however, availability is limited.
 - Others cited RSVP, volunteer driver programs, and Mobility Management Network.
- **Feel Engaged in Community**
 - Several comments were made about “feeling like I belong and are a part of the community”.
 - Some discussed having the perception of having a positive attitude towards aging and the desire to change/improve community issues to create age-friendly communities.
 - Several respondents cited volunteering within the community.
- **Other Responses**
 - A few comments indicated that broadband and cellphone plans are working well.
 - Accessing information including forums and newspapers is working.
 - One comment was made around legislation that was introduced this year as working well.

Question 2: What is not working well in your community as it relates to aging?

- **Transportation**
 - The need for transportation was discussed at almost all of the listening sessions. Some comments indicated that transportation was more difficult in rural areas.
 - The biggest barriers identified were access, availability, and cost. One stakeholder stated, “there are no alternatives if you are uncomfortable driving.”
 - Not knowing where or how to find transportation options.
 - While volunteer driver programs are useful there are concerns that the number of drivers is dwindling, and programs and volunteers have been impacted by COVID-19.



- **Healthcare Workforce**
 - Addressing the workforce crisis was a major theme throughout most listening sessions and many of the comments were similar.
 - Need to increase the number of healthcare workers (i.e., primary care doctors, direct care workers, geriatricians, etc.) to improve the availability of services.
 - Need to incentivize workers to stay at their job. Some solutions include raising the reimbursement rate.
- **Available, Accessible, and Affordable Housing**
 - Funding for home modifications and repairs.
 - Homelessness for older adults needs to be addressed. Shelters are unable to address the medical complexities of frail older adults.
 - Need chore services (i.e., trash removal, mowing lawn) to keep people at home longer.
- **Economic Security and Costs of Living**
 - Rapid increase in costs of living.
 - Property taxes are a burden and are pricing older adults out of their homes.
- **Healthcare System for Older Adults**
 - Need to improve how people access care. Several comments cited that older adults are using emergency rooms due to unavailability of other healthcare providers.
 - Discharge planning, preparing caregivers, and follow-up care at home needs to be improved.
- **Coordination Across Continuum of Care**
 - The LTSS continuum of care can be improved by streamlining services and creating better coordination across state departments and community organizations.
 - NH service provision is organized by towns meaning that services vary widely. This makes it difficult to access and hard to navigate.
- **Broadband Access**
 - Lack of internet and Wi-Fi impedes the ability to connect for telehealth appointments or to socially connect.
 - Cost of access is high.
- **Lack of Awareness and Communication about Accessing Information and Resources**
 - Some comments indicated that people did not know where or how to access services.
 - Need for increased communication (i.e., advertising, education and outreach) about navigating and understanding how to use aging services and preparing for getting older.
 - Improve accessibility in public spaces and meetings including providing disclaimers that services are available (i.e., CART reporter), language services (i.e., interpreter, captioning, etc.), and ensuring that spaces are ADA compliant.
- **Funding for More Services**
 - Many comments indicated a need for increased programming across a variety of agencies (i.e., senior centers, adult day programs, caregiver support, SLRC services, in-home services).
 - Some comments indicated that NH does not have enough funding to support these programs which is why they are limited in scope and duration. One comment stated that “NH ranks 49th out of 50 for state spending on older adult [services].”
- **Other**
 - *Nursing Home and Assisted Living Concerns.* Lack of availability and affordability.



- *Rural Areas of NH have Unique Challenges.* Feelings of inequity and invisibility related to available resources.
- *Fraud/Scams .* Occurring often, needs to be addressed.

Question 3: How can NH better serve and support its aging population today and in the future?

- **Improvement of Distribution and Coordination of Services**
 - Many comments indicated that people were unaware of current services, where to find services, and eligibility of services. Further, many expressed that services were siloed creating confusion and duplication. Therefore, increasing communication about available services (i.e., advertising, developing a newsletter, etc.) would help create awareness.
 - Creating a centralized, streamlined approach such as wraparound services, navigators, case managers, and stronger connections between agencies were discussed as solutions.
 - Some comments were specifically to DHHS such as creating a standardized application for DHHS programs, optional paper applications, and having a live person answer the phone.
- **Services and Supports**
 - Comments varied across a range of services and support.
 - Some comments indicated increasing the number of services (i.e., *adult day, senior centers, in-home support, and advanced care planning*).
 - *ServiceLink* needs more staff and funding to expand/promote the program.
 - *Adult Protective Services* needs more resources and funding to increase the number of staff.
 - *Caregiving support*
 - Increase education for caregivers such as creating an educational campaign (e.g., Granite State Visiting Nurses Prepare to Care) that provides information about what it is like to be a caregiver.
 - Create a system of care for caregivers including providing respite and pay.
 - Increase support and access to *internet and technology* (with training).
 - *Housing*
 - Increase housing. Models such as Laconia Housing Model or HomeShare could be replicated.
 - Home modification availability including changing housing zoning codes (i.e., accessory dwelling units) and developing smart homes is also a need.
 - *Transportation* is needed for medical appointments.
- **Accessibility and Universal Design**
 - Many comments discussed accessibility and always using adaptive/assistive equipment (i.e., microphone, captioning) during public forums, meetings, and in public spaces.
 - Support age friendly policies and universal design across state programs. For example, DOT could ensure that sidewalks are accessible for those with mobility challenges.
- **Future**
 - Intergenerational opportunities that develop connection between younger and older people.
 - Providing education (i.e., Keep Sharp, Build a Better Brain at Any Age book, Riverwoods/NHPR podcasts) to plan for the future.
 - Change the narrative on aging to celebrate and elevate older adult voices through community conversations.
 - Address cultural barriers and lack of diversity within the state.



- **Other**
 - *Social Engagement.* Several comments were made related to increasing socialization through virtual or live opportunities.
 - *Provide Healthy Meal Options and Preventative Programming.* Increase falls prevention programs, provide more nutritious options for OAA meal providers, and create opportunities to engage in physical exercise (i.e., walkable communities)
 - *Retain and recruit workforce.* Support pipelines for direct care workforce recruitment and retention. Increase training for healthcare workforce.
 - *Reduce property taxes for older adults.*

Question 4: What do you need to continue living in your home as you get older?

- **Chore management**
 - Many comments discussed the need for assistance with daily household chores (i.e., show shoveling, plumbing, trash removal, etc.).
 - Some individuals identified the need for a place to find trusted chore service providers.
- **Housing and Community**
 - Expansion of current housing models (i.e., HomeShare), increased accessory dwelling units, and more funding for home modifications.
 - Increase naturally occurring retirement communities, walkable communities, and explore implementing villages (i.e., Village to Village movement).
- **Health and Social Services**
 - *Increase health services* (i.e., foot care, eye care, long-term care planning, physical therapy)
 - *Ensure accessibility* across services through speech/hearing/visual accessibility, microphone use, and reducing use of stigmatizing labels.
 - *Develop a skilled Workforce* through training and vocational programs with high schools.
 - *Person-Centered Approach to Care.* Ability to tailor services to specific needs and create a plan that can be shared with family, friends, and service providers as a guide.
 - *Providing opportunities to socially connect* either virtually or in-person.
- **Providing Information to Resources.**
 - Some comments indicated that services are siloed, and it is difficult to navigate.
 - One solution is to have information be in one centralized repository. Other solutions discussed include senior newsletters and an elder resource directory.
- **Providing Education**
 - Comments varied on providing education on a wide array of topics from understanding aging, ageism, and caregiving.
 - Some discussed creating partnerships with colleges to develop mentorship programs to connect students and older adults.
- **Application and Eligibility Process**
 - Several comments indicated that eligibility should be reformed to reduce people from going into poverty to receive services.



- Some comments discussed concerns about personal information storage given the amount of applications completed.
- One comment indicated that the application process needs to be better supported.
- **Broadband, Internet, and Equipment Access.** Increase connectivity to broadband for older adults. Need to include training and assistance in utilizing technology.
- **Transportation.** Several comments indicated the need for transportation. Specifically, some individuals commented on the need for agencies to pay for volunteer driver insurance as well as changing policy to allow volunteer drivers to assist individuals getting in and out of the vehicle.

Question 5: What can we do to reduce isolation for older adults in NH?

- **Promote Livable Communities.**
 - *Promoting intergenerational opportunities.* Many comments stated the desire and need to connect younger and older people. Various activities (i.e., recreational, school-based, and housing activities) were mentioned.
 - *Fostering community cohesion and informal socialization.* Some comments discussed creating stronger community bonds by fostering local activities (i.e., community parks, neighborhood check-ins).
 - *Implement Activities led by Communities.* Comments indicated that communities needed to implement activities locally that could benefit residents. For example, friendly visitor programs, wellness checks/phone check-ins, and adopt-a-grandparent.
 - *Address safety concerns.* Fear could be a barrier to participating in social activities. Ensuring that people feel safe in their homes, streets, and neighborhoods is important.
- **Engaging and Expanding Current Programs and Activities.**
 - *Libraries.* Create more opportunities and stronger partnerships with libraries.
 - *Local wellness programs.* Organizations such as YMCA and Parks and Recreation were discussed to foster activity and wellness while engaging in healthy, physical activity.
 - *Home and community-based services.* Increasing in-home support services, community health workers, and Meals on Wheels were discussed as helping to improve social isolation.
 - *Adult Day.* Some comments were made about the benefits of adult day specifically in addressing isolation for individuals and respite for caregivers.
 - *Housing.* Co-housing solutions (i.e., ADUs, HomeShare) were mentioned as ways to reduce isolation.
- **Reducing barriers to participation.**
 - *Transportation.* Many comments cited transportation as a barrier. Comments including access, availability, and cost reduced the ability to get involved with social activities.
 - *Accessibility.* Need for inclusion including speech, hearing, and visual access.
 - *Language access.* Ensure that activities include different languages aside from English.
 - *Socioeconomic Status.* Some comments indicated that some people do not have enough assets and are isolated due to cost.
- **Enhancing Internet Access and Technology.** Several comments were made around increasing internet access and support for technology to reduce social isolation. Some comments cited that online is not a complete substitute for in-person socialization, but one comment indicated that “as people are becoming more familiar with technology, [there is] an expansion of their social world.”



- **Promoting and Distributing Information.** The need to promote and advertise programs was discussed. Some comments indicated that people did not know about activities, services, or resources that could reduce isolation.
- **Other.**
 - *Pets.* Several comments were made related to the benefits of having pets.
 - *Reframing activities.* Some comments were made on how “senior activities” are labeled and rebranding these activities could draw more people to them.



No Wrong Door (NWD) System Governance Grant – Overview

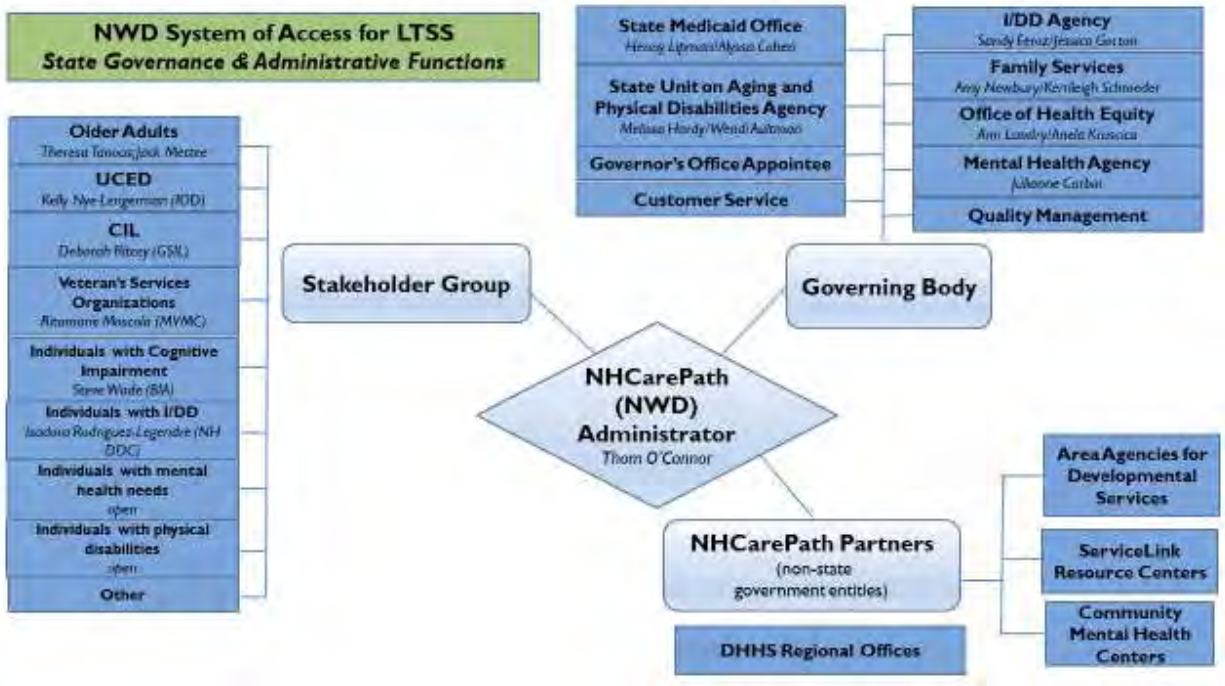
A key function of the NWD System is to serve as a bridge for the health systems to the community and to facilitate the transition of individuals with LTSS needs who are being discharged from acute care settings and nursing homes back to their own homes. For nearly two decades, NH DHHS has partnered with the Administration for Community Living (ACL), Centers for Medicare and Medicaid Services, and the Veterans Health Administration to create an efficient and person-centered service delivery system through streamlined access to services in the community for all populations. The ServiceLink ADRC has been recognized as a sustainable, high functioning statewide model for nearly a decade. The national Long-Term Services and Supports (LTSS) Scorecard (www.longtermscorecard.org/databystate/state?state=NH) ranks the State of New Hampshire second in the nation for ADRC/No Wrong Door (NWD) functions. The NWD System of Access for LTSS in NH is branded as NHCarePath. NHCarePath epitomizes the ongoing growth and improvements that partners across the LTSS system can achieve while being flexible around changing environments and opportunities.

Although NH has known to have a strong NWD system ([NHCarePath](#)), it has become clear to the BEAS leadership team that there needed to be a focus on the governance structure of the NWD system in order to maintain momentum of NHCarePath statewide. Therefore, NH BEAS has partnered with ACL on the administration of the “No Wrong Door System Governance” Grant, as ACL was awarded this grant.

Administration for Community Living has provided a vision for the No Wrong Door Governance grant, which includes:

- Recognition that there is no one agency or network that has the capacity, expertise, or authority to effectively carry out all the NWD System functions for all the different populations served by the NWD System.
- NWD System is governed by a multi-agency leadership team, responsible for the coordinating the System’s on-going development, implementation, financing, evaluation and continual improvement.
- Governing body actively and publicly promotes the philosophy, values, concepts and practices of person-centeredness throughout the NWD System.
- Include support from the governor and involvement from the state Medicaid agency, state agencies administering programs for Aging, Intellectual and Developmental Disabilities, Physical Disabilities and Mental/Behavioral Health.
- Involve input from external stakeholders, including consumers and their families, on the design, implementation and operation of the System.
- Designate agencies and organizations that play a formal role in carrying out NWD System.
- Use NWD System as a vehicle for making overall LTSS System more consumer-driven and cost-effective.





The goals of this project are as follows:

1st year:

- *Develop NWD governance structure which includes health systems (or health system state association) to establish partnerships that enable individuals to access services to transition from hospitals and nursing homes to home and the community*
- *Assessment of individual and family caregiver access to LTSS, including mapping key coordination referral sources such as Social Health Access Referral Platforms (SHARPS) sometimes used by health care providers and payers to refer patients to community based organizations and mapping of key referral sites in the NWD system*

2nd year:

- *Work with NWD governing body to develop a mitigation plan for addressing access issues for individuals and family caregivers (anticipate future funding opportunities to implement mitigation plan)*
- *Integration of Recognize, Assist, Include, Support, and Engage (RAISE) Goals and National Family Caregiving Strategy in NWD Governance (pages 5, 6, & 7 of RFP) mentions that states are asked to identify strategies, based on year 1 analysis, which align with the first 3 RAISE goals and recommendations 1.2, 1.3, 2.2, 3.1, 3.3, and 3.4 of the National Family Caregiving Strategy.*



Links to Resources and Tools Supported in the State Plan

- (a) [2023 Alzheimer's Disease Facts and Figures, Alzheimer's Association](https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf)
<https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf>
- (b) [2018 Across the States Profiles of Long Term Services and Supports, AARP](https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf)
<https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf>
- (c) [2019-2020 Annual Report: State Coordinating Council for Community Transportation, NH Department of Transportation](https://www.nh.gov/dot/programs/scc/documents/scc_annual_report_201920.pdf)
https://www.nh.gov/dot/programs/scc/documents/scc_annual_report_201920.pdf
- (d) [New Hampshire Statewide Mobility Management Network, 2022](https://www.nh.gov/dot/programs/scc/documents/scc_mobility_mgr_blueprint.pdf)
https://www.nh.gov/dot/programs/scc/documents/scc_mobility_mgr_blueprint.pdf
- (e) [Ask the Question Campaign, Department of Military Affairs and Veterans Services](https://www.askthequestion.nh.gov/)
<https://www.askthequestion.nh.gov/>
- (f) [Center on Aging and Community Living](https://chhs.unh.edu/center-aging-community-living)
<https://chhs.unh.edu/center-aging-community-living>
- (g) [Chronic Disease and Self-Management Program, Better Choices, Better Health, 2020](https://www.snhahec.org/uploads/1/3/2/1/132121212/fall_2020_cdsmp_report.pdf)
https://www.snhahec.org/uploads/1/3/2/1/132121212/fall_2020_cdsmp_report.pdf
- (h) [System of Care Bill, Senate Bill 36-N](https://www.gencourt.state.nh.us/bill_status/pdf.aspx?id=10079&q=billVersion)
https://www.gencourt.state.nh.us/bill_status/pdf.aspx?id=10079&q=billVersion
- (i) [Developing a Foundation for Integrated Care Coordination, Institute on Disability, UNH, Centers on Aging and Community Living, NH Alliance for Healthy Aging, 2018](https://chhs.unh.edu/sites/default/files/media/2018/12/care_coordination_part_1.pdf)
https://chhs.unh.edu/sites/default/files/media/2018/12/care_coordination_part_1.pdf
- (j) [Future In Sight](https://futureinsight.org/)
<https://futureinsight.org/>
- (k) [Medicaid Home and Community-Based Care Service Delivery Limited by Workforce Challenges](http://nhfpi.org/research/health-policy/medicaid-home-and-community-based-care-service-delivery-limited-by-workforce-challenges.html#_edn5)
http://nhfpi.org/research/health-policy/medicaid-home-and-community-based-care-service-delivery-limited-by-workforce-challenges.html#_edn5
- (l) [New Hampshire 10 – Year Mental Health Plan, 2019](https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf)
<https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>



- (m) [New Hampshire Alliance for Healthy Aging, Strategic Priorities](https://nhaha.info/strategic-priorities/)
<https://nhaha.info/strategic-priorities/>
- (n) [New Hampshire Alzheimer's Statistics, Alzheimer's Impact Movement, Alzheimer's Association, 2020](https://www.alz.org/media/manh/documents/facts-and-figures-factsheet-NH-2020.pdf) <https://www.alz.org/media/manh/documents/facts-and-figures-factsheet-NH-2020.pdf>
- (o) [New Hampshire Association of Counties, NH Long Term Services and Supports: An Assessment of the Current System and Implications for Reform, 2018](https://docs.wixstatic.com/ugd/2d2e8b_8dff5d59e3e0430f8f3ecb17c1817f7d.pdf)
https://docs.wixstatic.com/ugd/2d2e8b_8dff5d59e3e0430f8f3ecb17c1817f7d.pdf
- (p) [New Hampshire Healthy Aging Data Report, 2019](https://healthyagingdatareports.org/new-hampshire-healthy-aging-data-report/)
<https://healthyagingdatareports.org/new-hampshire-healthy-aging-data-report/>
- (q) [New Hampshire Commission on Aging – Aging in One's Community & Long-Term Supports in NH](https://www.nhcoa.nh.gov/documents/COA-LTSS-System-Reform-Issue-Brief-March-10-2022.pdf)
<https://www.nhcoa.nh.gov/documents/COA-LTSS-System-Reform-Issue-Brief-March-10-2022.pdf>
- (r) [New Hampshire Suicide Prevention Plan, 2021-2024](https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/2021-suicide-prevention-plan.pdf)
<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/2021-suicide-prevention-plan.pdf>
- (s) [Northeast Deaf & Hard of Hearing Services](https://www.ndhhs.org/)
<https://www.ndhhs.org/>
- (t) [Strengthen Your State and Local Aging Plan, LGBT](https://www.sageusa.org/wp-content/uploads/2022/05/new-older-americans-act-acl-guidelines-sua.pdf)
<https://www.sageusa.org/wp-content/uploads/2022/05/new-older-americans-act-acl-guidelines-sua.pdf>
- (u) [Tri-State Learning Collaborative on Aging](https://agefriendly.community/) - Age Friendly Communities -
<https://agefriendly.community/>



| Covid-19 Grants/Supplemental Appropriations | Award Amount | Projects & Initiatives |
|---|--------------|--|
| FFCRA - The Families First Coronavirus Response Act | \$1,198,800 | * To support the provision of home-delivered meals during the COVID-19 pandemic. |
| CARES Act - Title III B, C & E - Coronavirus Aid, Relief, and Economic Security Act | \$3,900,000 | * Funding to Adult Day Centers for Covid-19 pandemic response needs, Funding to New Legal Assistance for Covid-19 pandemic response needs, Funding to vendors to provide prevention services during the Covid-19 pandemic and Funding to help enhance IT systems within the State Unit on Aging. |
| Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act - APC5 | \$704,100 | * IT Enhancements for our Adult Protective Service System |
| Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act - Ombudsmans LOC5 | \$20,000 | * Funding to Ombudsman's Office for Covid-19 response needs. |
| STPH Public Health Workforce - OAA-STPH | \$78,610 | * The State Unit on Aging combined these funding sources to execute 2 primary project: 1) Re-establish NH's Volunteer Driver Program to increase access to vaccinations; and 2) Developed "WellnessLink" call center to provide accurate information and coordination around Covid-19 testing and |
| ADRC-NWD - COVID 19 Vaccine - NWC5 | \$158,836 | |
| Expanding Access to COVID-19 Vaccines via the Aging Network - VAC5 | \$250,000 | |
| Supplemental Nutrition Funding - HDC5 | \$840,000 | * Funding to Nutrition providers to address Covid-19 pandemic response needs and to provide additional home delivered meals. |
| ARPA - Ombudsman - OMC6 | \$49,750 | * Funding to Ombudsman's Office for Covid-19 response needs. |
| ARPA - Title IIIB - SSC6 | \$2,288,500 | * Funding to develop a Home Modification program to help support independence, investment to purchase licenses for evidence-based family caregiver assessment tools (TCARE), funding to In-home care providers to help address Covid-19 pandemic response needs and additional funding to help expand social isolation reduction strategies. |
| ARPA - Title IIIC-1 - CMC6 | \$1,492,500 | * This funding was 100% transferred to ARPA Title IIIC-2 funding to meet the continued increase demand for home delivered meals statewide. |
| ARPA - Title C-2 - HDC6 | \$2,238,750 | * Combined with ARPA Title IIIC-1 funding, these funds supported nutrition providers to meet the increase demand for home delivered meals statewide. |
| ARPA - Title IIID - PHC6 | \$218,900 | * Funding to enhance chronic disease self-management program address Covid-19 pandemic response needs. |
| ARPA - Title IIIE - FCC6 | \$721,375 | * Funding to help develop social isolation reduction strategies statewide and support Care Coordination. |
| ARPA - Adult Protective Services - APC6 | \$645,450 | * Funding to obtain consultation to assess and update adult protection safety & risk assessment tools. |





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For more information, call 1-800-351-1888 or
visit our website at:

<https://www.dhhs.nh.gov/programs-services/adult-aging-care>

*Thank you for your support to the State Plan on
Aging and to older adults in New Hampshire!*

