



# **New Hampshire Vocational Rehabilitation**

## **2019 Comprehensive Statewide Needs Assessment**

July 2020



**Submitted to:**

New Hampshire Bureau of Vocational Rehabilitation

**Prepared by:**

Human Services Research Institute

[www.hsri.org](http://www.hsri.org)

July 2020

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# Glossary of Common Terms

<b>Acronym/Abbreviation</b>	<b>Definition</b>
AARP	American Association of Retired Persons
ABLE	Advocates Building Lasting Equality
ACS	American Community Survey
ASD	Autism Spectrum Disorder
ASL	American Sign Language
BBH	Bureau of Behavioral Health
BDS	Bureau of Developmental Services
CAP	Client Assistance Program
CDC	Centers for Disease Control and Prevention
CRP	Community Rehabilitation Program
CSNA	Comprehensive Statewide Needs Assessment
DBEA	Department of Business and Economic Affairs
DD	Developmental Disability
DDS	Disability Determination Services
DHHS	Department of Health and Human Services
DoE	Department of Education
EBP	Evidence Based Practice
FG	Focus Groups
FY	Fiscal Year
HSRI	Human Services Research Institute
ELC	Employment Leadership Committee
ETS	Employment Transition Services
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IPE	Individualized Plan for Employment
IPS	Individual Placement and Support
KII	Key Informant Interviews
MA	Massachusetts
ME	Maine
MSD	Most significant disability
MOU	Memorandum of Understanding
N	Sample size
NH	New Hampshire
NHES	New Hampshire Employment Security
NHVR	New Hampshire Bureau of Vocational Rehabilitation
OOS	Order of Selection
PTE	Pre-transition employment
RCC	Regional Coordination Council for Community Transportation
RSA	Rehabilitation Services Administration
SBVI	Services for the Blind and Visually Impaired
SDHH	Services for the Deaf and Hard of Hearing

<b>Acronym/Abbreviation</b>	<b>Definition</b>
SAC	State Advisory Committee on the Education of Students with Disabilities
SCC	State Coordinating Council for Community Transportation
SD	Significant disability
SOP	Standard Operating Procedures
SRC	State Rehabilitation Council
TRIP	Transportation Reimbursement and Information Program
UNH	University of New Hampshire
US	United States
VR	Vocational Rehabilitation
VT	Vermont
WIOA	Workforce Innovation and Opportunity Act
WONDER	Wide-ranging ONline Data for Epidemiologic Research

# Executive Summary

## Introduction

To achieve the aim of ensuring that all New Hampshire citizens are empowered to achieve their employment goals, New Hampshire Vocational Rehabilitation supports people with disabilities to explore their career and employment opportunities, as well as prepare for, enter, advance in and/or maintain employment.

Title IV of the Workforce Innovation and Opportunity Act (WIOA) requires each state vocational rehabilitation agency conduct a Comprehensive Statewide Needs Assessment (CSNA) every three years. This CSNA describes the rehabilitation needs of individuals with disabilities residing within the State, particularly their vocational rehabilitation needs, investigates the need for rehabilitation services for specific populations in the state, identifies opportunities for further service development, and provides recommendations for system improvement across all agencies that provide services and supports to New Hampshire residents needing vocational rehabilitation services.

## Methods

The CSNA relied on a mixed-methods approach that combines insights from qualitative and quantitative data sources. Quantitative data sources included the United States Census Bureau's *American Community Survey* (ACS) and case-level data submitted to the Rehabilitation Services Administration (RSA). Results of qualitative data analyses from Key Informant Interviews (KII) and Focus Groups (FG) are also presented to offer first-person perspectives on the state rehabilitation system's strengths, service gaps, barriers to accessing services and suggestions for improvement.

## Summary of Results

This section provides a brief overview of the study's key results. More detail on the results is presented in the body of the report.

## Quantitative Analysis Results

The quantitative analyses addressed the following assessment questions:

1. Characteristics of New Hampshire residents with disabilities in comparison to neighboring states and the nation as a whole.

These comparisons are based on data from the *American Community Survey*, 2013-2017 five-year estimates.

- 47.1% of New Hampshire residents with disabilities age 18 or older are in the labor force, meaning they are either employed or are actively



looking for work. This figure is higher than the national level (41.4%) and the highest compared to neighboring states

- In New Hampshire 42.0% of people with disabilities age 16+ are gainfully employed, higher than the national level (35.5%) and the highest among the comparison states
- The unemployment rate among New Hampshire residents with disabilities age 18+ was 11.0%, slightly higher than the national figure (14.2%), though the lowest in the region
- Within New Hampshire, the median earnings among workers with a disability is \$22,893, slightly lower than the nation as a whole (\$22,274) while New Hampshire workers with no disabilities earn over \$4,000 more than their national counterparts (\$37,511 and \$32,924, respectively)
- In New Hampshire, 27.3% of people with disabilities live below 150% of the federal poverty threshold, compared to 34.5% of the national population with disabilities
- Among New Hampshire residents age 16+, there is a 15.2 percentage point difference in the prevalence of poverty—defined as living below 150% of the federal poverty threshold—between those with and without a disability. In the nation as a whole, the gap is 12.4 percentage points

## 2. What are the characteristics of NHVR’s participants?

For the analyses of NHVR participants, we used case data maintained by NHVR in compliance with the grant requirements of the Rehabilitation Services Administration (RSA), briefly called the RSA 911 database. For more information on the dataset and methodology, see the section titled “Methodology” in the body of the report.

- Close to two fifths (39.4%) of the NHVR sample was under age 21, while 60.7% was above 21.
- 29.3% of the sample were students with disabilities
- 55.1% of the sample was male
- 91.6% of the sample was White, non-Hispanic
- Over half (55.0%) of the NHVR sample lived in either Hillsborough, Merrimack or Rockingham counties
- A third (33.6%) of the sample had a primary impairment classified as “cognitive.” This is by far the largest participant group, followed closely

by “psychosocial” as the primary impairment (30.5%).<sup>1</sup> All other categories that were included in the sample each constituted less than 10% of the sample

3. How do the characteristics of NHVR’s service participants compare with the state’s overall population with disabilities?

- 6.6% of the state’s residents with disabilities is either non-white and/or of Hispanic origin; the corresponding percentage is 8.4% within the RSA sample. That is, the minorities are slightly “overserved,” suggesting overall success in reaching the state’s minority residents with disabilities. However, 13.9% of the students with disabilities in New Hampshire are either non-white or Hispanic or both, the corresponding figure in the RSA sample is 10.8%. That is, minority students with disabilities are slightly underserved by NHVR’s services, compared to their White, non-Hispanic peers
- About half of the state’s residents with disabilities is female (between 49.7% and 50.5%), compared to only 44.9% of the RSA sample. This indicates that women with disabilities may be less likely to apply for vocational rehabilitation services than are their male counterparts
- Rockingham County is noticeably underrepresented in the sample of participants. On the other hand, participants from Cheshire were slightly overrepresented in our sample compared to the county’s share in the state’s population with disabilities
- Cognitive impairments were more prevalent in the RSA sample than in the overall New Hampshire population with disabilities (42.2% compared with 37.5%)

4. How did the recent Order of Selection (OOS) impact the service system?

Please note: At the time of writing, all applicants on the OOS waiting list had been released into services.

- The OOS introduced a three-category waiting list based on the significance of the applicant’s disability. In line with federal regulations, those with the most significant disabilities (Category 1) were released from the list first, followed by the second and third categories.
- Of the 985 participants who exited the waiting list before the end of June 2019, 227 (23.0%) waited less than 100 days, 562 (57.1%) waited between 100 and 300 days, and 196 (19.9%) waited more than 300 days.

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<sup>1</sup> Full definitions of impairment categories used in the report are provided in Exhibit 13.

- Before the OOS, applicants waited an average of 38 days to have their eligibility determined. After the OOS went into effect, this period increased to 47 days
5. What were the education and employment outcomes of NHVR’s participants with closed cases?
- The average weekly earnings of employed participants was \$408.28 at IPE determination and \$381.79 at exit. The decrease is likely due to the relatively lower starting wages of newly-employed participants who had been unemployed at IPE determination but employed at exit
  - Using a definition of “successful employment outcome” that includes attaining employment, increasing earnings or maintaining earnings, majority (54.2%) of the closed cases qualified as successful closures
  - Likelihood of success significantly increased by age ( $p < 0.001$ ). Compared to 33.9% of participants ages 18 – 21, those ages 22 – 24 had a 56.7% success rate. This figure is slightly lower for the 25 – 49 age group (54.8%) but steadily increases through older ages to reach 72.3% in the 65+ age group
  - The rate of successful employment outcome significantly decreased as the extent of disability increased ( $p < 0.001$ ). The success rate was 48.4% for cases associated with the most significant disabilities, compared to 58.1% of cases assessed as “significant”
6. How will New Hampshire’s population with disabilities change through 2025?

The methodology used to determine these estimations is detailed in the body of the report.

- In 2017, the state’s total population with disabilities was estimated to consist of 83,940 New Hampshire residents ages 18 through 64. This number is predicted to 93,273 in 2020 and 93,432 in 2025

## Qualitative Analysis Results

The collection of primary data through key informant interviews and focus groups provided an opportunity to understand the vocational rehabilitation needs of individuals with disabilities across the state from the perspective of system participants, family members of participants and other key stakeholders. For more information on qualitative analysis methods, please see the body of the report.

Insight collected during key informant interviews and focus groups included:

- There is a need for more accessible transportation options across the state, particularly in the northern regions and other rural areas

- Service system participants, families, NHVR regional office staff, and Community Rehabilitation Programs (CRPs) all mentioned the need for staff stability within the statewide service system.
- Multiple informants noted the need for more rehabilitation service providers trained to work with specific populations such as people with complex disabilities, people with behavioral health issues, deaf participants and older adults with vision impairments.
- Students with disabilities and transition-age youth need better access to Pre-Transition Employment Specialists or Transition Specialists across the state and smoother transition between services and supports provided by the school system and the statewide vocational rehabilitation system
- Respondents noted that the availability of employment opportunities for rehabilitation service system participants varies widely across the state; rural areas have especially limited opportunities
- Informants noted the need for better communication within the service system. Informants stated that communications from the central office and regional offices tended to be complex and use high-level language. A similar observation was noted in reference to forms and required paperwork
- Informants shared that communications aren't always disseminated consistently to the rehabilitation service population and other stakeholders
- Qualitative analysis results suggest that the Governor's Commission on Disabilities, Client Assistance Program (CAP), a crucial resource for service participants, is underused. Informants reported that CAP needs to be better known and understood by participants and their families
- Informants noted a need to simplify and streamline the rehabilitation system's intake process and to disseminate information in plain language about the services available through each partner agency within the statewide rehabilitation system.
- Informants pointed out that more information/data sharing is needed between rehabilitation service system state agency partners. Protocols for interagency collaboration could be enhanced and standardized.
- According to informants, underserved groups include people living in rural areas and in the northern regions, low-income household members with disabilities, people who are deaf, people with complex and/or co-occurring disabilities, people with Autism Spectrum Disorder, and people with behavioral health issues

## Discussion and Recommendations

The CSNA concludes with recommendations for addressing some of the results of the quantitative and qualitative analyses. For full descriptions of these recommendations, please see the body of the report. Recommendations include:

- Strategies to reduce the travel burden on participants and their families which includes reducing the number of trips they need to make to access, fill-out, deliver paperwork, reducing the need for in-person meetings, etc.
- Strategies to increase the availability of transportation opportunities in rural areas
- Explore the effectiveness of current work-based learning experiences and potential to expand on these as well as to develop additional work-based learning opportunities
- The implementation of a workforce data collection effort to gather data on the rehabilitation service system workforce to help identify strategies to maintain and support a stable rehabilitation service system workforce
- A re-examination of training curricula for counselors and coaches
- A redesign of NHVR communication from the central office and the regional offices. The method for the dissemination of communications should also be re-examined
- Memoranda of understanding between NHVR and collaborating bureaus such as Bureau of Developmental Services, Local School Districts, Bureau of Behavioral Health, Office of Workforce Opportunity, etc.
- Enhancing the presence of rehabilitation service system representatives such as transition specialists in school districts in order to ensure that more students and families are aware of the rehabilitation service system and the supports it provides
- The exploration of strategies to expand the statewide service system's reach to currently underserved populations through outreach and community education initiatives

# Introduction

## New Hampshire Bureau of Vocational Rehabilitation

New Hampshire's Bureau of Vocational Rehabilitation is a public state agency housed within the Department of Education's Division of Workforce Innovation. At the federal level, Vocational Rehabilitation state grants are administered by the Rehabilitation Services Administration (RSA) in the Department of Education.

The mission of the Bureau of Vocational Rehabilitation (NHVR) is "to assist eligible New Hampshire citizens with disabilities secure suitable employment and financial and personal independence by providing rehabilitation services." (New Hampshire Department of Education, 2019).

To achieve the goal of ensuring that all NH citizens are empowered to achieve their employment goals, NHVR supports services such as (but not limited to) diagnostic testing, transition from school to work, assistive technology, and supported employment. NHVR also manages Services for the Blind and Vision-Impaired (SBVI) and Services for the Deaf and Hard of Hearing (SDHH). NHVR has six regional offices in Berlin, Keene, Concord, Manchester, Nashua and Portsmouth. These offices provide counseling and referrals and collaborate with other state agencies such as school districts, the ten (10) Area Agencies of the Bureau of Developmental Services, the ten (10) mental health centers and New Hampshire Employment Security (12 offices) to ensure continuity of services.

## Description of the NHVR Process

To be eligible for NHVR's services, one must (1) have a physical or mental impairment that (2) creates an impediment to employment and (3) require "VR services to become employed or to stay employed." (New Hampshire Department of Education, 2019).

Everyone who applies for or is referred to services are first assessed and, if found eligible for services, works with a counselor to determine an employment goal and a corresponding Individual Plan for Employment (IPE). The IPE is tailored to each participant and may include services such as guidance and counseling, training, education, job search, job placement, assistive technology, and supported employment.

NHVR provides services to students with disabilities with or without the need for a formal application and eligibility assessment process. For these students, NHVR works with the local education agency (the school district) during the transition process (starting as early as age 14). Some examples of services provided to students determined eligible are:

- Career guidance counseling;

- Counseling on the impact of disability on employment in order to develop tactics to circumvent limitations;
- Job seeking skills development;
- Job placement services (after the student's school hours) that support their academic program;
- Job keeping skills development;
- Advocacy for students with adult service agencies;
- Information and referral to appropriate community services;
- College planning;
- Providing information regarding classes which will support career pathway;
- Consultant resources regarding Registered Youth Apprenticeship (New Hampshire Department of Education, 2019)

In May 2018, NHVR entered into an Order of Selection (OOS) following an examination of the financial status of the bureau. Under the Order of Selection, all new applicants without Individual Plans for Employment (IPEs) are added to a waiting list to access future services. The order in which people are released from the waiting list is based on their assessed category of service as required by federal guidelines. There are three possible categories of service,

- Priority Category 1: Individuals with a most significant disability (MSD)
- Priority Category 2: Individuals with a significant disability (SD)
- Priority Category 3: Individuals with a less significant disability

Category I individuals began being served in September of 2018 and were completely served by April of 2019. All remaining category II and III participants were released from the waitlist by December 27<sup>th</sup>, 2019.

## Rehabilitation Program Partners

NHVR is located within the Department of Education's (DoE) Division of Workforce Innovation and provides rehabilitation and employment support services to students and adults with disabilities. DoE oversees the Workforce Innovation and Opportunity Act (WIOA) – Youth program, which provides employment and training services to youth who face challenges to employment. Adult Basic Education is also a WIOA partner located within the DoE.

The Department also provides transition services under the Individuals with Disabilities Education Act (IDEA). Coordination between NHVR and local school districts providing transition services as required under WIOA. Given these overarching responsibilities, NHVR works closely with the other bureaus within the



Department, such as the Bureau of Student Supports (Special Education), Bureau of Career Development, Bureau of Youth Workforce, and Bureau of Social Security Disability Determination Services (DDS).

Other departments within the New Hampshire government also play a critical role in the statewide rehabilitation service system:

**Department of Health and Human Services (DHHS):** DHHS's Bureau of Developmental Services (BDS) works closely with NHVR to provide supported employment services to participants through its Area Agencies. The Bureau of Behavioral Health (BBH), also within DHHS, provides rehabilitation services and employment supports to people with behavioral health disabilities through Community Mental Health Centers throughout the state.

**New Hampshire Employment Security (NHES):** NHES provides support to job seekers and employers. Through its statewide network of Job and Information Centers, it offers both self-directed and assisted employment services and provides job market information to both employers and job seekers.

**Department of Business and Economic Affairs (DBEA):** DBEA's Office of Workforce Opportunity, funded through Workforce Innovation Opportunity Act funds, promotes statewide workforce development programs, to impact individuals and business members.

There are also a broad range of non-profit community organizations outside of the state government that are part of the statewide rehabilitation service system. These include community rehabilitation provider organizations that employ job coaches and employment specialists for people with disabilities. Non-profits such as Northeast Deaf and Hard of Hearing, ABLE NH, the Brain Injury Association, the Parent Information Center, and the Disability Rights Center provide information and other resources to people with disabilities and their families. The Institute on Disability within the University of New Hampshire (UNH) is the state's University Center for Excellence in Disability, federally authorized by the Developmental Disabilities Act. Through its interdisciplinary research and dissemination initiatives, it contributes to the statewide efforts to address the needs of people with disabilities and their families.

## The Comprehensive Statewide Needs Assessment

The State Rehabilitation Council (SRC) is the advisory group of the NHVR program. The group is composed of NH volunteers, some of whom are persons with disabilities, who have been selected to advise the Governor on addressing rehabilitation and employment needs of people with disabilities. NHVR, in collaboration with the SRC, is required by the Rehabilitation Act as amended in Title IV of the Workforce Innovation and Opportunity Act (WIOA) to conduct a Comprehensive Statewide Needs Assessment (CSNA) every three years to examine the overall need for rehabilitation services for persons with disabilities in the state. This needs



assessment will guide NHVR in its strategic planning and goal development for the next state plan due in March of 2020.

The RSA asks that CSNAs pay special attention to the rehabilitation needs of vulnerable subpopulations such as:

- Individuals with the most significant disabilities,
- Unserved and underserved individuals,
- Minorities,
- Individuals who are being served through other state workforce investment agencies and
- Youth and students with disabilities, specifically those needing pre-employment or other transition services.

In May 2019, the Human Services Research Institute (HSRI) was contracted by NHVR to conduct this CSNA. Work began on June 24, 2019. The CSNA relied on a variety of data sources including data from the United States Census Bureau and case-level data required by the Rehabilitation Services Administration. Results from Key Informant Interviews (KII) and Focus Groups (FG) are also presented to offer first-person perspectives on the statewide service system.

This report describes the information gathered by this study regarding the statewide need for rehabilitation services of persons with disabilities, including identifying the groups currently served by the statewide service system as well as those that are under- or un-served. The report also assesses the current impact and reach of rehabilitation services within the state, forecasts future needs, and identifies gaps in access. Finally, the report provides policy and programmatic recommendations based on the results of qualitative and quantitative analyses.

## Legislative and Policy Context

The statewide rehabilitation service system operates within an environment of federal, state and local factors such as laws, regulations, policies, political and economic contexts, and historical developments. Some recent pieces of legislation and policy developments that have affected the provision of rehabilitation services and the rehabilitation needs of individuals with disabilities in the state include the Rehabilitation Act as amended by the Workforce Innovation and Opportunity Act (WIOA), and the NHVR Order of Selection.

The Vocational Rehabilitation state grants program was authorized by Title I of the Rehabilitation Act of 1973, as amended. In July 2014, the Workforce Innovation and Opportunity Act (WIOA) reauthorized the Vocational Rehabilitation (VR) state grants program through FY 2020. The annual federal appropriation for VR grants is determined using a formula that considers the state population, average per-capita income and original VR allotment in 1978. States are required to match a portion (21.3%) of the federal grant allotted to them (78.7%). programs (Congressional Research Service, 2014).

In addition to reauthorizing the Rehabilitation Act of 1973, the Workforce Innovation and Opportunity Act (WIOA) aims to increase the collaboration between state and federal programs targeted at skill development. This includes NHVR, other programs run by the Department of Education, Department of Labor-funded programs and programs run by the Department of Health and Human Services. Specifically related to NHVR, WIOA has required the allocation of more funds (15% federal funds) to Pre-Employment Transition Services (Pre-ETS) for students with disabilities transitioning out of school. In addition, as mentioned earlier, WIOA requires coordination between NHVR and local education agencies providing transition planning and services under the Individuals with Disabilities Education Act (IDEA).

## **New Hampshire's Geography, Economy and Workforce**

New Hampshire is the 46th largest state in area at 9,282 square miles (New Hampshire Office of Strategic Initiatives, n.d.). The population in 2018 was estimated to be 1,356,458 people (New Hampshire Office of Strategic Initiatives, n.d.). The population of New Hampshire, as a whole, is relatively dispersed, with 162.51 persons per square mile in 2018 (New Hampshire Office of Strategic Initiatives, n.d.) According to the 2010 Census, the largest population center can be found in Manchester with a population of 109,565, followed by Nashua with a population of 86,494 (New Hampshire Fiscal Policy Institute, 2018). Both cities lie within Hillsborough County, New Hampshire's most populous county. Thirty percent (30%) of New Hampshire's population resides in Hillsborough County.

The southeastern part of New Hampshire has larger concentrations of population, higher median incomes among residents, and lower poverty rates compared to regions to the north and west. Statewide, the unemployment rate has been below three percent (3%) since 2015 (New Hampshire Fiscal Policy Institute, 2018). However, there are disparities in population, education level, income and poverty rates between the different regions of the state. There are large differences between rural NH and Metro NH in income, poverty rates, and age. The population of rural NH is older (18.1% over age 65, compared to 13.4% of metro NH), has a higher percentage of residents living in poverty (10.1% living in poverty, compared to 7.2% of metro NH) and has a lower per capita income (\$28,070 compared to \$33,926 in metro NH) (Gittel, 2013)

Population changes also vary by county. Between 2010 and 2017 the larger, more populous counties in the south east of New Hampshire experienced population increases at a greater rate than other counties through natural increases or net migration. The counties to the north and west experienced slower growth, and some experienced population loss. (Vieira, 2018)

New Hampshire has the third highest median age of any state in the US at 42.7 years (United States Census Bureau, n.d.). The median age also varies by county, with higher median ages in the northern and western counties. In parallel with the aging population, the age of the workforce is also older with an estimated one out of five people in the labor force being between the ages of 55-64. The aging of the workforce as well as the slow or stagnant population changes in the western and northern counties may limit the workforce in those regions in coming years.

New Hampshire is fourth in the New England region for median wage, behind Connecticut, Massachusetts and Rhode Island. In May 2018, the median hourly wage in New Hampshire was \$19.17 (Bureau of Labor Statistics, 2018) and the annual median household income in 2018 was \$74,991 (2018 *American Community Survey* 1-year estimates).

Although New Hampshire has a relatively low unemployment rate, New Hampshire citizens do face barriers to employment. Lack of accessible childcare, unreliable transportation, lack of public transportation, an aging workforce, high rates of substance use and poor conditions of infrastructure such as bridges and roads have been documented to negatively affect the employment outcomes of New Hampshire residents (University of New Hampshire Carsey School of Public Policy, n.d.). These conditions may also directly or indirectly impact the rehabilitation needs and successful employment outcomes of the state's residents with disabilities.

# Methodology

## Quantitative Analysis

The quantitative analysis consisted of the following components:

- Characteristics of New Hampshire residents with disabilities in comparison to neighboring states and the nation as a whole
- Description of NHVR service participants
- Comparison of NHVR's participants to the state's overall population with disabilities
- Impact of the Order of Selection on participant experiences
- Employment outcomes of participants with completed (closed) cases
- Forecasts of the future size and characteristics of the state's residents with disabilities

## Data Sources

### RSA 911 Data

For participant-level analyses, we used case data maintained by NHVR in compliance with the grant requirements of the Rehabilitation Service's Administration (RSA), briefly called the RSA 911 database. The database contains detailed information about each case processed by the agency, including demographic data about the participant, initial assessment results, employment, education, and other resources at the start of services, services received, reasons for service exit, and employment status at service completion. The data are updated and submitted to RSA on a quarterly basis. For this study, we used the most recently updated data extract that was submitted to RSA for program year 2018, fourth quarter. The data contained all active cases at the time of extraction (June 28, 2019) and all closed cases since October 1, 2017. In the rest of this report, we refer to this dataset as "the RSA Sample" for brevity.

We used the statistical software SPSS to analyze these data. The RSA database extract was reformatted as an SPSS dataset that was then used for all case-level analyses. The dataset contained data for a total of 6,651 cases. There were 144 cases in which participants had exited the system but then re-applied for further services at a future date. Each service entry was recorded as a separate case in the database. Thus, the sample contains information on 6,507 unique individuals.

### State-Level Population Data for 2017

The *American Community Survey* (ACS) conducted by the U.S. Census Bureau annually collects demographic, socioeconomic, and disability data from a representative sample of the nation's population. National estimates from the survey

are available for single years. To obtain sufficient sample sizes for dependable state-level estimates broken down by demographic and other characteristics, The Census Bureau pools five years of data. The most recent estimates available for this study were from the 2013-2017 five-year pooled sample. This is the source for most of the analyses of state-level population characteristics conducted for this study<sup>2</sup>.

The population data on New Hampshire's students with disabilities came from the census of students with disabilities conducted by the NH Department of Education. County-level estimates of disability prevalence rates were taken from a recent report published by the University of New Hampshire Institute on Disabilities (Houtenville & Boege, 2019). The authors of that report used the same five-year ACS sample for their study as the one we used for this report; however, we cite their study as a separate data source because we used the county-level estimates that they made.

### State-Level Population Projections, 2020 and 2025

To forecast the future size of New Hampshire's population with disabilities, we combined the 2017 ACS data described above with projections of future population sizes by age and county. The data source for projected population sizes by age is the Centers for Disease Control and Prevention's (CDC) WONDER Database (CDC 2019). The data source for population projections for New Hampshire counties is a study published by the New Hampshire Regional Planning Commission (Regional Planning Commission, 2016).

## Quantitative Analysis Techniques

### Case- and Participant-Level Analyses

The RSA 911 data were used in two different ways. For reporting counts of participants by various characteristics, we used counts of unique individuals. For these analyses, we included a single case record for the 144 individuals who had two separate cases on file. For those individuals, the reported data came from the case with the more recent application date. There were no individuals with more than two cases in the sample.

Outcome analyses, however, were conducted at the case level because each case potentially had a different outcome. Including only a single case for individuals with two cases would have caused loss of valuable outcome information.

### Comparisons Between RSA 911 Numbers and ACS Estimates

In order to assess the extent to which NHVR services penetrate different subgroups among the state's residents with disabilities, we compared the characteristics of the RSA sample with the characteristics of the state's overall population with disabilities. These comparisons reveal the extent to which a given population subgroup is over- or under-represented among NHVR's participants. If, for example, a subgroup constitutes 20% of the state's population with disabilities but only 10% of NHVR's

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<sup>2</sup> Please note: estimates from the *American Community Survey* are subject to survey and estimation error.

service recipients, the subgroup may be experiencing more access difficulties than better-represented subgroups. These comparisons are not conclusive indications of service gaps because the lower access among under-represented groups may have causes external to the NHVR or may have received rehabilitation services from other components of the statewide service system. Nonetheless they highlight *potentially* underserved groups for further investigation. In that sense, they are useful planning tools.

As is the case with all survey data, ACS estimates have error margins. In cases where a comparison between the population and RSA sample estimates did not suggest a policy-relevant discrepancy, we reported the estimates without the error margins. If a comparison suggested a potential statewide need relevant to this assessment, we factored in the ACS error margins and discussed the relevance of the difference to statewide service needs *only* if it fell outside the survey's error margins.

In order to make valid comparisons between the ACS and the RSA sample, the definitions of disability used in the two data collection efforts needed to be reconciled. The RSA has 19 disability categories that are used to record the disability (or disabilities) of NHVR participants. We mapped as many of these 19 categories to the six impairment categories used by the ACS, using the RSA data collection manual and ACS question wording as guidelines for the meaning and intent of the two classification systems. Only four disability categories were reasonably comparable across the two data sources: vision, hearing, ambulatory, and cognitive. The 19 RSA categories had to be collapsed into fewer categories to make this mapping possible.

The details of the collapsed RSA categories and the ACS questions on disability are provided in the Results section (Exhibit 13).

### Analysis of Employment Outcomes

The RSA sample included 2,446 closed cases. Using this subsample, we conducted outcome analysis by comparing the employment status and earnings reported at exit with those reported at the time the individual's plan of employment (IPE) was developed. For this purpose, a closed case was defined as a "successful outcome" if:

1. The participant had no employment at the time of IPE determination and gained employment by program exit; or
2. The participant already had a job at IPE determination and increased her/his weekly earnings (by increasing hourly wages, weekly hours worked, or both); or
3. The participant already had a job at IPE determination and remained within \$1 of her/his hourly wages at program exit.

Criterion #3 in the above definition aligns with the vocational rehabilitation goal of supporting participants in *maintaining* their employment status. Put another way, this criterion is a measure of successfully *preventing* the participants from losing their employment status.

The outcome analysis included outcome comparison by demographic and disability characteristics. In these comparisons, we tested for statistical significance of inter-group differences using the chi-square test with an alpha level of 0.05.

### Forecasting the State's Future Population with Disabilities

As mentioned earlier, the forecasts combined data from two separate sources. The ACS data provide estimated percentages of the state's population with each of the six impairments for which survey data are collected (vision, hearing, ambulatory, cognitive, self-care, and independent living). We applied the ACS-estimated prevalence rate of each disability within each age group to the projected future population size of that age group in NH to obtain forecasted numbers of NH residents within each age group with the six disability categories.

To forecast the number of people with at least one disability in each NH county, we used a similar technique: We applied the county-specific prevalence rate of disability estimated for 2017 to county-level population projections to forecast the future numbers of people with disabilities in each county.

We repeated this procedure using 2020 and 2025 population projections to provide forecasts for those years.

## Qualitative Analysis

In addition to the review and summary of existing quantitative data, the collection of primary data through key informant interviews with representatives of multiple agencies and organizations with first-hand knowledge of the statewide service system and focus groups with people with disabilities and their families provided first-person opinions and perspectives on the rehabilitation needs of people with disabilities as well as the strengths of and opportunities for improvement in the statewide service system.

### Key Informant Interviews

Interviews with key informants provided an opportunity to understand the vocational rehabilitation needs of individuals with disabilities across the state from the perspective of key stakeholders with knowledge of and experience with the state's service system. NHVR provided HSRI with an initial list of informants, and through those interviews, HSRI accumulated an additional list of informants to interview as suggested by the initial informants.

We interviewed 23 Key Informants. Informants included:

- NHVR central office staff
- NHVR regional office staff
- Community Rehabilitation Program (CRP) senior staff and other employees
- State Rehabilitation Council members



- Representatives of the State Advisory Committee on the Education of Students with Disabilities (SAC)
- Researchers at the UNH Institute on Disabilities
- Senior staff at the NH Council on Developmental Disabilities
- Senior staff at ABLE NH
- Representatives from the Bureau of Developmental Services
- Representatives from the Division of Economic Development
- Representatives from the Bureau of Special Education
- Representatives from the Bureau of Mental Health Services

The Key Informant Interviews (KII) were conducted using a modular discussion guide that was reviewed and approved by NHVR before any KII were conducted. We then tailored the approved discussion guide for each interview based on the informant's area of expertise. This discussion guide was then used as an overall structure for the interview. If an additional topic of interest was raised during a KII, the interviewer would follow up with questions. The interviews started with a brief description of the informant's background and experience with the statewide service system. The informants were asked to share their perspectives on vocational rehabilitation services in the state, gaps in and barriers to services, their experiences providing or receiving rehabilitation services or partnering with state agencies to provide these services. Informants were also asked about potentially underserved populations and their perceptions of how the state's service system could be enhanced to meet the needs of service-users.

A member of the HSRI team also attended the annual retreat of the State Advisory Committee (SAC) on the Education of Students with Disabilities. The meeting gave HSRI the opportunity to describe the CSNA process and solicit SAC members' perspectives. The meeting lasted approximately an hour and was structured as a focus group. A set of tailored discussion questions was shared with the SAC members to loosely guide the discussion and to solicit the members' perspectives on the role of statewide rehabilitation services in the education of students with disabilities and their transition to employment.

All but one of the KIIs were conducted via phone conference or Zoom web conference technology. One interview was conducted in person.

### Focus Groups

Focus groups provided a forum for service users and family-members and, in the Berlin office, regional office staff, to provide meaningful feedback about statewide rehabilitation services. Four focus groups with service users, potential service users, and their families were held around the state in different regions. One focus group



was held in Concord and was advertised to participants served by the Concord and Manchester/Nashua regional offices. One focus group was held in Keene, one in Portsmouth and one in Berlin. Staff at each regional center were asked to extend focus group invitations to people receiving services, people desiring services but not yet receiving them, and family members. Regional staff were provided with flyers to distribute and post. In addition, one advocacy group shared information about the focus groups through social media and in an email newsletter and NHVR included information about the focus groups in an email to those participants who had consented to receiving email updates.

The focus groups were run similarly to the KII. A focus group protocol with guiding questions was used to structure the overall discussion, but the conversations were allowed to proceed organically if participants raised relevant points not included in the protocol. The focus groups were approximately one hour in length. Snacks were served and participants received a \$20 cash stipend for their participation.

Attendance at focus groups was in response to public announcements; therefore, participants were self-selected. In view of the possibility that individuals with negative experiences may be more motivated to attend than those who were satisfied with services, facilitators emphasized at the beginning that information about the positive aspects of the statewide service system was as important for the needs assessment as was information about unmet needs. At the end of the focus groups, the facilitators probed for examples of “success stories,” with increased emphasis in cases where the discussion had focused mostly on participants’ unmet needs.

## Qualitative Analysis Techniques

Transcripts of key informant interviews and focus group sessions were qualitatively analyzed to identify recurring themes. Observations and opinions that were brought up by multiple individuals were identified and weighed by factoring in the position of the informants with respect to the state’s rehabilitation system and their level of knowledge of the system. The background information gathered about each informant at the beginning of every interview and focus group were recorded together with the themes they had brought up and factored into the decision to include it in the report as an analysis result.

For example, if an informant who belonged to a specific agency offered a program offered by that agency as a “success story,” that comment was not taken at face value but recorded together with the individual’s organizational position and potential biases. However, if other informants with no stake in the success of that program also offered it as a positive aspect of the service system, then the program was flagged as a candidate for inclusion in the report. The team continued to record different comments about the program throughout the data collection process to build as complete a picture as possible. For example, if multiple informants brought it up, some with positive and others with negative connotations, the possibility that the program worked for specific groups but not for others was considered. The team would then gather information about the program from available documents such as

program manuals, background information, associated legislation, published reports and articles, and press reports in an effort to present the program in as complete a manner as possible.

The weight that a comment had in this analysis process also depended on the level of experience that the informant had with the state's rehabilitation service system. In other words, a comment or observation made by an individual with limited knowledge/experience of the system (e.g. a single service user) did not have the same weight in this thematic corroboration process as the same comment made by someone with extensive knowledge (e.g., representative of an advocacy organization with years of experience working with a broad range of individuals with disabilities).

Only recurring themes that met these multi-stakeholder corroboration and weighting criteria rose to the level of an analysis result for inclusion in the report. Given the weighted nature of this corroboration process, the report does not provide the numbers of informants whose information was used to arrive at the result. Although informants whose organizational positions gave them a broad understanding of the system have more weight in a theme discussed as a result, we refrained from mentioning the position of the individual or individuals who raised the theme to the level of a result because all of our informants were promised anonymity at the beginning of interviews and focus groups.

# Quantitative Analysis Results

This section addresses the following assessment questions:

1. What are the socioeconomic characteristics of New Hampshire residents with disabilities and how do they compare with neighboring states and the nation as a whole?
2. What are the characteristics of NHVR's participants?
3. How do the characteristics of NHVR's participants compare with the state's population with disabilities?
4. How did the recent order of selection impact services?
5. What were the education and employment outcomes of NHVR's participants with closed cases? Were there outcome differences by demographic and disability characteristics?
6. How will New Hampshire's population with disabilities change through 2025?

## Characteristics of New Hampshire Residents with Disabilities

Although the education and employment outcomes of people with disabilities in New Hampshire cannot be entirely attributed to NHVR services, these services constitute a major component of these outcomes. Thus, population-level comparisons with equivalent populations in neighboring states and the nation as a whole provides useful clues about the overall impact of the state's vocational rehabilitation service system. The comparisons discussed in this section are based on data from the *American Community Survey's* 2013-2017 five-year estimates. It is important to note that all of the numbers are estimates subject to survey and estimation error. Margins of error are not displayed in the charts to increase readability. However, they are included in discussions of results with potentially policy-relevant implications.

Exhibit 1 displays the size of New Hampshire's population with disabilities by age and disability type. The survey questions that define each disability type are as follows:

<b>Disability Type</b>	<b>Survey Question</b>
Hearing Impairment	Is this person deaf or does he/she have serious difficulty hearing?
Vision Impairment	Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?

<b>Disability Type</b>	<b>Survey Question</b>
Cognitive Impairment	<i>[Reported only if the person is 5 years old or older]</i> Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?
Ambulatory Impairment	<i>[Reported only if the person is 5 years old or older]</i> Does this person have serious difficulty walking or climbing stairs?
Self-Care Difficulty	<i>[Reported only if the person is 5 years old or older]</i> Does this person have difficulty dressing or bathing?
Independent Living Difficulty	<i>[Reported only if the person is 15 years old or older]</i> Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

Exhibit 1. NH Population With Disabilities by Age and Disability Type, 2017

Age	Hearing Impairment	Vision Impairment	Cognitive Impairment	Ambulatory Impairment	Self-Care Difficulty	Independent Living Difficulty	At least One Disability
<5	317	334	-	-	-	-	<b>560</b>
5-17	1,302	1,348	10,033	1,185	2,120	-	<b>12,128</b>
18-34	2,203	2,112	13,019	3,174	2,335	7,843	<b>18,587</b>
35-64	16,276	9,438	24,179	32,726	10,193	20,544	<b>65,353</b>
65-74	12,157	3,977	5,391	17,100	4,194	6,865	<b>29,750</b>
75+	20,177	6,729	9,126	22,747	7,630	16,369	<b>38,771</b>
<b>Total</b>	<b>52,432</b>	<b>23,938</b>	<b>61,748</b>	<b>76,932</b>	<b>26,472</b>	<b>51,621</b>	<b>165,149</b>

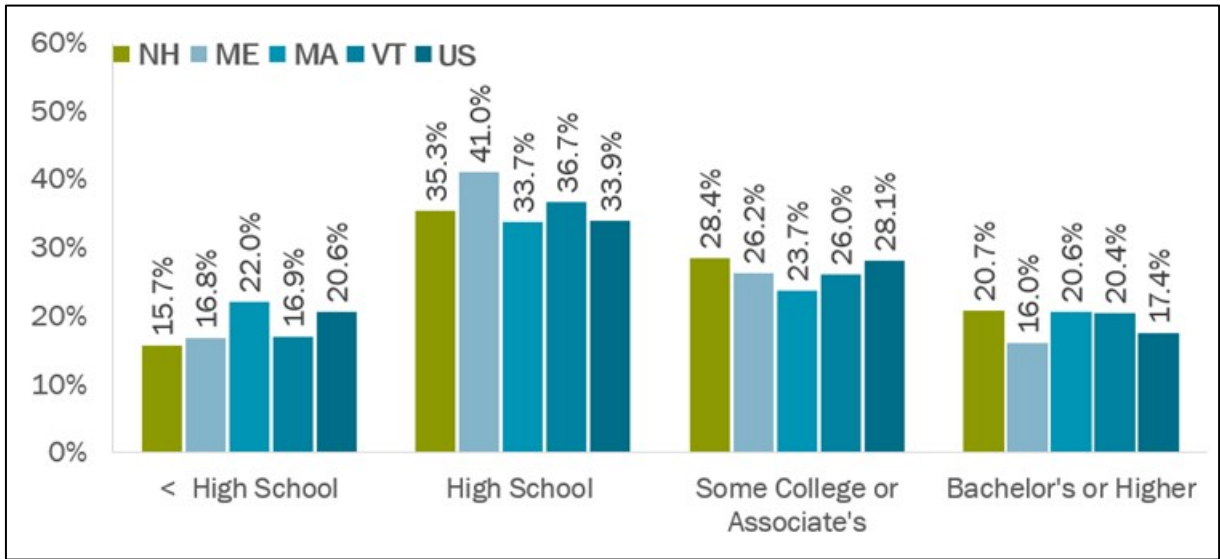
Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Note: Data on independent living difficulty are collected for people aged 15 and older. However, this table displays this number for ages 18 and older because the state-level sample size in the 5 - 17 age range is too small.

We now turn to the educational and employment characteristics of this population, two characteristics most influenced by the penetration and outcomes of vocational rehabilitation services in the state. To provide a context for interpreting these results, New Hampshire is compared to neighboring states and to national benchmarks.

Exhibit 2 compares the educational attainment of New Hampshire's population with disabilities to neighboring states and the nation. In New Hampshire, 15.7% of people with disabilities ages 25 or older had less than a high school diploma, a lower percentage than the nation as a whole (20.6%) and the lowest among neighboring states. At the higher end of the educational spectrum, 20.7% of this population had at least a bachelor's degree, higher than the national average (17.4%) and the among neighboring states. These numbers indicate that overall, New Hampshire's adult population with disabilities has similar or better educational outcomes compared to these benchmarks.

Exhibit 2. Educational Attainment of People with Disabilities age 25 or Older, 2017

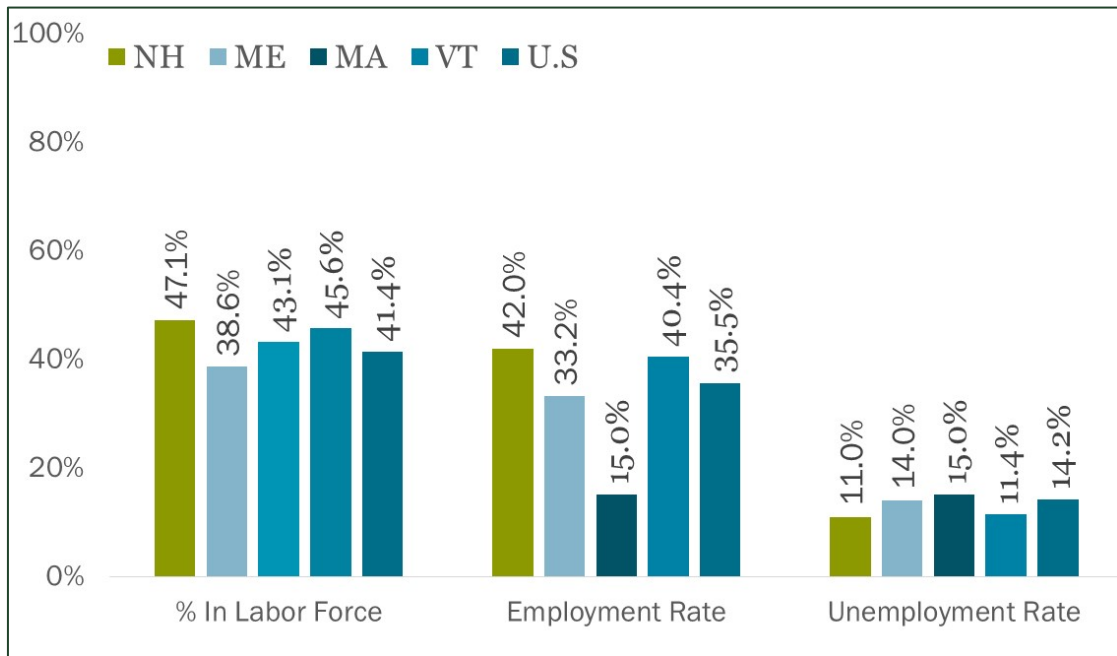


Source: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample. The national estimate is from the 2017 survey.

Exhibit 3 summarizes the labor force status of the population with disabilities. 47.1% of New Hampshire residents with disabilities age 18 or older are in the labor force, meaning they are either employed or are actively looking for work. This figure is higher than the national level (41.4%) and the highest among the neighboring states. Employment rate refers to the percentage of the population with gainful employment. This number is not routinely reported as an indicator of the state of the job market because it is calculated over the entire population without correcting for people who are not currently in the job market for various reasons. However, it is an important indicator of community inclusion, frequently used in population-level studies of people with disabilities (Smith & Shepard, 2017). In New Hampshire 42.0% of people with disabilities age 18+ are gainfully employed, higher than the national level (35.5%) and the highest among the comparison states. This suggests that efforts to enhance community inclusion have been more successful in New Hampshire than in the nation as a whole and the region.

Unemployment rate, unlike employment rate, is an indicator of job market performance, since it is calculated for people in the labor market; therefore, it is a measure of failure to find employment among those who are actively looking for work. The unemployment rate among New Hampshire residence with disabilities age 18+ was 11.0%, lower than the national figure (14.2%) and the lowest among the comparison states.

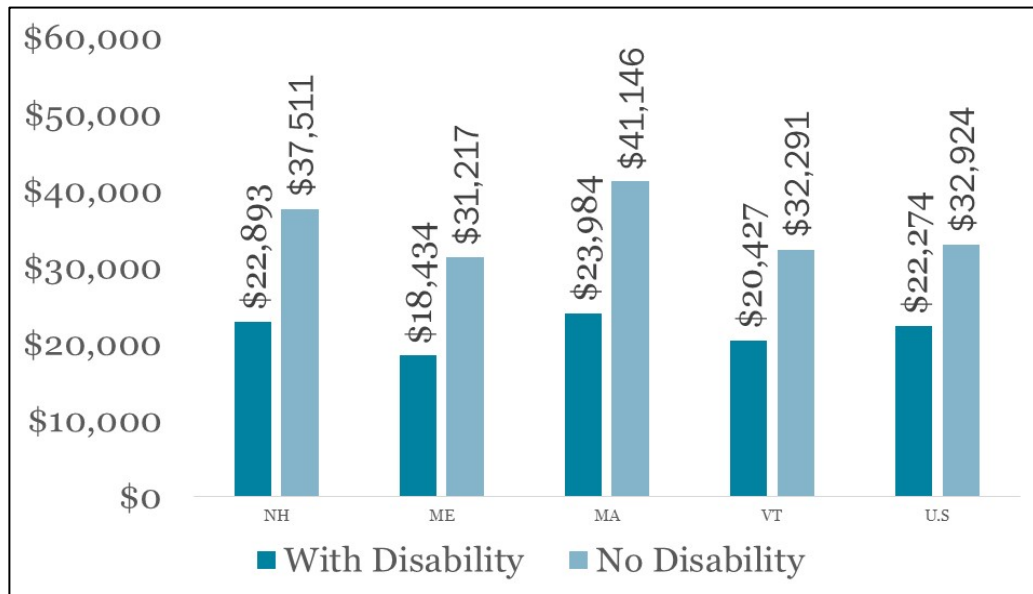
Exhibit 3. Labor Force Status of People with Disabilities Age 18 or Older, 2017



Source: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample.

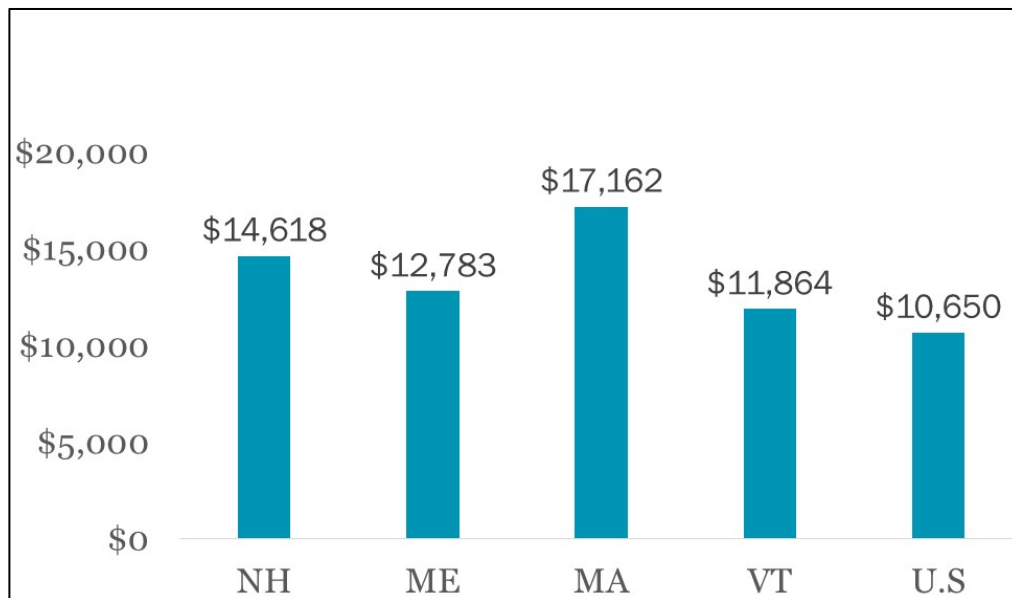
Exhibit 4 compares the median yearly earnings of workers age 16 and older with and without disabilities. Within NH, the median among workers with a disability is \$22,893, slightly higher than the nation as a whole (\$22,274) and New Hampshire workers with no disabilities earn over \$4,000 more than their national counterparts (\$37,511 and \$32,924, respectively). Exhibit 5 depicts the difference between the median earnings of workers with and without disabilities, also known as the disability earnings gap. In New Hampshire the earnings gap is \$14,618, larger than it is in the nation as a whole (\$10,650), and higher than Maine (\$12,783) and Vermont (\$11,864). Before further discussing the implications of these comparisons for the rehabilitation needs of New Hampshire residents, we checked whether or not the difference between the state and the nation is within the error margin of the ACS. Even factoring in the survey’s margin of error, the state’s disability earnings gap is higher than the national average: The low and high estimates for the state’s disability earnings gap are \$13,006 and \$16,230, respectively (based on a 90% margin of error) while the national figure is between \$10,489 and \$10,811 at the same level of confidence.

**Exhibit 4. Median Yearly Earnings of Workers Age 16 or Older with and without Disabilities, 2017**



Source: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample.

**Exhibit 5. Disability Earnings Gap Among Workers Age 16 or Older, 2017**

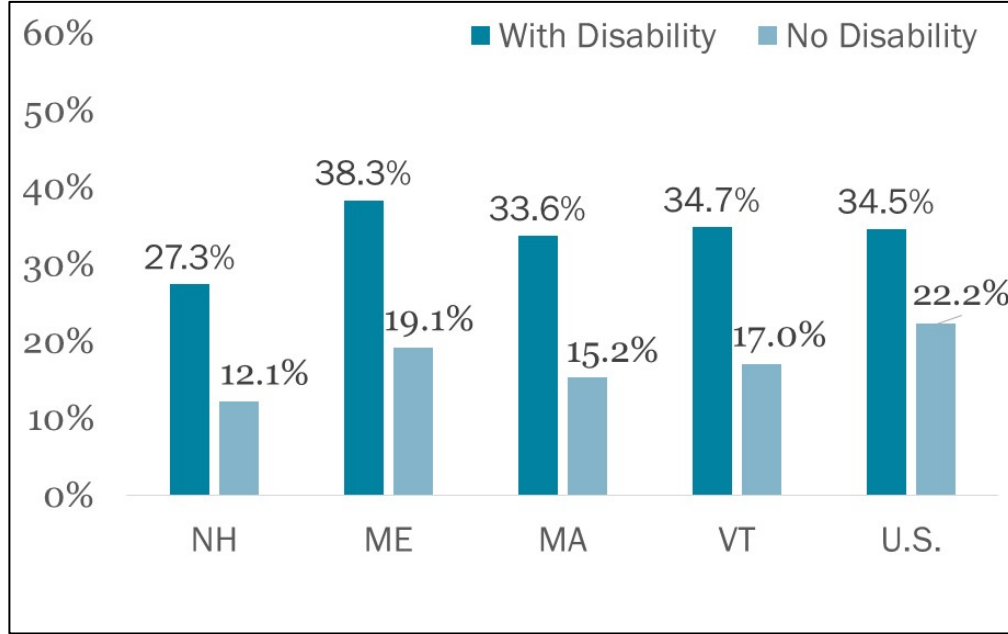


Source: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample.

The state’s population (both with and without disabilities) is less likely to be poor, defined as living in a household with income below \$37,641 for a family of four, that is, below 150% of the federal poverty threshold in 2017 (Exhibit 6). In New Hampshire, 27.3% of people with disabilities live in poverty, compared to 34.5% of

the national population with disabilities. The corresponding figures for people without disabilities are 12.1% in NH and 22.2% in the nation as a whole.

**Exhibit 6. Percentage of Population Living Below 150% of the Poverty Level, 2017**

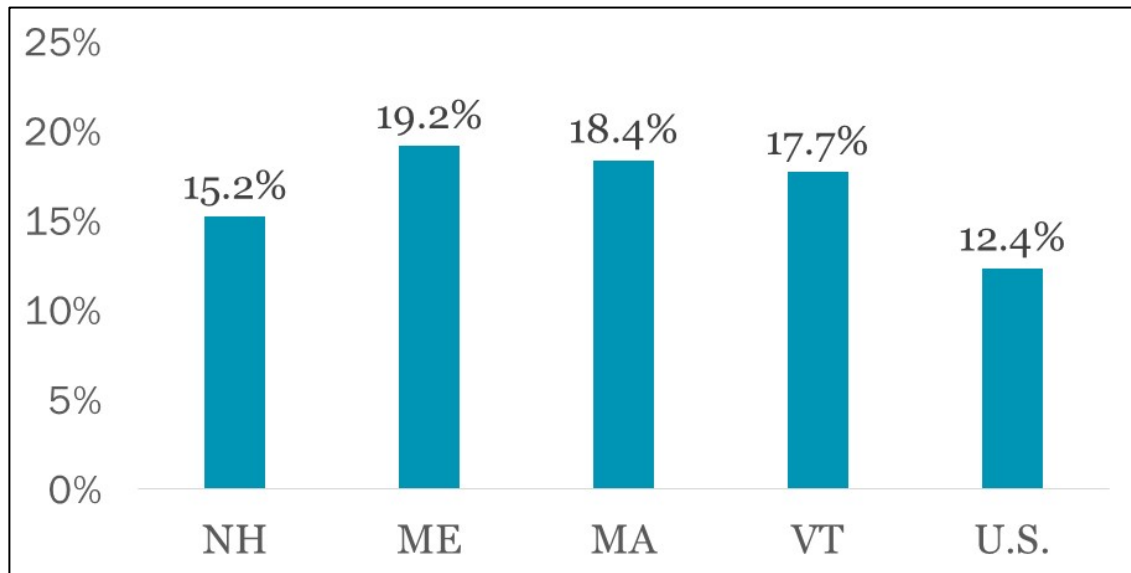


Source: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample.

On the other hand, people with disabilities may not be benefiting from the state’s economic resources at a level comparable to people without disabilities. Exhibit 7 depicts the disability poverty gap, that is, the difference between the poverty rates of people with and without disabilities. Among New Hampshire residents, there is a 15.2 percentage point difference in the prevalence of poverty between those with and without a disability. In the nation as a whole, the gap is 12.4 percentage points, suggesting that the state’s low-income residents with disabilities need support in remaining above poverty. Factoring in the 90% error margin of the ACS yields low and high estimates of 14.1 and 16.3 percentage points, respectively, for the state’s disability poverty gap. At the national level, the estimated poverty gap is between 12.2 and 12.5 percentage points. These numbers indicate that New Hampshire’s disability poverty gap is higher than the national average after factoring in ACS’s margin of error.



### Exhibit 7. Poverty Gap Between Populations With and Without Disabilities, 2017



Source: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample.

In sum, the New Hampshire population with disabilities is generally better educated and shows higher community inclusion than comparable populations in the region and the nation. The earnings and poverty gaps between the state’s population with and without disabilities, however, suggest that the state’s low-income residents with disabilities may be especially in need of economic supports, including vocational rehabilitation services. This point is discussed in further detail in later sections.

## Characteristics of New Hampshire’s Vocational Rehabilitation Participants

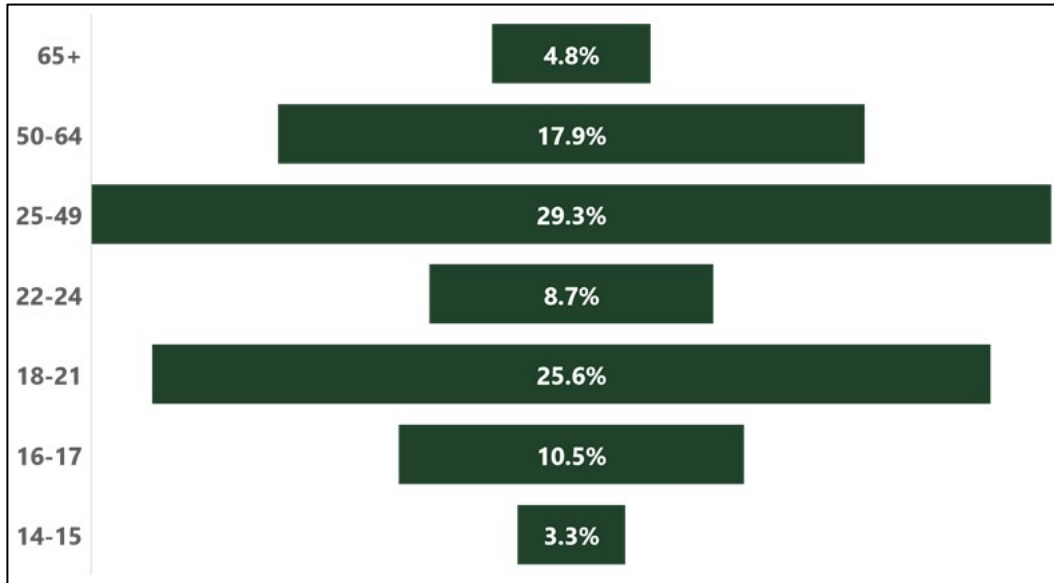
In this section, we report results from analyses of case-level data extracted from New Hampshire’s Case Service Reports database maintained by NHVR in line with the reporting requirements of the Rehabilitation Services Administration (RSA). The state submits these data, briefly referred to as RSA-911 reports, on a quarterly basis. For this study, we analyzed the Program Year 2018 Quarter 4 extract, the most recent case-level data submitted to RSA at the time of the study. The data included all open cases as of June 28, 2019 and all cases closed between October 1, 2017 and June 28, 2019, for a total of 6,651 cases and 6,507 unique individuals. There were 144 individuals with two cases during this period. In the rest of the report, we refer to this dataset as “the RSA sample.”

### Demographic Characteristics

Exhibit 8 shows the age distribution of the RSA sample. As would be expected, the sample consists mostly of the age groups typically identified as transitional- and working-age; ages 65 and older comprise less than 5% of the sample. By far the largest

proportion of the sample (29.3%) is in the 25 – 49 age range, closely followed by those ages 18 – 21 (25.6%).

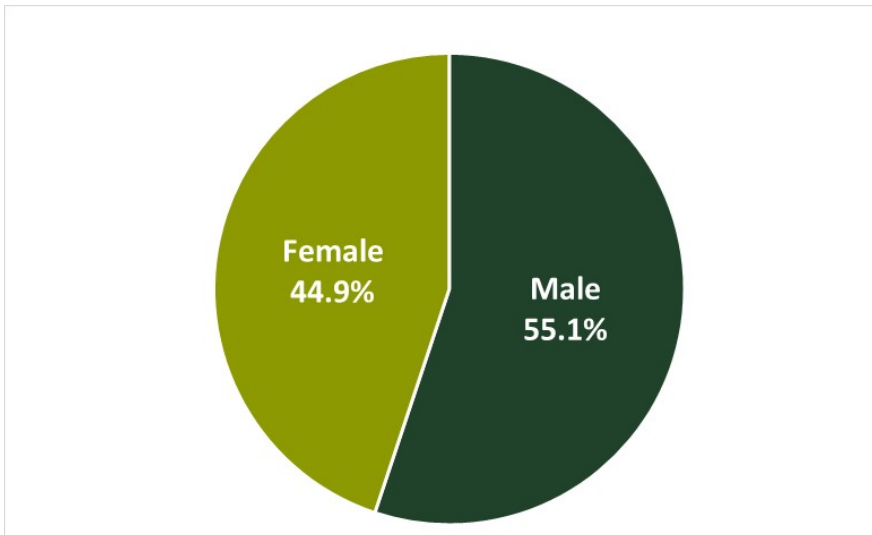
### Exhibit 8. Age Distribution of the RSA Sample



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Age information was available for 5,520 participants.

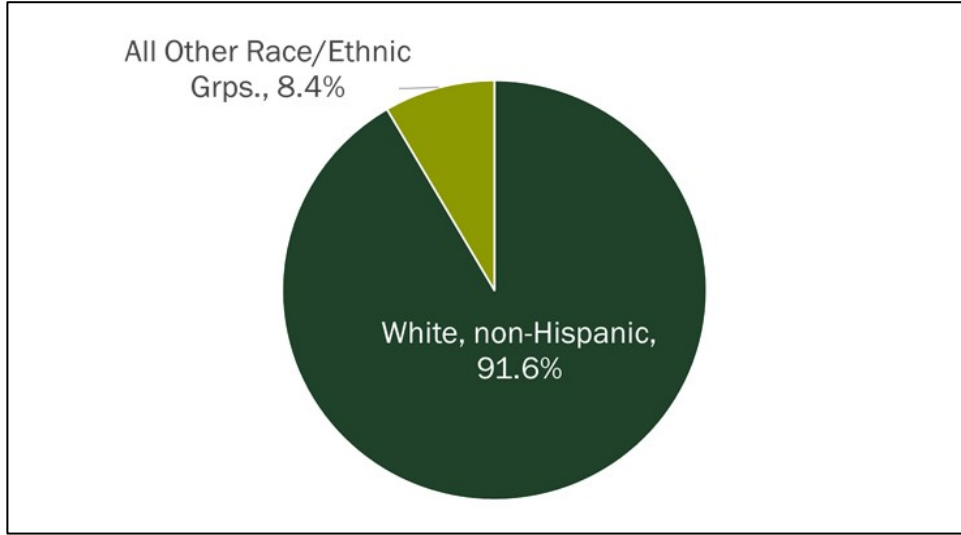
Exhibits 9, 10, and 11 respectively display the gender, racial/ethnic, and geographic distribution of the sample. The sample is majority male (55.1%) and over 90% of the sample were identified as White, non-Hispanic.

### Exhibit 9. Gender Composition of the RSA Sample



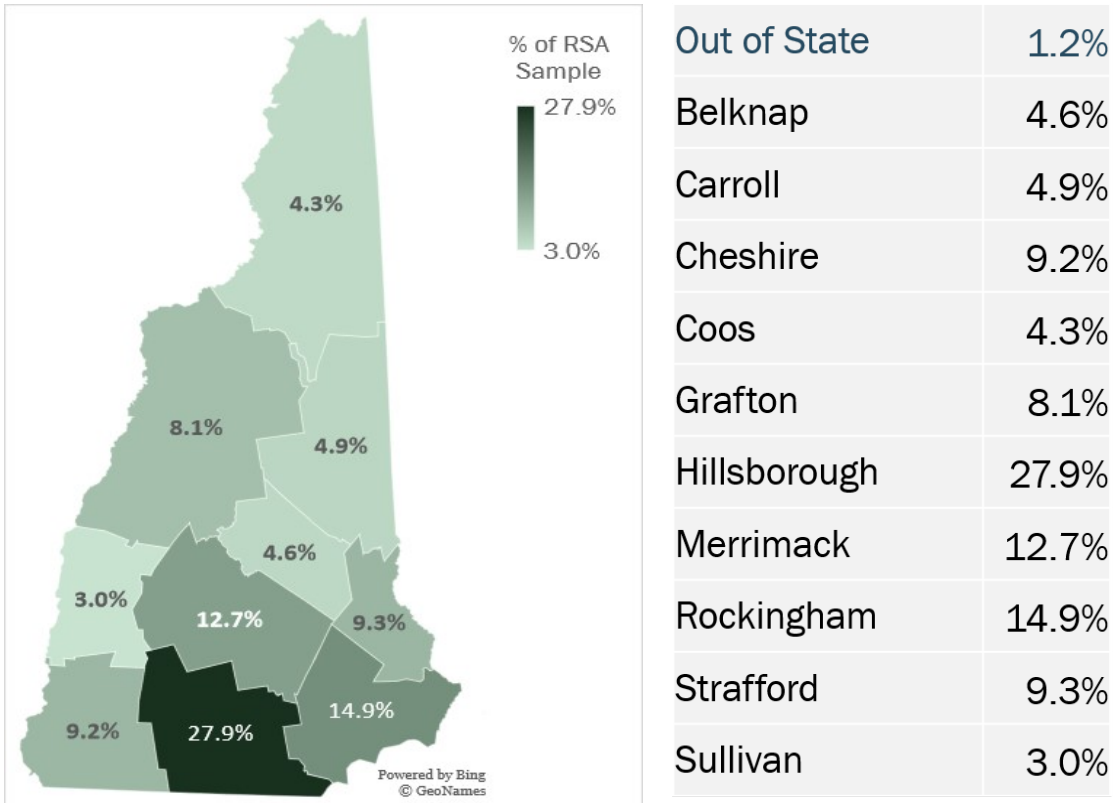
Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Gender information was available for 5,517 participants.

Exhibit 10. Racial/Ethnic Composition of the RSA Sample



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Race/ethnicity information was available for 6,499 participants.

Exhibit 11. Geographic Distribution of the RSA Sample



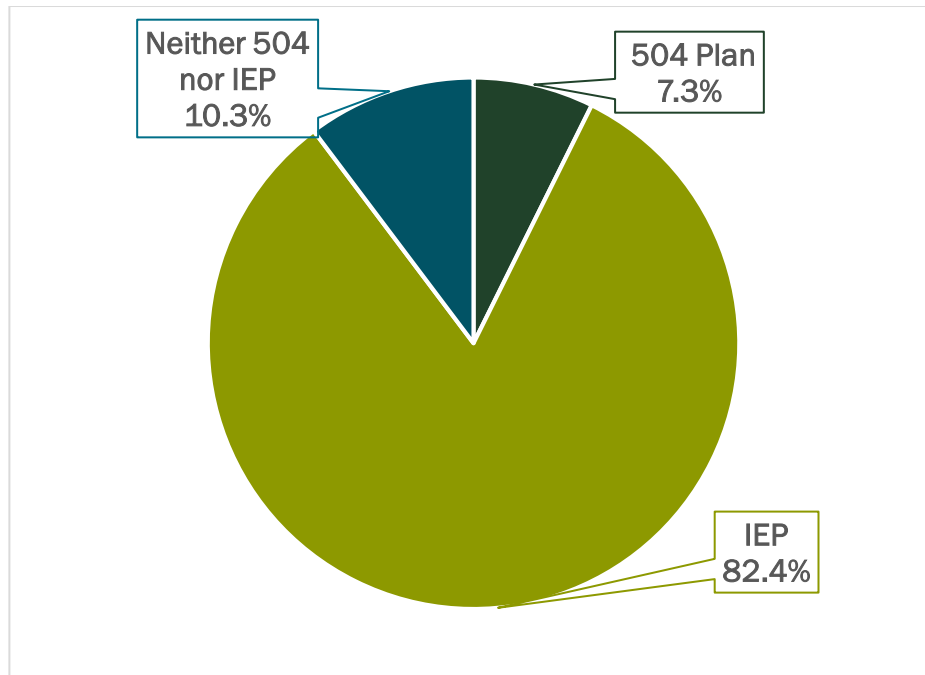
Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Information on county of residence was available for 5,597 participants.

## Disability Characteristics

### Students with Disabilities

Of the 6,507 participants in the sample, 1,908 (29.3%) were identified in the RSA 911 dataset as “students with disabilities.” Exhibit 12 shows the type of accommodation for these students. The Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act both provide for services to students with special needs. IDEA specifies the conditions under which a student with disabilities is eligible for an Individualized Education Program (IEP) that usually includes adapting the content and delivery method of educational materials to meet the specific needs of the student. A substantial majority (82.4%) of the students with disabilities served by NHVR had an IEP. Eligibility for a Section 504 plan is less restrictive; any student with a physical or mental disability that impacts a major life function will likely meet the eligibility criteria. 504 plans are best suited for students who function well in a regular educational environment with some support to accommodate their disability. Of the 1,908 participants identified as a student with a disability, 140 (7.3%) had a 504 plan, while one in ten had neither an IEP nor a 504 plan.

Exhibit 12. Students with Disabilities by Type of Accommodation



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. The figure is based on data from 1,908 participants identified as a student with disability.

### Primary and Secondary Impairments

During service eligibility determination, all NHVR participants are assessed for a primary and, if relevant, secondary impairment. Any changes in these assessments are updated quarterly. The assessment results reported here are based on the most recent diagnoses as of the date of data extraction (June 2019). There are 19

impairment categories in the RSA forms which we classified into fewer categories to facilitate reporting and interpretation of results. Our classification also took into consideration comparability with the impairment definitions used by the *American Community Survey* to allow the population prevalence comparisons discussed later in the report. Exhibit 13 is a crosswalk between the RSA-911 diagnostic definitions and the reduced number of collapsed categories used in this report.

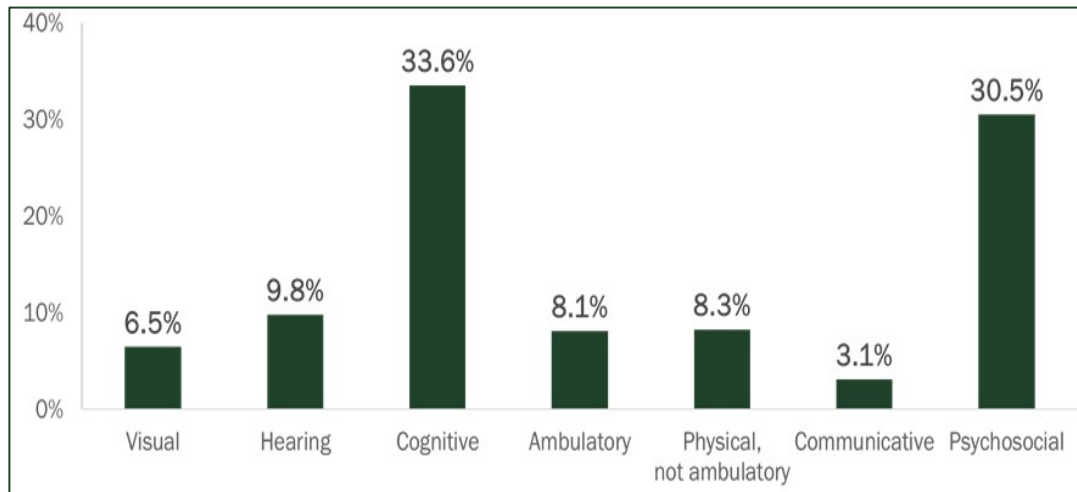
**Exhibit 13. RSA-911 Equivalents of Impairment Categories Used in This Report**

<b>Reported Impairment Category</b>	<b>RSA-911 Definition</b>
Visual*	Blindness, deaf-blindness, other visual impairments
Hearing*	Deafness, hearing loss, deaf-blindness, other hearing impairments (Tinnitus, Menieres Disease, hyperacusis, etc.)
Cognitive*	Cognitive Impairments (e.g., impairments involving learning, thinking, processing information and concentration)
Ambulatory*	Mobility or combination of mobility and manipulation/dexterity orthopedic-neurological impairments; general physical debilitation (e.g., fatigue, weakness, pain, etc.)
Physical, non-ambulatory	Manipulation/dexterity orthopedic-neurological impairments; other orthopedic impairments (e.g., limited range of motion), and other physical impairments not accompanied by mobility restriction
Communicative	Communicative impairments (expressive/receptive)
Psychosocial	Interpersonal and behavioral impairments, difficulty coping, other mental impairments

\*Comparable to American Community Survey data

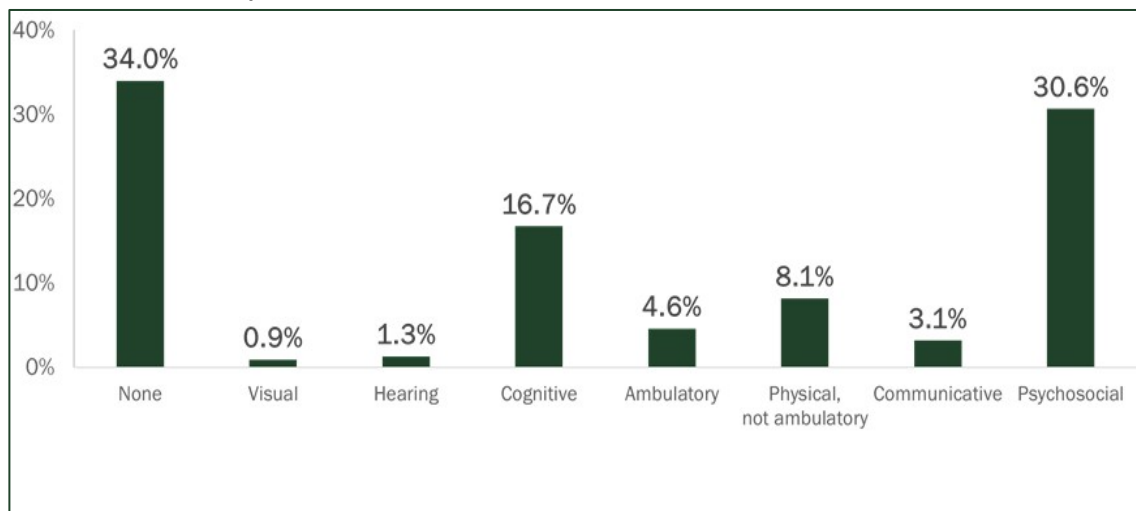
The next two graphs show the distribution of these categories within the RSA sample, assessed as primary (Exhibit 14) and secondary (Exhibit 15) impairments. A third (33.6%) of the participants had a primary impairment classified as “cognitive.” This is by far the largest participant group, followed closely by “psychosocial” as the primary impairment (30.5%). All other categories each constituted less than 10% of the sample. Exhibit 15 indicates that 34.0% of the participants had no secondary impairment. Slightly under a third (30.6%) had a secondary impairment that was psychosocial in nature and 16.7% had a cognitive secondary impairment.

**Exhibit 14. Distribution of Primary Impairment Categories in the RSA Sample**



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Impairment assessment information was available for 5,302 participants.

**Exhibit 15. Distribution of Secondary Impairment Categories in the RSA Sample**



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Impairment assessment information was available for 5,302 participants.

## Service Penetration: Comparison of NHVR Service Users with the State’s Population with Disabilities

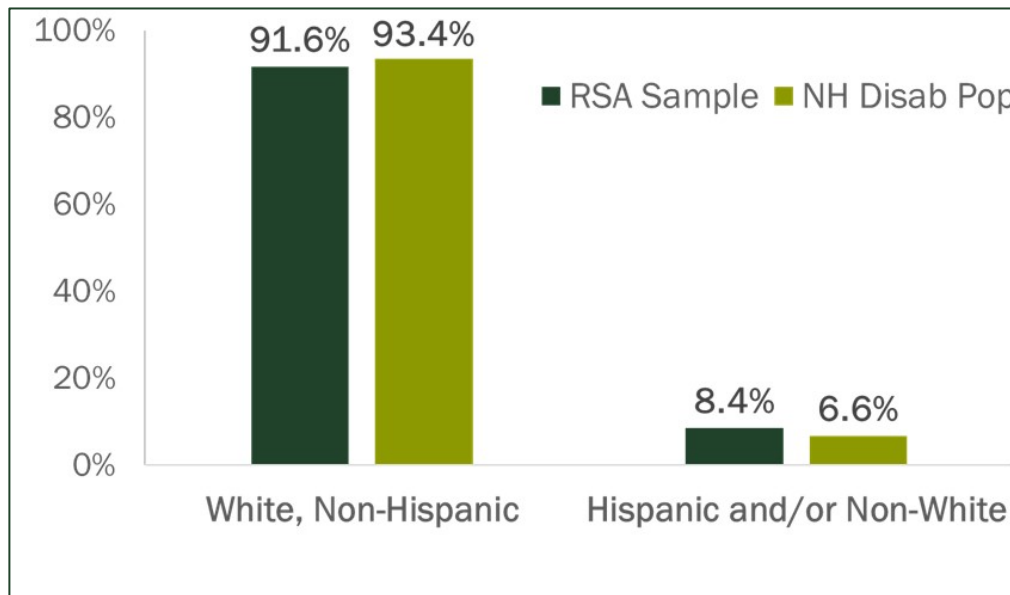
Comparing the characteristics of the RSA sample with those of the state’s overall population with disabilities provides clues about the ability of NHVR services to “penetrate” the population of potential participants. Discrepancies between sample and population characteristics highlight areas of the population that may not have benefited from NHVR’s services to the same extent as other population groups and may therefore be characterized as potentially “underserved.” However, the results of these comparisons should be interpreted with caution. The RSA sample provides us

with information about service users only if they received services provided by NHVR. Those receiving employment support services from other state agencies such as the Bureau of Developmental Services or New Hampshire Employment Security are not included in this sample unless they also received NHVR services. Nonetheless, considering that NHVR is the lead state agency for vocational rehabilitation, the comparisons provide useful clues for further investigation, possibly revealing statewide service needs.

We first look at the representation of the small racial/ethnic minority community in this predominantly White, non-Hispanic state in the RSA sample. Exhibit 16 suggests that for the sample as a whole, the racial/ethnic composition of the sample reflects the state’s overall population with disabilities. Whereas 6.6% of the state’s residents with disabilities is either non-White or of Hispanic origin, this percentage is 8.4% within the RSA sample. That is, the minorities are slightly “overrepresented,” which would not be likely if the state’s minority residents with disabilities were experiencing more access difficulties than the rest of the state residents with disabilities.

However, when we restrict the analysis to students with disabilities (Exhibit 17), we find the opposite result. Whereas 13.9% of the students with disabilities in New Hampshire are either non-White or Hispanic or both, the corresponding figure in the RSA sample is 10.8%. The population figure, in this instance, is based on a census rather than a sample of students, and therefore, not subject to the type of error margin typical of surveys. The results of this comparison suggest that minority students with disabilities are slightly *underrepresented* in the RSA sample.

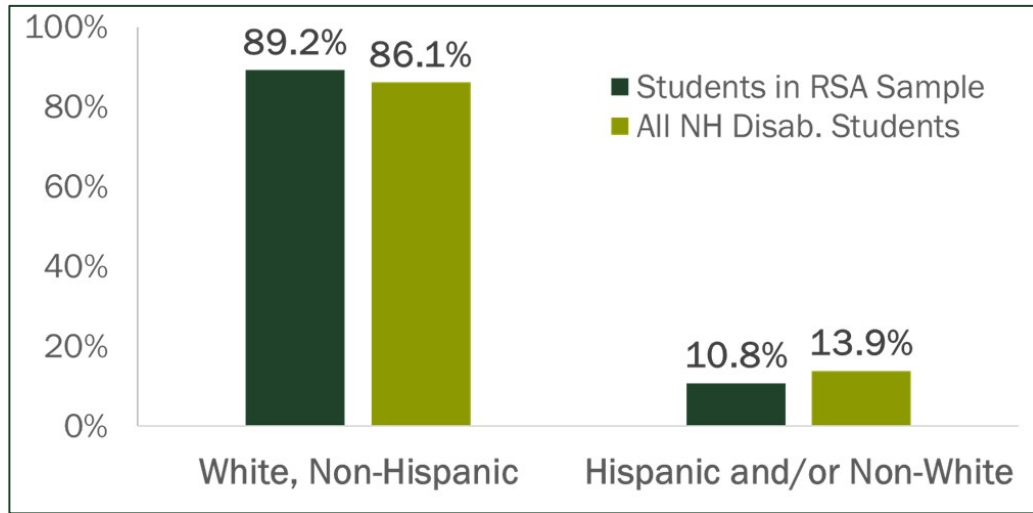
**Exhibit 16. Racial/Ethnic Composition of the RSA Sample Compared to the State’s Residents with Disabilities**



Source for sample data: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Race/ethnicity information was available for 6,507 participants.

Source for population data: U.S. Census Bureau, *American Community Survey*. State estimates are from the 2013 – 2017 five-year sample.

**Exhibit 17. Racial/Ethnic Composition of Students with Disabilities in the RSA Sample Compared to All Students with Disabilities in the State**

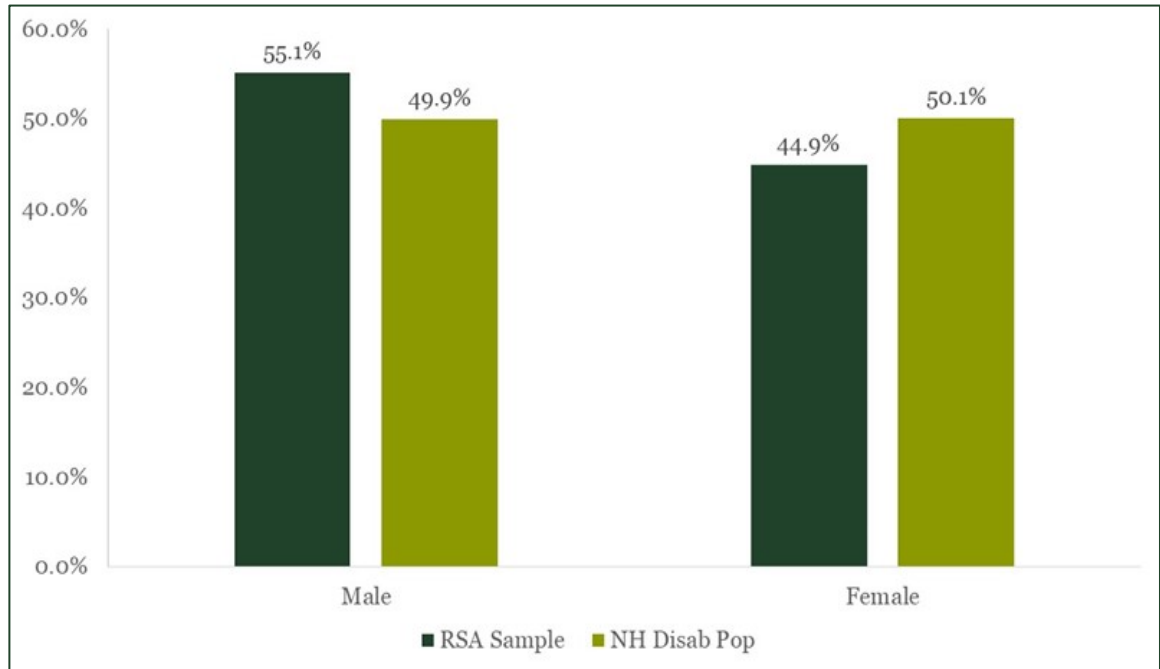


Source for sample data: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Race/ethnicity information was available for 1,904 students with disabilities in the RSA sample. Source for population data: NH Department of Education, *Census of Students with Disabilities*, 2018.

We next compare the gender composition of the RSA sample to the state’s population with disabilities (Exhibit 18). About half of the state’s residents with disabilities is female—between 49.7% and 50.5% when we factor in the ACS margin of error—compared to only 44.9% of the RSA sample. This indicates that women with disabilities are less likely to apply for NHVR’s services than are their male counterparts. The implications of this comparison is further discussed at the end of the section on quantitative results.



**Exhibit 18. Gender Composition of the RSA Sample Compared to the State’s Residents with Disabilities**

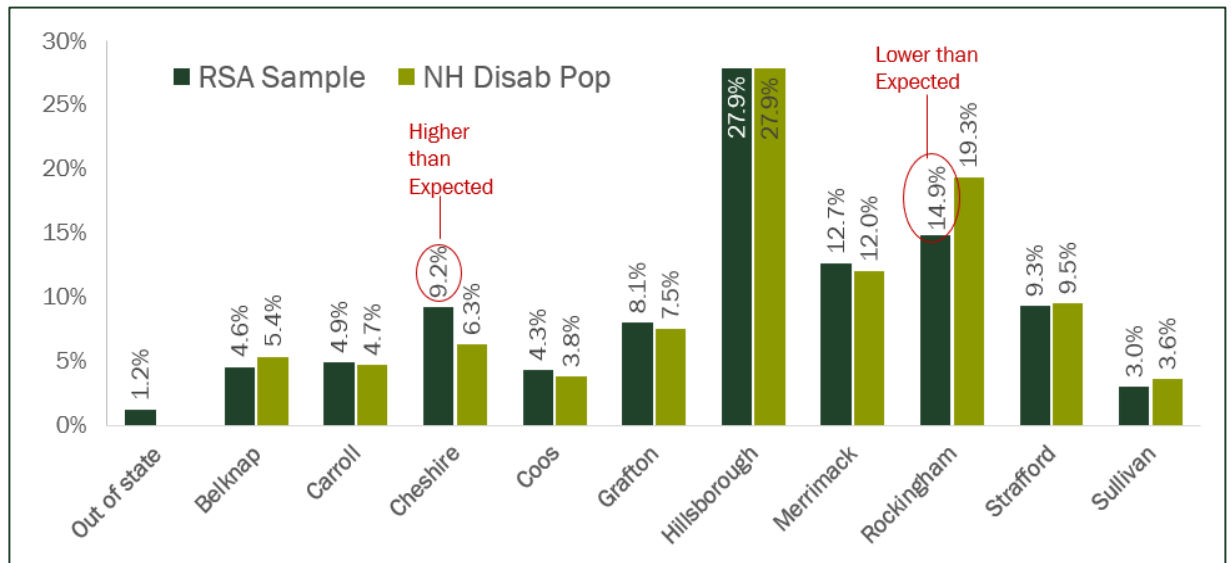


Source for sample data: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Gender information was available for 5,517 participants.

Source for population data: U.S. Census Bureau, American Community Survey. State estimates are from the 2013 – 2017 five-year sample.

New Hampshire has substantial regional differences in demographic and socioeconomic characteristics, raising the possibility that statewide rehabilitation services may differ in their regional penetration. Especially the northern part of the state with extensive rural areas and small towns with relatively large distances in between are vulnerable to service shortfalls. Exhibit 19 shows the geographic penetration of vocational rehabilitation services. Contrary to expectations, the northernmost county, Coos, does not appear to be underrepresented within the RSA sample. Neither do Grafton and Carroll whose northern portions are relatively rural. The only county that is noticeably underrepresented in our sample is Rockingham, which constitutes the southwestern corner of the state. On the other hand, people with disabilities residing in Cheshire in the southeast are slightly overrepresented in our sample compared to the county’s share in the state’s overall population with disabilities.

### Exhibit 19. Geographic Distribution of the RSA Sample Compared to the State's Residents with Disabilities



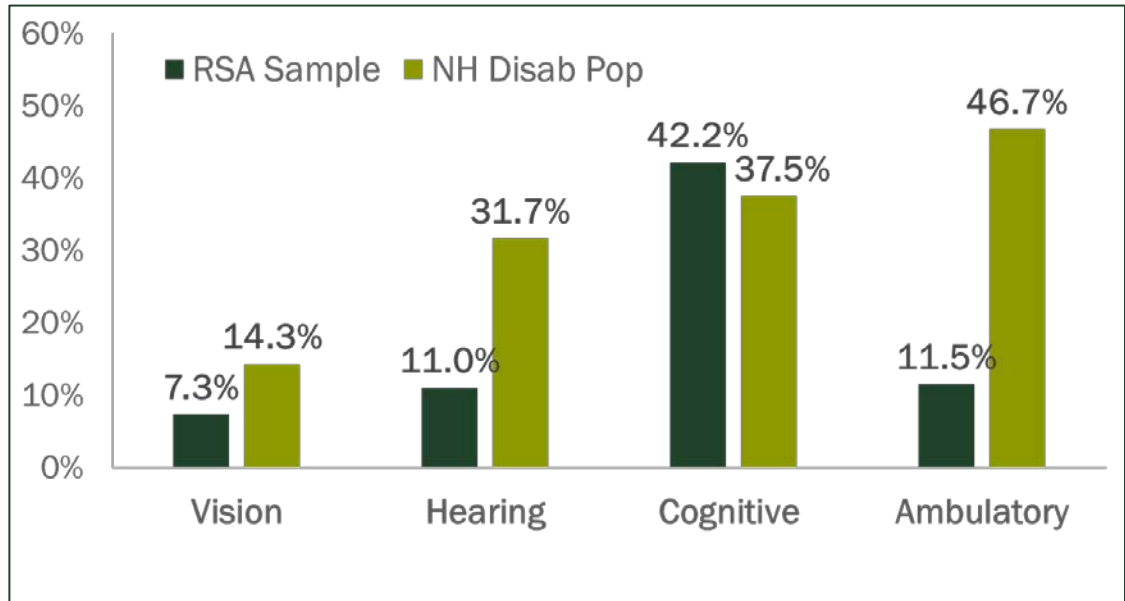
Source for sample data: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4.

Information on county of residence was available for 5,597 participants.

Source for population data: Houtenville, A., & Boege, S. (2019). *Facts & Figures: The 2019 Report on Disability in New Hampshire*. Durham, NH: University of New Hampshire, Institute on Disability.

To address the question, “Do NHVR services reach people with different types of disability equally well?,” we compared the distribution of disability types in our sample with the state’s overall population with disabilities. As indicated earlier, the population data come from the *American Community Survey*; this restricted the type of comparisons that were possible. The survey asks whether the person has “any” of four impairment types: vision, hearing, cognitive, and ambulatory. To maximize comparability of the population data with the RSA sample, we coded a participant as having a given impairment if they had that impairment either as a primary or secondary disability. Exhibit 20 shows the results of the comparison. Of the four impairment categories that could be compared to population data, only cognitive impairments were more prevalent in the sample than in the overall population with disabilities (42.2% compared with 37.5%). The largest discrepancy in representation is observed among people with ambulatory disabilities. Although they comprise 46.7% of the people with disabilities in the state, their share in the sample is only 11.5%. People with vision and hearing impairments are also underrepresented in the sample. Although these comparisons provide useful clues to service penetration, they should be interpreted with caution. Every effort was made to maximize the comparability of these categories across the two data sources; however, some definitional differences remain. Differences in data collection methods also lead to “noise” in comparing these two distributions. It should also be kept in mind that survey data are subject to error. Finally, it is important to keep in mind that the sample is restricted to participants receiving services from NHVR. Individuals receiving rehabilitation services from other agencies or organizations within the statewide service system are not represented in the RSA sample, but are represented in other parts of the analysis.

**Exhibit 20. Disability (Primary or Secondary) Distribution of the RSA Sample Compared to NH’s Residents with Disabilities**



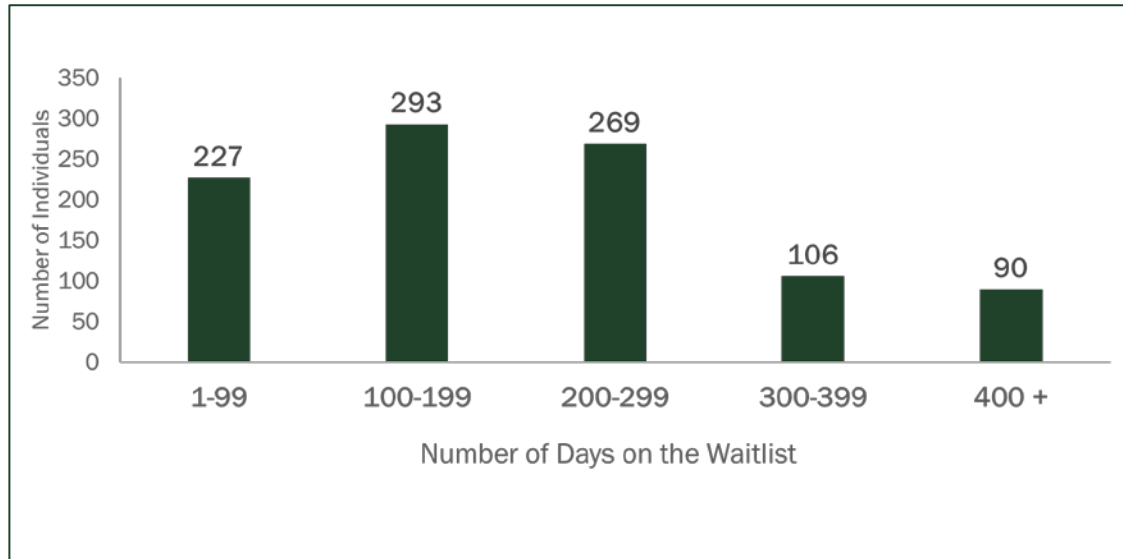
Source for sample data: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. Impairment assessment information was available for 5,302 participants.  
 Source for population data: U.S. Census Bureau, American Community Survey. State estimates are from the 2013 – 2017 five-year sample.

## Impact of the Order of Selection

At the time of this study, NHVR had a waitlist for services that went into effect during May 2018. The case-level RSA 911 database used for this study was extracted at the end of June 2019, providing approximately 13 months of data spanning this period. During that period, 1,548 applicants were placed on the OOS waiting list and 985 exited the list. The age, gender, and race/ethnicity characteristics of those placed on the waiting list were similar to the sample as a whole.

The average time between entering and exiting the waiting list was slightly over 6 months (191 days). Exhibit 21 shows the distribution of wait duration among waitlisted applicants. Of the 985 individuals who exited the waiting list before the end of June 2019, 227 (23.0%) waited less than 100 days, 562 (57.1%) waited between 100 and 300 days, and 196 (19.9%) waited more than 300 days before being released from the list.

## Exhibit 21. Distribution of Wait Duration Among Waitlisted Individuals



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4.

As mentioned earlier, the waiting list had three categories with those disabilities were assessed as “most significant” placed in Category 1 (highest priority), those with “significant” disabilities in Category 2 and those with “less significant” disabilities in Category 3 (lowest priority). Distribution of the 1,548 waitlisted individuals across these three categories was as follows:

- Most significant disability: 763 (49.3%)
- Significant disability: 712 (46.0%)
- Less significant disability: 73 (4.7%)

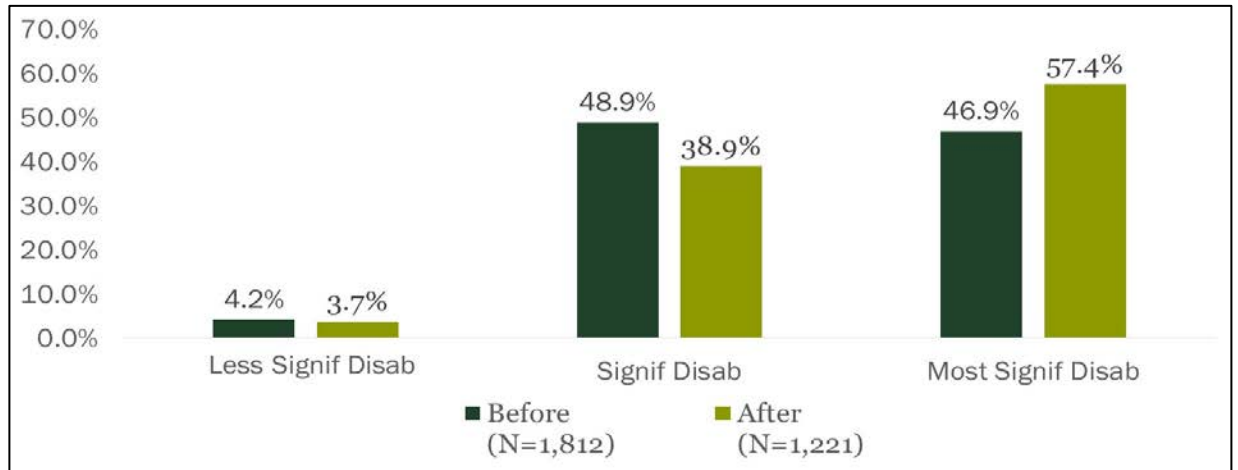
As would be expected, time on the waiting list heavily depended on one’s disability assessment. Average wait time was slightly under 5 months for those assessed as having a most significant disability while those whose disability was assessed as significant remained on the waitlist for about a year. Only 6 individuals assessed as having less significant disability exited the waiting list, an insufficient sample size for statistical analysis.

To further investigate the impact of the OOS on participant experience, we compared disability assessment and time between application and eligibility assessment of individuals who applied for services after the OOS came into effect with those who applied during the 13 months preceding the OOS, that is, between April 1, 2017 and April 30, 2018. Limiting the comparison group to the period immediately preceding the OOS reduces the likelihood that differences observed between the two groups were due to policy changes other than the OOS.

As mentioned earlier, the OOS introduced additional consequences to the assessment of disability significance; upon application for services, one’s placement on the waiting list was determined by the outcome of that assessment. Considering the increased relevance of the assessment, NHVR took measures to ensure the

consistency of the assessment across the state. New assessment forms were introduced and staff underwent special training in the assessment process. We compared assessment results during the 14-month period preceding the OOS to assessments during the 14-month period following the OOS to explore the impact of these measures (Exhibit 22). The results indicate that applicants were less likely to be assessed as having a most significant disability before than after the OOS start date (46.9% before and 57.4% after). There was a corresponding decrease in the percentage of applicants assessed with significant disabilities (48.9% before and 38.9% after).

**Exhibit 22. Assessment of Disability Significance Before and After May 1, 2018**



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4.

We also compared the average time between application and service eligibility assessment before and after the OOS. Before the OOS, applicants waited an average of 38 days to have their eligibility determined. After the OOS went into effect, this period increased to 47 days.

## Employment Outcomes at Program Exit

In this section we investigate the employment outcomes of closed cases. The RSA sample contains 2,446 closed cases and 2,341 unique individuals with exit dates between October 1, 2017 and June 28, 2019. Only 21 of these individuals were younger than 18, two-thirds were between 18 and 49, and a third were older than 50. Similar to the sample as a whole, slightly over half were male and over 90% were identified as White, non-Hispanic. The disability significance of these participants was assessed as follows:

- Most Significant: 45.5%
- Significant: 49.6%
- Less significant: 4.8%

105 of the participants in the sample had two closed cases. For the purposes of outcome analysis, each closed case is treated as a separate outcome since each is associated with potentially different service needs. Participants can have multiple cases with the agency over time to assist them with rehabilitation needs and advancement.

At the time of the Individualized Plan for Employment (IPE) determination, the weekly earnings averaged over all cases that were closed on or before June 28, 2019 was \$107.50. At exit, this average had increased to \$170.50. The earnings of unemployed individuals are included as \$0 in these averages to account for the overall change in the employment status of participants who were unemployed at IPE determination and employed at exit.

Average wages calculated only among employed participants provides a more accurate picture of the earning potential of service users. The average weekly earnings of *employed* participants was \$408.28 at IPE determination and \$381.79 at exit. The number of employed participants was 644 at IPE determination, increasing to 1,066 at exit. The decrease in average wage among employed participants is likely due to the relatively lower starting wages of newly-employed participants who had been unemployed at IPE determination but employed at exit.

We constructed a measure of successful outcome in line with the key aim of vocational rehabilitation services, that is, to help participants obtain or maintain existing employment. The measure counts a case as a successful outcome if:

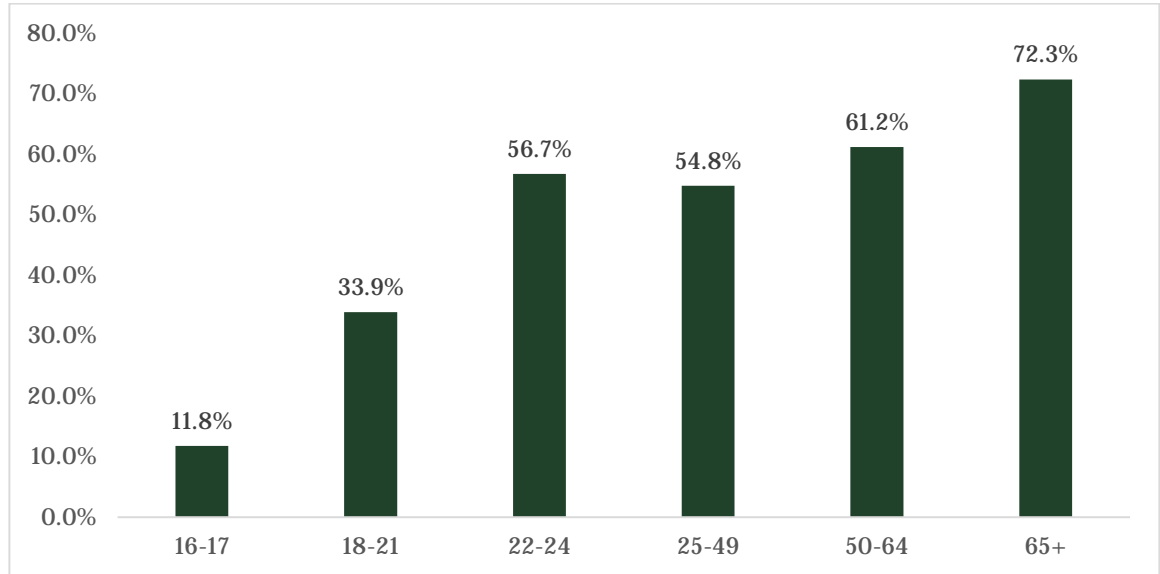
- The participant had no employment at the time of IPE determination and gained employment by program exit; or
- The participant already had a job at IPE and increased her/his weekly earnings (by increasing hourly wages, weekly hours worked, or both); or
- The participant already had a job at IPE and remained within \$1 of her/his hourly wages at program exit (i.e., maintained her/his income).

Applying this definition of “success,” 54.2% of the closed cases qualified as successful closures. This calculation and the outcome analysis that follows excludes cases where the participant could not be employed due to reasons external to NHVR. These are cases for which the reason for exit included transfer to another agency, institutionalization, criminal justice involvement, non-eligibility for services, or a medical condition that prevented service provision for the coming 90 days.

Exhibit 23 breaks down the success rate by age group. Likelihood of success significantly increases with age ( $p < 0.001$ ). Compared to 33.9% of participants ages 18 – 21, those ages 22 – 24 had a 56.7% success rate. This figure is slightly lower for the 25 – 49 age group (54.8%) but steadily increases through older ages to reach 72.3% in the 65+ age group. Although the oldest group would be expected to find it harder than others to become employed due to the reluctance of employers to hire

older candidates, this group may have met the definition of success by increasing their income through increased hourly wages or weekly work hours.

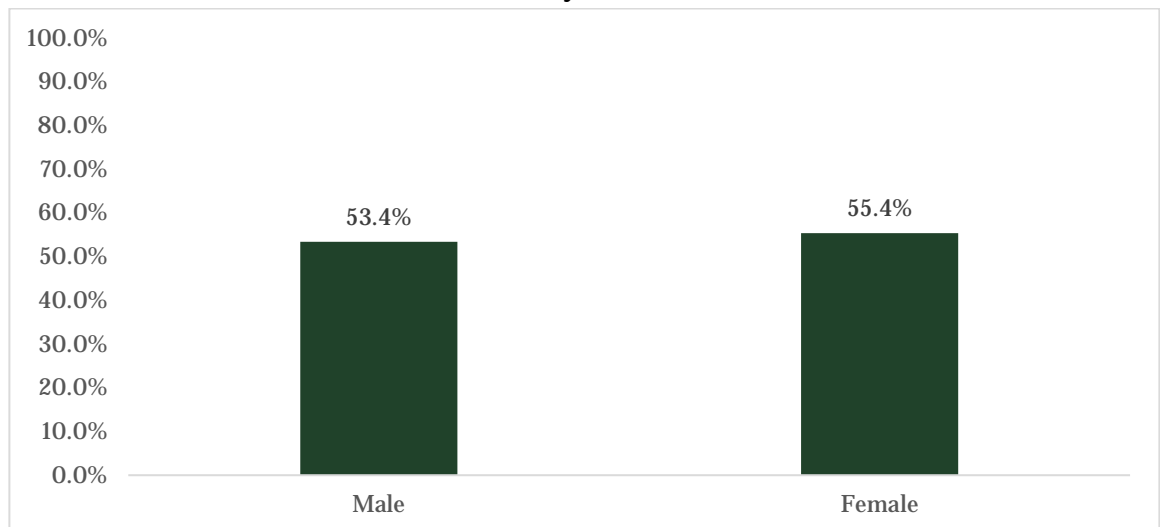
### Exhibit 23. Successful Outcomes by Age Group



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. There were 17 participants ages 16-17; 378 participants ages 18-21; 284 participants ages 22-24; 893 participants ages 25-49; 600 participants ages 50-64 and 184 participants age 65 or older.

Exhibit 24 breaks down case-level success rates by gender. Over half of both male and female participants had successful outcomes; there was no significant outcome difference by gender ( $p = 0.346$ ).

### Exhibit 24. Successful Outcomes by Gender



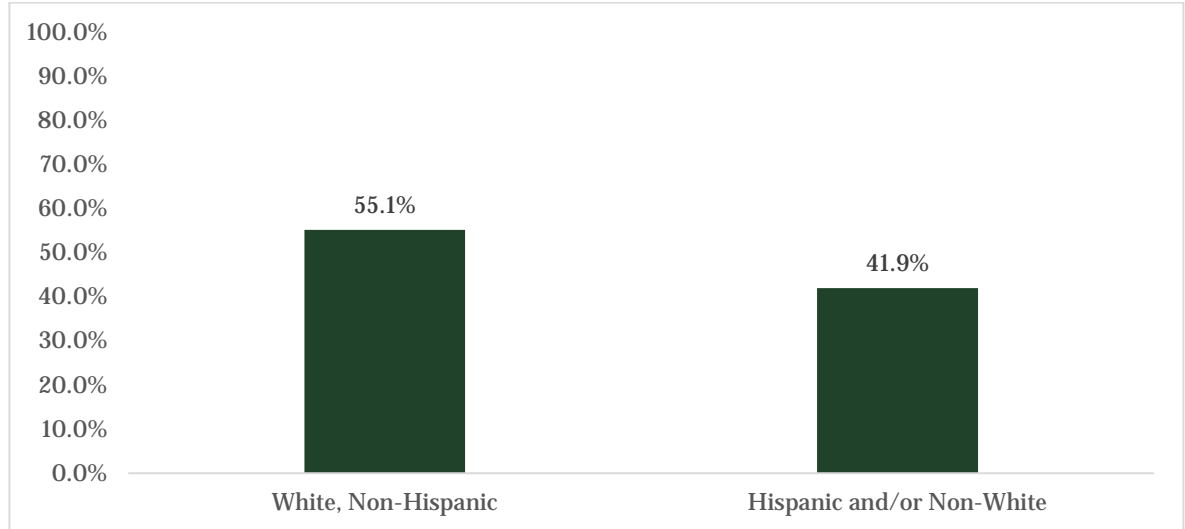
Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. The chart is based on data from 1,280 male and 1,084 female participants.

Exhibit 25 examines outcomes by race/ethnicity. White, non-Hispanic participants had a success rate of 55.1% compared to 41.9% among non-White and/or Hispanic



participants. Although the number of minority participants with closed cases was considerably smaller than White, non-Hispanic participants (155 vs. 2,210), this difference is statistically significant ( $p = 0.001$ ).

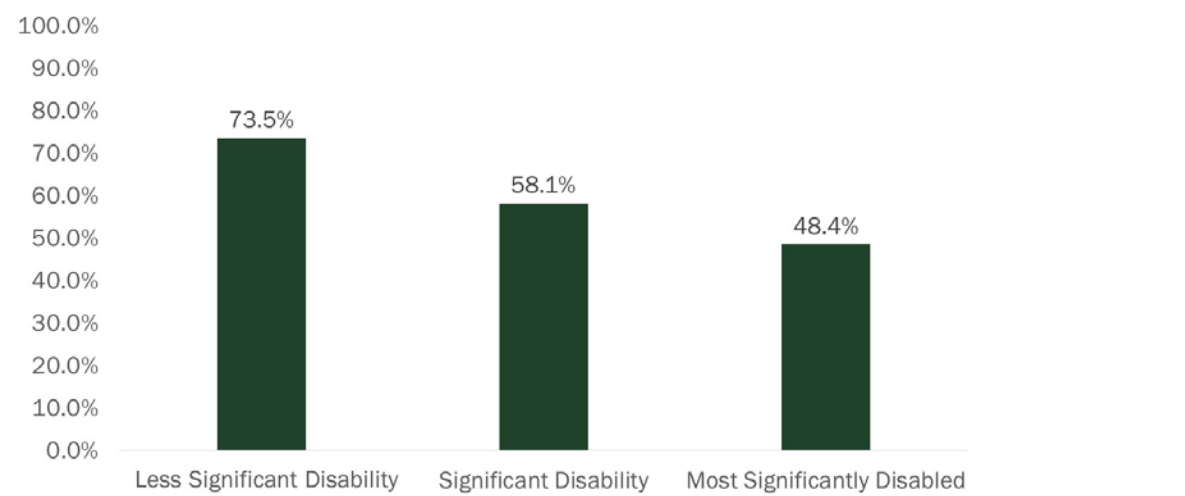
**Exhibit 25. Successful Outcomes by Race/Ethnicity**



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. The chart is based on data from 2,210 White, non-Hispanic participants and 155 non-White or Hispanic participants.

Finally, we look at success rates separately by extent of disability (Exhibit 26). As would be expected, the success rate significantly decreased as the extent of disability increased ( $p < 0.001$ ). The success rate was 48.4% for cases associated with the most significant disabilities, compared to 58.1% of cases assessed as “significant.” The relatively few cases for participants with less significant disabilities had a success rate of 73.5%.

**Exhibit 26. Successful Outcomes by Disability Significance**



Source: New Hampshire Vocational Rehabilitation RSA-911 data for Program Year 2018, Quarter 4. The chart is based on data from 113 participants with less significant disabilities, 1,162 participants with significant disabilities, and 1,085 participants with most significant disabilities.

## Future Size of New Hampshire's Population Most Likely to Need Vocational Rehabilitation Services

In estimating forecasted numbers of New Hampshire residents with disabilities, we applied estimates of disability prevalence rates based on 2017 ACS data to projected population sizes in 2020 and 2025. The assumption underlying this projection method is that prevalence rates will remain relatively stable and the major component of change will be overall population size and age composition. Detailed results of the projections by age group and type of disability and information on data sources are available in the Appendix. This section presents a brief summary of the potential need for vocational rehabilitation services in the coming years, focusing on ages 18 through 64, the age group most likely to need these services.

In 2017, there were an estimated **83,940** New Hampshire residents with a disability ages 18 through 64. This number is projected to be **93,273** in 2020 and **93,432** in 2025. The type of impairment provides information about the types of rehabilitation services that an individual is likely to need. Exhibit 27 shows estimated and projected numbers of NH residents by the type of impairment, using the ACS disability categories described earlier in this section.

Exhibit 27. Estimated and Projected Numbers of NH Residents with Disabilities Ages 18 Through 64, by Type of Impairment

<b>Impairment Type</b>	<b>2017</b>	<b>2020</b>	<b>2025</b>
Hearing Difficulty	18,479	20,514	20,628
Vision Difficulty	11,550	13,057	13,094
Cognitive Difficulty	37,198	41,055	40,919
Ambulatory Difficulty	35,900	39,470	39,743
Self-Care Difficulty	12,528	13,679	13,722
Independent Living Difficulty	28,387	31,718	31,704
<b>At Least One Impairment</b>	<b>83,940</b>	<b>93,273</b>	<b>93,432</b>

Population forecasts are useful clues to the extent of need for statewide rehabilitation services in coming years. However, it is important to keep in mind that they are based on several layers of statistical estimation procedures, all of which involve error margins. The numbers reported in this section and in the Appendix should be interpreted with this caveat in mind.

## Implications of the Quantitative Results for Statewide Service Needs

### Individuals with Cognitive and Psychosocial Impairments

Exhibits 14 and 15 above indicate that cognitive and psychosocial disabilities are the most prevalent assessment categories among service users, both as primary and secondary impairments. This suggests a need for counselors sufficiently skilled in serving participants with mental health issues and intellectual and developmental disabilities. These participants likely need additional services provided by other state agencies, such as the Bureau of Mental Health Services and the Bureau of Developmental Services, suggesting the need for strong links between NHVR and these agencies, both at the management and field staff levels.

The second take-away from the distribution of impairments among NHVR's participants is the prevalence of co-occurring disabilities. The majority (66.0%) of participants were assessed with a secondary impairment, most often cognitive or psychosocial in nature. This observation suggests the need for service menus and counselors with skills suited to the needs of individuals with complex disabilities. In addition, the prevalence of cognitive impairments among participants points to a need for outreach to provide information about available services and means of access, delivered in a manner suited to the needs of individuals with intellectual and developmental disabilities. These individuals can also benefit from enhanced help in navigating the statewide service system, understanding the requirements, and learning about the slate of available services, from initial application all the way to case closure. Another point to consider is that the families of individuals with complex disabilities have multiple stressors in their lives. Communications with them require sensitivity and appropriate messaging, a further need for special training to direct service providers. These were all brought up by multiple key informants and focus group participants as service needs of individuals with complex disabilities, as discussed in more detail later in the report under qualitative results.

### Low-Income Individuals with Disabilities

Exhibits 5 and 7 highlight the earning and poverty gaps between NH residents with and without disabilities and suggest that low-income people with disabilities will benefit from additional supports and services to help them obtain gainful employment and, if already employed, to enhance their income.

During 2017, New Hampshire's seasonally-adjusted average unemployment rate was 2.7% compared to the national rate of 4.4%, the lowest in New England (U.S. Bureau of Labor Statistics, 2019). During the past decade, growth in the state's labor force has been accompanied by employment growth, keeping unemployment low (New Hampshire Employment Security, 2018). In fact, there were press reports that NH businesses were "scramble[ing] to find enough workers to fill open positions"

(National Public Radio, 2018). These trends indicate that the state's job market is favorable to job seekers in salary negotiations.

The state's poverty and earning gaps may be an indication of the challenges that people with disabilities face in the job market. Services to help them overcome these challenges are especially crucial for low-income individuals. For example, low-income households may have limited time and resources needed to learn about available rehabilitation services and to help a family member with disabilities navigate these services. This suggests that increased outreach in low-income areas to educate these communities about rehabilitation services available through the statewide system and the steps needed to obtain these services will be helpful. Low-income families with family members with disabilities may also benefit from self-advocacy education. In addition to services to help low-income individuals with disabilities obtain and maintain sufficient earnings, statewide efforts to inform the business community of this pool of potential workers will help address the earning and poverty gaps.

One rough estimate of the level of statewide need for efforts to improve the earnings of people with disabilities is the statewide number of people with disabilities who would benefit most from these efforts. In 2017, between 41,864 and 47,606 NH residents with disabilities lived under 150% of the federal poverty threshold and the majority were either transitional- or working-age.<sup>3</sup> This group would likely benefit from help in enhancing their earnings. As another indicator of the statewide population that would benefit from employment supports and a business community more open to hiring individuals with disability, we also looked at numbers of working-age people with disabilities who are not in the labor force (i.e., neither employed nor actively looking for work). Based on data from the 2017 *Current Population Survey*, a New Hampshire Employment Security report (2018) estimated that 54,590 working-age New Hampshire residents who were not in the labor force reported their disability as their reason for this. This is a population group that would benefit both from a more receptive business community and services and supports to help them connect with the job market.

## Minorities with Disabilities

There are two quantitative analysis results that provide information about the specific service needs of the state's minority population with disabilities. First, our outcome analysis indicated that Non-White or Hispanic participants of NHVR services were less likely than the rest of the participants to have a successful outcome at exit. This difference was statistically significant in spite of the relatively small number of minorities in the analysis (N=155). There are multiple likely factors underlying this discrepancy, suggesting the need for further investigation. It is quite possible that the business environment in this predominantly White, non-Hispanic state poses additional challenges for minorities with disabilities. This would suggest services tailored to those specific needs and for the statewide service system to work with the

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<sup>3</sup> Estimates and error margins derived from the 2013-2017 *American Community Survey*, 5-year sample.

business community to increase the receptiveness of the labor market to minorities with disabilities seeking jobs. This group may also benefit from self-advocacy education tailored to overcoming the multi-layered discrimination experienced by racial/ethnic minorities with disabilities. The size of the state's minority population with disabilities may serve as a rough proxy for potential users of such services. In 2017, there were an estimated 11,000 NH residents with disabilities who identified with a racial/ethnic group other than "White, non-Hispanic." Over half of them were within the age group typically identified as transitional- or working-age.

The second relevant quantitative result discussed earlier in this section is that the state's minority students with disabilities may be underrepresented among NHVR's service users. This result warrants further investigation to determine whether minority students experience specific difficulties in accessing pre-employment and transitional supports. According to the 2018 Statewide Census of Disability conducted by the NH Department of Education, there were 4,162 minority students with disabilities in the state. Minority youth with disabilities who have dropped out of school are not included in this number but may be an especially vulnerable group that could benefit from outreach and tailored services.

## Women with Disabilities

Whereas women and girls constitute roughly half of the state's residents with disabilities, they represent about 45% of NHVR's service users. It is not clear to what extent this discrepancy can be explained by the lower representation of women in the labor force *in general* for reasons such as retirement or full-time home and family care. It is worth investigating further whether service access barriers contribute to the lower utilization of available services among women compared to men with disabilities. The 2018 study by New Hampshire Employment Security report cited above provides numbers that may be a clue to unmet need for employment support among working-age women with disabilities: In 2017, more women than men living in New Hampshire reported disability as the main reason why they were not in the labor force (30,496 women vs. 24,094 men). As noted earlier, all working-age individuals prevented by a disability from joining the labor force could benefit from vocational rehabilitation services. These numbers suggests that there are more women than men in this category.

Our outcome analysis indicated that women who do receive services from NHVR are equally as likely as men to have a successful outcome at exit.

# Qualitative Analysis Results

Key Informant Interviews (KII) and Focus Groups (FG) provided the opportunity to gather first-person narratives and perspectives on the statewide vocational rehabilitation service system. The informants who participated in the KIIs and the FGs came from a variety of locations and were related to the statewide service system in differing ways. Our informants also varied in terms of their exposure to and level of knowledge of the statewide service system.

FGs and KIIs provided an opportunity to understand the rehabilitation needs of individuals with disabilities across the state. The concerns with the statewide system expressed in the KII and FGs can be examined to understand where and how to focus energy to engage and enroll people who are finding it difficult to navigate the state's service system.

In the rest of this section, we review recurring themes that emerged from our qualitative analysis of stakeholder interviews and focus groups with service participants, potential participants, and their families. Opinions expressed by informants during KIIs and FGs are discussed with careful consideration of the informant's position within the system and are weighted by their level of exposure to the system before rising to the level of a qualitative analysis result. For example, an observation by a single stakeholder is not considered an analysis result unless corroborated by others with different positions within the system. Likewise, an observation made by an informant with limited experience of the system is not reported as an analysis result unless corroborated by multiple informants with similar experience.

## Overall Service Needs – Needs of multiple population groups

The needs discussed in this section were noted by KIIs and FGs as affecting the accessibility of statewide rehabilitation services for multiple potential and current service recipients, highlighting possible opportunities for improvement within the system.

### Need for Accessible Transportation

Numerous informants brought up the difficulty in accessing transportation. Informants discussed the obstacles encountered in getting to and from work sites and rehabilitation-related meetings. These obstacles were reported to affect members of several potentially underserved populations.

Transportation difficulties are experienced more acutely in rural areas, especially in the northern parts of the state. These regions typically have small towns located far apart from each other and from larger urban centers. The lack of public transportation, taxi or ride-share options in these regions is compounded by the lack

of transportation vendors. In addition, people living in these areas experience more poverty and thus may have less access to personal transportation, such as owning or leasing a car or an accessible van.

The state has the organizational infrastructure in place for addressing this need. Established in 2007, the State Coordinating Council for Community Transportation (SCC) brings together representatives from the Departments of Transportation, Health and Human Services, Education, and the Governor's Commission on Disability. Additional organizational partners include the UNH Institute on Disability, NH branch of the American Association of Retired Persons (AARP), Easter Seals, the community action agencies, regional planning commissions, the Coalition of Aging Services, the Endowment for Health, and Granite State Independent Living. The state is divided into nine (9) Community Transportation Regions with each region represented by its own Regional Coordination Council (RCC) that brings together local transportation providers and service agencies/organizations (SCC, 2019). This organizational structure provides a suitable platform for addressing the transportation needs of people with disabilities both at the state and regional levels.

## Rehabilitation Services Workforce Stability

The statewide workforce helping those with disabilities to look for and maintain work is comprised of numerous roles and responsibilities. Multiple KIIs and FG participants emphasized the dedication evidenced by employees at all levels of the statewide service system and those informants that reported being able to access services feel like their needs are being met.

Informants in both KIIs and FGs noted a need to address the high turnover of the overall statewide vocational rehabilitation workforce. This includes turnover of assessment providers, counselors at the regional offices, transition and pre-transition employment specialists, support staff at the regional offices to help with reporting and paperwork, job developers and coaches and other direct support professionals, and the availability of Community Rehabilitation Providers (CRP) in certain areas.

Based on the frequency with which this factor was brought up in KIIs and FGs, staff turnover is a pervasive issue for the statewide vocational rehabilitation system. Informants claimed that workforce turnover makes it difficult for service recipients of various populations to experience the continuity and quality of services that they need and expect. Participant and family informants noted the disruption caused when a counselor or coach leaves his/her position. This point was most strongly stressed in the context of co-occurring multiple disabilities or disabilities co-occurring with mental health problems. One informant's narrative was typical in this respect: She noted that her family member with multiple disabilities had been placed with several different counselors since the family began working with the vocational rehabilitation system a few years ago. She noted that each time the counselor changes it "feels like you have to start from the beginning" of the job placement process. This can be particularly disorienting for participants with Autism Spectrum Disorder for whom a stable social environment and established routines are crucial.



Regional office staff and Key Informants affiliated with provider organizations also noted that the difficulties caused by frequent staff turnover such as incurred overtime by the remaining staff, costs of training and onboarding new staff, and loss of institutional knowledge and awareness of local opportunities and resources can affect the financial stability of CRPs, limiting their availability to dedicate time and other resources to customizing employment opportunities for people with complex disabilities. The loss of local contacts, institutional knowledge and awareness of local opportunities resulting from frequent turnover can similarly limit the vocational rehabilitation system's ability to find employment opportunities for those with unique needs and job goals.

## Communication, Outreach, and Community Education

Multiple informants with lived experience or representing advocacy groups noted a need for more frequent communication from NHVR offices, both central and regional. They noted a need for more accessible language in explanations of available services, eligibility, access procedures, and updates about policy changes.

Informants noted that the communications often used high-level language that was inaccessible to those with lower reading levels. This was particularly noted in regard to communications about the Order of Selection and what it meant for participants and their families. The need for simpler explanations of vocational rehabilitation policies was brought up by participants of multiple focus groups and generated long and spirited conversations. For example, most focus group participants were under the impression that the categorized waiting list was simply a new policy; it was not clear to most that it was a temporary measure and that the agency was making every effort to resume normal services. Based on our quantitative results that cognitive disability is the most prevalent primary disability of vocational rehabilitation service users, it is critical that communications from agencies within the statewide service system be accessible to individuals of all reading levels to ensure that all populations can access information at the same level.

Participants and family members noted a need for clearer and more accessible instructions on the vocational rehabilitation process. Some informants noted that they were often confused as to what the next steps were in their service system experience. As a result, some participants and their families felt alienated and lost in the process. The narrative from one family member is a typical example of the types of communication difficulties related by participants: The family received a phone call from a counselor informing them that their son's case was being closed because the family had taken no action in recent months, while they had assumed that the next step was NHVR's responsibility.

Relatedly, family members and service participants conveyed the need for a central place to go to access information about all the supports that NHVR can provide. They were not aware of a website or other information source that described the service "menu." Most informants relied on word-of-mouth information about available services from others. An informant said: "Our counselor says they don't have a 'menu'



of services but without any idea about what a person might be eligible for, families have no idea what is possible.” For example, one focus group participant expressed difficulty finding information about vehicle modification support available to NHVR service recipients.

Informants also noted a need for a more standardized, consistent information dissemination process. For example, in focus groups, participants reported learning about the Order of Selection from a variety of sources with varying information content. Some families reported hearing the news from their counselor, some through friends, and some had not heard about the Order of Selection at all. A more consistent process for information dissemination can also help prevent the spread of misinformation, such as the mistaken belief that the Order of Selection was a permanent policy change as opposed to a temporary action designed to remedy current financial issues. Consistency in messaging could help strengthen the reach and effectiveness of statewide vocational rehabilitation services in important ways. For example, the spread of misinformation about the Order of Selection to potential participants may have discouraged some from applying for services.

Focus group participants also brought to light the need for a different strategy to inform stakeholders of the Client Assistance Program (CAP). In one focus group, four informants who voiced grievances about the vocational rehabilitation system were asked whether they had shared these with CAP and all revealed that they had never heard of the CAP. It is quite possible that these families did receive CAP information but failed to fully comprehend it due to the complexity of the language or did not retain the information about the CAP because it was not something they needed at the time the information was delivered.

Regarding outreach, multiple participants and families noted a need for a more streamlined and less complex process for intake into the vocational rehabilitation system. Suggestions included limiting the number of forms and reducing the number of assessments. According to informants, the more complex the process, the more likely a person was to drop out of the system without receiving all the services they needed.

Several informants also noted a need for detailed and accessible information for students with disabilities and their families navigating the IEP and transition-planning process for the first time. They also noted that they would need this information earlier in the process than is currently typical. This last point was also brought up during the SAC retreat and multiple SAC members concurred that students with disabilities and their families need information about available pre-employment and transition support services before they need them. Families indicated that they received insufficient communication or guidance on how to become connected to rehabilitation services at the school level. They noted a need for Pre-Employment Transition Specialists and Transition Specialists from NHVR to visit schools, attend IEP meetings, and talk to students and families about available services and access processes. Enhanced and early communication and outreach

about this process is critical to ensuring the smooth transition of students with disabilities from school to vocational rehabilitation services. This need is particularly acute for students with a history of trauma or behavioral health support needs for other reasons, because they may be less acquainted with the rehabilitation service system and may need additional support navigating the system.

One key stakeholder with extensive knowledge of current statewide services expressed a need for more outreach by the statewide vocational rehabilitation system to potential service participants. The informant noted that the statewide rehabilitation system does not pro-actively contact people who would benefit from services, such as students with IEPs or people who develop disabilities while already part of the workforce. The informant referenced having seen billboards and television advertisements in other states publicizing vocational rehabilitation services to the general public which, they suggested, would help bring those services to eligible individuals currently not connected to the statewide service system.

### Interagency Collaboration

Informants also noted a need for enhanced communication and information sharing between different agencies providing supports to individuals with disabilities. For example, NHVR staff noted that when they received a referral from agencies such as the Bureau of Disability Services (BDS), the school systems, or the Bureau of Behavioral Health (BBH), they often did not receive much information about the potential service recipient beyond demographic information. The completeness and detail of the information received also varied by the referring agency. They indicated that a more standardized and complete sharing of information about newly-referred participants' histories would help NHVR staff in service planning.

In addition, service participants and their families indicated a need for more information about the different agencies offering rehabilitation services, the types of services they offer, and how they collaborate with each other. A typical example of this need is the parent of a student with an intellectual/developmental disability who expressed confusion about how NHVR and BDS work together to help their child maintain long term employment with supports.

Related to the above need, multiple key informants working within the statewide rehabilitation system indicated a need for more standardization and guidance on how multiple bureaus/agencies work together in providing rehabilitation services. For example, all regional NHVR offices work closely with the BDS office in their catchment area ("Area Agencies"); however, there are no statewide standard operating procedures (SOP) for this collaboration. Similarly, multiple NHVR staff and several key informants with knowledge of the statewide system expressed a need to clarify and standardize the collaboration between local school districts and the statewide rehabilitation system to provide students with disabilities a smooth transition from school to the job market.

Results of our qualitative analysis indicate that the need for better coordination among multiple agencies has been acknowledged by the state's vocational rehabilitation leadership, resulting in recent efforts to standardize interagency collaboration. For example, one senior official with extensive knowledge of the statewide service system pointed out that a regional NHVR office had developed an SOP to guide the regional staff in collaborating with the local Area Agency. The official indicated that this draft document was under review and would form the basis for a statewide guidance document that would go a long way toward standardizing the collaboration at the field level. Another statewide effort in this direction is a Memorandum of Understanding currently under development between NHVR and the Department of Health and Human Services, the umbrella agency under which BDS operates. Officials also mentioned the formation of the Employment Leadership Committee (ELC) as a positive development in interagency collaboration. Comprised of representatives from the Area Agencies, NHVR, service vendors, the DD Council, New Hampshire Employment Security, and the University of New Hampshire Institute on Disability, ELC meets regularly to discuss issues facing NH residents with disabilities seeking employment and how agencies can work together to mitigate challenges.

These relatively new developments have started to have a positive impact on participants. When probed for positive experiences, multiple informants noted that recently, they have seen more engagement and communication from NHVR in soliciting feedback from participants and regional office staff. They noted opportunities such as open forums and feedback sessions during which NHVR staff asked stakeholders to provide feedback on programs and policies. Informants with long-term knowledge about the statewide vocational rehabilitation system indicated that this is a noted improvement from previous years. They also noted an improved responsiveness to questions and concerns directed to NHVR's Central Office and attributed this change to the increased involvement of the Field Operations Unit.

Several KIIs noted a need for better data sharing between agencies within the statewide system, such as BDS and NHVR. For example, there is a need for a data system that would allow the state to better track employment outcomes for people receiving long-term supports from an area agency, a BDS funded support that is often put in place for individuals in BDS once the short-term vocational rehabilitation services end. More data continuity could allow for more granular analysis of outcomes and the identification of populations that are being underserved or whose outcomes differ from other populations.

## **Service Needs of Students with Disabilities and Transitional Age Youth**

### **Clarity on timing and continuity of services and process of transition**

Several KIIs and FG participants addressed the need for increased continuity in services, particularly for those referred to vocational rehabilitation services from other agencies. For example, a few participants and families expressed confusion about the process for accessing rehabilitation services once an eligible student has graduated from high school. There was a widespread mistaken impression among focus group participants that vocational rehabilitation services are not available between graduation from high school and age 21, the age at which many believed that service eligibility kicks in.

Confusion about the timeline and continuity of services causes people to “fall through the cracks,” and contribute to unmet need for services for youth between graduation (typically around age 18) and age 21. Some of this confusion could be addressed by clear and consistent communication, outreach and resources detailed in the previous section.

### **Need for Pre-Transition Employment Specialists and Transition Specialists**

Families and KIIs noted a need for more Pre-Transition Employment Specialists and Transition Specialists in some areas of the state and some school districts, particularly in the north and western parts of the state. These families and KIIs noted that the reduced number of these specialists limited families’ abilities to obtain information about available transition services and to access such services at the appropriate times. Multiple informants suggested that these specialists should be attending IEP meetings for students in transition and nearing transition. It was noted that the specialists are not able to attend these meetings regularly. As a result, some students may not be learning about available vocational rehabilitation services available in the state and application processes in time to be sufficiently prepared for the next steps. The need for early information and advance preparation was most strongly emphasized by parents of students with multiple disabilities or co-occurring mental health issues for whom abrupt changes in their environment are especially challenging.

## **Service Needs of Individuals with the Most Significant Disabilities**

Several populations were identified as needing additional attention from the statewide rehabilitation system, as perceived by KIIs and FG participants.

## **Multiple disabilities and co-occurring mental health conditions**

Focus groups and KIIs noted a need for more vocational rehabilitation service providers with experience and expertise in complex disabilities or multiple disabilities to help that population achieve positive outcomes. There is a widespread belief among people with disabilities and their families that people with severe, complex, and co-occurring disabilities would likely be assessed as ineligible for vocational rehabilitation services on the grounds that they would not benefit from these services.

In cases when these individuals are able to access services, informants noted a need for increased training and knowledge within the statewide service system about best practices for working with this population, specifically how best to assess skills and goals to customize employment plans for these participants.

In reference to the need for more knowledge within the statewide service system on how to work with people with multiple and complex disabilities, two focus group participants in two different regions noted that their respective family members had been told that they would not benefit from NHVR services, and their cases were closed before finding employment. Several key informants whose positions gave them broad experience of the statewide service system indicated a system-wide need to dispel the inherent ableism that is built into the workforce development process across the state. They concurred with several participants' impression that the current system does not incentivize searching for and supporting employment for people with complex needs, noting that "counselors are not trained to have any expectation of success with these cases." Several key informants mentioned that the current data reporting structure rewards "closures" and shorter times between eligibility determination and placement, reducing the incentive to invest the time and effort into cases that are more complex and may take more time and effort to place successfully. Informants also noted that the determination of "not likely to benefit from vocational rehabilitation" is not applied consistently across the state.

## **Service Needs of Minorities with Disabilities**

Qualitative analysis results do not indicate specific needs related to vocational rehabilitation supports for minority populations with disabilities. However, the need for clearer, more accessible communication from the statewide service system discussed above is most relevant to populations whose cultural background and language present additional challenges to accessing and interpreting informational materials from the service system. This subgroup needs information about available rehabilitation services in the state and the process of accessing those services, in plain language without technical terminology or acronyms.

## Underserved or Unserved Populations

Qualitative analysis of KII and FG transcripts identified several common themes regarding population groups that may not be receiving all the services they need, in response to our probes about the service needs of specific populations.

### Rural residents

KIIs and FG participants noted that there is a need for additional attention from the state's rehabilitation system to the specific circumstances of potential service recipients living in rural areas and the Northern region of the state. The rural areas and the Northern counties have fewer opportunities for success within the rehabilitation service system, as there are fewer resources such as CRPs to choose from, fewer transportation options and fewer potential employers. In addition, it was noted that Internet access and cell-phone services are less consistent in these regions, so people with disabilities living in those areas may have more limited access to information and communications. These factors also limit the capabilities of regional staff to connect people with resources or to stay in touch with participants.

### Deaf and hard of hearing individuals

KIIs noted that there is a need to enhance services available to participants who are deaf or hard of hearing. They stressed the need for easier access to American Sign Language (ASL) interpreters across all regions of the state and more counselor and CRPs trained in ASL.

### Blind and low vision individuals

A similar need for service enhancement was noted in reference to vocational rehabilitation services for blind or visually impaired people, though there is a dedicated NHVR division called Services for The Blind and Visually Impaired (SBVI). Additional services are needed within SBVI for adults and older adults who become blind later in life and consequently need additional assistance adapting to the loss of sight.

### Individuals with substance use disorders

Similar skills needs were noted in reference to interactions between rehabilitation service providers and participants with substance use disorders. Upon discharge from a detoxification or recovery facility, these participants may need rapid-response employment services. More targeted rehabilitation approaches to work with this population may be beneficial.

### Individuals with Autism Spectrum Disorders

KIIs and FGs also noted a need for more knowledge within the rehabilitation system on how to work with people with Autism Spectrum Disorder (ASD). People with ASD may have unique needs within the statewide service system. They may need additional assistance in socialization and office comportment. They may also need



additional help finding a job that meets their specific needs, and employers may need additional information about employing a person with autism (KTER Center, 2017). The need for staff stability discussed earlier is especially relevant to this population. Multiple family members of individuals with disabilities and co-occurring ASD mentioned negative experiences when a service provider with whom their child had bonded left the organization and a new staff member took their place.

### **Individuals with disabilities experiencing homelessness**

KIIs and FGs noted that people without permanent homes may have additional needs in accessing and utilizing rehabilitation services. Not having a permanent home can impose additional stress that can cause a person to miss appointments, be unable to complete paperwork, be unable to receive mail or email, or have difficulty concentrating on issues beyond their immediate stressors. This population may need special outreach efforts and help in navigating the service system. Homeless youth was mentioned as especially vulnerable to service shortfalls.

### **Youth coming out of foster care**

An informant indicated that students with disabilities in foster care may benefit from a more targeted, population-specific transition planning process and vocational rehabilitation services to access employment after high school. Studies have also shown that youth who are transitioning out of foster care and those who are homeless face disadvantages (U.S. Department of Education, 2016; National Center for Homeless Education, 2018) in attaining employment post high school, and increased attention and targeted rehabilitation supports may be a cost-effective method to help these students successfully navigate transition to employment.

## **Needs of NHVR Staff and Community Rehabilitation Providers (CRPs)**

Although not directly related to the rehabilitation needs of NH citizens with disabilities, the needs of regional agency staff and CRPs are intrinsically tied to the outcomes of those receiving or eligible for rehabilitation services. Ensuring that staff and providers are able to do their jobs as best as possible can affect the ability of the statewide system to help all eligible populations reach their employment potentials.

### **Regional Office Staff and Counselors**

Several informants commented on the dedication and perseverance demonstrated by many regional office staff and counselors, particularly since entering the Order of Selection. They noted that the regional office staff and counselors clearly “had their hearts in the right place” and strived to help people as well as possible.

In general, KIIs and FGs noted a need for more training of staff and a need to prioritize hiring counselors experienced with different populations, especially those with more complex disabilities and co-occurring behavioral health challenges.

Participants in several focus groups and multiple KIIs brought up the need for reducing the workload and stress levels of counselors at regional offices. It was noted that the Individualized Plan for Employment (IPE) process needed some changes; they indicated that it took too long and wasn't always sufficiently tailored to the participants' specific interests and goals.

Regional office staff noted that they needed help keeping up with reporting requirements, specifically those for fulfilling WIOA and RSA requirements. These requirements are time consuming for regional offices, which may indicate a need for additional support staff to help with these and other paperwork.

### Community Rehabilitation Programs (CRPs)

Informants from the more populous regions of the state (southern regions, for example) noted that there were adequate numbers of CRPs to whom referrals could be made. However, in the northern regions of the state (the Berlin area, for example) there is a need for more CRPs.

One informant noted that the state's rehabilitation system has an adequate continuum of services on its "menu", but because of vendor shortages, counselors have to be "creative" when trying to craft individually tailored service plans.

Similarly, informants noted a need to address regional disparities in availability of employers to hire people with disabilities. Mirroring the regional differences in unemployment rates across the state with more rural and northern areas such as the Berlin Micropolitan area experiencing higher unemployment than southern and more urban areas (New Hampshire Employment Security, 2019), informants indicated that the northern and more rural areas had fewer employers available to employ participants of vocational rehabilitation services. Viewed together with our quantitative analysis results on the relatively large poverty gap between people with and without a disability, this qualitative insight may indicate that individuals with disabilities living in more rural, northern regions with higher general unemployment rates may need more targeted help from the statewide service system in gaining employment, as options for employment are lower in those areas.

### Observations on the Effects of the Order of Selection (OOS)

As mentioned earlier, this study was conducted during a challenging time for NHVR. Of particular methodological relevance was the fact that the waiting list closely impacted most of the stakeholders we interviewed as well as those who participated in our focus groups. As a result, our qualitative database contains multiple references to individuals' experiences with the waiting list, told from a range of vantage points. Although these observations obviously do not reflect *typical* experiences with the state's rehabilitation services outside of the Order of Selection, they do provide useful and policy-relevant insights into the impact of these measures on service systems. This section briefly describes this impact as related to us by our informants.



## Effects on Participants

Informants noted that the Order of Selection may have exacerbated difficulties in access experienced by some population groups in the state and created new barriers to access. In addition to inconsistencies in the information reaching the public and the spread of misinformation discussed earlier, those who applied for services during the OOS and were put on the waitlist may have dropped out because the wait was too long. Informants noted that the OOS also affected public perceptions of the system. The perceived lack of transparency about the OOS process was also reported to have negatively impacted public trust in the statewide system.

## Effects on Regional Office Staff

According to key informants within the statewide service system, the high turnover rate in all levels of the system was exacerbated by the staffing cuts as a result of the recent Order of Selection. The situation was further exacerbated by the fact that the more experienced and seasoned staff were the most likely to leave in response to negative factors in the work environment, tilting the workforce toward less experienced workers. Not only do the newly-hired staff by nature lack institutional and community knowledge, they often also lack the benefit of mentorship by their more experienced co-workers. Additional training and mentorship may be needed for the newly-hired staff.

In addition, the staffing cuts added to remaining counselors' already-heavy workloads. As a result, as applicants were released from the waiting list, counselors felt pressed to balance their time between intaking new participants and working with their existing ones.

## Effects on Community Rehabilitation Providers

Informants noted that the Order of Selection affected CRPs in two major ways. As would be expected, the number of referrals dropped precipitously. At least one CRP noted that this drop threatened the sustainability of employment services at that agency. In addition, the first disability category to be released from the waiting list were those whose disabilities were assessed as "most significant." Many CRPs were not prepared to provide employment services exclusively to that population. They did not have staff with appropriate skills or training to adequately serve that population. As a result, they were forced to cease working with NHVR.

# Discussion and Recommendations

Both the quantitative and qualitative analyses conducted for this CSNA revealed several areas of need that can be addressed to ensure that all eligible NH citizens receive the rehabilitation services they need. This section discusses some ways that the statewide service system can address these areas. The suggestions resulting from the CSNA range from small process-related alterations to larger system-wide changes. Though they range in scale, we hope each of these suggestions spark imagination and innovation within the system and that system-wide improvements will be evident in the next CSNA.

## Transportation

The need for expanded accessible transportation was a common theme noted in the KIIs and FGs. In reference to the northern and more rural areas of the state, informants conveyed the difficulty participants experienced both getting to jobs on time, but also getting to meetings with rehabilitation service providers and job interviews. In conjunction with the numerous forms that needed to be filled out and returned in order to access services, the travel requirements for both participants and their families pointed to a need for more transportation options to ensure that service recipients across the state are able to access the system without undue burden.

## Suggestions

- Explore creating forms that can be completed online or downloadable, fillable PDF forms that can be completed and emailed to the appropriate parties.
- Explore the possibility of using online video-conferencing technology to replace some meetings. Further research into tele-health models can aid in the development of protocols for this mode.
- Investigate implementing more micro-transit collaborations in rural areas. Micro-transit is privately operated transit systems that may be on demand or run on a schedule with designated stops.
- Work with the SCC, RCCs, and CRPs to help them collaborate on transportation options. For example, CRPs and other disability/aging provider agencies in rural areas could share the cost of a fleet of vans and a dispatcher.

Such collaborations might take the form of:

- Sharing a vehicle between multiple provider organizations in the same town or neighboring communities
- Sharing a pool of drivers across multiple organization

- Sharing a single dispatch system across providers in the same region or statewide
- Investigate implementing a Transportation Reimbursement and Information Program (TRIP) model for friends/community members willing and able to provide transportation. See the [Independent Living Project](#) website for more information.
- Create an accessible website or application to aid participants and CRPs experiencing transportation difficulties. This website could include information on transportation instruction, creating a volunteer transportation network, partnering and coordinating with other organizations, etc. The site could also aggregate funding opportunities for local transportation initiatives. See the [Massachusetts Human Service Agencies and Community Transportation](#) webpage for an example from a neighboring state.

## Workforce Development

The need to address the high turnover among counselors, job coaches and job developers was another recurring theme in KII and FGs. In addition, as indicated earlier, informants conveyed a need for training rehabilitation service providers on service provision to participants with complex disabilities, mental health issues, and substance use disorders. Additional training efforts on evidence based practices in job placement for people with disabilities would also help enhance the statewide rehabilitation service system.

Informants also noted a need for an expanded network of CRPs in the northern and more rural areas and a need for more pre-transition employment specialists and transition specialists across the state.

## Suggestions

- Begin a data collection effort on the vocational rehabilitation workforce (counselors, job coaches, job developers, etc.) across the state. This can take the form of a survey administered to CRP/regional office HR or payroll staff and could include information from regional offices and CRPs on staff turnover rates, wages, vacancy rates, length of employment of workers on payroll and numbers that left the organization within the past year. Using this information, NHVR can examine areas of need, look at the relationship of staff stability and outcomes, identify trends, benchmark and investigate the impact of potential workforce initiatives to address workforce stability and quality.
- Develop a state-wide specialty unit that is highly trained in job-search and transition methodologies for people with complex disabilities. For example, the state could create a subset of counselors trained in specific disabilities

(Autism Spectrum Disorder, behavioral challenges, intellectual and developmental disabilities, etc.). This specialty unit could mobilize and provide services at various regional offices across the state depending on need.

- CRPs might consider creating a special unit trained to find customized employment for those with complex needs.
- The statewide vocational rehabilitation service system could re-examine the counselor training curricula. A revised curriculum could include training on evidence-based practices for employment of people with disabilities such as
  - Individual Placement and Support
  - Solution-Focused Brief Therapy
  - Behavioral Activation
  - Psychological Capacity
  - Positive Psychotherapy
  - Acceptance and Commitment Therapy
  - Mindfulness-Based Interventions

[The Rehabilitation Research & Training Center for Evidence-Based Practice in Vocational Rehabilitation \(RRTC-EBP VR\)](#) offers useful resources and their [Evidence-Based Practice Counselor Toolkit Vocational Rehabilitation Curriculum For People with Disabilities](#) is a good resource for counselors to become familiar with these practices.

## Interagency Communication, Outreach, and Community Education

KIIs and FGs noted a need for improvement in internal and external communications, collaboration and outreach.

Informants revealed a need for clearer and more accessible written communications from NHVR. Furthermore, there is a need for a more standardized information dissemination strategy about available rehabilitation services. Informants noted the need for less burdensome and more streamlined paperwork for individuals and families to complete throughout the rehabilitation process. KIIs and FGs revealed that there is a need for more clarity and information on the Governor's Commission on Disabilities Client Assistance Program (CAP) and how it can help participants navigate the service system.

Enhanced communication between state agencies/bureaus within the rehabilitation service system was also indicated as an area of need. For example, the Bureau of

Developmental Services and NHVR often provide services to the same individuals and needed more standardized processes to share data in an efficient and consistent manner. This need for standardized communication is also evident at the regional level, where BDS Area Agencies and NHVR Regional Offices may need more standardized guidelines on processes and responsibilities when providing services to the same individuals.

Communication between the regional offices and CRPs is another area of communication that offers opportunities for enhancement. Informants noted that CRPs are often provided with very basic demographic information about participants when they receive a referral; more detailed and standardized information would help participants by providing enhanced service continuity and a smoother transition between providers.

## Suggestions

- State agencies within the vocational rehabilitation system could work on developing communications that use more accessible language and formatting. Consider using different media to communicate, such as videos and infographics. This online toolkit from The [Model Systems Knowledge Translation Center has an online toolkit](#) with useful templates.
- Consider a more dynamic, user-friendly Vocational Rehabilitation System website with an interface that guides users to resources. The [website developed by the Delaware Division of Vocational Rehabilitation](#) is an example of such an interface.
- Various agencies providing vocational rehabilitation services across the state could collaborate to develop a standard information dissemination protocol to increase reach and minimize misinformation. This can include multiple modes of information sharing such as emails, letters, verbal communications from counselors, etc.
- Through collaborations across RCCs, NHVR's regional offices, BDS's Area Agencies, community mental health clinics, and local CRPs, disseminate directories of available transportation options for people with disabilities. Each transportation region already has a directory of community transportation providers. These could be customized to the needs of people with disabilities, frequently updated, widely distributed within the region's rehabilitation service system, and provided to each service participant as a routine part of their information package.
- Strengthened interagency collaboration would help streamline services and information sharing. For example, NHVR is in the process of developing an MOU with DHHS. This MOU will outline the responsibilities of respective bureaus, identify areas for collaboration and clarify processes and protocols.

- NHVR and BDS central offices should work together to standardize the communication and data sharing between regional offices and BDS Area Agencies when working with participants eligible for both services. This could be done between regional offices and local school districts, community mental health centers and other regional agencies that work with NHVR to provide rehabilitation services.
- Identify ways to increase the influence of NHVR's outreach and ensure that all eligible New Hampshire citizens are aware of available services. As noted by KII and FG informants, this is a particularly salient need for students with disabilities and their parents/guardians, individuals experiencing homelessness, population groups with limited English knowledge, and youth exiting the foster care system.
- Work with the Client Assistance Program (CAP) to better understand how and when participants and their families are informed of the CAP and how that messaging can be optimally timed, designed and disseminated.

## Continuity

The need for service continuity as a person moves within the statewide service system was a common theme in KIIs and FGs. More specifically, informants felt that the process of transitioning between school and adult vocational rehabilitation services was confusing and, as a result, people often left the service system though supports were still needed.

## Suggestions

- Investigate engaging more workers to be trained as Pre-Employment Transition and/or transition specialists.
- PTE and transition specialists could have more consistent presence in high schools, holding frequent drop-in office hours for students and families, informational presentations, or other events to ensure that families are aware of the services available for eligible students.
- PTE specialists could be actively engaged very early in the IEP process for students who are eligible for vocational rehabilitation services.
- Explore the effectiveness of current work-based learning experiences and potential to expand on these as well as to develop additional work-based opportunities.
- Consider a collaboration between NHVR, BDS, and school districts to reduce the redundancy in application forms and assessments.

## Underserved Populations

Quantitative analysis results, KIIs and FGs revealed the need to target several populations that may require increased job search or employment support, or outreach from the state's rehabilitation system. These populations include:

- Residents of rural and northern regions
- Women who are not in the labor force due to a disability
- Deaf/hard of hearing people and those who are blind/visually impaired
- Individuals with complex disabilities (dually diagnosed or limited functioning)
- Individuals with Autism Spectrum Disorder
- Individuals with mental health diagnoses
- Individuals with substance use disorders
- Youth in/transitioning out of foster care
- Individuals experiencing homelessness
- Individuals with disabilities in low-income households

## Suggestions

- Investigate and promote microenterprise and self-employment as employment options for participants who may be considered difficult to place or those living in areas where there are fewer employment options.
- Promote the use of labor-market information tools to examine industry sectors projected to experience growth in NH in the future. Begin working with leaders in those industries to find employment opportunities for those receiving vocational rehabilitation services.
- Gender difference in access to vocational rehabilitation that were suggested by the demographic composition of NHVR participants reported in the quantitative results is supported in the national data (Mwachofi, 2009). Examine the potential reasons for gender disparities in rehabilitation service usage and explore potential strategies to alleviate these disparities.
- Recruit counselors with experience with American Sign Language (ASL) or incentivize current counselors to study ASL.
- The uptick in behavioral health referrals and particularly substance use will require increasing collaboration with the Bureau of Behavioral Health and community organizations that serve youth and adults in recovery. Collaboration and training to counselors and providers on ways to help participants address the multiple dimensions of recovery would benefit the

statewide service system. Behavioral health specific employment interventions (e.g. IPS) could be promoted and vendors could be incentivized to offer them. The NH-developed EBP Individual Placement and Support (IPS) Supported Employment model has demonstrated successful outcomes (see page 153 in [this \*Journal of Vocational Rehabilitation\* article](#)) and is considered the gold standard of employment interventions in behavioral health.

- For those individuals who do not respond well to IPS, the Thinking Skills for Work Program (cognitive enhancement services that can improve outcomes) may be a viable alternative.



# Limitations

As is the case in any research effort, there are several limitations of this study that should be considered before generalizing the results to a wider population.

## General Limitations

As mentioned earlier, the timing of this study imposed limitations on the degree to which the analysis results represent typical experiences with the state's rehabilitation system. Stakeholders with whom we had conversations were, for the most part, closely affected by the Order of Selection, likely coloring their perspectives. Although we made a special effort, in our key informant interviews and focus groups, to solicit participants' views of the system "before the OOS," this unique circumstance likely affected the qualitative and quantitative data collected and analyzed for our research. This may affect the generalizability of the results.

## Limitations of the Quantitative Analysis

The datasets used for qualitative analyses had limitations that should be considered. The RSA 911 dataset only includes data on individuals who apply for NHVR services. As a result, we were not able to examine data for eligible people who do not apply, limiting our ability to pinpoint gaps in service provision. We used population-level data on the state's residents with disabilities as a proxy for the size and characteristics of the state's eligible participant base whereas individual- and case-level data were only available for those served by NHVR. Data on participants of services offered by other agencies within the statewide service system were not available for comparison with population data.

The RSA dataset was a snapshot of participants active at the time of extraction and included two years of data on closed cases. This meant that for some data elements, we did not have access to the full history of the individual. For data fields that are updated quarterly, we only had access to the most recent information recorded in the database.

There were a few variables in the RSA dataset that did not exactly correspond with other data sources. As a result, comparisons made to RSA data (including those made using American Community Survey data) must be interpreted with caution. For example, the disability categories collected by the RSA and the ACS did not correspond exactly. In addition, the county level data collected in the RSA did not correspond exactly to the coverage area of the NHVR Regional Offices, so it was difficult to assess which regional office oversaw specific cases.

Similarly, projections relied on multiple survey-based sources and estimates that involved error margins. The projected numbers should therefore be regarded as approximate.

## Limitations of the Qualitative Analysis

Advertisements and publicity for the focus groups may not have reached all interested parties. As a result, we had access to a limited group of participants and families for the focus groups. Further, the focus groups were also held during work hours and transportation to and from the meeting venue was not provided. This may have further limited the representativeness of the focus groups in spite of our best efforts to hold the meetings in easily accessible venues with which participants were likely to be familiar.

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# Appendix: Detailed Projections of the Numbers of New Hampshire Residents with Disabilities

Exhibit A1 shows the estimated and projected numbers of New Hampshire residents with disabilities by county in 2017, 2020, and 2025. The estimated growth rate of the state's population with disabilities between 2017 and 2025 is highest in Merrimack (6.9%) followed by Strafford (5.9%) and lowest in Sullivan (2.5%). The only decrease in the size of this population is projected for Coos between 2020 and 2025.

Exhibit A1. Estimated Numbers of the NH Population with a Disability by County of Residence, 2017-2025

County	2017	2020	2025
Belknap	8,858	9,112	9,259
Carroll	7,775	7,970	8,072
Cheshire	10,379	10,696	10,744
Coos	6,282	6,766	6,519
Grafton	12,355	12,743	12,983
Hillsborough	46,080	46,933	47,732
Merrimack	19,891	20,707	21,261
Rockingham	31,913	32,639	33,426
Strafford	15,705	16,167	16,632
Sullivan	5,911	6,033	6,060
<b>State Total</b>	<b>165,149</b>	<b>169,765</b>	<b>172,688</b>

Data source for disability prevalence rates by county: Houtenville, A., & Boege, S. (2019). Facts & Figures: The 2019 Report on Disability in New Hampshire. Durham, NH: University of New Hampshire, Institute on Disability.

Data source for population projections by county: State of New Hampshire Regional Planning Commissions, [County Population Projections, 2016 By Age and Sex](#).

The rest of this section presents population projections from 2017 to 2020 and 2025 by age and disability type\*. To obtain these numbers, we started with the estimated percentages of New Hampshire residents with each of six disability types (vision, hearing, ambulatory, cognitive, self-care difficulties and independent living difficulties) by age group, based on data from the

\* Data sources for the rest of the exhibits in this section are:

Disability prevalence rates: U.S. Census Bureau, American Community Survey. State estimates are from the 2013 - 2017 five-year sample.

Population projections: Population Projections, United States, 2004 - 2030, by state, age and sex, on [CDC WONDER Online Database](#).

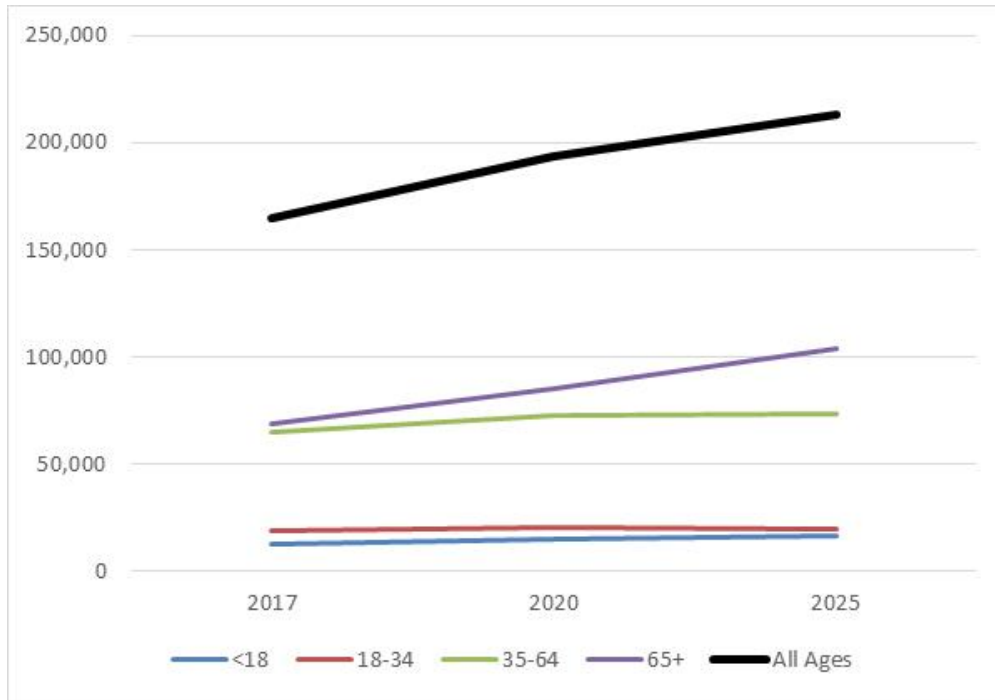
*American Community Survey (ACS) five-year estimates, 2013-2017. We then applied these estimated rates to population sizes within each age group, projected to 2020 and 2025, to obtain forecast number of individuals with disabilities by age. As with the county projections, the underlying assumption in these calculations is that these percentages are likely to remain relatively stable across time while population size by age will change in response to multiple factors (birth, death, and migration rates).*

Exhibits A2 and A3 provide an overview of these forecasts in tabular and graphic formats, respectively; they display the state's estimated population with at least one of the six disabilities for which ACS collects data. In 2017, the state's total population with disabilities was estimated to consist of 165,149 individuals. This number is predicted to increase to 193,923 in 2020 and 213,270 in 2025. The largest increases are expected to be in the older age groups. Increases among in younger age groups are expected to slow down between 2020 and 2025 after a larger increase from 2017 to 2020, whereas numbers in the older ages will likely continue to increase steadily through 2025, tilting the age composition of individuals with disabilities toward older ages. One implication of this result for future support needs is that individuals with disabilities will increasingly encounter ageism in the job market. This suggests an increasing need for rehabilitation counselors skilled in addressing this barrier and a slate of employment opportunities for mature job seekers with disabilities.

#### Exhibit A2. Estimated Numbers of NH Residents with At Least One Disability, 2017-2025

Age	2017	2020	2025
<5	560	823	827
5-17	12,128	14,545	15,400
<18	12,688	15,368	16,227
18-34	18,587	20,566	19,977
35-64	65,353	72,707	73,455
65-74	29,750	36,736	41,566
75+	38,771	48,546	62,045
<b>All Ages</b>	<b>165,149</b>	<b>193,923</b>	<b>213,270</b>

Exhibit A3. Estimated Numbers of NH Residents with At Least One Disability, 2017-2025



The next six exhibits provide these forecasts separately for the different disability types.

Exhibit A4. Estimated Numbers of NH Residents with Vision Disabilities, 2017-2025

Age	2017	2020	2025
<5	334	457	460
5-17	1,348	1,669	1,767
18-34	2,112	2,493	2,421
35-64	9,438	10,564	10,673
65-74	3,977	4,909	5,554
75+	6,729	8,384	10,716
<b>Total</b>	<b>23,938</b>	<b>28,476</b>	<b>31,591</b>

Exhibit A5. Estimated Numbers of NH Residents with Hearing Disabilities, 2017-2025

Age	2017	2020	2025
<5	317	457	460
5-17	1,302	1,669	1,767
18-34	2,203	2,493	2,421
35-64	16,276	18,021	18,207
65-74	12,157	15,043	17,020
75+	20,177	25,256	32,279
<b>Total</b>	<b>52,432</b>	<b>62,940</b>	<b>72,155</b>



Exhibit A6. Estimated Numbers of NH Residents with Cognitive Disabilities, 2017-2025

Age	2017	2020	2025
5-17	10,033	11,922	12,623
18-34	13,019	14,334	13,923
35-64	24,179	26,721	26,996
65-74	5,391	6,651	7,525
75+	9,126	11,386	14,552
<b>Total</b>	<b>61,748</b>	<b>71,014</b>	<b>75,619</b>

Exhibit A7. Estimated Numbers of NH Residents with Ambulatory Disabilities, 2017-2025

Age	2017	2020	2025
5-17	1,185	1,431	1,515
18-34	3,174	3,428	3,329
35-64	32,726	36,043	36,414
65-74	17,100	21,060	23,829
75+	22,747	28,465	36,381
<b>Total</b>	<b>76,932</b>	<b>90,426</b>	<b>101,467</b>

Exhibit A8. Estimated Numbers of NH Residents with Self-Care Difficulties, 2017-2025

Age	2017	2020	2025
5-17	2,120	2,623	2,777
18-34	2,335	2,493	2,421
35-64	10,193	11,186	11,301
65-74	4,194	5,225	5,912
75+	7,630	9,523	12,171
<b>Total</b>	<b>26,472</b>	<b>31,050</b>	<b>34,583</b>

Exhibit A9. Estimated Numbers of NH Residents with Independent Living Difficulties, 2017-2025

Age	2017	2020	2025
5-17	--	--	--
18-34	7,843	8,725	8,475
35-64	20,544	22,993	23,229
65-74	6,865	8,551	9,675
75+	16,369	20,495	26,194
<b>Total</b>	<b>51,621</b>	<b>60,763</b>	<b>67,573</b>