

# ***SENIORS COUNT POLICY INITIATIVE FINAL REPORT***

PRESENTED TO:  
THE ENDOWMENT FOR HEALTH

***May 26, 2009***



**SENIORS COUNT POLICY INITIATIVE**  
FINAL REPORT TO THE ENDOWMENT FOR HEALTH

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## **Senior Count Policy Initiative**

### Final Report to the Endowment for Health

#### **I. Introduction**

Eight years ago, the *Seniors Count* program was conceived by community stakeholders as a bold initiative aimed at redefining aging in Manchester, and throughout this State. The program's objectives are to engage the entire community to fundamentally alter the systems that deliver assistance and information to frail seniors and their families/caregivers, as well as to change the way the community thinks about and relates to seniors. Since 2001, the collaboration has guided this transformation process. The partnership is highly participatory and inclusive, composed of seniors and their caregivers, public sector representatives, nonprofit senior service providers, community advocates and activists, as well as local business and industry representatives. *Seniors Count* accomplishes its stated objectives by combining partnership and institutional capacity development with initiatives to raise awareness; to challenge perceptions; to change values; to mobilize resources; and to improve services, policies, and regulations. Our logic model lays the "road" to achieve our overall impact, including a short term outcome that directly relates to this report: "policies and regulations affecting seniors improved" (see Appendix A). On a direct service level, we focus on and locate frail seniors who have "fallen through the cracks" and ensure that they have on-going coordination of a wide range of community services and support. *Seniors Count* has demonstrated the effectiveness of its approach over the past several years and the initiative is making progress towards its ultimate objective of having seniors, especially the frail and underserved, experience the highest possible quality of life.

*Seniors Count* recently turned to the Endowment for Health for grant monies to support a twelve-month series of activities that would aid it in taking some critical steps toward improving the policy, regulatory, and funding factors to benefit at-risk seniors and to improve the long-term care system. The Technical Assistance grant was sought to support the hiring of a Policy Analyst who would be responsible for conducting and overseeing the analytical work to document the policy, regulatory, and funding barriers that seniors and their caregivers face. The year's work would culminate with the development of a three-year workplan that the *Seniors Count* Collaborating Council (the leadership group) would use as a template for action regarding policy initiatives. Additionally, the Analyst also would serve as a catalyst to stimulate networking among targeted audiences. The goal of the networking was to promote the need for policy reform, and to allow the Analyst to work closely with community stakeholders to ensure their awareness of specific policy interventions and funding issues.

The overall goal of the project is to improve the policy, regulatory, and funding factors to benefit at-risk seniors and improve long-term care systems. Based upon this goal, four outcomes were identified that correlated with the *Seniors Count* overall logic model. These outcomes are:

- Increase knowledge about unmet needs, service gaps, and barriers to access related to frail seniors.
- Increase knowledge about the *Senior Count* philosophy and issues of life-long aging among selected local, regional, and state political leaders.
- Increase collaborations with social service agencies.
- Increase knowledge about funding issues and ways to increase funding for frail seniors.

## II. Approach to Grant

To accomplish these outcomes, *Seniors Count*, through the work of the Policy Analyst, performed various activities. The following details the approach taken to accomplish the stated outcomes.

- *Seniors Count* created an ad hoc subcommittee of the *Seniors Count* Collaborating Council, known as the *Seniors Count* Policy Advisory Workgroup, to provide guidance to the Policy Analyst and to offer recommendations to the Collaborative Council to increase the knowledge about unmet needs, service gaps, and barriers to access related to frail seniors. This Workgroup helped to identify the activities for the year that would further aid in the accomplishing of the goal and outcomes of the project.
- The Policy Analyst then identified, documented, researched, and analyzed existing policy, regulatory, and funding barriers that prevent the provision of timely and appropriate long-term care to frail seniors in New Hampshire. To accomplish this objective, the Analyst reviewed existing literature on gaps in service and worked with local, county, and state government entities; service providers; community groups; *Senior Count* Initiatives; and *Senior Count* committees and workgroups to facilitate this effort. One deliverable for this activity was an Anthology of Readings and Reference (Appendix B.)
- To support the information obtained through the review of policies and literature, the Policy Advisory Workgroup suggested individuals and groups with whom the Policy Analyst should speak. These individuals and groups were identified because of their knowledge of issues facing frail seniors, as well as the supports that are available to them. The Policy Analyst then conducted individual interviews and convened listening sessions to obtain more detailed information about barriers to care which our frail seniors' experience. The Policy Analyst conducted thirty-nine interviews with individuals ranging from consumers themselves to State Representatives to discuss those issues facing our seniors. (See the list of interviewees located in Appendix C). An Interview Form (Appendix D) was created and used to capture information in a consistent manner.
- In addition to these individual interviews, the Policy Analyst held five listening sessions as a means to obtain additional input and information about New Hampshire seniors to supplement what was gleaned from the individual interviews. (See the letters of invite, the agenda, the list of listening session attendees and sample handouts Appendix E).

## III. How the information was analyzed

Following the interviews and the listening sessions, the Policy Analyst began to sort the information obtained, which included approximately one hundred identified barriers and many suggested solutions to these barriers (see Description of Problem and/or Barrier and Suggestion, Appendix F).

The Policy Analyst next created a document that was discussed with the Policy Advisory Workgroup, the *Seniors Count* Collaborating Council and Coordinating Committee, and the Evaluation Committee. These groups were asked to help identify and prioritize which of the identified issues *Seniors Count* should focus upon and which should be included in the three-year policy plan of *Seniors Count*. (See Identified Problems, Appendix G).

The document was arranged in the following categories<sup>1</sup>:

1. Caregivers (6 issues identified)
2. Education/Community Awareness (12 issues identified)
3. Funding/Financial (17 issues identified)
4. Housing (10 issues identified)
5. Safety (5 issues identified)
6. Systems Change (8 issues identified)
7. Transportation (6 issues identified)
8. Workforce- paid and volunteer (13 issues identified)
9. Other (9 issues identified)

Feedback from the discussions led to the creation of a tool that would allow these groups to help further identify which of these barriers should be addressed immediately, staged over the next three years, and accepted as a long-term goal. The document, *Setting Priorities for Senior Count Policy Initiative*, that was provided to the Policy Advisory Workgroup, the Collaborating Council, the Coordinating Committee, and the Evaluation Committee can be found in Appendix H. Analysis of the information gathered by the tool, as well as subsequent discussions with the stakeholders, was used to create the SUMMARY: *Priorities for Senior Count Policy Initiative* (see Appendix I).

To ensure no unnecessary duplication of work, the Policy Analyst identified actions taken by other advocacy groups to address the barriers/issues facing our seniors. If a barrier/issue is being addressed by other advocacy group(s) in NH, *Seniors Count* has pledged to provide support to these groups but removed the barrier/issue as its own priority.

Through this prioritization process, and then with in-depth discussions in the different committees, *Seniors Count* decided it would focus its policy initiative around the following six distinct categories:

- Caregiver Support;
- Coordination of Medical Concerns, Community Living/Social Service Concerns and Caregiver Concerns;
- Flexibility in Policy, Procedure, and Regulations;
- Education – Community Awareness;
- Livable Communities; and
- Limited Resources of the Near Poor.

The culmination of the work of the Policy Analyst is a detailed three-year policy workplan for *Seniors Count* which identifies the barriers, suggested strategies to address the barriers, and short-term and intermediate steps to be taken to address the barriers (see Appendix J).

The following provides an overview of the issues *Seniors Count* will focus on pertaining to frail seniors looking to age in the community and the potential strategies to address these issues.

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<sup>1</sup> The February 2009 Report by the Bureau of Elderly and Adult Services (BEAS) about their Community Listening Sessions conducted during the Summer 2008 reported similar concerns as our findings. Its audience was somewhat different from ours (we focused on local/regional/state policy maker, providers, and legislators whereas they had mainly consumers/community representatives and providers) and its purpose was different (they wanted input to the state plan, and we wanted to create a policy initiative for *Seniors Count*). However, the issues and barriers noted by both processes were parallel. BEAS broke their findings into twelve categories and we used nine, but the categories compared very closely.

## **Caregiver Support**

### Issues

The National Caregivers Association provides compelling information about the scope of 'informal' caregiving for seniors in the US:

1. Family caregivers provide the overwhelming majority of long term-care services in the U.S., **approximately eighty percent**. Over three-quarters, **seventy-eight percent**, of adults living in the community and in need of long-term care depend on family and friends as their only source of help; **fourteen percent** receive a combination of family and purchased assistance, and only **eight percent** used paid help only.<sup>i</sup>
2. Over **forty percent** of family caregivers provide some type of "nursing care" for their loved ones, such as giving medications, changing bandages, managing machinery, and monitoring vital signs.<sup>ii</sup>
3. More than **fifty million people** provide care for a chronically ill, disabled, or aged family member or friend during any given year.<sup>iii</sup>
4. Approximately **sixty percent** of family caregivers are women. The typical family caregiver is a 46-year-old woman caring for her widowed mother who does not live with her. The caregiver is married and employed.<sup>iv</sup>
5. **Thirty percent** of family caregivers caring for seniors are themselves aged 65 or over; another **fifty percent** are between the ages of 45 and 54.<sup>v</sup>
6. Family caregivers experiencing extreme stress have been shown to age prematurely. This level of stress can take as much as **ten years off a family caregiver's life**.<sup>vi</sup>
7. Family caregivers report having a chronic condition at **more than twice the rate** of non-caregivers.<sup>vii</sup>
8. In NH in 2003, there were 121,467 family caregivers providing 130 million hours/year of care at an annual value of \$1.1 billion.<sup>viii</sup>

Although there is an important need, the options for the safety-net of respite care, either emergency or planned, are limited when a community caregiver is unable to temporarily provide assistance/care for the senior. These limitations can sometimes be attributed to the guidelines (some statutory and some institutional and/or professional bias) for those organizations providing care to seniors in the community. For example, *Seniors Count* has piloted a short stay nursing home initiative for several years and although the project has been modestly successful, it has run into many barriers. When community respite options are not available, the consequences are: 1) hospitals often become the fall-back, whether or not this expensive alternative is suitable and/or necessary; 2) frail seniors sometimes are the recipients of insufficient and/or unsafe care due to frustrated caregivers; and/or 3) premature permanent admission to nursing facilities because of caregiver burnout or because caregivers are not able to afford remaining at home to take care of their frail loved one.

### Overview of Suggested Strategies for *Seniors Count*

To address the issue of respite care, it was suggested that *Seniors Count* support the funding of the Federal Lifespan Respite Act, increase the funding for the National Caregiver Grant, and advocating for legislation to improve respite care options. Another suggestion was that the Department of Health and Human Services request Medicaid waivers for the short stay nursing home initiative for emergency and planned stays processes. Lastly, *Seniors Count* will consider supporting incentive plans for families who are taking care of frail seniors. These plans could contain financial incentives for those families losing wages, as well as incentives to ensure that the care provided is sufficient and done so in the most safe and efficient manner.

## ***Coordination of Medical Concerns, Community Living/Social Service Concerns and Caregiver Concerns***

### Issues

To successfully remain in the community, frail seniors need support in three arenas of concern: medical, community living/social service, and caregiver.

*Medical Concerns:* Frail seniors are especially needy of medical care coordination. They often have multiple chronic health problems and require visits to medical specialists. These visits sometimes result in multiple prescriptions for medicines which sometimes have significant side effects or therapies that can be complicated. With increasing health care costs, technology, specialization, and fragmentation of care, the concept of a “medical home” is steadily gaining interest and standing in the public eye. The term “medical home” refers to an approach to provide primary health care that is accessible, patient centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.

*Community Living/Social Service Concerns:* Frailty can lead to the inability to handle all the non-medical concerns of daily living. Over and over again we have learned from consumers, providers, caregivers, and others that the senior network is complicated, multifaceted, and difficult to negotiate. In addition, frail seniors can be challenged with everyday living issues such as getting household supplies, home maintenance, bill paying, and other financial issues...services are not typically covered by insurance or offered by typical agencies and organizations serving seniors. There is a lack of resource coordination available to the frail seniors in New Hampshire, services that often necessitate on-going coordinated oversight. Instead, our system offers short-term coordination during a crisis, such as VNA assistance after hospitalization, but these are sporadic, time-limited, and related to an acute medical episode, and are often income driven.

*Caregiver Issues:* As discussed earlier, informal caregivers provide the majority of care for the frail elders. However, our system does not provide adequate support for caregivers to mitigate emotional and/or financial burnout, possible abuse/neglect, respite, training in care issues, etc. If the caregiver “breaks,” the consequence is that the frail senior loses his/her support and ends up in a nursing home prematurely, inadequately cared for, or hospitalized.

Through the experience of serving frail seniors who fall through the cracks, *Seniors Count* has learned that frail seniors need ***coordination within and among each of the above three concerns*** in order to maximize their ability to remain in the community. Currently, our system struggles to provide consistent, ongoing coordination within each area and has not yet determined how to coordinate among the three. The analogy is that the current system is like a three-legged stool with maybe only one or two legs working. We want to build a system whereby each of the three legs is strong, attached, and interrelated thus providing a strong foundation for the stool.

Of significant note, *Seniors Count* has been invited to participate as an active voice at the Manchester Sustainable Access Project (MSAP) to represent the needs of the population over age 65. The synergy between the two collaborations will enhance our ability to reach the goals of *Seniors Count*.

### Overview of Suggested Strategies for Senior Count

Seniors Count is assuming that each frail senior of a certain level (to be defined by assessment) could greatly benefit from having his/her medical, community living/social service and caregiver concerns coordinated. Therefore, we advocate that: 1) each frail senior be given what we are calling a “community living home.” This would involve each senior being assigned a Senior Resource Coordinator who would be responsible for ensuring

that the senior also has a "medical home." The Senior Resource Coordinator will also be charged with coordinating all appropriate services for the senior; 2) every frail senior have a "medical home," that is one primary care doctor who is familiar with all aspects of the senior's life; and 3) if there is informal caregiver involved, that he/she is linked to proper support such as the ServiceLink caregiver specialist. It would be necessary for the three above arenas to communicate when appropriate so that there is an overall coordinated approach. The concept of creating and coordinating the "medical," "community-living," and "caregiver" homes is new and therefore there are many details to be worked out. *Seniors Count* will look for resources to pilot a program in Manchester that links all frail seniors of a certain level with a Senior Resource Coordinator. It is also suggested that Catholic Medical Center, Elliot Hospital, and Dartmouth develop plans for their patients deemed "high risk" to help reduce the "revolving door" issue that many frail seniors face. By revolving we mean the frequent in and out of emergency room and hospitalization.

### ***Flexibility in Policy, Procedure, and Regulations***

#### **Issues**

There is a plethora of federal, state, local, and institutional real and/or perceived rules, regulations, and procedures that affect the way our communities provide long-term care services to frail seniors. Most, if not all, are created with good purpose and intention. However, there are often unintended consequences or rigidity in interpretation that causes barriers to care for the frail seniors. For example, a local zoning ordinance that disallowed in-law apartments made sense to the community for "protecting property values," but was a disincentive for families taking care of their own frail loved ones, therefore limiting options for those seniors. There is also the "informal" procedure followed by many agencies that do not allow their staff to drive clients in their cars because of exposure to liability, but thereby significantly decreasing staff's ability to provide wrap-around services for their frail senior clients including taking them to the doctor, shopping, or for a haircut. The last example is an existing legislation, RSA.151, whose unintended consequence is that it inhibits neighbors from helping frail seniors in the community. The statute requires the licensing of all people who provide in-home assistance to individuals in their homes whether they are doing it for profit or not, thus discouraging "good citizens" from helping others. This is an example of a disconnect that can occur after legislation that is passed with a certain intention such as to keep seniors safe from exposure to people who might take advantage of them. But when the law is put into practice in the community, it may have an unintended consequence like undermining the neighbor helping neighbor network. The ultimate result in the community may not accurately reflect the intent of the sponsor/author of the bill.

It is often the experience of providers and others helping frail seniors that once a rule is written it is rigidly enforced with little or no avenue for exception. Many of the barriers mentioned during the interviews and information gathering sessions could be summarized as examples of rigidity and lack of flexibility.

#### **Overview of Suggested Strategies for *Seniors Count***

One strategy to address the issues surrounding policy procedures and regulations is to sensitize legislators to the importance of the need for flexibility within the statutes/rules/regulations pertaining to frail seniors. This could be accomplished through education and by encouraging the legislators to "test" each law against a "checklist," or other guideline, developed in partnership with *Seniors Count*, to ensure that the proposed legislation will adequately address the issues it seeks to correct.

## **Education**

### Issues

There is insufficient education of seniors and their families/caregivers, policy makers, and other stakeholders regarding preparing for aging, the stages of aging, the range of choices that can reduce the current risks associated with aging in community, and the impact policy initiatives have on frail seniors looking to remain in the community. The need for more education was repeated often during our interviews. *Seniors Count* recognizes that many agencies, organizations, and institutions are involved in education. However, it is such a compelling need that can help ameliorate future issues that we feel it should be addressed in our policy initiative.

### Overview of Suggested Strategies for *Seniors Count*

As a means to provide education about the aforementioned issues, the *Seniors Count* education committee should take the lead and convene stakeholders to develop education modules and to determine how the modules are to be presented. Also, *Seniors Count* should conduct regular seminars for legislators pertaining to senior issues so that the legislators can be prepared to create appropriate and relevant legislation.

## **Livable Communities**

### Issues

AARP reports that people highly engaged in their communities are more likely to age successfully.<sup>ix</sup> AARP defines “successful aging” as involvement with the world and other people; the ability to make choices that affect life, to care for one’s self (or get the help they need), and to pursue interests; and not feeling isolated.

Older people, especially the most frail, are too often invisible to many members of society, including businesses and institutions. This invisibility results in people not understanding the needs of seniors to be part of communities. For example, this lack of understanding is evidenced by the limited knowledge and unfamiliarity of local Planning Boards regarding issues concerning frail seniors, which ultimately makes it likely that vital information will not be considered in order to support necessary changes to local ordinances/regulations that promote seniors remaining active and part of their communities. It is also evidenced by the fact that zoning ordinances do not encourage inter-generational, mixed-use neighborhoods, that is zoning that allow housing, business, education, etc co-located in the same neighborhood, that could allow seniors to remain in their homes and communities longer.

The concept of livable communities has been promoted by numerous organizations, including AARP. AARP describes livable communities as “places where people of all ages and abilities have housing and mobility options and supportive community features that meet their needs to be safe and comfortable and to get to where they need to go...they are places where people can live lives of purpose on their own terms where they choose...it is a key ingredient for independence, choice and control – essential elements for successful aging.”<sup>x</sup> The concept is related to Universal Design, making physical environment usable by multiple populations such as able-bodied, disabled, frail, pregnant, youth, etc, and Smart Growth. Smart Growth invests time, attention, and resources in restoring community and vitality to center cities and older suburbs; it is more town-centered, is transit and pedestrian oriented, and has a greater mix of housing, commercial and retail uses; and it also preserves open space and many other environmental amenities thus providing a means for frail seniors to age in the community.

### Overview of Suggested Strategies for *Seniors Count*

*Seniors Count* has promoted the concept for livable communities for several years. In October, 2007, in partnership with Dartmouth Community Medical School, we held a forum

entitled "**Seniors Count: Imagine a Senior-Friendly Community.**" We also engaged architects, city planners, builders, and local government in several focus groups about the topic. There is a growing consensus among the stakeholders that we must 'reinvent' the way we structure our communities to promote a better quality of life for all.

Moving forward to address the issue of livable communities, it is suggested that *Seniors Count* assist the City of Manchester in initiating a Community Planning Board as outlined in HB 717. HB 717 allows municipalities, as an option, to establish civil planning boards if they feel they could use a tool like this to help them strengthen their community's social and civic well-being. There is flexibility to allow local communities to use these boards in their own ways to make their communities better. Ideally, *Seniors Count* will have representation on the Community Planning Board to ensure senior issues are addressed and considered prior to decisions being made. This Board member will develop a process as to how and where to best influence the city planning agenda. Lastly, it is suggested that *Seniors Count* will work with zoning board members and other planning organizations to educate them on senior issues.

### ***Limited Resources of the Near Poor***

#### Issues

The poor, usually defined as having income under 200 percent of currently national poverty guidelines, have access to help. The poor are entitled to a variety of long-term care services under Medicaid's Choices for Independence Program, including nursing home care, in-home care, adult day services, emergency responses system, and transportation. There are also some additional, albeit limited, services for the poor through the Older American's Act Title XX for things such as adult day programs and homemaker service. The poor also, most likely, qualify for fuel assistance, old age assistance, city welfare, town welfare, food commodities, weatherization programs, electric assistance, subsidized housing, PSNH energy assistance, NH Legal Assistance, and pharmaceutical company subsidies.

The rich can usually pay for their own care, or have insurance that covers them. Middle class individuals might struggle, but usually can manage to get at least some of what they need. However, the near poor, that is, those individuals who are just above the financial eligibility for services such as adult day programs, and homemaker services, have extremely limited options regarding community services. One such example of this is that seniors with limited fixed incomes often do not have the means to purchase emergency and/or unanticipated items not covered by Medicare. This situation often leaves a senior to have to choose between heat, rent, food, and medicine, ultimately putting his/her health at risk. Additionally, many services are not available for seniors whose income is just slightly above the Medicaid threshold and for those who do not clinically qualify for Medicaid. This lack of services further compromises seniors because they are needed to help prevent deterioration, yet the cost to receive them is beyond seniors' ability to pay.

#### Overview of Suggested Strategies for *Seniors Count*

This is a difficult issue to address because no matter where the cutoff line is, there will always be those who are just above it. One suggestion to address this issue is to enhance community connectivity in neighborhoods, families, faith-based institutions, intergenerational opportunities, and community supports. *Seniors Count* advocates for stronger community involvement and a return to some old fashion concepts such as neighbor helping neighbor and business involvement with helping seniors. These concepts are illustrated by creating volunteer capacity for lawn maintenance and snow removal; having youth "adopt" a senior to help with chores; encouraging local markets to do home delivery of food and supplies; or creating neighborhood time banks for services. All of these examples are clearly aligned with the concept of Livable Communities discussed earlier.

*Seniors Count* will advocate for policies and regulations which support these initiatives, making it easier for communities to help themselves.

#### **IV. Synopsis**

"Most aging policy in this country is sharpened by the states....As the older population rapidly increases in most states over the next several years, state-level policy makers and public and private organizations will be challenged to address a wide range of policy and administrative issues in a cost-effective and timely fashion....We need to...develop a consensus strategy in order to avoid being swamped by the emerging policy battles over the funding of the entitlement programs and healthcare reform...state policy encourages or discourages, permits or prohibits various kinds of marketplace arrangements."<sup>xi</sup>

The work done in preparation for the *Seniors Count* Policy Workplan has sharpened our focus on our priorities. It has also given us the opportunity to think more abstractly about what the stakeholders were saying. Not only did we compile a list of regulatory barriers, but we also took the next step to ask "what is the list telling us," and then extrapolated the salient issues that we wanted to address. Along the way, some ideas were supported by the findings, such as the need for more education; some were solidified by the findings, such as the concept of livable communities or needs of the near poor; and one was newly created, the concept of a way to envision coordination of medical concerns, community living/social service concerns and caregiver concerns.

An overarching issue related to all the barriers is the need for flexibility in the system. The sheer number of seniors aging into frailty in our communities mandates that we create regulations that are somewhat pliable so that they can meet *the needs of the frail seniors* rather than just *the letter of the law*. Certainly we must be concerned about safety, confidentiality, risk, litigation, liability, etc, but we also must be smart enough to create a regulatory environment that morally, philosophically, and ethnically can address the needs of the frail seniors. This issue opens the door for many healthy, vigorous debates, but they are just the kind of discussions we must be having – sooner rather than later – before the tsunami of the baby boomers crashes around us causing much unnecessary regret, hardship, pain, suffering, and death.

This report provides highlights of our findings. Our three-year workplan, which is included with this report, takes each of the areas and gives suggested strategies, short term (within the first year), intermediate (one to three years) activities, and lists the responsible parties. Also, please note that we have included the completed Public Policy Improvement Project Workplan as was required by Endowment for Health (see Appendix K).

#### **V. Next steps**

The results of this grant will be outlined in a report and will be distributed first on June 18, 2009 at the *Seniors Count* Symposium entitled "Making Seniors Visible: Policy & Advocacy." Following the Symposium, we will mail the report to approximately 2,000 stakeholders including politicians, planners, senior network providers, and governmental staff.

Ultimately, the next steps depend on funding and the following details each option.

*If no additional funding is available* to carry out the details of the three-year workplan, *Seniors Count*, with input from all of its committees, will review the workplan to determine what activities can be accomplished with no additional funding. Based on this information, *Seniors Count* will design a plan to accomplish these objectives.

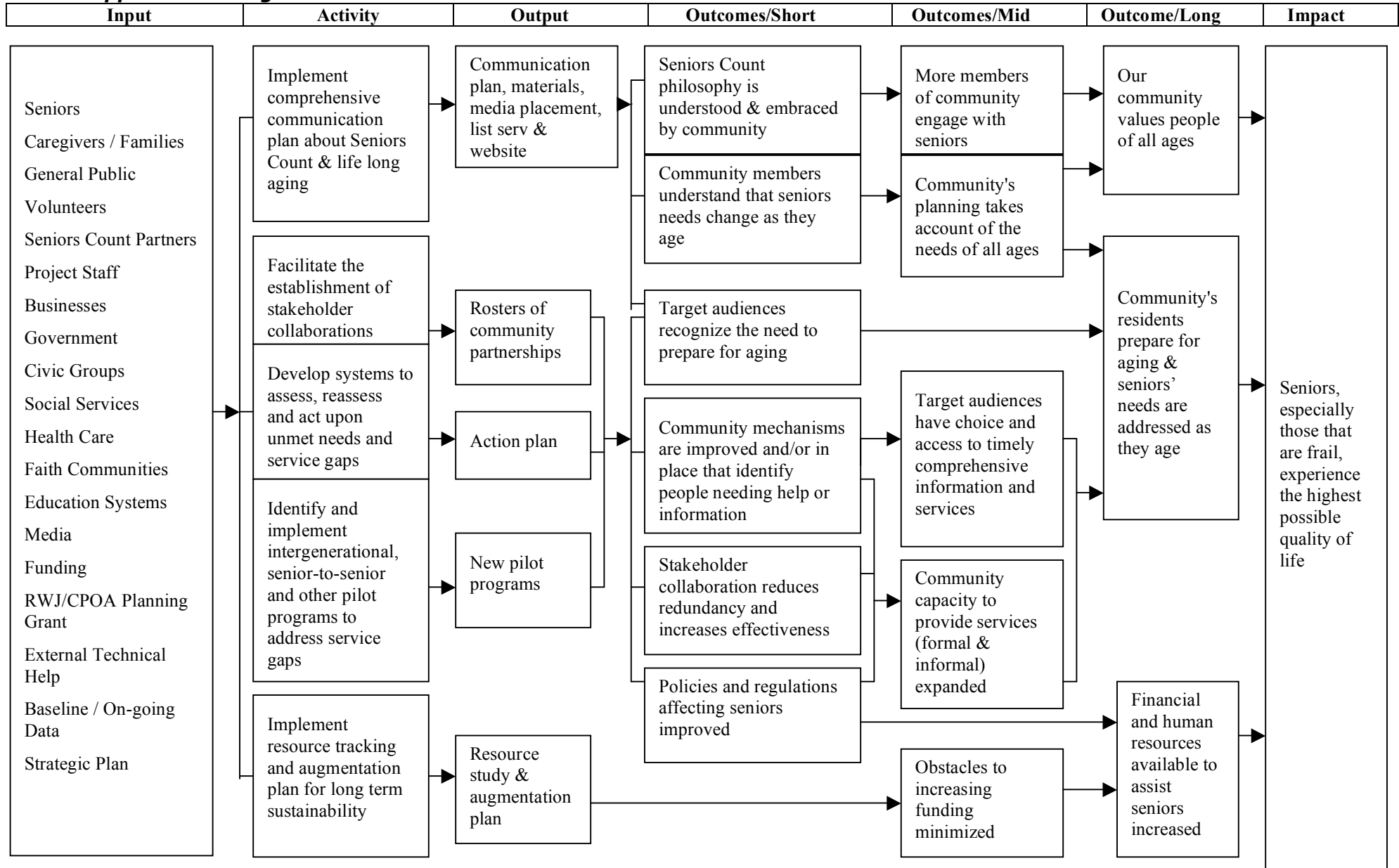
*If Seniors Count is fortunate enough to receive implementation funding it will work with its committees to devise a plan to implement the entire three-year workplan that has been developed as a result of this grant.*

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## **VI. Appendices**

- A. *Seniors Count* Logic Model
- B. Anthology of Readings and Reference
- C. List of Interviewees
- D. Interview Form
- E. Letters of Invitation, Agenda, Listening Session Attendees, and Sample Handouts
- F. Description of Problems and/or Barriers and Suggested Solutions
- G. Identified Problems
- H. Setting Priorities for *Seniors Count* Policy Initiative document
- I. Summary of Priorities for *Seniors Count* Policy Initiative
- J. Three-year Policy Plan for *Seniors Count*
- K. Public Policy Improvement Project Workplan

**Appendix A – Logic Model**



## **Appendix B – Anthology of Readings and References**

### **January 2009**

AARP - New Hampshire Long Term Commission Report

A COMMUNITY'S VISION 2010; Aging Well Strategic Plan, 2006-2010: Greater Lyons Township, Illinois

American Public Concern About Care for Chronic Conditions: Partnership for Solutions: Baltimore, MD 2020

Aging – The Ultimate Adventure...Journeying Together; Report to the Community 2006; A Community Plan for Improving the Quality of Care for Older Adults in Fremont, Newark and Union City California

Beyond Pensions: AgeLab; Projects / Independent Living and Caregiving 2005

Boomers At Midlife 2004: the AARP Life Stage Study; Wave 3 - 2004

Boomer Consumer: Ten New Rules for Marketing to American's Wealthiest and Most Influential Group; Matt Thornhill & John Martin - Founders of the Boomer Project, 2007

Beyond 50.04: A Report to the Nation on Consumers in the Marketplace; AARP

City of Manchester; Mayor Guinta: Health & Human Services Transition Team, Senior Services Sub-Committee, February - 2006

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Communities As Partners In The Long-Term Care Solution; Policy Resource Center Brief, Institute for Health, Law and Ethics at Pierce Law Center, Susan Fox and Michelle M. Winchester, Spring 2005

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**Appendix C - Interviewees**

<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>TITLE</u>	<u>ORGANIZATION</u>	<u>CITY</u>
Arel	Bev	Consumer	Member of MRACOA	Manchester
Baines	Barry	author and physician	Ethical Wills - Book	Minneapolis, MN
Boynnton	Paul	President & CEO	Moore Center Services	Manchester
Burke	Jill	Managed Care /Senior Advocate	Granite State Independent Living	Concord
Butenhof	Ann	Attorney	Senior Project	Manchester
Clark	Kelly	State Director	AARP	Manchester
Donovan	Thomas	State Representative HHS& Elderly Comm.	Independent Counselor (HCBC)	Claremont
Frydmann	David	Legal Counsel	Speaker of House	Concord
Folkemer	Donna	Nat'l Council on State Leg	STAFF	DC
Fox	Sue	Institute on Disability	UNH	Concord
Francese	Peter	Communities & Consequences	New Hampshire - Book	Exeter
Gagnon	Raymond	Gerontologist - Representative	G2M Associates	Claremont
Gorin	Stephen, PhD	Professor of Social Work	Plymouth State University SCOA	Canterbury
Harding	Laurie	RN Home Health & State Rep	Armistead	Lebanon
Hutchinson	Rebecca	Assisted Living Professional Mgr State Representative & Nursing Home Owner	House Policy Analyst	Deerfield
Irwin	Anne-Marie		Hillsborough Nursing Home	Peterborough
Janelle	Peter	President & CEO	Mental Health Ctr. of Gr. Man.	Manchester
Jones	Judith	Attorney	Butenhopf-Bomster	Manchester
Kerrigan	Maureen	Attorney	CMS	Boston
Lockhead	Terry	Director, Direct Care Workforce	NH Community Loan Fund	Concord
Mann	Sandra	Health Care Attorney	Divine, Millimet & Branch	Manchester
McCollough	Dennis	author and physician	Slow Medicine - Book	Lebanon
McNutt	Doug	Associate State Director Community Outreach	AARP	Manchester
Merrow	Katie	Executive Director	NH Women's Policy Institute	Concord
Miller	Joseph	Physician (retired) & State Representative	State Representative	Durham
Otte	Kathleen	Chief, Bureau of Elderly and Adult Services	NH DHHS	Concord

Houghton	Owen	President	SCOA	Keene
Pilotte	Maurice	Chair Joint Committee on Administrative Rules	State Representative	Manchester
Rollins	Nancy	Director, Division of Community Based Care	NH DHHS	Concord
Salvatore	Barbara	Advocate	engAging NH SCOA	Bedford
Schulze	Joan	State Representative HHS & Elderly	Elderly Affairs Committee	Nashua
Skinder	Carla	State Representative Nurse/Director	Valley Regional Hospital	Claremont
Soucy	Tim	Director Public Health Department	City of Manchester	Manchester
Stamatakis	Carol	Director of Planning -	NH Council on Dev Disability	Concord
Rosenwald	Cindy	State Representative - Chair	Health Human Servs. & Elderly	Nashua
Terry	Clyde	Chief Executive Officer	Granite State Independent Living	Concord
Wieczorek	Raymond	Executive Counselor & former Mayor	Region 3	Manchester
Winchester	Michelle	Health and Long Term Policy Analyst	Institute on Health, Law & Ethics	Concord
Zarnowski	Helen	Consumer	MRACOA	Bedford

**Appendix D – Interview Form**

**SENIORS COUNT PUBLIC POLICY IMPROVEMENT PROJECT  
INTERVIEW FORM**

DATE \_\_\_\_\_ IN PERSON \_\_\_\_\_ BY PHONE \_\_\_\_\_

NAME \_\_\_\_\_ ORGANIZATION \_\_\_\_\_

Address \_\_\_\_\_ PHONE \_\_\_\_\_

\_\_\_\_\_ E-Mail \_\_\_\_\_

**BARRIERS TO SERVICES FOR FRAIL ELDERLY**

**PRIORITIZE**

Regulatory State Laws, Rules/Regs Federal Laws, Rules/Regs (i.e. HIPPA, driving liability)  
Municipal, Local, Regional Housing & Zoning Codes/Ordinances/Growth Limits  
Life Safety (fire, building) Public Health Codes  
Organizational/Institutional - Risk Aversion  
County - Taxes i.e. nursing home capacity v alternative housing v assisted living

1.

2.

3.

**OTHER DISCUSSION**

## **Appendix E1 – Letter of Invite to Listening Session**

Date:

XXXXXX  
XXXXXX  
XXXXXXXX, XXXX

Dear xxxxxxxx:

I invite you to participate in a policy discussion that *Seniors Count* will conduct regarding the challenges of growing old in New Hampshire. Your significant knowledge of our community is vital to address policies, rules or laws that affect our seniors.

*Seniors Count* has embarked upon a strategic policy initiative aimed to keep the good and change the ineffective! They believe our state can be a better place for frail seniors, now and into the future.

***We need your valuable input to assure that decisions that impact frail elderly are considered as part of local, regional and state planning initiatives.***

**DATE:**

**TIME:**

**PLACE:**

**RSVP:** [pmcmahon@eastersealsnh.org](mailto:pmcmahon@eastersealsnh.org)

Refreshments will be served.

*Seniors Count* is dedicated to long term changes and to a robust dynamic discussion of practical and creative approaches. Your participation will inform the planning decisions of the *Seniors Count* leadership team and will become the foundation to offer ideas to address the critical needs of seniors.

Please make it a priority to participate and to help guide us to steer a course that will make a difference in the lives of the frailest in our state.

If you have any questions please contact either Arlene Kershaw, Seniors Count Project Director at 621-3558 [akershaw@eastersealsnh.org](mailto:akershaw@eastersealsnh.org) , or Ricia McMahon, Seniors Count Policy Analyst, at 621-3496 [pmcmahon@eastersealsnh.org](mailto:pmcmahon@eastersealsnh.org) .

Thank you in advance for your consideration.

Sincerely,

Mayor Guinta or Joan Schultze or Arlene Kershaw or Ricia McMahon depending on the audience and date

Title

\* Thank you to the Endowment for Health for supporting this project.

## **Appendix E2 – Listening Session Agenda**

### **Seniors Count Policy Sessions ANNOTATED AGENDA TOTAL TIME: 2 Hours**

#### **5 min WELCOME (Chris McMahon)**

FOCUS for session convened by *Seniors Count* \*  
Needs of Frail Elderly - Defined by Need not Age (i.e. over 65+?)  
EH Grant: 3 year work plan IMPACT 2020 and beyond...  
*Seniors Count* Collaborating Council will use info/data to inform planning decisions  
Impact that policy, laws, regulations, rules have on our citizens: Fed/Reg/State/Local

#### **5 min INTENT: Historical Perspective re Seniors Count (Chris McMahon)**

Unintended consequences of the process  
*Seniors Count* addresses shortfalls re service delivery, interpretation of laws & rules  
Reach out to those Frail Elders who fell through the cracks  
Examples i.e. *Seniors Count* Flex Spending, Community Liaison, Fall/Spring Clean Up

#### **5 min INTRODUCTIONS (Chris McMahon)**

Short Introductions by each Participant - (30 seconds or less!!!) Name and Title/Role  
How you are involved or had experience with seniors (professional or personal)

#### **5 min “Are You Listening” Video**

#### **5 min Brief discussion: Audience Reaction to video**

#### **20 min Setting the Tone: WHAT SENIORS COUNT LEARNED (Ricia McMahon)**

History / Discovery / Inventory  
OVERVIEW of Data Gathering Process  
Refer To Fact Sheet in Folder  
CREATE MODEL - Framework (logic model)  
Gaping Holes - Triage - Laboratory (2 new *Seniors Count* in 2008/09)

Systems Failure re "Invisible Frail" - Regulatory Barriers  
Seniors above poverty line who fall short of funds for basics  
Intended/Unintended or Advertent/Inadvertent Consequences

What Did We Learn? "Legislature Authorized" or Interpreted  
Implementation - Planners respond to legislative requirements  
(but without an obligation, do not have the will or authority to expand beyond role/rule)

#### **10 min Get audience feedback re: Observations re Barriers (Ricia McMahon)**

Distribute 3x5 cards to list (want to get 3 to 5 examples each person)

*Ask them to note on cards:* What are the observations, conversations, reports (either direct or indirect) that you have knowledge about that create barriers for frail seniors i.e. access to health care or limits participation in the social fabric of our community? Can be examples addressed @ federal, state or local level. full  
Please print "so someone else could read them" (name not required on cards)  
Prioritize - 1 (top) - 5 (bottom)

**Examples:** What would it take for a senior to remain a vital part of the community? Zoning? Walk/Ride? Doctor (tx), shopping (rx), faith service, club/congregate meal? Downtown living, mother-in-law apartment, collective housing situated in village - OTHER

10 min **Share Observations** re Barriers with partner/person next to you (**Ricia McMahon**)

Discuss each card: can you come to consensus over priorities?

20 min **Setting Priorities:** Group Discussion (**Ricia McMahon**)

Pairs present their discussions, what you have shared and learned how they prioritized.

Each pair list their top 2 priorities (on newsprint) until all priorities are listed

After all have presented, audience feel free to add some ideas that you believe are a priority to your card

20 min **HOW WE GET FROM HERE TO THERE: Do Priorities lead to policy?** Group Discussion (**Ricia McMahon**)

All of us! What could I/We do now (as individuals and as part of our community) that would "Fundamentally" change the "fate" of our frail senior residents who are most likely to become vulnerable - to IMPACT 2020 and beyond, based on the facts we now know... Areas of finance, health, transportation, housing, loss/move, community participation, workforce, zoning, OTHER re outcome data/projections (i.e. 80% of health care costs are in last 6 mos).

What can we do to change?

Use one or two top priorities to review what could be done not to make a change and impact the system

5 min **Follow Up – next steps to Seniors Count Policy Initiative** (**Ricia McMahon**)

5 min **THANK YOU for participating!** (**Ricia McMahon**)

**Appendix E3 – Listening Session Attendees**

LastName	FirstName	Title	Organization	City
Anagnost	Dick	President and Owner	Anagnost Companies	Manchester
Arel	Bev	Advocate	Advocate	Bedford
Bascom	Rod	Health Facilities	NH DHHS	Concord
Beerel	Annabel	Distinguished Chair in Ethics	Southern New Hampshire University	Manchester
Bimbo	Linda	Deputy Director	UNH - Institute on Disability	Concord
Boynton	Paul	President & CEO	Moore Center Services	Manchester
Brensinger	Barry	President	Lavallee/Brensinger PA	Manchester
Case	Frank	state rep	NH House of Reps - Rockingham County	Nottingham
Clark	Kelly	State Director	AARP New Hampshire	Manchester
Cooney	Mary Ann	Deputy Commissioner	DHHS	Concord
Crouch	Jean	Seniors Count Program Manager	Easter Seals NH	Manchester
Drelick	Patti	President	NH Senior Center Association	Salem
Emerson	Sue			Rindge
Esperian	Joni	Executive Director	NH Commission for Human Rights	Concord
Faist	Paula	Director	Silverthorne Adult Day Program	Salem
Feldstein	Lewis	President	NH Charitable Loan Fund	Concord
Gale	Sylvia	Executive Director	NH Commission on the Status of Women	Concord
Hamilton	William	Advocacy Director	AARP New Hampshire	Manchester

Helms	Ned	Director	NH Institute For Health Policy & Practice	Durham
Hicks	Sandy	Advocate	Advocate	Manchester
Houghton	Norma	Advocate	Advocate	Jaffrey
Houghton	Owen	Chair	State Council on Aging	Jaffrey
Kassler	William	Chief Medical Officer, Boston Regional Office	Centers for Medicare & Medicaid Services	Boston
Kershaw	Arlene	Seniors Count Project Director	Easter Seals NH	Manchester
Kershaw Jr.	Newton	Attorney at Law	Devine, Millimet	Manchester
Koontz	Lynn	Adult Protective Services Administrator	DHHS - BEAS	Concord
Littlefield	Ralph	Executive Director	Belknap/Merrimack Counties - CAP	Concord
Maggioncalda	Mary	Administrator II	DHHS - BEAS	Concord
Martin	John	Commissioner, Bureau of Health Facilities Administration	New Hampshire Department of Health and Human Service Office of Program Support	Concord
McConnell	Liz	Manager, Advocacy & Community Relations	Alzheimer's Association - NH Office	
McGuire	Mary	Legal Coordinator	Bureau Elderly and Adult Services	Concord
McMahon	Christine	Chief Operating Officer	Easter Seals NH	Manchester
McMahon	Ricia	Seniors Count Policy Analyst	State Representative	Manchester
McNutt	Doug	Assistant State Director of Community Outreach	AARP New Hampshire	Manchester
Merrill	Katie	policy specialist	NH Charitable Loan Fund	Concord
Montero	Jose	Director of Public Health Services	Division of Public Health Services	Concord

Norton	William	President, Principal	Norton Asset Management, Inc.	Manchester
Otte	Kathleen	Bureau Chief	DHHS - BEAS	Concord
Pappas	Toni	County Commissioner	Hillsborough Board of Commissioners	Goffstown
Preece	David	Executive Director and CEO	Southern New Hampshire Planning Commission	Manchester
Riera	Erik	Bureau Chief	Behavioral Health	Concord
Salvatore	Barbara	Advocate	State Council on Aging	Bedford
Schulze	Yvonne	Seniors Count Director	Easter Seals NH	Manchester
Schulze	Joan	State Representative-House	Chair, Joint Legislature Committee on Elderly Affairs	Nashua
Shumway	Donald	President	Crotched Mountain Rehab Center	Greenfield
Spratt	Steve	state rep	Hillsborough County	Greenville
Stamatakis	Carol	Director Of Planning	NH Council on Developmental Disabilities	Concord
Wason	Sharon	Director	Central NH Regional Planning Preece	Concord
Young	Susan	Executive Director	Home Care Association	Concord
Hodes	Paul	Legislative Assistant	Congressman Paul Hodes	Concord
Porter	Carol Shea	Senior Advisor	Congresswoman Carol Shea-Porter	Manchester

## Appendix E4 – Sample Handout

### Did You Know...?

#### Aging of NH

New Hampshire is the 6<sup>th</sup> Oldest State (seniors aging in place, low birth rate and younger leaving)  
New Hampshire is the 5<sup>th</sup> oldest state in the nation re median age (ME, VT, WV, FL, NH)  
New Hampshire anticipated growth from 2000 to 2030 will be 410,685 or 33.2% of total population  
New Hampshire population for 65 years and over will be 204,816 or 138.4%  
Our average lifespan has increased by 30 years between 1900 and 2000! This is unprecedented!  
The fastest growing segment of the population is 100+

#### In a statewide Seniors Count survey (conducted by the University of New Hampshire Survey Center)

96% of residents surveyed throughout New Hampshire strongly agree that their community *should* support seniors  
82% think that dealing with issues affecting the aging population *should* be a priority in their community  
66% believe their community has the infrastructure to help seniors with modest needs  
**However, only 44% agree that their community is a good place for the frailest, least mobile seniors who need the most help with staying in their homes.**

#### Social Security in NH

231,000 NH residents depend on Social Security benefits each month  
102,000 NH residents live at the poverty level or lower  
35,000 NH residents depend on Social Security benefits for 90% of their income  
\$2.9 billion flows into the NH economy from Social Security each year  
\$1,114 per month is the average Social Security check for individual retirees in NH  
\$ 867 per month is the amount it takes to stay above the poverty level

#### Medicaid Benefits in NH

31% of Medicaid Expenditures are for old age beneficiaries  
70% of these Medicaid Expenditures are for women  
81% if these beneficiaries are 85 and over (most costly group)

#### Gender as a factor

Women earn less over their lifetime  
Women live longer – five years longer on average  
NH women earn 72% of what men earn on average and earnings decrease relative to men's as they age  
Women are 2.4 times more likely to live below poverty than men  
Number of women aged 65 and over is projected to nearly double by 2020  
38% of NH women over 65 live alone; most women living alone have low income  
10.3% of NH women 65 and older live at or below the poverty level  
44% of income for women living alone, 65 years and over, is for housing

(over)

**Manchester** as an example

50% of Manchester residents age 65 and older live alone

40% of Manchester frail seniors are seriously limited to care for themselves or move freely

30% of Manchester inner-city seniors have no vehicle

12% of Manchester inner-city seniors have no phone

26% of Manchester inner-city seniors live below the poverty level (8% NH residents @ poverty level)

14% live below poverty (higher than the state average)

34% of the 3,021 who live alone are women

In the inner city, 57% live alone

By 2020 = ¼ of Manchester will be over age 65

Manchester Police receive 800+ calls annually involving elderly, 20% related to  
abuse/neglect/exploitation

Affordable, assessable housing is a priority on every community assessment survey

***Trends:***

Falls are the most frequent cause of injury requiring hospitalization and 60% fall in their homes

Nearly all elderly encounter severe chronic illness and disability in the last phase of life

Average length of disability before death = 2 – 5 years

On average, 80% of healthcare costs are spent in the last 6 months of life

Proliferation of 55+ communities have impacted the community-scape of the southern tier  
of NH, inadvertently causing isolation and/or potential lack of access to services for many elders

## ***Appendix F – Description of Problem and/or Barriers and Suggestions***

### **Description of Problem and/or Barrier and Suggestion (if provided) Developed November 2008**

Below is a listing of any problem or barrier mentioned during the interviews or listening sessions held between February and October 2008. If there was a suggested 'fix' to the problem, it is included. *PLEASE NOTE:* this document includes ALL barriers and suggestions made without an attempt to verify the validity of the comment.

After all comments were collected, they were sorted into logical groups. They ended up falling into nine categories:

1. Caregiver Issues
2. Education ~ Community Awareness Issues
3. Funding/Financial Issues
4. Housing Issues
5. Safety Issues
6. Systems Change Issues
7. Transportation Issues
8. Workforce Issues (paid and volunteer)
9. Other Issues

#### **CAREGIVER ISSUES**

**Problem:** A working son/spouse/family member who is the caregiver of a senior is constricted because hours for delivery/pickup @ day care facility are not always flexible (cost of travel can also be a limitation)

**Suggestion:** Extend hours of service, offer pick up/delivery or alternatives.

**Problem:** Options for respite care are limited when a caregiver is unable to temporarily provide assistance/care for the senior when a hospital is not suitable or necessary. Emergency respite care is very difficult to arrange.

**Suggestion:** Review criteria and consider alternative rules under circumstances.

**Problem:** Planned admissions for respite care are often too tentative on the part of the assisted living facility or nursing home to allow peace of mind for caregiver to accept or make travel plans in advance (weeks/months) whether private/public ability to pay. Suggestion: Flexibility and design of admission criteria based on the reality of caregiver circumstances will allow for overall longer duration of care in the home.

**Problem:** Limitations on length of stay within Choices for Independence (formerly HCBC), frequency of intervals for admission and reluctance to pre-arrange admissions to nursing homes create additional stress on the caregiver that can shorten the ability of the frail elderly to remain in the community.

**Suggestion:** Presumptive eligibility across the state with safety net, flexibility re timing and duration to improve individual situations, anticipate preliminary assessments or updates to reduce risk of remaining at home.

**Problem:** Limits on who is financially eligible for the Choices for Independence (formerly HCBC) program for seniors creates a group of near poor who can not get services.

**Suggestion:** Make Choices for Independence an entitlement, train staff and fund providers to offer home care to serve a larger number of frail elderly.

**Problem:** County nursing homes most often provide a place of last resort for the most ill and the least able to pay for care but they are the most avoided alternative even though they are publicly funded.

**Suggestion:** Educate the families to assist the elderly with a transition program that helps the elderly remain in their homes longer, invites visits to the facility and for the counties to explore creating a "community center" and events such as viewing movies, cafe visits, and group activities plus arrangements for hospice, respite etc all in one location.

**Problem:** Because of rules re scope of practice caregivers are limited in administering medications even though a family member or neighbor is not prohibited to do the same.

**Suggestion:** Review the scope of practice and consider rewriting for homecare workers, social workers and LPN's.

**Problem:** Seniors often have multiple chronic health problems that require several specialists and multiple medications but there is not a coordinated comprehensive approach and the frail elderly are often confused about care and medications.

**Suggestion:** Create a "Medical Home" or anchor to address personalized patient-centered medical needs to determine the predominant problems, serve as the case manager to assure the coordination by multiple providers of primary, preventive, and chronic condition care, utilize health information technology and electronic health records.

**Problem:** Caregivers not only have a need for respite but also for training and information that will alleviate stress and facilitate care of their family member or neighbor but often can not avail themselves of further education due to time constraints or lack of support.

**Suggestion:** Offer tips or training for those who provide care to seniors through the professional organizations and institutions (contractors) and have incentives for both the caregiver as well as the entity doing the training.

**Problem:** In home support is limited and needs to be expanded to a larger number of seniors in the community with a greater range of supports.

**Suggestion:** Create waiver programs for support such as in home clinical services as well as flexible funding for retrofitting home and covering other expenses.

**Problem:** There are few incentives for the caregiver who stays home to provide for the frail elder parent/family member despite the loss of family income.

**Suggestion:** Offer tax credits, respite and supplemental income to offset the reduced finances.

**Problem:** Fewer opportunities for seniors who reside in nursing homes to return home and settle back into the community because of limited services to support their independence.

**Suggestion:** Enhance the nursing home transition program that identifies older adults who may be physically able or eligible to return to the community.

**Problem:** Increased numbers of at risk older adults are not identified early enough in the community to prevent long term and/or permanent nursing home stays.

**Suggestion:** Create outreach programs to locate and identify at risk seniors and engage services to avoid premature nursing home admissions such as the REAP program.

**Problem:** Few physicians are choosing to specialize in geriatrics which will leave future elderly without the ideal professional care and limit their ability to remain at home.

**Suggestion:** Offer incentives and financial support for choosing the "senior" specialty.

**Problem:** Limited acceptance of Adult Day Programs prevents seniors from fully participating and remaining in the community.

**Suggestion:** Orientation for the senior to consider and accept this alternative and to offer justification for the cost of Adult Day program.

## **EDUCATION ~ COMMUNITY AWARENESS**

**Problem:** Seniors and family are unaware of stages of aging, choices ahead, planning in order to enhance ability to age in place that can reduce risk.

**Suggestion:** Provide seminars/education available to seniors and other members of the community. (How can we meet your needs and wishes? Planning ahead? Do you have a support system? What your family should know? What do you wish your kids to ask?)

**Problem:** Nursing homes have been organized to serve large numbers of seniors based on economies of scale that can be impersonal and may accelerate incapacity.

**Suggestion:** The concept of Green Nursing Homes that are smaller and created to reflect more of a family situation increases interaction and has the potential to consider patient directed care. (Dr. Bill Thomas via Dr. Joe Miller)

**Problem:** Seniors often are not aware of arrangements that can be made to facilitate end of life decisions. Family may also be averse to bringing up difficult topics such as pain, comfort, medication and cessation of medical devices/support.

**Suggestion:** Introducing the concept of Ethical Wills (Dr. Barry Baines) through educational sessions offers gentle and helpful opportunities to initiate discussion

and to enhance the ability to remove the pressure on the elder and the family or impulse to avoid the event that each of us must experience.

**Problem:** The medical model often used in later age to extend life at whatever cost financially, physically and emotionally compounds the stress and decisions for all.

**Suggestion:** Slow Medicine which enhances potential for circles of care and patient directed care could become the antidote to heroic efforts and unrealistic expectations at the end of life if families become familiar with alternatives and conversations are encouraged. (Dr. Dennis McCullough author of *'My Mother, Your Mother'*)

**Problem:** Seniors are not informed early enough in their working career to prepare for health care and living accommodations by setting aside enough funds to cover the costs.

**Suggestion:** Education regarding the advantage to planning, saving vehicles or for long term care insurance could assure adequate care and lifestyle that would be comfortable.

**Problem:** Legislators do not always have timely or complete information and must rely upon constituents and organizations that are knowledgeable about the elderly to inform them of concerns and trends.

**Suggestion:** Regular education sessions and collaboration with the Joint Elderly Affairs Committee to focus on achievable goals to consider the big picture as well as small steps to implementation and enabling legislation.

**Problem:** Remaining independent is difficult for seniors as advice is liberally offered, but often not directly solicited and there is a limit to active listening by others.

**Suggestion:** Educate the senior and those who are primary caregivers, family and friends to the concept that an elder may wish to remain independent. The senior should be encouraged to write down their thoughts on what they want (to live life as they wish as long as possible) and not do what others think is good for you.

**Problem:** As seniors age it is probable that their health will require additional prescriptions are they may not be aware of medical interactions.

**Suggestion:** Workshops for seniors and readily available information from doctors and health care professionals must be prepared for the elderly in the wise use of medicine.

**Problem:** Local Planning Boards are not familiar with frail elderly issues in order to support necessary changes to their ordinances /regulations to promote seniors remaining vital and active in their communities.

**Suggestion:** Senior advocacy group ask to present information to "Planners Seminars" on topics such as "echo housing," granny flats, mother-in-law apartments, livable and sustainable communities and infrastructure disincentives to family care for seniors.

**Problem:** There is on one stop resource in each smaller area i.e. village or neighborhood clusters that provides information/ referral / follow up and monitoring / LTC plan.

**Suggestion:** Empower elder consumer and encourage Service Link type organization to identify neighborhood resources to help each other (i.e. Y2K emergency response)

**Problem:** Medicare Part D that covers prescription drugs is not fully understood by recipients or their families. The gap in coverage begins sooner than expected because the "doughnut hole" begins at \$2,510 which combines both the enrollees' spending and the health plan's spending. The enrollee must pay full cost for all drug costs out of pocket until their costs reach \$3,850.

## **FUNDING/FINANCIAL ISSUES**

**Problem:** Rigid rules define what can be paid for by service delivery organizations making potential appropriate services out of reach for those near poverty level for items, products, care, services which are not covered.

**Suggestion:** Increase options/coverage and Flex Funds.

**Problem:** Additional staff is needed by facilities as Medicare penalizes hospitals financially if patients return and are re-admitted within "at least" 30 days of initial discharge. Hospitals are hiring staff to manage and coordinate the care giving to avoid "frequent flyers" returning prematurely and repeatedly to the institution.

**Suggestion:** Assign community liaisons to be bridge builders between the hospital, community care givers and frail seniors.

**Problem:** Seniors are limited to fixed incomes that are often not adequate to purchase needed items that are emergencies and not planned, Medicare and Medicaid recipients also are not eligible for some needs that are not covered.

**Suggestion:** Emergency funds can prevent the senior from skimping on medicine, food or heat in order to acquire a necessary component or asset (crutches? artificial eye?)

**Problem:** There is population of frail elderly that are near poor but not Medicaid eligible who do not have funds for long term community support.

**Suggestion:** Service Link may be able to offer screening for those who are just above eligibility for Medicaid (ie10%-15%) and allow support for Medicare recipients to receive similar services by elderly perhaps for funds or personnel.

**Problem:** Round the clock home care is often more expensive than nursing home care and is not readily available and a challenge if the individual is not Medicaid eligible.

**Suggestion:** Alternative financial options for families and communities who are able to have the elderly remain at home.

**Problem:** Visitation to seniors by a social worker is limited and yet for a senior to remain in the home of a family member, the ability to assess the progress or regress is critical to long term well being.

**Suggestion:** Review the requirement for those on Medicare in order to continue independence as long as possible to prevent institutionalization at a greater cost.

**Problem:** Many of our citizens, especially women have not considered the financial obligations and limitations as they reach later stages in life.

**Suggestion:** Financial Literacy should be part of community education and council on aging activities, as well as part of students before graduating from high school.

**Problem:** Seniors are vulnerable to fraud and often are not fully informed regarding consumer protection.

**Suggestion:** Community forums, literature and public service announcements should be part of educational activities. Collaboration with AARP, local police and attorney general's office should be a yearly project.

**Problem:** Seniors can be financially compromised when their spouse has dementia and inadvertently creates debt.

**Suggestion:** Local councils on aging, physicians, community congregate meal sites and volunteers should offer information that helps to educate the senior on key indicators.

**Problem:** As Seniors on a limited income without family or a circle of care become frail living in their own home, their finances may limit home care assistance (i.e. VNA) and medical care may be beyond their physical capacity.

**Suggestion:** Create a fund within a housing/loan agency to consider the assets in the home and provide "bridge" financing and/or hold the property for re-sale with the proceeds reimbursing the home care agency for their services.

**Problem:** Dividend and income taxes primarily impact older retired adults and may reduce their ability to remain in their community because of reduced earnings and higher property taxes.

**Suggestion:** Allow more flexibility with range of dividend taxes and consider general income taxes as a more equitable approach to providing services.

**Problem:** Barriers to supporting vulnerable community members are directly related to limited financial resources i.e. no taxes, no services therefore sidewalks can be installed at federal expense, but community budgets do not support their maintenance and upkeep.

**Suggestion:** Consider alternative revenue sources to assist local government.

**Problem:** As hospitals and providers maximize profits, lower cost care is sacrificed with a replacement of what had been "in office" care with "out-patient surgery" costing the patient and insurer additional funds.

**Suggestion:** Incentives for alternative treatment protocols and service delivery flexibility.

**Problem:** A person who qualifies for Medicaid's QUIMBY program is categorized as not being capable of paying their \$96.00 Medicare premium, but are responsible for \$130.00 Medicaid spend down each month.

**Suggestion:** Organize and request a change by CMS and have a waiver to the arbitrary rule that unfairly discriminates against poor elderly.

**Problem:** Many services are not available for seniors whose income is slightly above the Medicaid limit and lack of services for those not clinically eligible for Medicaid services but need and can't afford help that will prevent their deterioration.

**Suggestion:** CMS could consider a review of the level allowable for services in terms of inconsistencies, prevention measures and reduced medication costs (drug importation) and relief for out of pocket expenses.

## **HOUSING ISSUES**

**Problem:** Zoning ordinances that prohibit mother/father-in-law apartments prohibit inter-generational living arrangements.

**Suggestion:** The City of Manchester modified its ruling to allow the change. The legislature enables municipalities through HB 717 to create community planning to address potential issues and this should be supported.

**Problem:** Plans for buildings and locations exclusively for seniors, poor seniors or disabled seniors limit their interactions and experiences - what can seem to a resident to be a Senior Ghetto or a virtual prison.

**Suggestion:** Involve diverse members of the community in the planning including seniors and their families to make sure that the aging population is not isolated and can not access services, parks/recreation friends and family.

**Problem:** Elderly women often live alone, live longer, and are widows, without pensions, more at risk, vulnerable and isolated and with health challenges from age 55-64 pre Medicare/Medicaid.

**Suggestion:** Work with New Hampshire Women's Lobby to address inequities and prevent risk.

**Problem:** As seniors age the home they move into or the house they are aging in is often not suitable for their circumstances, health and fitness.

**Suggestion:** Communities should require new buildings and retrofitted buildings to utilize Universal Design and seniors should be educated to the concept when remodeling. When the need arises homes should be ADA adapted.

**Problem:** Affordable housing is not readily available for the workforce and for the 50+ year old workers they will need a home that will be useful and fit their budget in their later years.

**Suggestion:** Communities can allow mother/father-in-law apartments that can ease the transition as workers age providing a home that is convenient to family.

**Problem:** In recent years the increase in population, zoning ordinances that drive up land values have added pressure on housing opportunities pushing development of homes for seniors to more isolated areas.

**Suggestion:** Work with planners and municipalities re diverse communities, to include aging and disabilities in discussions re intergenerational and livable communities.

**Problem:** Affordable housing for independent elderly who have modest incomes is not available in most communities because of zoning limits on density.

**Suggestion:** Tax break for developers to introduce housing that is suitable and affordable.

**Problem:** Short term emergency housing is a rare commodity and in-home emergency service providers are almost non-existent for medical care or supervisory monitoring.

**Suggestion:** Explore alternatives and additional flexibility for the financially eligible and consider adjusting eligibility criteria for the near poor.

**Problem:** Older adults with mental illness and without relatives who can provide care have few alternatives other than institutionalization.

**Suggestion:** Create specialized capacity for 24 hour residential programming

**Problem:** Condo Association By-laws together with town zoning ordinances prevent in-home care givers to elderly because of marital status/age/unreasonable requests for private medical history in violation of law.

## **SAFETY ISSUES**

**Problem:** Personal cars used by volunteers or staff to provide transportation for the elderly is seen as a liability by risk averse organizations re adequate insurance coverage and limits ability to convey seniors.

**Suggestion:** Local agencies have the option to write policy guidelines to address requirements re coverage; enabling legislation introduced to waive liability.

**Problem:** Communities are not aware of number or severity of at risk frail elderly who do not have mobility or ability to evacuate.

**Suggestion:** Encourage municipalities to utilize enabling legislation (HB 717) as a local planning initiative to determine potential locations of seniors living alone and at risk circumstance and incorporate approaches for pandemic and disaster planning.

**Problem:** RSA: 151 requires licensing all people who provide in-home assistance to folks in their homes whether they are doing it for profit or not. This can inhibit a neighbor helping a senior, yet the legislature (perhaps of necessity) wants to protect seniors from fraud and the risk of someone unsavory in their homes.

**Suggestion:** Create a level of who must be licensed or not by revisiting legislative intent and defining services allowed by certain individual in respect to their level of training or certification.

**Problem:** Erosion of infrastructure such as sidewalks and ramps, potholes increase across the state and make it treacherous for the frail who are mobile and creates a fear of falling.

**Suggestion:** Target most serious problem and fund the repairs most advantageous to frail.

**Problem:** Street crossings can be slippery when wet, length of crossing light too short and building door openings often are not working or doors are too heavy.

**Suggestion:** Municipal maintenance or transportation departments could assess the level of safety and recommend changes to community leadership and publicize adjustments.

## **SYSTEMS CHANGE ISSUES**

**Problem:** Shortage of respite care beds across the state prompted a Senate Resolution to implement a review.

**Suggestion:** Certificate of Need (CON) waiver to determine if Mary Gale beds can be allocated out of the county.

**Problem:** Limited focuses on planning for future needs and increased population of frail senior citizens in the state.

**Suggestion:** Secure a lobbyist to advocate for seniors through the umbrella of SCCC.

**Problem:** State planning organizations are limited in advocacy and preparation for the increased services that will be required to address needs of seniors.

**Suggestion:** Collaborate with other organizations for a Long Term Care Commission and secure broad endorsement.

**Problem:** Some frail elderly reach a point when they do not have the capacity to live alone because they do not have family or neighbors to assist them with household or daily activities. Few sanctioned state programs exist that expand long term care options for elders in our communities.

**Suggestion:** Creating the capacity for Foster Care for Elderly could help the frail to stay in the community and avoid premature institutionalization.

**Problem:** There can be a disconnect when legislation introduced at the state level, amended and passed becomes the responsibility of the appropriate department and agency that develops the rules for implementation but the result may not accurately reflect the intent of the sponsors/authors or the legislative description or "blurb".

**Suggestion:** Engage the Joint Legislative Committee on Administrative Rules to not only review the rules formulated by the department but to confirm the

legislative intent. Consider a "checklist" to assure fidelity, better educate legislators on the realities and consequences of rule making and engage a lobbyist to follow the process.

**Problem:** Many communities are not aware of limitations created by municipalities that increase the possibility of frail elderly falling through the cracks.

**Suggestion:** *Seniors Count* expanded across the state (in addition to two new pilots).

**Problem:** Financial limits and constraints in difficult economic times may prevent increased funds on frail senior projects.

**Suggestion:** Create an Executive Order (or Legislative) to develop or assign a study committee to review senior issues (or expand scope of Joint Committee on Elderly).

## **TRANSPORTATION**

**Problem:** Current bus systems are not meeting the needs of seniors who are reluctant to use bus transportation because of fear, discomfort or unfamiliarity.

**Suggestion:** Need alternatives as well as orientation, assistance, motivation or encouragement on bus use.

**Problem:** Seniors and family members complain that in rural areas transportation to locations with activities or appointments in their own and other communities are not available, reliable or convenient.

**Suggestion:** Transport elderly when special education "buses" are not in use.

**Problem:** Seniors with limited income who drive other elderly friends are reluctant to ask for contributions toward gas, parking or other limited upkeep and expenses.

**Suggestion:** Consideration should be given to introducing a 'hold harmless clause' re liability under the Good Samaritan concept even when contributions are made for gas.

**Problem:** Without adequate transportation that can assure wrap around services for the elderly to access dental, mental health, primary care and a pharmacy, their health will fail and they will no longer be able to remain in their home.

**Suggestion:** Flex funds are needed for taxi cabs fares because gas prices are rising and/or subsidized transportation to allow seniors to remain in their homes.

**Problem:** Utilizing a vehicle and driver for Mental Health appointments for several patients to the same doctor with sequenced appointments is not allowed under HIPPA.

**Suggestion:** Allow waivers signed by individual patients that are approved by the agency.

## **WORKFORCE (paid and volunteer)**

**Problem:** Home health workers are not eligible for workers compensation insurance for those who are employed in the homes of the elderly or disabled.

**Suggestion:** Blanket coverage for home health workers can be obtained by an umbrella organization i.e. Granite State Independent Living.

**Problem:** Limitations by federal requirement on income levels of the RSVP volunteer is a disincentive and hinders the number of potential recruits eligible for the stipend.

**Suggestion:** Reconsideration of volunteer goals, the number of frail elderly who would benefit from a visit by a companion and the income eligibility of the potential volunteer.

**Problem:** Some home health care workers provide services as "independent" operators who may be "under trained" or are "underground" and do not have access to updated training and courses because of access, conditions, cost and proximity.

**Suggestion:** The elderly as well as the home health worker would benefit from offering course(s) to the public that would enhance their quality and productivity and have some credential associated with the activity. This could also be useful for family members.

**Problem:** Elders with limited mobility often experience isolation because support and companionship are no longer available as friends have passed on.

**Suggestion:** Train volunteers and provide a stipend to be companions while the working family member is away during the day (night).

**Problem:** Hiring home care workers is a challenge for family members who wish their elder parent or spouse can remain at home but are faced with caring for and finding reliable, honest caregivers when they must be away from home.

**Suggestion:** Create a subsidized community liaison or community case worker who could organize trained volunteers, conduct background checks or hire others to assist in short term situations if the frail elder is able to be at home and does not require full time nursing home care.

**Problem:** Because of insurance prohibitions and potential liability neighbors are reluctant to intervene or to offer to provide assistance or help.

**Suggestion:** Make sure insurance is not a deterrent to neighbors helping neighbors.

**Problem:** Those who come in contact with seniors are not always attuned to the limitations of the frail elderly such as failing eyesight, level of literacy, language, poor lighting, or need for large print documents.

**Suggestion:** Assemble an "Army" of nice young people to canvas a neighborhood with useful information through face to face visits so the senior does not see it as charity.

**Problem:** It is difficult for individuals to hire direct care (for any purpose) to obtain criminal background checks for prospective providers because of the procedure and the cost.

**Problem:** For both paid and volunteer workers, the cost of fuel and limited reimbursement, car repairs and cost of insurance are deterrents to recruitment for an adequate number of Meals on Wheels drivers with a vehicle from the potential pool.

**Problem:** Lack of communication or impractical expectations between State of NH and providers of services as well as among/between providers exacerbated by HIPPA rule interpretations and use of "labels" among "healthy seniors" who don't want to be with CVA elder or DD elder, plus sometimes unrealistic "Yankee Spirit" that fosters "I don't need help."

## **OTHER**

**Problem:** Currently a frail elder who possesses a driver's license is not eligible for Meals on Wheels delivery (i.e. a 92 year old gentleman who no longer drives but retains his license).

**Suggestion:** Review of criteria and circumstances for eligibility.

**Problem:** Frail seniors living alone need support/assistance to safely remain in their home overnight but do not have funds for a paid caregiver. Observations by local professionals (police) during visits see that the only immediate options for supervision such as overnight hospitalization or a homeless shelter are inappropriate.

**Suggestion:** Provide more flexible criteria for short term or overnight caregivers and review income level of near poor for eligibility.

**Problem:** Seniors who can not drive or can not depend on others can become isolated and not able to access services on their own such a banking, shopping, attending worship services and other medical and social amenities.

**Suggestion:** Municipalities should incorporate walkable opportunities in their planning and zoning approvals in order to make their community more livable.

**Problem:** There is uneven resolution for a family when seniors have been exposed to medical malpractice in the course of being hospitalized and treated.

**Suggestion:** Education of seniors, physicians and medical facilities as well as the Board of Medicine as to the disadvantage of seniors under their care and collaborate with the NH Medical Society in addressing this issue re professional standards, transparency, oversight and disciplinary action.

**Problem:** Termination of older workers for the "legitimate business reason" that they earn too much (or that they require compensation commensurate with their experience).

**Suggestion:** Provide education as to the value of older workers and awareness of ageism and law that prohibits discrimination

**Problem:** Failure to hire and promote older workers out of fear they will retire soon anyway or cost too much in insurance premiums.

**Suggestion:** Provide education as to the value of older workers and awareness of ageism and law that prohibits discrimination

**Problem:** Senior Centers fights over building ownership because of value or history.

**Suggestion:** Assistance with legal resource and mediator to benefit of participants.

**Problem:** Medicaid liens potentially preventing seniors from staying in their home.

**Suggestion:** Negotiate so the individual can get a home equity loan.

**Problem:** Older people are invisible to many members of society including business and institutions re needs of elders.

**Suggestion:** Cultivate a vision of an inclusive community that promotes universal design, encourages cross-generational interaction, and addresses misconceptions about aging.

## **Appendix G – Identified Problems**

### **SENIORS COUNT POLICY INITIATIVE**

#### **IDENTIFIED PROBLEMS**

Draft 12.5.08

This is a compilation of problems identified between February-October 2008 by Ricia McMahon, *Seniors Count* Policy Consultant, funded for one year by an Endowment for Health Grant. Information gathered through exchanges with over 125 stakeholders (36 interviews and 6 policy sessions). The process allowed for open-ended responses from participants to discover rules, laws, and regulations at federal, state, local levels that they perceived as problems and/or barriers needing to be addressed.

Below are the responses as reported and have not been verified or vetted as completely accurate. The categories were established to organize the information and provide a framework for discussion after all the interviews/meetings were complete.

***The categories are listed alphabetically below; there is no prioritization within the categories.***

#### **CAREGIVER**

1. Times of services, such as Adult Day facilities, may not be convenient or reasonable or flexible for a working family member who is the caregiver of a senior.
2. Options for respite care, either planned or emergency are limited when a community caregiver is unable to temporarily provide assistance/care for the senior. Too often now, hospitals are the fall-back even if it is not suitable or necessary.
3. Caregivers cannot get timely and certain commitment from facilities (assisted living or nursing homes) that will allow them to plan in advance for respite (such as for travel, family events, work obligations, etc).
4. Currently, Medicaid allows 20 days a year of respite care for person eligible for Choices for Independence (formerly HCBC). There is limited flexibility regarding frequency of intervals for admission and/or extending a stay due to extraordinary circumstance.
5. The stigma of the County Nursing Home causes caregivers to be reluctant to use this publicly funded resource.
6. Seniors often have multiple chronic health problems that require several specialists and multiple medications but there is not a coordinated comprehensive

approach. The elderly and their caregivers are often confused about proper care and medications interactions that compromise safety.

7. Caregivers not only have a need for respite but also for training and information that will alleviate stress and facilitate safe care of their family member/neighbor/loved one but often can not avail themselves of further education due to time constraints, lack of support or opportunity.

8. There is a lack of flexibility and options for in-home services provided (such as staff transporting seniors, or giving meds). With the anticipated growth of senior population, access and affordability must be considered.

9. Frail seniors may be getting insufficient and/or unsafe care or premature admission to nursing facility because working caregivers cannot afford losing income to remain at home to take care of their frail loved one.

## **EDUCATION ~ COMMUNITY AWARENESS**

1. Seniors and their families are unaware of the stages of aging and are not prepared for the choices that can reduce the risks that they face and they are not equipped with the information to plan ahead in order to enhance their ability to age in place.

2. Without information about programs that enhance a seniors aging through full participation in the community there will be limited acceptance of Adult Day Programs that could prevent seniors from deteriorating which puts them at risk of remaining in the community.

3. Nursing homes can be impersonal and may accelerate incapacity of the elderly because they are organized to serve large numbers of seniors based on economies of scale.

4. Seniors often are not aware of arrangements that can be made to facilitate end of life decisions. Family may also be averse to bring up difficult topics such as pain, comfort, medication and cessation of medical devices/support or cost because they are reluctant to initiate discussion and are misinformed or do not feel informed.

5. Without education regarding alternatives such as patient directed care, elderly and family members may believe that "heroic efforts" is the only option. This medical model is often used in later stages of illness to extend life at whatever cost: financially, physically and emotionally which compounds the stress and can make difficult decisions uncomfortable for all involved.

6. Seniors who are not informed early enough in their working careers about saving vehicles that are needed to prepare ahead for the costs of health care and living accommodations are at risk of falling short of enough funds for long term care in their retirement years.

7. Legislators do not always have timely or complete information to assist them in creating laws that benefit seniors without unintended consequences. They rely upon constituents, lobbyists and organizations that are knowledgeable about the elderly to inform them of concerns and trends.

8. Education for seniors, family and their caregivers is not always available to enhance and assist in communication to increase the possibility of remaining independent and in the community. It can be confusing and difficult for seniors as they age because advice is liberally offered, often not directly solicited and there is limited active listening by others resulting in assumptions and frustration.

9. As seniors age it is highly probable that their deteriorating health will require additional prescriptions but without information and training regarding the wise use of medicine they may not be aware of dangerous medical interactions that could threaten their life.

10. Limited knowledge and unfamiliarity of local Planning Boards about issues concerning frail elderly makes it likely that vital information will not be considered in order to support necessary changes to local ordinances/regulations that promote seniors remaining active and part of their communities.

11. Most rural areas do not have the resources in their communities i.e. village or neighborhood clusters to provide one stop resources or have limited information/referral, follow-up/ monitoring or LTC planning opportunities.

12. Confusing Medicare Part D rules are not fully understood by recipients or their families and often surprise seniors who anticipate coverage for prescription drugs to last longer. The gap in coverage begins earlier than expected because the "doughnut hole" begins at \$2,510 which combines both the enrollees' spending and the health plan's spending. The enrollee must pay full cost for all drug costs out of pocket until their costs reach \$3,850.

## **FUNDING/FINANCIAL**

1. The near poor (those just above the financial eligibility for Medicaid's Choices for Independence program, formerly HCBC) have extremely limited options to receive community services

2. Rigid rules for Medicare and Medicaid define what can be paid for by service delivery organizations making potential appropriate services out of reach for those near poverty level for items, products, care, or services that are not covered.

3. Medicare penalizes hospitals financially if patients return and are re-admitted within "at least" 30 days of initial discharge. Hospitals now hire staff to manage and coordinate the care-giving to avoid "frequent flyers" returning prematurely and repeatedly to the institution.

4. Seniors are limited to fixed incomes that are often not adequate to purchase needed items that are emergencies and not anticipated. Medicare and Medicaid recipients also are not eligible for some important items not covered by rules. This situation may leave a senior with a compromised choice between heat, rent, food and medicine and put their health at risk.
5. There is a population of frail elderly that are near poor but not Medicaid eligible who do not have funds or other resources for long term community support.
6. Round the clock home care is often more expensive than nursing home care and is not readily available and becomes a critical challenge for the senior or family if the individual is not Medicaid eligible.
7. Visitation to seniors by a social worker is limited by Medicare rules and yet for a senior to remain in the home of a family member, the ability to assess their progress or regress is critical to long term well being for the senior and offers reinforcement and confidence for the family.
8. Many of our older citizens, especially women have not considered and have not been educated about financial obligations or their personal limitations as they reach later stages in life, often finding themselves without the resources to remain independent.
9. Seniors are most vulnerable to fraud, often are not fully informed regarding consumer protection and have not had seminars available to them or realize their importance.
10. Seniors can be financially compromised when their spouse has dementia and inadvertently creates debt. Often the resources in the community to help understand the consequences are non-existent or discovered too late.
- 11 Education by local councils on aging, physicians, community congregate meal sites and volunteers is not always offered in a format or information is not delivered in ways that is most suitable to help enlighten the senior or their family on key financial indicators or eligibility criteria.
12. As Seniors on a limited income without family or a circle of care become frail living in their own home, their finances may limit home care assistance (i.e. VNA) and adequate medical care may be beyond their physical and financial capacity.
13. Dividend and income taxes primarily impact older retired adults and may reduce their ability to remain in their community because of reduced earnings and higher property taxes.
14. Barriers to support vulnerable community members are directly related to limited financial resources therefore sidewalks can be installed at federal expense, but community budgets do not support their maintenance and upkeep.

15. As hospitals and providers maximize profits, lower cost care is sacrificed with a replacement of what had been “in office” care with “out-patient surgery” costing the patient and insurer additional funds.

16. Confusing regulations exist when a person who qualifies for Medicaid’s QUIMBY program is categorized as not being capable of paying their \$96.00 Medicare premium, but are responsible for \$130.00 Medicaid spend down each month.

17. Many services are not available for seniors whose income is slightly above the Medicaid limit and a lack of services for those not clinically eligible for Medicaid services further compromise the elder because they need, but can’t afford the help that would prevent their deterioration.

## **HOUSING**

1. Zoning ordinances that prohibit mother/father-in-law apartments prevent inter-generational living arrangements that could allow the senior to remain in their home and community longer.

2. Plans for buildings and locations exclusively for seniors, poor seniors or disabled seniors limit their interactions and experiences and can be viewed by a resident as a Senior Ghetto or as a virtual prison.

3. Elderly women often live alone, live longer and are widowed, without pensions, more at risk, vulnerable and isolated, coupled with health challenges from age 55-64 pre Medicare/Medicaid.

4. As seniors remain in the aging family home or a smaller house that they move into, it is often not suitable for their circumstances, health and fitness and needs retrofitting and a floor plan or design conducive to safety and ease.

5. Affordable housing is not readily available for the workforce (including caregivers) and for the 50+ year old workers who will need a home that will be useful and fit their budget in their later years.

6. In recent years increases in population and zoning ordinances have added pressure and competition for housing opportunities that drive up land values and push development of homes for seniors to more isolated areas which are not ideal as individual’s age and become more frail.

7. Affordable housing for independent elderly who have modest incomes is not available in most communities because of zoning limits on density.

8. Short term emergency housing is a rare commodity and in-home emergency service providers are almost non existent for medical care or supervisory monitoring.

9. Older adults with mental illness and without relatives who can provide care have few alternatives other than institutionalization.

10. Condo Association By-laws together with town zoning ordinances prevent in home care givers to elderly because of marital status/age and unreasonable requests for private medical history which are in violation of law.

## **SAFETY**

1. Personal cars used by volunteers or staff to provide transportation for the elderly is seen as a liability by risk averse organizations re adequate insurance coverage and limits ability to convey seniors.

2. Communities are not aware of the number or severity of at risk frail elderly who do not have mobility or ability to evacuate.

3. Laws inhibit neighbors helping seniors. RSA: 151 requires licensing all people who provide in home assistance to folks in their homes whether they are doing it for profit or not. Yet the legislature (perhaps of necessity) wants to protect seniors from fraud and the risk of someone unsavory in their homes.

4. Erosion of infrastructure such as sidewalks, ramps and more potholes increase across the state making it treacherous for the frail who are mobile and creates a fear of falling or a reluctance to venture out.

5. Street crossings can be slippery when wet, length of crossing light too short and building door openings often do not work or doors are too heavy and can put a senior at risk of falls or other injury.

## **SYSTEMS CHANGE**

1. Increased numbers of at risk older adults are not identified early enough in the community to prevent long term and/or permanent nursing home stays.

2. There is a shortage of respite care beds across the state which prompted a Senate Resolution to implement a review and complete an accurate and needed assessment.

3. There is limited focus on planning for future needs, lack of coordinated efforts for key initiatives and an increasing population of frail senior citizens in the state who will prefer to remain in their own homes.

4. State planning organizations are limited in advocacy and preparation for the increased services that will be required to address future needs of seniors.

5. Some frail elderly reach a point when they do not have the capacity to live alone because they do not have family or neighbors to assist them with household or

daily activities. Few sanctioned state programs exist that expand long term care options for elders in our communities.

6. There can be a disconnect when legislation is introduced at the state level is amended and passed becomes the responsibility of the appropriate department and agency that develops the rules for implementation. The result may not accurately reflect the intent of the sponsors/authors or the legislative description or “blurb” and further adds unintended consequences.

7. Many communities are not aware of limitations and restrictions created by municipalities that increase the possibility of frail elderly falling through the cracks (literally and figuratively).

8. Financial limits and constraints in difficult economic times may prevent increased funds for frail senior projects or services.

## **TRANSPORTATION**

1. Current bus systems are not meeting the needs of seniors who are reluctant to use bus transportation because of fear, discomfort or unfamiliarity.

2. Seniors and family members complain that in rural areas transportation to locations with activities or appointments in their own and other communities are not available, reliable or convenient.

3. Seniors with limited income who drive other elderly friends are reluctant to ask for contributions toward gas, parking or other limited upkeep and expenses and consequently create a shortfall in their own budget.

4. Without adequate transportation that can assure wrap around services for the elderly to access dental, mental health, primary care and a pharmacy, their health will fail and they will no longer be able to remain in their home.

5. Utilizing a vehicle and driver for Mental Health appointments for several patients to the same doctor with sequenced appointments is not allowed under HIPPA and makes transportation duplicative and more expensive.

6. For those seniors needing assistance walking who have no family nearby and live at a distance from a surgical center often need to hire an ambulance to take them for follow-up appointments creating costs resulting in thousands of dollars.

## **WORKFORCE (paid and volunteer)**

1. Because of rules re scope of practice, professional non-nursing caregivers are limited in administering medications even though a family member or neighbor is not prohibited to do the same.

- 2.. Few physicians are choosing to specialize in geriatrics which will leave future elderly without the ideal professional care and limit their ability to remain at home.
3. Limited number of community services/workforce prevents appropriate nursing home residents from returning to their community, thereby requiring them to stay in the facility (which is more costly and a more restrictive environment).
4. Home health workers are not eligible for workers compensation insurance for those who are employed in the homes of the elderly or disabled.
5. Limitations by federal requirements on income levels of the RSVP volunteer are a disincentive and hinder the number of potential recruits eligible for the stipend.
6. Some home health care workers provide services as "independent" operators who may be "under trained" or are "underground" and do not have access to updated training and courses because of access, conditions, cost and proximity.
7. Elders with limited mobility often experience isolation because support and companionship are no longer available as friends have passed on and there are limited home care personnel available.
8. Hiring home care workers is a challenge for family members who wish that their elder parent or spouse can remain at home but are faced with caring for and finding reliable, honest caregivers when they must be away from home.
9. Because of insurance prohibitions and potential liability, neighbors are reluctant to intervene or to offer to provide assistance or help.
10. Those (caregivers) who come in contact with seniors are not always attuned to the limitations of the frail elderly such as failing eyesight, level of literacy, language, poor lighting, or need for large print documents.
11. It is difficult for individuals to hire direct care (for any purpose) and to obtain criminal background checks for prospective providers because of the procedure and the cost.
12. For both paid and volunteer workers, the cost of fuel and limited reimbursement, car repairs and cost of insurance are deterrents to recruitment for an adequate number of Meals on Wheels drivers with a vehicle from the potential pool available in a community.
13. Lack of communication or impractical expectations between the State of NH and providers of services as well as among providers are exacerbated by HIPPA rules and interpretations. Use of "labels" among "healthy seniors" who don't want to be with a CVA elder or DD elder, plus sometimes unrealistic "Yankee Spirit" that fosters "I don't need help" is also detrimental to serving seniors and complicates the workplace.

## **OTHER**

1. Currently a frail elder who possesses a driver's license is not eligible for Meals on Wheels delivery (i.e. a 92 year old gentleman who no longer drives but retains his license)
2. Frail seniors living alone need support/assistance to safely remain in their home overnight but do not have funds for a paid caregiver. Observations by local professionals (police) during visits see that the only immediate options for supervision such as overnight hospitalization or a homeless shelter are inappropriate.
3. Seniors who can not drive or can not depend on others can become isolated and not able to access services on their own such a banking, shopping, attending worship services and other medical and social amenities.
4. There is uneven resolution and determination by the Board of Medicine to the disadvantage of seniors and their family when seniors have been exposed to medical malpractice in the course of being hospitalized and treated.
5. Termination of older workers occurs for the "legitimate business reason" that they earn too much (or that they require compensation commensurate with their experience).
6. Failure to hire and promote older workers out of fear they will retire soon anyway or cost too much in insurance premiums is a discriminatory practice.
7. Senior Centers' fights happen over building ownership because of value or history.
8. Medicaid liens potentially prevent seniors with few financial resources from staying in their home.
9. Older people are invisible to many members of society including businesses and institutions re needs of elders which disadvantages them from numerous aspects of community participation.

**Appendix H – Setting Priorities**

Review the below list of 'problems' identified and help identify what Seniors Count should/will work on in our 3-year policy plan. In column A, place either a + - 0. (+ = YES, Seniors Count definitely should address this issue in our policy plan; - = NO, Seniors Count definitely should not address in the policy plan; 0 = Not the highest priority but Seniors Count can consider addressing in the policy plan). In column B, <b>ONLY FOR THOSE YOU MARKED WITH +</b> , note <b>A = take immediate action steps</b> <b>B = plan action steps that are staged over the next year years</b> <b>C = accept as long term goal</b>		
mark with + - or 0	For + only	
	rank A, B or C	
		<b>CAREGIVERS</b>
		1. Times of services, such as Adult Day facilities, may not be convenient or reasonable or flexible for a working family member who is the caregiver of a senior.
		2. Options for respite care, either planned or emergency are limited when a community caregiver is unable to temporarily provide assistance/care for the senior. Too often now, hospitals are the fall-back even if it is not suitable or necessary.
		3. Caregivers cannot get timely and certain commitment from facilities (assisted living or nursing homes) that will allow them to plan in advance for respite (such as for travel, family events, work obligations, etc).
		4. Currently, Medicaid allows 20 days a year of respite care for person eligible for Choices for Independence (formerly HCBC). There is limited flexibility regarding frequency of intervals for admission and/or extending a stay due to extraordinary circumstance.
		5. The stigma of the County Nursing Home causes caregivers to be reluctant to use this publicly funded resource.
		6. Seniors often have multiple chronic health problems that require several specialists and multiple medications but there is not a coordinated comprehensive approach. The elderly and their caregivers are often confused about proper care and medications interactions that compromise safety.
		7. Caregivers not only have a need for respite but also for training and information that will alleviate stress and facilitate safe care of their family member/neighbor/loved one but often can not avail themselves of further education due to time constraints, lack of support or opportunity.

		8. There is a lack of flexibility and options for in-home services provided (such as staff transporting seniors, or giving meds). With the anticipated growth of senior population, access and affordability must be considered.
		9. Frail seniors may be getting insufficient and/or unsafe care or premature admission to nursing facility because working caregivers cannot afford losing income to remain at home to take care of their frail loved one.
		<b>EDUCATION ~ COMMUNITY AWARENESS</b>
		1. Seniors and their families are unaware of the stages of aging and are not prepared for the choices that can reduce the risks that they face and they are not equipped with the information to plan ahead in order to enhance their ability to age in place.
		2. Without information about programs that enhance a seniors aging through full participation in the community there will be limited acceptance of Adult Day Programs that could prevent seniors from deteriorating which puts them at risk of remaining in the community.
		3. Nursing homes can be impersonal and may accelerate incapacity of the elderly because they are organized to serve large numbers of seniors based on economies of scale.
		4 Seniors often are not aware of arrangements that can be made to facilitate end of life decisions. Family may also be averse to bring up difficult topics such as pain, comfort, medication and cessation of medical devices/support or cost because they are reluctant to initiate discussion and are misinformed or do not feel informed.
		5. Without education regarding alternatives such as patient directed care, elderly and family members may believe that “heroic efforts” is the only option. This medical model is often used in later stages of illness to extend life at whatever cost: financially, physically and emotionally which compounds the stress and can make difficult decisions uncomfortable for all involved.
		6. Seniors who are not informed early enough in their working careers about saving vehicles that are needed to prepare ahead for the costs of health care and living accommodations are at risk of falling short of enough funds for long term care in their retirement years.
		7. Legislators do not always have timely or complete information to assist them in creating laws that benefit seniors without unintended consequences. They rely upon constituents, lobbyists and organizations that are knowledgeable about the elderly to inform them of concerns and trends.

		8. Education for seniors, family and their caregivers is not always available to enhance and assist in communication to increase the possibility of remaining independent and in the community. It can be confusing and difficult for seniors as they age because advice is liberally offered, often not directly solicited and there is limited active listening by others resulting in assumptions and frustration.
		9. As seniors age it is highly probable that their deteriorating health will require additional prescriptions but without information and training regarding the wise use of medicine they may not be aware of dangerous medical interactions that could threaten their life.
		10. Limited knowledge and unfamiliarity of local Planning Boards about issues concerning frail elderly makes it likely that vital information will not be considered in order to support necessary changes to local ordinances/regulations that promote seniors remaining active and part of their communities.
		11. Most rural areas do not have the resources in their communities i.e. village or neighborhood clusters to provide one stop resources or have limited information/referral, follow-up/ monitoring or LTC planning opportunities.
		12. Confusing Medicare Part D rules are not fully understood by recipients or their families and often surprise seniors who anticipate coverage for prescription drugs to last longer. The gap in coverage begins earlier than expected because the “doughnut hole” begins at \$2,510 which combines both the enrollees’ spending and the health plan’s spending. The enrollee must pay full cost for all drug costs out of pocket until their costs reach \$3,850.
		<b>FUNDING/FINANCIAL</b>
		1. The near poor (those just above the financial eligibility for Medicaid’s Choices for Independence program, formerly HCBC) have extremely limited options to receive community services
		2. Rigid rules for Medicare and Medicaid define what can be paid for by service delivery organizations making potential appropriate services out of reach for those near poverty level for items, products, care, or services that are not covered.
		3. Medicare penalizes hospitals financially if patients return and are re-admitted within “at least” 30 days of initial discharge. Hospitals now hire staff to manage and coordinate the care-giving to avoid “frequent flyers” returning prematurely and repeatedly to the institution.
		4. Seniors are limited to fixed incomes that are often not adequate to purchase needed items that are emergencies and not anticipated. Medicare and Medicaid recipients also are not eligible for some important items not covered by rules. This situation may leave a senior with a compromised choice between heat, rent, food and medicine and put their health at risk.
		5. There is a population of frail elderly that are near poor but not Medicaid eligible who do not have funds or other resources for long term community support.

		6. Round the clock home care is often more expensive than nursing home care and is not readily available and becomes a critical challenge for the senior or family if the individual is not Medicaid eligible.
		7. Visitation to seniors by a social worker is limited by Medicare rules and yet for a senior to remain in the home of a family member, the ability to assess their progress or regress is critical to long term well being for the senior and offers reinforcement and confidence for the family.
		8. Many of our older citizens, especially women have not considered and have not been educated about financial obligations or their personal limitations as they reach later stages in life, often finding themselves without the resources to remain independent.
		9. Seniors are most vulnerable to fraud, often are not fully informed regarding consumer protection and have not had seminars available to them or realize their importance.
		10. Seniors can be financially compromised when their spouse has dementia and inadvertently creates debt. Often the resources in the community to help understand the consequences are non-existent or discovered too late.
		11 Education by local councils on aging, physicians, community congregate meal sites and volunteers is not always offered in a format or information is not delivered in ways that is most suitable to help enlighten the senior or their family on key financial indicators or eligibility criteria.
		12. As Seniors on a limited income without family or a circle of care become frail living in their own home, their finances may limit home care assistance (i.e. VNA) and adequate medical care may be beyond their physical and financial capacity.
		13. Dividend and income taxes primarily impact older retired adults and may reduce their ability to remain in their community because of reduced earnings and higher property taxes.
		14. Barriers to support vulnerable community members are directly related to limited financial resources therefore sidewalks can be installed at federal expense, but community budgets do not support their maintenance and upkeep.
		15. As hospitals and providers maximize profits, lower cost care is sacrificed with a replacement of what had been “in office” care with “out-patient surgery” costing the patient and insurer additional funds.
		16. Confusing regulations exist when a person who qualifies for Medicaid’s QUIMBY program is categorized as not being capable of paying their \$96.00 Medicare premium, but are responsible for \$130.00 Medicaid spend down each month.

		17. Many services are not available for seniors whose income is slightly above the Medicaid limit and a lack of services for those not clinically eligible for Medicaid services further compromise the elder because they need, but can't afford the help that would prevent their deterioration.
		<b>HOUSING</b>
		1. Zoning ordinances that prohibit mother/father-in-law apartments prevent inter-generational living arrangements that could allow the senior to remain in their home and community longer.
		2. Plans for buildings and locations exclusively for seniors, poor seniors or disabled seniors limit their interactions and experiences and can be viewed by a resident as a Senior Ghetto or as a virtual prison.
		3. Elderly women often live alone, live longer and are widowed, without pensions, more at risk, vulnerable and isolated, coupled with health challenges from age 55-64 pre Medicare/Medicaid.
		4. As seniors remain in the aging family home or a smaller house that they move into, it is often not suitable for their circumstances, health and fitness and needs retrofitting and a floor plan or design conducive to safety and ease.
		5. Affordable housing is not readily available for the workforce (including caregivers) and for the 50+ year old workers who will need a home that will be useful and fit their budget in their later years.
		6. In recent years increases in population and zoning ordinances have added pressure and competition for housing opportunities that drive up land values and push development of homes for seniors to more isolated areas which are not ideal as individuals' age and become frailer.
		7. Affordable housing for independent elderly who have modest incomes is not available in most communities because of zoning limits on density.
		8. Short term emergency housing is a rare commodity and in-home emergency service providers are almost non-existent for medical care or supervisory monitoring.
		9. Older adults with mental illness and without relatives who can provide care have few alternatives other than institutionalization.
		10. Condo Association By-laws together with town zoning ordinances prevent in-home care givers to elderly because of marital status/age and unreasonable requests for private medical history which are in violation of law.

		<b>SAFETY</b>
		1. Personal cars used by volunteers or staff to provide transportation for the elderly is seen as a liability by risk averse organizations re adequate insurance coverage and limits ability to convey seniors.
		2. Communities are not aware of the number or severity of at risk frail elderly who do not have mobility or ability to evacuate.
		3. Laws inhibit neighbors helping seniors. RSA: 151 requires licensing all people who provide in home assistance to folks in their homes whether they are doing it for profit or not. Yet the legislature (perhaps of necessity) wants to protect seniors from fraud and the risk of someone unsavory in their homes.
		4. Erosion of infrastructure such as sidewalks, ramps and more potholes increase across the state making it treacherous for the frail who are mobile and creates a fear of falling or a reluctance to venture out.
		5. Street crossings can be slippery when wet, length of crossing light too short and building door openings often do not work or doors are too heavy and can put a senior at risk of falls or other injury.
		<b>SYSTEMS CHANGE</b>
		1. Increased numbers of at risk older adults are not identified early enough in the community to prevent long term and/or permanent nursing home stays.
		2. There is a shortage of respite care beds across the state which prompted a Senate Resolution to implement a review and complete an accurate and needed assessment.
		3. There is limited focus on planning for future needs, lack of coordinated efforts for key initiatives and an increasing population of frail senior citizens in the state who will prefer to remain in their own homes.
		4. State planning organizations are limited in advocacy and preparation for the increased services that will be required to address future needs of seniors.
		5. Some frail elderly reach a point when they do not have the capacity to live alone because they do not have family or neighbors to assist

		them with household or daily activities. Few sanctioned state programs exist that expand long term care options for elders in our communities.
		6. There can be a disconnect when legislation is introduced at the state level is amended and passed becomes the responsibility of the appropriate department and agency that develops the rules for implementation. The result may not accurately reflect the intent of the sponsors/authors or the legislative description or “blurb” and further adds unintended consequences.
		7. Many communities are not aware of limitations and restrictions created by municipalities that increase the possibility of frail elderly falling through the cracks (literally and figuratively).
		8. Financial limits and constraints in difficult economic times may prevent increased funds for frail senior projects or services.
		<b>TRANSPORTATION</b>
		1. Current bus systems are not meeting the needs of seniors who are reluctant to use bus transportation because of fear, discomfort or unfamiliarity.
		2. Seniors and family members complain that in rural areas transportation to locations with activities or appointments in their own and other communities are not available, reliable or convenient.
		3. Seniors with limited income who drive other elderly friends are reluctant to ask for contributions toward gas, parking or other limited upkeep and expenses and consequently create a shortfall in their own budget.
		4. Without adequate transportation that can assure wrap around services for the elderly to access dental, mental health, primary care and a pharmacy, their health will fail and they will no longer be able to remain in their home.
		5. Utilizing a vehicle and driver for Mental Health appointments for several patients to the same doctor with sequenced appointments is not allowed under HIPPA and makes transportation duplicative and more expensive.
		6. For those seniors needing assistance walking who have no family nearby and live at a distance from a surgical center often need to hire an ambulance to take them for follow-up appointments creating costs resulting in thousands of dollars.
		<b>WORKFORCE (paid and volunteer)</b>

		1. Because of rules re scope of practice, professional non-nursing caregivers are limited in administering medications even though a family member or neighbor is not prohibited to do the same.
		2.. Few physicians are choosing to specialize in geriatrics which will leave future elderly without the ideal professional care and limit their ability to remain at home.
		3. Limited number of community services/workforce prevents appropriate nursing home residents from returning to their community, thereby requiring them to stay in the facility (which is more costly and a more restrictive environment).
		4. Home health workers are not eligible for workers compensation insurance for those who are employed in the homes of the elderly or disabled.
		5. Limitations by federal requirements on income levels of the RSVP volunteer are a disincentive and hinder the number of potential recruits eligible for the stipend.
		6. Some home health care workers provide services as "independent" operators who may be "under trained" or are "underground" and do not have access to updated training and courses because of access, conditions, cost and proximity.
		7. Elders with limited mobility often experience isolation because support and companionship are no longer available as friends have passed on and there are limited home care personnel available.
		8. Hiring home care workers is a challenge for family members who wish that their elder parent or spouse can remain at home but are faced with caring for and finding reliable, honest caregivers when they must be away from home.
		9. Because of insurance prohibitions and potential liability, neighbors are reluctant to intervene or to offer to provide assistance or help.
		10. Those (caregivers) who come in contact with seniors are not always attuned to the limitations of the frail elderly such as failing eyesight, level of literacy, language, poor lighting, or need for large print documents.
		11. It is difficult for individuals to hire direct care (for any purpose) and to obtain criminal background checks for prospective providers because of the procedure and the cost.
		12. For both paid and volunteer workers, the cost of fuel and limited reimbursement, car repairs and cost of insurance are deterrents to recruitment for an adequate number of Meals on Wheels drivers with a vehicle from the potential pool available in a community.

		13. Lack of communication or impractical expectations between the State of NH and providers of services as well as among providers are exacerbated by HIPPA rules and interpretations. Use of “labels” among “healthy seniors” who don’t want to be with a CVA elder or DD elder, plus sometimes unrealistic “Yankee Spirit” that fosters “I don’t need help” is also detrimental to serving seniors and complicates the workplace.
		<b>OTHER</b>
		1. Currently a frail elder who possesses a driver's license is not eligible for Meals On Wheels delivery (i.e. a 92 year old gentleman who no longer drives but retains his license)
		2. Frail seniors living alone need support/assistance to safely remain in their home overnight but do not have funds for a paid caregiver. Observations by local professionals (police) during visits see that the only immediate options for supervision such as overnight hospitalization or a homeless shelter are inappropriate.
		3. Seniors who can not drive or can not depend on others can become isolated and not able to access services on their own such a banking, shopping, attending worship services and other medical and social amenities.
		4. There is uneven resolution and determination by the Board of Medicine to the disadvantage of seniors and their family when seniors have been exposed to medical malpractice in the course of being hospitalized and treated.
		5. Termination of older workers occurs for the “legitimate business reason” that they earn too much (or that they require compensation commensurate with their experience).
		6. Failure to hire and promote older workers out of fear they will retire soon anyway or cost too much in insurance premiums is a discriminatory practice.
		7. Senior Centers’ fights happen over building ownership because of value or history.
		8. Medicaid liens potentially prevent seniors with few financial resources from staying in their home.
		9. Older people are invisible to many members of society including businesses and institutions re needs of elders which disadvantages them from numerous aspects of community participation.



**Appendix I – Summary of Priorities**

<b>SUMMARY: Priorities for Seniors Count Policy Initiative</b>	
<b>OVERARCHING GLOBAL ISSUES</b>	<b>Suggested Strategies</b>
To best address regulatory barriers, there are five universal strategies recommended. (see next column).	
	1) Adopt a policy workplan at Council level to oversee SC Policy Initiative, paying attention to Fed, state, county and municipal components of plan.
	2) Recruit to Council reps from fed, state, county and municipal elected officials and other key stakeholders from 'power' sectors such as Planning/zoning commissions, attorneys, developers, etc.
	3) Collaborate with partners and stakeholders to access information, research, and expertise from their advocacy efforts for each of the six identified work plan categories. Consider appointing, selecting or hiring a CHAMPION to advocate on behalf of Seniors Count for each of the six identified workplan categories (see below).
	4) Invite other advocacy organizations to joint us at the table to support our common interests that will remove barriers and improve the long term independence of seniors.

	5) Create communication vehicle (i.e. produce a white paper on specific topics, develop a quarterly e-newsletter, Facebook, my space, linkedin, plaxo, listserv, etc.) that includes the policy makers as participants.
<b>#1 CAREGIVER SUPPORT ISSUES</b>	
Options for <b>respite care</b> , either planned or emergency, are limited when a community caregiver is unable to temporarily provide assistance/care for the frail senior. Too often now, hospitals are the only fall-back even if it is not suitable.	Support the funding of the Federal Lifespan Respite Act; support increased funding for National Family Caregiver Grant; advocate for legislation that improves respite.
<b># 2 COORDINATION OF MEDICAL, SOCIAL/COMMUNITY, AND CAREGIVER ISSUES</b>	
Need for every frail senior to have a ' <b>medical home</b> ' (primary care doctor with care coordinator) and ' <b>social/community home</b> ' (social worker or other resource coordinator) and ' <b>caregiver home</b> ' (support for natural family/other caregiver) because a ) seniors often have multiple chronic health problems that require several specialists and multiple medications but there is not a coordinated comprehensive approach and b) complications of benefits, community resources, etc often necessitate coordinated oversight and c) to avoid or mitigate burnout, premature institutionalization, health issues of caregiver.	Working with the Manchester Public Health Department's MSAP project, consider a pilot that establishes a mechanism whereby frail seniors (to be defined) each will have an agreed upon primary 'Senior Resource Coordinator' responsible for ensuring each has a medical home, caregiver support, and coordination of appropriate services . If there is NO ONE ELSE, then the Community Liaison will be primary UNTIL one is found. CMC, Elliot and Dartmouth will be encouraged to also develop a plan for high risk discharged clients to decrease 'revolving door' issue.

<b># 3 FLEXIBILITY IN POLICY PROCEDURES AND REGULATIONS</b>	
There is a lack of <b>flexibility</b> of rules, regulations and procedures. There are too few <b>options</b> and too many barriers to obtain necessary services.	Sensitize legislators of the importance of the need for flexibility within the statutes/rules/regulations, by encouraging them to 'test' each law against a "checklist" or other guideline that SC co-develops with them.
<b># 4 EDUCATIONAL ISSUES</b>	
Seniors, their families, policy makers and other stakeholders need more <b>education</b> to become aware of the <b>stages of aging</b> , range of <b>choices</b> that can reduce the current risks associated with aging in community, and impact of policy initiatives.	SC education committee takes the lead to convene stakeholders to utilize current and develop other education modules and decide how they will be presented.
<b># 5 LIVABLE COMMUNITIES</b>	
Older people, especially the most frail, are too often invisible to many members of society including businesses and institutions re needs of elders to be part of communities, which disadvantages them from numerous aspects of community participation.	SC will assist Manchester initiate a Community Planning Board as outlined in HB 717; see if SC can have member on that board.

<b># 6 LIMITED RESOURCES OF THE "NEAR POOR"</b>	
The <b>near poor</b> (those just above the financial eligibility for Medicaid's Choices for Independence program, formerly HCBC) have extremely limited options to receive community services.	Enhance neighborhood, family, faith based, intergenerational and community supports, and expand Flex Fund model

**Appendix J – Three-year Workplan**

	<b>Suggested Strategies</b>	<b>Short Term (within the first year)</b>	<b>Intermediate (1-3 yrs)</b>	<b>Stakeholder Teams</b>
<b>OVERALL/OVERARCHING/GLOBAL STRATEGIES</b>				
To best address regulatory barriers, there are six universal strategies recommended. (See next column).				
	1) develop SC policy committee at Council level to oversee SC Policy Workplan, paying attention to Fed, state, county and municipal components of plan.	Use the Policy Committee of the Collaborating Council to expand it's membership; write up goals & objectives; and oversee this workplan	continue overseeing workplan	Collaborating Council members
	2) recruit to Council reps from fed, state, county and municipal elected officials and other key stakeholders from 'power' sectors such as Planning/zoning commissions, attorneys, developers, etc	Invite current Council members to recommend specific people from categories needed to cover those areas of seniors issues focused on in this workplan	ensuring proper balance on Council	Collaborating Council members
	3) appoint or select or recruit or hire a CHAMPION to advocate/promote for each of the six identified workplan categories (see below)	Council will determine the qualities of a leadership for each workplan categories, and suggest names. Recruit champion for each category. Also, consideration will be given to hiring lobbyist if funds are available. Determine role/responsibilities of champion(s) including recruiting Seniors Count partners to help.	regular reporting back to Council from Champion(s).	Collaborating Council members
	4) Help Manchester initiate a Community Planning Board as outlined in HB 717; see if SC can have member on that board.	Educate SC Collaborating Council on role and necessity of Community Planning Board. Determine Champion/liaison	regular reporting back to Council	staff with Council member(s)

		with board.	about Board activities	
	5) Invite other advocacy organizations to joint us at the table to support our common interests that will remove barriers and improve the long term independence of seniors.	Consider Summit (maybe at the June 09 Symposium) to education other advocates and invite them to join us to actualize our workplan (or parts of it) if it is compatible with their mission.	Bring advocates in on the specific Seniors Count policy workplan area of their interest.	staff with Council member(s)
	6) Create communication vehicle (i.e. Facebook, my space, linkedin, plaxo, listserv, etc.) that includes the policy makers as participants	Do exploration, determine which (if any) communication vehicle we will use to facilitate the workplan goals and strategies	Implement communication strategy	staff with Council member(s)
<b>#1 CAREGIVER SUPPORT ISSUES</b>				
Options for <b>respite care</b> , either planned or emergency are limited when a community caregiver is unable to temporarily provide assistance/care for the senior. Too often now, hospitals are the fall-back even if it is not suitable or necessary.	Support the funding of the Federal Lifespan Respite Act; support increased funding for National Family Caregiver Grant; advocate for legislation that improves respite.	meet with DHHS to explore if respite qualifies for the stimulus funds or if there are other sources; ask how we can accomplish goals of law w/out funding; partner w them to encourage Fed to fund. Council write letter that endorses specific initiatives to improve caregiver support.	Determine emerging issues around caregiver support	staff
a. Improving access to emergency and short term respite services. See example of barriers below that we want to mitigate:	request that DHHS ask for a waiver for emergency and planned short nursing home stay process	Present idea(s) to Joint Committee on Elderly Affairs to then work with DHHS-BEAS to explore alternatives;	work with state to implement	staff and Council member(s)

- cannot get timely commitment from facilities for planned respite	see above			
- Procedures/protocols make it hard to get in quickly for emergency respite	see above			
- There is a shortage of the variety of needed respite care options	see above			
b. Frail seniors may be getting insufficient and/or unsafe care or premature admission to nursing facility because working caregivers cannot afford losing income to remain at home to take care of their frail loved one.	Research plans that would encourage families (both financially for possible lost wages, and other) for taking care of frail elders.	Present idea(s) to Joint Committee on Elderly Affairs; lobby representatives to bring forth national bill explore alternatives;	work with state to implement	staff and Council member(s)
<b># 2 MEDICAL HOME &amp; SENIOR RESOURCE COORDINATION</b>				
Need for every frail senior to have a ' <b>medical home</b> ' (primary care doctor) and ' <b>Senior Resource Coordinator</b> ' (care coordinator) because a ) seniors often have multiple chronic health problems that require several specialists and multiple medications but there is not a coordinated comprehensive approach and b) complications of benefits, community resources, etc often necessitate coordinated oversight. Examples of 'problems' in this area include:	Pilot in Manchester - for level 1 frail seniors, each will have an agreed upon primary 'Senior Resource Coordinator' responsible for ensuring each has a medical home, and coordinating appropriate services . If there is NO ONE ELSE, then the Community Liaison will be primary UNTIL one is found. CMC, Elliot and Dartmouth will also develop plan for high risk discharged clients to decrease 'revolving door' issue.	Assemble stakeholders to further articulate the plan and identify possible sources of funding.	write grant	BEAS or CFI worker, Elliot Senior Health worker, mental health worker, Dartmouth Hitchcock worker, Medical Community Center worker, VA worker, hospice worker, VNA worker or other
a. Medicare penalizes hospitals financially if patients return and are re-admitted within “at least” 30 days of initial discharge. Hospitals now hire staff to manage and coordinate the care-giving to avoid “frequent flyers” returning prematurely and repeatedly to the institution.	see above			

b. Visitation to seniors by a social worker is limited by Medicare rules. Yet for a senior to remain in the community, they need to have their degree of functionality and progress assessed regularly because it is critical to the long term well being for the senior and offers reinforcement and confidence for the family.	see above			
c. Increase number of at risk older adults is not identified early enough and followed/supported by care management in the community to prevent long term and /or permanent nursing home stays.	see above			
d. As seniors age it is highly probable that their deteriorating health will require additional prescriptions but without information and training regarding the wise use of medicine they may not be aware of dangerous medical interactions that could threaten their life.	see above			
<b># 3 FLEXIBILITY IN POLICY, PROCEDURES AND REGULATIONS</b>				
There is a lack of <b>flexibility</b> of rules, regulations and procedures. There are too few <b>options</b> to obtain necessary services. See below examples:	To sensitize legislators of the importance of the need for flexibility within the statutes/rules/regulations, by encouraging them to 'test' each law against a "checklist" or other guideline that SC co-develops with them.	Create team through the Joint Committee on Elderly Affairs and reps from SC to create and 'test' a pilot checklist. Work with Joint Committee on Legislative Rules to develop a process in assuring that intent of the legislature is carried out by those making the rules; invite Maurice Pilotte, Rip Holden and Peter Schmidt incorporate into checklist a way to assure legislative intent.	pilot checklist and evaluate its effectiveness	SC reps and legislators;
a. Rigid rules for Medicaid define what can be paid for by service delivery organizations making potential appropriate services out of reach for those	In Manchester, making sure the Flex Fund is robust enough to cover critical, non-repetitive needs	Continue working with Mary Gale Foundation, and raising funds for those who do not fit	share with Nashua and Portsmouth	Staff and Council members

<p>near poverty level for items, products, care, or services that are not covered.</p>	<p>for all frail seniors falling through the cracks, and share lessons learned with the state.</p>	<p>their criteria; present findings of the Flex Fund to DHHS, BEAS, and brainstorm with them how extensive the problems are and how costly these problems can be.</p>	<p>and the state</p>	
<p>b. There can be a disconnect when legislation is introduced at the state level is amended and passed becomes the responsibility of the appropriate department and agency that develops the rules for implementation. The result may not accurately reflect the intent of the sponsors/authors or the legislative description or “blurb” and further adds unintended consequences.</p>	<p>see above re: checklist development</p>			<p>SC reps and legislators;</p>
<p>c. Laws inhibit neighbors helping seniors. Example 1) RSA: 151 requires licensing all people who provide in home assistance to folks in their homes whether they are doing it for profit or not, discouraging 'good citizens' from helping others. Example 2) It is difficult for individuals to hire direct care (for any purpose) and to obtain criminal background checks for prospective providers because of the procedure and the cost. Example 3) For both paid and volunteer workers, the cost of fuel and limited reimbursement, car repairs and cost of insurance are deterrents to recruitment for an adequate number of Meals on Wheels or other volunteer drivers with a vehicle from the potential pool available in a community. Example 4) Because of insurance prohibitions and potential liability, neighbors are reluctant to intervene or to offer to provide assistance or help. We understand the legislative intent is to protect seniors from fraud etc, however an unintentional consequence of the law is it limits 'pool' of pool potential helpers.</p>	<p>Make request of Rep Schulze if the Joint Committee on Elderly Affairs could work w/ SC and DHHS staff to start the critical dialogue of safety vs. risk vs. number of people (volunteer and paid) that will be needed to care for frail seniors. Enabling legislation to allow an oversight organization to have a prudent person disclaimer that says I looked over the neighbors' qualifications and it seems like it is ok. Objective: we should be encouraging neighbor helping neighbor!</p>	<p>Seek potential sponsors to support efforts of Joint Committee. Encourage Manchester legislators and other area communities to consider this as a priority.</p>	<p>Work with Nashua and Portsmouth to work with local legislators to support this effort</p>	<p>SC reps and legislators;</p>

d. Because of rules re scope of practice, professional non-nursing caregivers are limited in administering medications even though a family member or neighbor is not prohibited to do the same.	Support adding an amendment to the HB that expands who can qualify people for CFI that would allow non-nurses professionals to administer medications.		If amendment isn't successful, then work to introduce bill in 2010 session	SC and sponsors for current bill: Ricia McMahon (Sutton) and Susan Butcher (Keene)
e. There is an array of transportation issues.	Have SC liaison on state transportation initiatives and support those that we agree with.			staff and Council member(s)
<b># 4 EDUCATIONAL ISSUES</b>				
Seniors, their families, policy makers and other stakeholders need more <b>education</b> to become aware of the <b>stages of aging</b> , range of <b>choices</b> that can reduce the current risks associated with aging in community, and impact of policy initiatives. Examples include:	SC education committee takes the lead to convene stakeholders to develop education modules and decide how they will be presented.	Add to Seniors Count Education Committee; convene meeting with Stakeholders; set goals/objections and tasks.	implement education	Examples of stakeholders include: SCOA, EnGaging NH, Area Agencies on Aging, CAP, Senior Center Association, hospital community wellness initiatives, hospice movement, Alz. Association, etc.
a. Seniors who are not informed early enough in their working careers about saving vehicles that are needed to prepare ahead for the costs of health care	see above			

and living accommodations are at risk of falling short of enough funds for long term care in their retirement years.				
b. Confusing Medicare Part D rules are not fully understood by recipients or their families and often surprise seniors who anticipate coverage for prescription drugs to last longer.	Communicate with members of Congress to advocate for streamlining and simplifying the prescription drugs insurance program	create and send letter to Senators/Congressman;	follow up letter and track voting records	staff and Council member(s)
c. Many of our older citizens, especially women have not considered and have not been educated about financial obligations or their personal limitations as they reach later stages in life, often finding themselves without the resources to remain independent.	Include state treasurer (Katherine Provencher) and women's lobby and other women's advocacy groups in education discussions			
d. Seniors are most vulnerable to fraud, often are not fully informed regarding consumer protection and have not had seminars available to them or realize their importance.	Include input from Mayor, police chief and Weed and Seed initiative to get partners spreading the word on crime issues that affect seniors. Consult with the Attorney General's office and Senior Law Project.			
f. Legislators and other policy makers do not always have timely or complete information to assist them in creating laws that benefit seniors without unintended consequences.	SC conducts regular seminars for legislators (beginning with local) on senior issues so they can be best prepared to create appropriate legislation. Partner with the Joint Committee on Elderly Affairs to accomplish.	Local meeting: Complete before 2009 Leg session is to include discussion of stimulus funding	Statewide: once a year, The Joint Committee on Elderly Affairs sponsors an information session on issues critical to seniors where SC presents.	staff and Council member(s) and Education Committee

g. Misunderstandings and misinterpretations of the HIPPA laws have resulted in the inability to offer some services completely, efficiency, and in a coordinated manner.	From Bar Association or other legitimate source, obtain information about HIPPA, what it is and what it isn't.	Encourage State Conference on Aging to hold session their next year's annual meeting.		staff
<b># 5 LIVABLE COMMUNITIES</b>				
Older people, especially the most frail, are too often invisible to many members of society including businesses and institutions re needs of elders to be part of communities, which disadvantages them from numerous aspects of community participation.	SC will assist Manchester initiate a Community Planning Board as outlined in HB 717; see if SC can have member on that board.	SC can utilize this planning process and provide a member of the Council to give updates and can provide guidance as to current trends and alternatives	SC will encourage Nashua and Portsmouth to beginning planning process and SC will serve as a resource	staff, regional planning commission
a. Limited knowledge and unfamiliarity of local Planning Boards about issues concerning frail elderly makes it likely that vital information will not be considered in order to support necessary changes to local ordinances/regulations that promote seniors remaining active and part of their communities.	SC appoint person(s) to be on planning board(s) or to observe planning board meetings. Then develop process of how and where to best influence the planning agenda. Invite the head of Regional Planning Commission (David Preece) to join the SC Council, and work to develop checklist of items Planning Boards need to consider when working on a project.	SC can utilize this planning process and provide a member of the Council to give updates and can provide guidance as to current trends and alternatives	SC will encourage Nashua and Portsmouth to beginning planning process and SC will serve as a resource	staff, regional planning commission
- State planning organizations have limited knowledge base re: impact of senior demographics to prepare for the increased services that will be required to address future needs of seniors.	At presentation by SC to Legislators, discuss the need for coordinated, mindful understanding within the state planning process about senior issues now and into the future.	SC will support Joint Committee on Elderly Affairs in effort to provide information about planning opportunities at the community level and SC Council members can serve as a resource		staff and Council member(s)

<p>b. <b>Zoning</b> ordinances do not encourage inter-generational, multi-use neighbors that could allow the senior to remain in their home and community longer.</p>	<p>Work with zoning board members and other planning organizations to educate them on senior issues; develop strategies that allow us to have more influence on them.</p>	<p>Present at Conferences to motivate and educate zoning boards and planning boards; provide information for municipal efforts that include consideration of senior housing</p>	<p>Provide success stories of municipalities that considered the need re elderly remaining near family; expand information to area communities and Nashua &amp; Portsmouth</p>	<p>staff and Council member(s)</p>
<p>- As seniors remain in the aging family home or a smaller house that they move into, it is often not suitable for their circumstances, health and fitness and needs retrofitting and a floor plan or design conducive to safety and ease.</p>	<p>Promote concept of Universal Design (UD) for all new housing and re-habilitated structures. Statutes should be considered in order to promote the immediate adoption of UD</p>	<p>Work with architects, developers, planners, and senior advocates to promote building permits to include UD as a criteria for building new or updating/modifying</p>	<p>Potential tax incentives or tax breaks to developers and property owners when UD is incorporated</p>	<p>staff and Council member(s)</p>
<p>- In recent years increases in population and zoning ordinances have added pressure and competition for housing opportunities that drive up land values and push development of 55+ housing to more isolated areas which are not ideal as</p>	<p>Encourage planning organizations to learn about senior housing located in more central areas of the community that have economic benefits</p>	<p>Planners and builders as well as senior advocates need to encourage alternatives to the current trend</p>		<p>staff and Council member(s)</p>

individuals' age and become frailer.				
- Impact of insufficient/inferior infrastructure (such as sidewalks, ramps and potholes, non-ADA compliance, etc) that makes it treacherous for the frail who are mobile and creates a fear of falling or a reluctance to venture out.	Mayors, alderman, planners, senior advocates and stakeholders must be educated to the hazards that frail elders face as they navigate their communities	Communities may consider making repairs by using funds from the stimulus grants		staff and Council member(s)
- There is limited focus on planning for future needs, lack of coordinated efforts for key initiatives and an increasing population of frail senior citizens in the state who will prefer to remain in their own homes.	SC should work with DHHS-BEAS to expand commitment to incorporate programming to assist with daily living activities in order for frail elderly to remain at home.	Consider financial incentives for caregivers or expand external assistance		staff and Council member(s)

<b># 6 LIMITED RESOURCES OF THE NEAR POOR</b>				
The <b>near poor</b> (those just above the financial eligibility for Medicaid's Choices for Independence program, formerly HCBC) have extremely limited options to receive community services. Examples below:	Enhance neighborhood, family, faith based, intergenerational and community supports. Consider expansion of Flex Fund model.	Work with legislators and DHHS to explore waivers and review eligibility	Support community alternatives	staff and Council member (s)
a. Seniors with limited fixed incomes often do not have adequate means to purchase needed items that are emergencies and/or unanticipated (and Medicare and Medicaid do not cover many necessary items or services). This situation may leave a senior with a compromised choice between heat, rent, food and medicine and put their health at risk.	see above	More flexibility is needed to accommodate the unanticipated needs of seniors by creating local support and advocates to cover the need		staff and Council member (s)
b. There is a population of frail elderly that are near poor but not Medicaid eligible who do not have funds or other resources for long term community support.	see above	Consideration to "foster families" or other alternatives such as "circles of care" need to be promoted; explore funding options for these alternatives	Reverse Rent could be considered via community loan contributions toward local seniors	staff and Council member (s)
c. Many services are not available for seniors whose income is slightly above the Medicaid limit and a lack of services for those not clinically eligible for Medicaid services further compromise the elder because they need, but can't afford the help that would prevent their deterioration.	see above	Advocate with Members of Congress as to the extent of this problem and the rigidity of rules		staff and Council member (s)

**Appendix K – Project Workplan**

**Project Goal Statement:** Improve the policy, regulatory and funding factors to benefit at-risk seniors and improve long-term care systems.

**Outcome #1:** Increase knowledge about unmet needs, service gaps, and barriers to access related to frail seniors.

**Preliminary Outcome Evaluation:** Report with detailed analysis and recommendations for action will be prepared and disseminated.

Activity	Inputs	Timeframe	Responsible Person	Anticipated Outputs	Progress Reporting
Conduct thorough analysis of regulatory environment re: policies, rules, regulations, statutory laws, and funding restrictions that act as barriers to service.	Seniors Count Collaborative Council (SCCC), Seniors Count Coordinating Committee (SCCCom), Seniors Count Administrative Work Group (SCAWG), ServiceLink Resource Center (SLRC), NH Division of Health and Human Services (DHHS), Bureau of Elderly and Adult Services (BEAS), Nursing/Social Workers/Pharmacy Boards, Center for Medicare/Medicaid Services (CMS), US Administration on Aging (AOA), Manchester City Welfare, etc.	11/07 – 9/08	R McMahon	Analysis conducted	COMPLETED. Federal & State laws, rules and regulations were discussed with professionals and administrators of programs, staff of service delivery systems and leaders in various senior related organizations. Categorization of the shared concerns re obstacles and any unique perspectives in a format to aggregate the results and compile the suggestions are assembled.
Prepare and disseminate report.	SCAWG	May 2009	A Kershaw	1) Report to Endowment 2) Summary Report to Community	1) Completed 2) To be distributed 6.18.09 @ Symposium

**Outcome #2:** Increase knowledge about the Seniors Count philosophy and issues of life long aging among selected local, regional and state political leaders.

**Preliminary Outcome Evaluation:** Increased attention paid to seniors’ issues in community planning activities.

Activity	Inputs	Timeframe	Responsible Person	Anticipated Outputs	Progress Reporting
Create Fact Sheet and distribute as appropriate.	SCAWG	6/08-9/08	R McMahon	Fact Sheet prepared.	Completed

Activity	Inputs	Timeframe	Responsible Person	Anticipated Outputs	Progress Reporting
Convene Seniors Count information breakfast with up to 30 Manchester area political leaders to advocate for seniors issues on planning agendas.	SCAWG SCCC, SCCCom	8/08-10/08	R McMahan	Compelling message delivered.	Completed
Convene Seniors Count information breakfast with up to 12 regional and state political leaders to advocate for seniors issues on planning agendas.	SCAWG SCCC, SCCCom	9/08-10/08	R McMahan	Compelling message delivered.	Completed

**Outcome #3:** Increase collaborations with Social Service agencies.

**Preliminary Outcome Evaluation:** Consensus established on list of selected regulatory barriers targeted for improvement.

Activity	Inputs	Timeframe	Responsible Person	Anticipated Outputs	Progress Reporting
Conduct 2 two-hour seminars to open dialogue around regulatory barriers that impede access to services. Prioritize issues for consideration of actions.	SCAWG. SCCC, SCCCom	6/08-10/08	R McMahan	List of priority issues.	Completed (done at Seniors Count Council and Committee meetings.

**Outcome #4:** Increase knowledge about funding issues and ways to increase funding for frail seniors.

**Preliminary Outcome Evaluation:** Detailed plan to increase revenues in selected funding streams prepared.

Activity	Inputs	Timeframe	Responsible Person	Anticipated Outputs	Progress Reporting
Conduct panel discussion with up to 35 people re: funding barriers that impede access, and identify opportunities to increase access to services.	SCAWG, SCCC, SCCCom, DHHS	06/08-10/08	R McMahan	Panel discussions completed.	Not accomplished (focused on barriers instead of funding)
Create plan for increasing funding, using reports generated during RWJ/CPFOA development grant, and other information gathered...	SCAWG Project data	06/08-10/08	R McMahan	Plan formulated.	Not accomplished (focused on barriers instead of funding)

## VII. Endnotes

- <sup>i</sup> Source: Thompson, L., *Long-term care: Support for family caregivers [Issue Brief]*. Washington, DC: Georgetown University, 2004.
- <sup>ii</sup> Source: National Family Caregivers Association, *Random Sample Survey of Family Caregivers, Summer 2000*.
- <sup>iii</sup> Source: U.S. Department of Health and Human Services, *Informal Caregiving: Compassion in Action*. Washington, DC: 1998, and National Family Caregivers Association, *Random Sample Survey of Family Caregivers, Summer 2000, Unpublished*.
- <sup>iv</sup> Source: National Alliance for Caregiving and AARP, *Caregiving in the U.S., 2004*. Non-paid caregivers.
- <sup>v</sup> Source: U.S. Department of Health and Human Services, *The Characteristics of Long-term Care Users*. Rockville: Agency for Healthcare Research and Quality, 2001.
- <sup>vi</sup> Source: Elissa S. Epel, Dept of Psychiatry, Univ of Calif, SF, et al, *From the Proceedings of the National Academy of Sciences, Dec 7, 2004, Vol 101, No. 49*.
- <sup>vii</sup> Source: Health and Human Services, *Informal Caregiving: Compassion in Action*. Washington, DC: Department of Health and Human Services. Based on data from the National Survey of Families and Households (NSFH), 1998 and the National Family Caregivers Association, *Random Sample Survey of Family Caregivers, Summer 2000, Unpublished* and National Alliance for Caregiving and AARP, *Caregiving in the U.S., 2004*.
- <sup>viii</sup> American Network of Community Options and Resources, NH Fact Sheet.
- <sup>ix</sup> Beyond 50.05, A Report to the Nation on Livable Communities Creating Environments for Successful Aging, 2005.
- <sup>x</sup> Community Chest: *Maintaining Mobility...Keeping the Connection*, May 2007.
- <sup>xi</sup> *Generations Journal of the American Society on Aging, Aging Policy and the States*, Fall 2008.