The Long-Term Care Plan for North Carolina: 2001

2007 Update on Progress

The North Carolina Institute of Medicine

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INTRODUCTION

In 1999, the North Carolina General Assembly directed the North Carolina Department of Health and Human Services (DHHS) to develop a long-term care system that could provide a continuum of care for older adults, people with disabilities, and their families.[1] In the fall of 1999, the then Secretary of DHHS, the Honorable H. David Bruton, MD, asked the North Carolina Institute of Medicine (NC IOM) to convene a statewide Task Force to assist DHHS in developing a comprehensive long-term care plan. The Task Force was chaired by Robert A. Ingram, then Chairman of Glaxo Wellcome Inc., and Secretary Bruton. The full Task Force included 49 of the state's leading citizens and professionals, including members of the North Carolina General Assembly, representatives of county commissioners, local governmental agencies, long-term care providers and industry associations, consumer advocacy groups, and businesses. The Task Force also included all the agency directors within DHHS charged with the provision or oversight of long-term care services to older adults or people with disabilities. The Task Force began meeting in November 1999 and held 11 day-long meetings through December 2000. The final report, entitled "*A Long-Term Care Plan for North Carolina: Final Report*," was released in January 2001. The full report, executive summary, and issue brief can be accessed on the Internet at http://www.nciom.org/pubs/long-term.html.

The Task Force made a total of 47 recommendations addressing seven areas: 1) structure of the state and local long-term care infrastructure; 2) entry into the system of long-term care; 3) availability of long-term care services and supports; 4) long-term care workforce; 5) assuring quality of long-term care services and supports; 6) financing long-term care services and supports; and 7) local initiatives and demonstrations.

Periodically, the NC IOM tries to update the progress of past task forces. The NC IOM last updated the Long-Term Care report in 2003. The following document describes the progress on the recommendations of the NC IOM Task Force on Long-Term Care. This report includes the original recommendations (in bold), along with a description of the progress, to date, on implementation of the recommendations. The report is available online at http://www.nciom.org/pubs/long-term.html.

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[1] Sec. 11.7A(a) of 1999-237 as amended by Sec. 11b of the Session Law 2000-67.

Program Administrator, Office of Long-Term Services and Supports; Gary Cyrus, Business Officer, Division of Aging and Adult Services; Cindy DePorter, Branch Manager, Division of Facility Services; Jesse Goodman, Chief, Health Care Personnel Registry, Division of Facility Services; Susan Harmuth, NC NOVA Project Manager, North Carolina Foundation for Advanced Health Programs, formerly with the Office of Long-Term Services and Supports; Mark Hensley, Fiscal Program Specialist, Division of Aging and Adult Services; Tara Larson, Assistant Director, Clinical Policy and Programs, Division of Medical Assistance; Suzanne Merrill, Adult Services Section Chief, Division of Aging and Adult Services; Marjorie Morris, Chief, Eligibility Unit, Division of Medical Assistance; Jan Moxley, Office of Long-Term Services and Supports; Larry Nason, Senior Policy Analyst, Division of Medical Assistance; Lynne Perrin, Chief, Facility and Community Care Section, Division of Medical Assistance; Carol Potter, Assistant Director for Community Services, Division of Vocational Rehabilitation; Andy Raby, Data Manager, Office of Citizens Services and the CARELINE; Jackie Sheppard, Assistant Secretary for Long-Term Care and Family Services; and Dennis Streets, Director, Division of Aging and Adult Services. We would also like to thank Louis Belo, Senior Deputy Commissioner, Technical Services Group and Carla Suitt Obiol, Director, Senior Health Insurance Information Program, within the North Carolina Department of Insurance.

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A LONG-TERM CARE PLAN FOR NORTH CAROLINA: FINAL REPORT 2007 UPDATE

LONG-TERM CARE POLICY STATEMENT

1. North Carolina's policy for long-term care is to support older adults and persons with disabilities needing long-term care, and their families, in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting. (Priority)

This policy continues to be the vision guiding the Department's work. However, the vision has been changed to focus on long-term services and supports, to better reflect the vision of more inclusive and supportive communities in which people can live and receive services.

The new mission statement for the North Carolina Office of Long-Term Services and Supports is:

> "To create a statewide, integrated, person and family-centered system for those who need long term services and supports so that they can live and actively participate in communities of their choice."

The vision statement is:

> "People of all ages and their families live in inclusive, responsive communities where they have choices and control over their long term services and supports."

DHHS ORGANIZATION FOR LONG-TERM CARE

2. A new Long-Term Care Cabinet and an Office of Long-Term Care should be created within the Office of the Secretary. The Office of Long-Term Care should have responsibility for organizing and maintaining a new Forum on Long-Term Care.

The Office of Long Term Care and the Long Term Care Cabinet were established in 2001 (both of which have been subsequently renamed as Long Term Care Services and Supports). Both are directed by Jackie Sheppard, Assistant Secretary for Long-Term Care and Family Services. The Cabinet, which includes all the Directors of the appropriate DHHS divisions, coordinates long-term care policies and meets on a quarterly basis. Staff in the Office of Long Term Services and Supports (OLTS) has primary responsibility for coordinating transportation, direct care workforce initiatives across the Department, and efforts with the housing and homeless program. In addition, the OLTS staff works with staff in other divisions to coordinate all the Departmental

long-term care initiatives. In early 2006, the OLTS coordinated a "Connect the Dots" forum in which DHHS leadership and agency staff met and focused on connecting long-term services and supports initiatives across the Department. Additionally, the forum resulted in a "core" planning team across DHHS divisions, which will develop a cohesive action plan to tie current/past initiatives with the goals of the OLTS and recommendations from the North Carolina Intstitute of Medicine Long Term Care Plan. Once the OLTS develops its preliminary action plan, it will bring it back to other stakeholder groups for their input, including consumers, advocates, and providers.

ENTRY INTO THE LONG-TERM CARE SYSTEM

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3. **North Carolina's long-term care system should be accessible and understandable for both public- and private-pay consumers, and uniform for all in need of long-term care services. (Priority)**

See Recommendations 4-9 below.

4. **The North Carolina Department of Health and Human Services (DHHS) should develop a "uniform portal of entry" system for long-term care services, in which confidentiality of information is ensured, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) confidentiality regulations.**

   The uniform portal of entry system should be defined by functions, as opposed to place or agency. Uniform portal of entry characteristics include:

   - **common information and assistance, screening, level of service assessment, and care planning assessment tools;**
   - **automated information sharing between agencies (local to local and local to state) that meet specified confidentiality protections;**
   - **entry functions (information and assistance, screening, initial level of service assessment, and financial eligibility determination) as readily accessible and understandable to consumers as possible; and**
   - **simplification of the financial eligibility determination process. The state should develop mechanisms to simplify the application process. For example, the state could outstation Division of Social Services Medicaid eligibility workers, collect the financial information by other agencies, and transmit it to DSS, or where possible, have the same agency that conducts the initial level of service assessment conduct the financial eligibility determination.**

   The state should provide guidelines and parameters for the uniform portal of entry system, but which agency provides what services should be determined locally. In designing the uniform portal of entry, DHHS should examine whether this system should be expanded to include long-term care services for people with developmental

disabilities., or if not, how the uniform portal of entry can be coordinated with the existing system for people with developmental disabilities. (Priority)

The goal of a uniform portal of entry system has remained a driving force for action at the state and local levels. Several steps have been taken to support this recommendation. First, the North Carolina Department of Health and Human Services (DHHS) helped establish two pilot Aging and Disability Resource Centers to help clients understand and identify appropriate long-term care services and supports. In addition, the state has started to develop a statewide information and assistance web-based resource system (NC Care Link). Finally, the Department has helped to simplify the Medicaid application.

Aging and Disability Resource Centers (ADRC): The Division of Aging and Adult Services received funds from the Administration on Aging (AoA) and Centers for Medicare and Medicaid Services (CMS) to develop ADRCs in Forsyth and Surry Counties in 2005. The ADRC helps coordinate the work of existing agencies to ensure that the client experiences "no wrong door." The ADRCs help ensure that clients receive the same information about long-term services and supports, regardless of which agency the client contacts for assistance. The ADRCs will also be responsible for maintaining a database of local long-term services and supports. This information will be fed into the statewide information and assistance web-based resource (see below). The Department will use funding from the Medicaid long-term care transformation grant to expand the existing ADRCs to five additional communities.

Information and Assistance web-based resource: The Department contracted with an information and assistance vendor, North Light, to purchase a web-based software (called Resource House) that will be used to develop a statewide referral database.[1] Resource House software is currently being used in Ohio and Minnesota. The Department is working with North Light to modify this software to meet the needs of the state. The new system will be called NC Care Link and will include information on human services and health agencies across the state. (See Recommendation 7 below). NC Care Link will be used to help link older adults, people with disabilities, and their families to appropriate long-term services and supports. When implemented, the ADRCs, as well as other local, regional or state agencies, will be able to input client information into the Resource House care management system. This information will follow the client to other agencies (who will also have access to this software system), so that client information does not need to be re-entered each time the client or his or her family seek services at a different agency. NC Care Link will also have client tracking capability and a decision support tool (to help clients identify appropriate resources). The Resource House care management system has security protections to ensure client confidentiality. Resource House has the capacity to be tailored to the needs of different agencies, so that different human services systems can create their own screening tools. Thus, as the state develops a long-term care level of services screening tool (see Recommendation 5 below), this tool can be built into the Resource House software and used by Medicaid trained ADRCs.

Simplified Medicaid eligibility form: The Division of Medical Assistance (DMA) simplified the Medicaid application form for adults and people with disabilities. The DMA implemented a Medicaid mail-in application in October 2005; it is designed for persons to download from a

[1] Information about North Light and Resource House is available at http://www.northlightsoft.com/default.asp.

website, complete, and mail in or for persons to request that the form be mailed to them for completion and return.[2] County Departments of Social Services (DSS) have worked with other local agencies on the best placement of the mail-in application so potential applicants can access it.

Despite the progress made in simplifying and streamlining entry into the long-term care system, more work is needed. In 2004, the NC General Assembly directed DHHS to conduct a study to determine whether an institutional bias existed in the financing and delivery of long-term care services. The Department hired the Lewin Group to conduct this study.[3] The Lewin Group, in its Institutional Bias report (2006), noted that "the lack of simplified access and consistent service coordination systems across Medicaid services makes it more difficult to coordinate the range of LTC services and supports in the community than in an institution." The report recommended that the Department "study ways to improve efficiency and effectiveness of the eligibility process and case management."[4] More work is needed to ensure that whatever system North Carolina develops is available statewide.

5. **The North Carolina Department of Health and Human Services should begin using uniform screening, level of service assessment, and care planning instruments based on the Resident Assessment Instruments (RAI) family. These instruments should be used by the Division of Social Services (DSS), Division of Aging (DOA), and Division of Medical Assistance (DMA) for all long-term care services. (Priority)**

The Division of Medical Assistance (DMA) has made significant progress on implementing this recommendation. At the time of the North Carolina Institute of Medicine Long-Term Care report (2001), there were many different forms required for screening, level of care determinations, and care planning across long-term care settings. The only automated tools were the RAI-MDS instrument, which the Centers for Medicare and Medicaid Services (CMS) required nursing homes to use for care planning, and the OASIS, which CMS required certified home health agencies to use to establish a home health plan of care.

Subsequent to the 2001 report, DMA has begun to develop and implement more uniform screening and assessment tools across long-term care settings. DMA has been working with different vendors or contractors to develop automated tools for screening, level of care

[2] http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/MA2302f4.pdf
[3] The Lewin Group. North Carolina Institutional Bias Study Combined Report. Prepared for the North Carolina Department of Health and Human Services. April 2006. Available at http://www.ncdhhs.gov/dma/LTCReport.pdf.
[4] Lewin report at p. 20. The Lewin Group noted that other states are also struggling to simplify the eligibility process and coordinate financial eligibility and medical/functional assessment processes. The Florida legislature recently passed legislation to create statewide Aging Resource Centers (similar to the ADRCs developed in Forsyth and Surry Counties in North Carolina). Georgia is in the process of developing a single point of entry program, in which a computerized screening tool helps link consumers to available services. The NC Care Link program will serve as the initial entry point for consumers into many health and human services programs. Organizations across the state will be able to use NC Care Link to help people identify their long-term care needs and potential public funding sources. The NC Care Link will capture information about the individual's needs and financial resources, and then link them to appropriate agencies. Eventually, some of the Aging and Disability Resource Centers with Medicaid qualified screeners will be able to screen individuals to determine the appropriate level of care (and which long-term care services may be appropriate). The information that is collected in the initial screen can be transferred into the Medicaid uniform screening instrument (once developed).

assessments, and care planning. Data from these tools is also being used, in some settings, to establish case-mix payments.

Level of services screening tool: Approximately four years ago, DMA worked with Provider Link to develop an automated level of services instrument that health care providers could use to determine whether an individual would be eligible for nursing home or adult care home placement. (Provider Link is a company which helps providers manage faxes, online communications, and online forms.)[5] This tool could be used in lieu of a FL-2 form to determine the appropriateness of placement in certain long-term care settings. This tool, which was developed at no cost to the state, was only available to providers who used the Provider Link system (approximately 15-20% of health care providers). Other providers continued to use and submit the FL-2 form to EDS to determine appropriateness of placement.

In August 2006, DMA contracted with EDS to develop an automated screening tool that will be used to determine medical eligibility for nine Medicaid-funded long-term care programs:

1. Nursing Facility Care (including a special screen for ventilator patients in nursing facilities subject to review by DMA nurses through the new uniform screening program);
2. Adult Care Homes – Personal Care Services – including regular, enhanced, and special care unit placements;
3. Community Alternatives Program for Disabled Adults (CAP/DA);
4. Community Alternatives Program for Disabled Adults (CAP/DA) Choice Program;
5. Community Alternatives Program for Children (CAP/C);
6. Private Duty Nursing;
7. Personal Care Services (PCS);
8. Personal Care Services Plus (an enhanced PCS program); and
9. PACE

The goal of the new uniform screening program is to ensure timely, appropriate placement of Medicaid recipients in the right service or setting of care. The goal is to have the screening tool in use by September 2007. The uniform screening should help:

- Reduce inappropriate placements;
- Reduce paperwork of referring agencies;
- Provide a clearer picture of the applicant's needs to providers to whom the applicant shall be referred;
- Provide recipients a clearer set of service options responsive to their current needs and to encourage choice;
- Establish, as feasible, a level of acuity and an associated budget for waiver programs;
- Allow the Division staff to redirect their resources to broader program oversight and quality priorities by shifting the Division screening and prior approval responsibilities to a single Contractor;
- Reduce the costs of screening through streamlined processes, procedures, automation, consolidation of screening responsibilities, and attendant staffing reductions; and
- Foster the creation of a more coherent, comprehensive system of long-term care services.

[5] Information about Provider Link is available at http://www.providerlink.com/.

Care Planning instruments: In June 2004, DMA started to use an automated assessment tool, largely based on the RAI-MDS to assess CAP/DA clients. This tool has many of the same elements as the MDS tool but also captures home and community supports. Beginning November 2005, DMA also began requiring Medicaid recipients who receive in-home personal care services (PCS) be assessed using a uniform assessment and care plan tool (PACT). The PACT assessment and care planning document is also based on the RAI-MDS and must be completed by a registered nurse who passes a state approved curriculum and is certified in the in-home PCS assessment.

On a broader basis, DMA is committed to the automation of care planning and assessment tools. This effort is part of the continuum that starts with NC Care Link, the screening tool, and eventually an automated assessment and care planning tool. The long-term vision is to develop an automated home and community-based services assessment system that will be used to assess client's functional, medical needs and systems of support in order to develop an individualized plan of care (based on evidence-based quality measures). This automated assessment system will include data elements from the RAI tools. The goal is to have a tool ready to be piloted in the summer of 2007 with adult care homes and the CAP for Children program.

Case mix payment systems: DMA is using the RAI-MDS resident assessment data to establish a case mix score for each facility based on the acuity of the patients they serve. The Resource Utilization Grouper (or "RUG") patient classification system is used to reimburse nursing facilities based on this case mix methodology. This methodology helps establish payments that more closely reflect the costs of caring for a specific group of nursing facility residents. Nursing facilities that serve a large number of patients with more complex conditions or high acuity receive higher payments than facilities serving residents with fewer needs. This payment system was implemented retroactive to October 1, 2003 and is being financed from an assessment on nursing facilities. The amount of the financial assessment varies according to the number of beds and type of facility. This payment mechanism was approved by CMS in May 2004.

6. **The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should work with the Instruments Technical Work Group to complete the development of a telephone-screening tool that is based on the RAI-family of instruments and that can also be used for information and assistance purposes. The telephone-screening tool shall include questions to identify people with mental health, developmental disabilities, or substance abuse problems in order to refer them to appropriate area programs. Telephone screening and/or information and assistance can be provided by multiple agencies in communities, as long as they use the same telephone screening protocol. (Priority)**

NC Care Link, once fully implemented, will include a telephone screening tool to help individuals and their families identify appropriate health and human services resources in their communities. While NC Care Link may be able to help steer consumers toward appropriate resources, the NC Care Link telephone screening component will not be a substitute for the level of services screening needed to determine medical eligibility for Medicaid-funded long-term services and supports (discussed in Recommendation 5 above). Once the uniform level of

screening instrument is developed, it can be built into the NC Care Link software so that appropriate agencies can use the tool to screen individuals to obtain the information needed to determine medical eligibility for Medicaid-funded long-term services and supports.

7. **The North Carolina Division of Aging, in conjunction with the Office of Long-Term Care, should continue its work to develop or identify existing computerized information and assistance systems that can be used statewide. This system should include long-term care resources for both older adults and other people with disabilities. The goal is to have comprehensive, professionally administered, and computerized information and assistance systems that work together with long-term care telephone-screening tools in local communities. The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should work with the Division of Aging to assure adequate support for development and maintenance of this system. The NC General Assembly should appropriate $125,000 both years of the biennium to the Division of Aging to facilitate the development of this information and assistance system statewide. (Priority)**

Significant progress has been made in developing a web-based information and assistance system that will maintain data on all health and human services programs. The North Carolina Department of Health and Human Services (DHHS) Office of Citizen Services (OCS) and the Division of Information Resource Management (DIRM) are leading this effort, working closely with the Division of Aging and Adult Services (DAAS) and other state and local stakeholders. DHHS contracted with an information and assistance vendor, North Light, to develop this referral database. This initiative, called NC Care Link, will enable the public to have 24-hour access to up-to-date community resource information. The database will include federal, state, local non-profit, and faith-based health and human services agencies. As a general rule, for-profit organizations will not be in the NC Care Link database, unless they accept Medicaid, Medicare, or a sliding scale payment, or if they are the only provider of services in a particular community. The program is currently being tested in four areas of the state: Northwest Piedmont Council of Government (regional), Cumberland County Coordinating Council for Senior Citizens, Office of Citizen Services (CARELINE), and Alcohol and Drug Council of North Carolina. The web-based tool is expected to be implemented statewide by fall of 2007, with plans to update data every six months. An NC Care Link Governance Body, including public and private stakeholders and chaired by a representative of the Governor's Office, was created in 2004 to oversee operational policy for NC Care Link.

NC Care Link is not expected to replace existing information and assistance telephone lines or agencies (such as CARELINE, the 211 systems, or local information and assistance agencies). Instead, this web-based tool will be available to existing information and assistance organizations to help provide referrals to appropriate services. NC Care Link also will be available to the public through the internet. Local information and assistance organizations may have information on other community resources (including for-profit organizations) that are not included in the NC Care Link public website.

8. **The Office of Long-Term Care, in conjunction with the Instruments Technical Work Group, should develop a level of service instrument based on the RAI family of instruments. The level of service assessment instrument should: be less detailed than the care planning instrument; help consumers and providers determine the level and type of service needed or desired; and eventually be used to substitute for the FL-2 and other level of service eligibility tools used by the state.**

    Everyone seeking state publicly-funded, out-of-home services in a long-term care facility or state publicly-funded in-home or community-based long-term care services would be required to use the level of service assessment instrument to determine what level and types of services are needed. For this purpose, state publicly-funded, in-home services include: home delivered meals, adult day care, adult day health, care management, ongoing respite services, in-home aides, home health care, and durable medical equipment (if an assessment is already required for the service). Individuals who are seeking privately-funded or Medicare-funded long-term care services shall be advised about the opportunity to obtain a full level of service assessment on a private-pay basis.[6] Individuals not currently seeking publicly-funded long-term care services shall be informed that eligibility for publicly-funded services is based on a person's functional and medical needs and may also include financial eligibility requirements. Exhaustion of private or third-party payment sources for long-term care services does not guarantee public-funding.

    In addition to developing a level of service assessment instrument, the Office of Long-Term Care, in conjunction with the Instruments Technical Work Group, should:

    - **develop consumer preference items, if needed, for the RAI family of instruments;**
    - **explore whether to use the RAI family of instruments for long-term care services provided by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS), or whether the specialized assessment tools used by DMHDDSAS can be coordinated with the use of the RAI family of instruments for long-term care services;**
    - **explore whether to use the RAI family of instruments for long-term care services provided by the Division of Vocational Rehabilitation and/or Services for the Blind;**
    - **review RAI generated information to use in measuring outcomes and setting outcome goals for both individuals and the system;**
    - **develop training protocols and work with people in the field to garner support for the use of the new tools;**
    - **evaluate the cost of universal screening and assessment across the whole system; and**

[6] The Task Force recommends that the Department pull together a workgroup of local and state agency staff, long-term care providers, and other stakeholders to evaluate whether the level of service assessment should be required of all individuals seeking non-state funded out-of-home services in a long-term care facility or licensed in-home or community-based service. This evaluation should occur after the state has at least one year of experience using the level of service assessment instrument for state-publicly-funded long-term care services.

- **set a timetable for developing, modifying, and testing instruments in the field.**

See Recommendation 5 above.

9. **The Office of Long-Term Care, within the North Carolina Department of Health and Human Services (DHHS), should develop an assessment process that will help individuals make an informed choice and will assist in determining eligibility for state publicly-funded programs. The Office should develop procedures to ensure that assessments can be conducted in a timely manner so as to not delay placement in long-term care facilities or delay the provision of needed in-home and community-based services. The Office should develop procedures to ensure that assessment agencies that provide long-term care services directly do not inappropriately self-refer. In addition, the Department should contract to conduct "look-behind" assessments of a randomly selected subset of the assessments to assure the reliability of the assessment instrument. The Office of Long-Term Care should explore possible Medicaid funding to help pay for the costs of the level of service assessment.**

   The Secretary of DHHS should offer the public an opportunity for public comment on the tools and the assessment process before implementing the new system statewide.

   See Recommendation 5 above.

10. **The NC General Assembly should appropriate $3,888,000 in State Fiscal Year (SFY) 2002 and $7,128,000 in SFY 2003 to the North Carolina Department of Health and Human Services to provide care management services to non-Medicaid eligible individuals age 18 or older with incomes below 200% of the federal poverty guidelines who are at-risk of institutionalization. Individuals who are eligible for these care management services are those who require on-going care coordination of in-home and community-based long-term care services.**

No action taken.

AVAILABILITY AND NEED FOR LONG-TERM CARE SERVICES

11. **Every North Carolinian should have access, either in the county of residence or within reasonable distance from the county, to the following long-term care services:**

    - **Long-term care information and assistance services**
    - **Transportation**
    - **Housing and home repair and modification assistance**
    - **Home delivered meals**
    - **Durable medical equipment and supplies**
    - **Medical alert or related services**

- **Nursing services**
- **Respite care, adult day care/day health, or attendant care**
- **In-home aide services**
- **Home health care**
- **Adult care homes (various types)**
- **Nursing homes**
- **Care management for high-risk or complex conditions**

In addition to the long-term care services listed above, older adults and people with disabilities need other medical, mental health, dental, vision, and hearing services to meet specific health and functional needs. Individuals who have functional, medical, or cognitive impairments may also need guardianship services or protective services to ensure that their long-term care needs are being met. (Priority)

The Division of Aging and Adult Services (DAAS) developed tools to help evaluate 22 core services (including hospice and assistive technology/rehabilitation technology, which were not included in the original Long-Term Care Plan, and treating Adult Protective Services and Guardianship separately).[7] Each of these tools examines a service along six dimensions (i.e., existence, adequacy, accessibility, efficiency, equity, and quality/effectiveness). See Recommendation 16 below.

The North Carolina Department of Health and Human Services (DHHS) has made significant progress in expanding access to certain core services. For example, the state has expanded the availability of CAP-DA and CAP-MR/DD (see recommendation 29 below), home and community-based services (see recommendations 12, 34, and 36 below), and caregiver support (see recommendations 12 and 43 below).

The lack of decent, safe, affordable, and accessible housing remains a significant challenge for lower income older adults and people with disabilities who want to remain in the community. The Secretary established a Housing Coordinator, who works with all the Divisions to coordinate and maximize housing resources for low income individuals and families. Since 2002 DHHS has partnered with the North Carolina Housing Finance Agency to expand the availability of housing for people with disabilities (including frail adults). Since 2004, all housing developed using Low Income Housing Tax Credits (LIHTC) must develop a targeting plan that makes 10% of the units available to extremely low income persons with disabilities,[8] including those who are homeless. In addition, 5% of units must meet higher than legally mandated levels of accessibility (since 2006). To date, 947 units of quality, affordable rental housing have been funded. To assure that these units are affordable to extremely low income households, the two agencies created the Key Program, the state's first state-funded rental assistance program. The Department also received funding through the Real Choice Systems Change grant (from the Centers for Medicare and Medicaid Services) to offer technical assistance to local communities to expand the capacity of the human service system to encourage the development of housing resources linked with long-term supports. The grant was used to hire three housing professionals

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[7] Available on the internet at http://www.dhhs.state.nc.us/ltc/localplanning.htm.
[8] Housing must be financially affordable to people who are receiving Supplemental Security Income, currently $603/month for an individual (2006).

who are currently working with communities across the state. In addition, in 2006 the NC General Assembly included $10.9 million in capital funding for the Housing Trust Fund and $1.2 million of recurring operating subsidies for DHHS, so that the two agencies could work together to design and help fund the production of 400 additional independent and supportive housing units targeted to persons with disabilities with very low incomes.

DHHS has identified transportation as a priority for the Department because of its importance to the populations the Department serves. The Transportation Program Administrator at the NCDHHS is responsible for addressing the transportation needs of the elderly, disabled, and financially disadvantaged. This position serves as the transportation program and policy liaison between the NCDOT and NCDHHS and works with the respective divisions and local community transportation systems regarding programs that support human service transportation. There are 84 community transportation systems, all of which provide transportation for a number of human service agencies in their operating areas on a contractual basis. State and local communities plan to pursue additional funding opportunities under the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETE-LU) that will be available to provide transportation services for the elderly and disabled populations in the next fiscal year and beyond.[9]

DMA is working with three organizations to develop PACE (Program for the All-inclusive Care of the Elderly) sites in North Carolina. Elderhaus, Inc. of Wilmington is developing a PACE site to serve New Hanover and Brunswick Counties. Piedmont Health Services, Inc. of Carrboro is developing a PACE site to serve Alamance and Caswell Counties. St. Joseph of the Pines (Southern Pines) is studying the feasibility of developing PACE sites in Moore and Robeson Counties. The first PACE site is expected to be operational in New Hanover/Brunswick Counties by the fall of 2007.

12. The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should assure that all policy and program development activities consider and respect the importance of family caregiving and examine how to further strengthen the capacity of families to perform their caregiving functions. (Priority)

The Division of Aging and Adult Services (DAAS) continues to take a leading role in activities designed to support family caregivers. Three examples of this include: (1) Project C.A.R.E., (2) the Family Caregiver Support Program, and (3) the State-County Special Assistance (SA) In-Home Option. DAAS secured a federal Alzheimer's Demonstration Grant in 2004 to extend its Project C.A.R.E. ("Caregiver Alternatives to Running on Empty") to assist families with care advice and respite. Family consultants offer guidance, counseling, support, advocacy, and education for family caregivers in crises, matching families with local respite and community services. Caregivers of individuals with dementia may spend up to $2,000 a year towards respite utilizing adult day services, group respite, private or agency in-home care, and overnight residential respite. Three pilot sites serve ten counties. Four of these counties are piloting a consumer direction option (families can choose to hire a family member, friend, or neighbor). The only barrier is that demand for Project C.A.R.E. exceeds funding. Sustaining and expanding Project C.A.R.E. after the federal grant ends in June 2007 remains a major area of concern.

[9] 23 U.S.C.§410.

Project C.A.R.E. targets individuals in low-income, rural, and minority communities that do not qualify for Medicaid (or are on a waiting list for Community Alternative Program for Disabled Adults services).

DAAS also continues to grow the federally funded Family Caregiver Support Program by leveraging other resources, largely through the efforts of the Area Agencies on Aging (AAA) and their local partners. The Caregiver Program has further emphasized self-directed supports. In some AAA regions, families are given vouchers or budgets, usually under $1,000. They may purchase group, in-home, adult day services, or institutional respite. Some counties have additional funds to supplement services for families receiving respite care, which can cover one-time costs for accessibility equipment, transportation, or other immediate needs. All self-directed supports have a key person (care manager or other professional) to educate families on available resources.

The Special Assistance (SA) In-Home Option has grown substantially since it began. In 1999, the NC General Assembly initiated a demonstration to pilot use of State/County Special Assistance funds (optional Supplemental Security Income supplement) to support individuals in their homes, bringing more equity into the choice of staying home or going to an adult care home. Eighty-seven counties now voluntarily participate, serving 875 individuals out of an authorized 1,500 (October 2006). The number of individuals being served has nearly doubled since May 2004. The 2006 Report on the SA In-Home Option discusses how it has become a cost-effective way of supporting families in their continued care of persons who might otherwise be in adult care homes.[10] SA In-Home funds can be used to pay for housing, health care, food, adult day care, and personal care assistance.

13. The North Carolina Department of Health and Human Services should explore the possibility of establishing uniform payment rates for in-home aide services across funding streams. The Department should explore the need, if any, for regional variations in reimbursement rates or shift differentials among long-term care facility or program staff.

The Department reviewed this recommendation and determined that a uniform payment rate was not practical. The Medicaid rates would be insufficient to support some of the smaller agencies that are currently providing home and community-based services. However, the Division of Aging and Adult Services has targeted agencies with the highest rates for in-home aide services with technical assistance and has developed and offered training on developing fair rates.

14. If the state establishes more uniform rates, the North Carolina Department of Health and Human Services should consider requiring all licensed providers of long-term care services that participate in state-funded programs to provide some services to Medicaid clients. The goal of this recommendation is to ensure that consumers can continue to be served by the same provider if they change their source of public financing for these services and to maximize the use of federal Medicaid funds.

[10] Available at http://www.dhhs.state.nc.us/aging/adultsvcs/SAInHomeFinalReport2006.pdf.

The Division of Aging and Adult Services (DAAS) is encouraging providers, as appropriate, to enroll as Medicaid-approved providers to ensure continuity of care opportunities for clients served with DAAS funding who may also become Medicaid eligible and to ensure that funding administered by DAAS is targeted to non-Medicaid eligible persons.

15. The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should collect North Carolina-specific data to determine the need for long-term care services in the state.

One of the biggest challenges facing the North Carolina Department of Health and Human Services (DHHS) is the ability to obtain and share information on clients, use of services, and outstanding needs across divisions and offices. The Department's current information technology (IT) is characterized by:

1) A duplication of development costs;
2) Operational inefficiencies;
3) Data disparities that prevent cross-analysis of programs;
4) Inability of multiple involved entities to access recipient information, check on the status of admissions, and track services;
5) Frustration by providers working with multiple programs; and
6) Lack of common IT platforms and technologies.

This problem is not limited to long-term care services and supports but applies to most programs, services, and client and community needs that cross agency or division lines. However, this lack of communication across agencies also adversely impacts on the Department's ability to comprehensively assess the need for long-term services and supports across the state. The Department has just completed a business plan, and the inability of Divisions to share information was one of the issues highlighted as needing to be addressed.

Individual divisions within DHHS have taken steps to obtain better data to determine the need for long-term care services and supports. For example, DHHS contracted with Myers and Stauffer, LC to compare the acuity levels and public expenditures for long-term care populations, including those in nursing facilities, Community Alternative Program for Disabled Adults (CAP/DA), Adult Care Homes (ACH), Adult Day Care (ADC), and Adult Day Health (ADH). Myers and Stauffer performed clinical assessments of a random sample of clients in ACH, ADC, and ADH using a common assessment tool based on the Minimum Data Set (MDS). The Division of Medical Assistance provided similar MDS data for a random sample of clients in nursing facilities and CAP/DA. Their final report was issued in 2005.[11] Myers and Stauffer calculated scores for the individuals based on their abilities to perform activities of daily living (ADL scores) and calculated a cognitive performance score (CPS score). The ADL score is based on the person's ability to perform certain activities, such as bed mobility, transfer, toilet use, and eating. The score ranged from 4 (an independent client) to 18 (a totally dependent client). The CPS score measures the clients' mental status, including short-term memory ability,

[11] Myers and Stauffer, LC. Assessment on Long Term Care Populations. Project Report. September 2005. Available at http://www.dhhs.state.nc.us/dma/nursingfacility/LTCReport.pdf (accessed November 16, 2006).

daily decision-making ability, and the ability to make themselves understood. The CPS score ranges from 1 (intact cognition) to 6 (very severe impairment of cognition).

On average, Myers and Stauffer found that people residing in nursing facilities had the most functional limitations (followed by people who were receiving CAP/DA services). People in nursing homes and in Adult Day Health settings also had more cognitive impairments than those in other settings.

Average ADL and CPS Score Across Long-Term Care Settings

Population Group	Average ADL Score	Average CPS Score
2004 All Nursing Facilities	12	3
300 Nursing Facilities Random Sample	12	3
CAP/DA	8	2
ACH	6	2
ADC	5	2
ADH	6	3

Source: Table 6.4.

These data were used to determine the appropriateness of placement in different long-term care settings and to identify appropriate payment levels.

The Division of Aging and Adult Services (DAAS) is also taking steps to collect more information to aid state and local planning, management, and evaluation of home and community care services. DAAS revised its client registration form to include additional information to use in long-term care planning. In addition to this revision in the client registration form, DAAS is working with the Division of Information Resource Management to convert its Aging Resources Management System (ARMS) into a web-based system. These changes should contribute to the Department's overall capacity to examine and report on home and community services. DAAS also has continued its participation in the federally funded Performance Outcomes Measures Project (POMP), having participated in this national demonstration since 2001. For example, the Division has learned:

- Nearly half of North Carolina home-delivered meals clients (49%) say that their home-delivered meal provides 1/2 or more of their daily food intake. (The federal requirement for the home-delivered meal is that it meets 1/3 of the minimum daily nutritional allowance.)
- Caregivers in 2002 who indicated that they needed more respite and/or adult day care services were significantly more likely to have placed the person they were caring for in a facility by 2003.
- More than two-thirds (69%) of transportation clients say that there is no vehicle in working condition in their household, and of those who do have a working car, more than half say they cannot drive it.

The Division also has started to collect additional information on client disposition (e.g., what happens after the client stops receiving services).

16. **The NC General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level.**

    The local planning initiative should broadly represent agencies involved in the provision of long-term care services, including representatives of local social service departments, health departments, area mental health programs, aging councils and departments, Home and Community Care Block Grant (HCCBG) and Community Alternative Placement for Disabled Adults (CAP/DA) lead agencies, hospitals, home health and home care agencies, nursing homes, assisted living facilities, adult day care/adult day health agencies, group homes for people with mental illness or developmental disabilities, independent living programs and facilities, area agencies on aging, long-term care ombudsman programs, community advisory committees, older adults and persons with disabilities and their caregivers, advocates for older adults and persons with disabilities, and representatives of county government. The local planning committee should be required to:

    - **review and analyze service utilization data through county data packages;**
    - **track the flow of consumers from referral to disposition through core service agencies;**
    - **identify barriers to a comprehensive system of care and services;**
    - **determine how to design the uniform portal of entry;**
    - **determine the need for additional core long-term care services; and**
    - **communicate findings to local, state, and federal policymakers.**

    To facilitate these local-planning efforts, the North Carolina Department of Health and Human Services should:

    - **develop county data packages that include information on the number of people age 18 or older using publicly-funded, long-term care services at the county level and information on expenditures for these services;**
    - **provide information on the availability and need for core services in each county and the balance of different services needed; and**
    - **provide technical assistance to counties to assist them with their long-term planning process. (Priority)**

In 2003, the NC General Assembly directed the North Carolina Department of Health and Human Services (DHHS) to implement a communications and coordination initiative to pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level.[12] The Division of Aging and Adult Services (DAAS), along with a state team made-up of all DHHS Divisions with long-term care responsibilities, developed four

[12] Sec. 10.8F of Session Law 2003-284.

resources for counties interested in developing a local LTC planning and coordination effort: 22 core LTC service evaluation tools and a planning matrix, a 300+ page Planning Basics resource guide,[7] a website where all the resources and planning information can be downloaded,[13] and several training pieces.

Mecklenburg and New Hanover Counties were selected to participate in the initiative. The Department of Social Services and the New Hanover Department of Aging were lead agencies in their respective counties. Mecklenburg and New Hanover Counties completed their voluntary participation in the DHHS/DAAS-guided local planning effort, with substantial effort and progress. Mecklenburg produced an extensive report in 2005 on its initiative, focusing on developing a seamless entry into the system.[14] New Hanover has also finished its planning, but is continuing its efforts around preventing older and younger people with disabilities. Other counties, including Rowan, have adopted use of the core LTC service evaluation tools to aid local planning.

In addition to Mecklenburg and New Hanover's local initiatives, Haywood County has taken a lead in developing a seamless continuum of care. Funded through a $750,000 Robert Wood Johnson grant (2006), Haywood intends to develop a county-wide strategic plan to ensure that long-term care services and supports are available to those in need. The grant will be used to create a community collaboration, which includes community members, organizations, and businesses, to identify and eliminate service gaps and make long-term services and support options more available to at-risk older adults.

In 2005, DAAS was one of eight State Units on Aging selected by the U.S. Administration on Aging to help develop a national model for a comprehensive and coordinated aging plan. DAAS is working closely with the Area Agencies on Aging (AAAs) on a statewide basis to strengthen local planning and develop an approach that is consumer-driven, simple to administer, and outcome-based. Each of the AAAs are working with at least one county to develop local aging plans. DAAS helps support the work of the AAAs through technical assistance on local planning strategies, county-level information, and best practices. DAAS also has created an Aging Planning Bulletin (APB) to communicate information to the local planning teams. The first APB was focused on the recent expansion of the Special Assistance In-Home care program (from 1000 to 1500 slots). This information was useful in educating local AAAs about new long-term care resources and encouraged more counties to participate in the program.

LONG-TERM CARE WORKFORCE

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17. The NC General Assembly should appropriate $17,227,597 in State Fiscal Year (SFY) 2002 and $23,460,713 in SFY 2003 for Medicaid-funded in-home and adult care home Personal Care Services (PCS) and nursing home care by increasing the PCS hourly rate and nursing home daily rate for direct care. This enhancement must be used for wages, benefits, and/or payment of shift differentials (e.g., nights/weekends). Providers should

[13] Available at http://www.dhhs.state.nc.us/ltc/localplanning.htm.
[14] Available at http://statusofseniors.charmeck.org.

be required to submit additional cost data to ensure accountability for use of these funds as intended. The Division of Medical Assistance should institute a cost-settlement process to ensure that funds are expended on labor enhancements for direct care providers. Personal care services providers should be required to submit audited cost data (as is currently required of nursing homes and adult care homes). The Division of Medical Assistance should study the PCS rate-setting methodology to determine whether the rate should be adjusted to reflect costs unique to this care setting, such as the travel time/mileage between clients. (Priority)

The NC General Assembly has not appropriated funds to increase wages or benefits paid to direct care workers. However, the state has taken a national leadership role in developing a voluntary licensure program for home care agencies, adult care homes, and nursing facilities. This initiative is intended to improve the recruitment and retention of direct care workers and the quality of care provided. The state received a Better Jobs/Better Care grant through the Robert Wood Johnson Foundation and Atlantic Philanthropies in July 2003 to develop this special licensure initiative, called NC NOVA (New Organizational Vision Award). NC NOVA encompasses four major areas, including supportive workplaces, training, career development, and balanced workloads. [15] Long-term care organizations must show that they meet certain criteria within each of these areas.[16] Legislation was passed (SB1277) establishing NC NOVA as a statewide program effective January 1, 2007. It is currently being piloted in 64 organizations. The pilot will continue through December 2006.[17] The goal is to tie any future wage enhancement or reimbursement differential to the special licensure designation.

18. The NC General Assembly should appropriate $1,406,029 in State Fiscal Year (SFY) 2002 and $2,097,301 in SFY 2003 to the Division of Facility Services to develop a continuing education and professional development initiative for long-term care aides. The initiative should be modeled after the TEACH program for child care workers. Funding should be used to develop the continuing education program and to provide bonuses, tuition, and other financial assistance and incentives to support continuing education and professional development for long-term care aides. (Priority)

The NC General Assembly has not appropriated funding to support this activity. However, some progress has been made. Building upon a pilot program implemented with funding from the Kate B. Reynolds Charitable Trust, the North Carolina Department of Health and Human Services, in conjunction with the Institute on Aging, has implemented the "Win A Step Up" program in nursing facilities. This on-going effort is funded with civil penalty fine monies. Nurse aides agree to work for their employer after finishing a 30-hour curriculum, and employers agree to reward the nurse aides with a bonus or raise. The curriculum covers such topics as coaching supervision, mobility training, and a program on how to work with people with Alzheimer's or dementia. Over the last five years, Win A Step Up trained 845 nurse aides in 53 nursing homes in 40 counties and more than 200 front-line nurse supervisors. The program had

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[15] Available at http://www.dhhs.state.nc.us/ltc/bjobcare.htm.
[16] Information on the criteria used to determine who qualifies for the NC NOVA special licensure designation is available at http://www.dhhs.state.nc.us/ltc/bjobcare.htm (Application document).
[17] An evaluation of the national Better Jobs/Better Care grants is being conducted by Penn State University, and is expected to be completed in the spring of 2007.

been funded at $450,000/year; however, funding was reduced to $205,000 in FY 2006-07 (due to a lower than projected amount of federal civil monetary penalties).

19. The NC General Assembly should appropriate $100,000 in State Fiscal Year (SFY) 2002 to the Division of Facility Services to develop a career ladder and associated curricula requirements and job category qualifications for long-term care aide workers. The purpose of the career ladder is to provide a career path for aide workers that recognizes the attainment of additional skills and broadens the pool of potential workers by providing additional job opportunities. The Department should work with the North Carolina Board of Nursing, the North Carolina Center for Nursing, the North Carolina Community College System, long-term care provider organizations, and other appropriate organizations to consider the need to re-engineer current job categories of aide workers to meet the current and future needs of long-term care clients and patients. (Priority)

The North Carolina Department of Health and Human Services (DHHS) worked with the North Carolina Board of Nursing, provider organizations, and other stakeholders to develop two new categories for direct care workers: a medication aide and a geriatric aide specialist. Initially, the medication aide option was explored for direct care workers who work in different long-term care or community settings, such as nursing facilities and home health. Later, this effort focused on nurse aides in nursing facilities.

Legislation passed in 2005 to allow the use of medication aides in skilled nursing facilities (beginning July 2006). The Board of Nursing approved the medication aide training program in January 2006 for both the registered nurse faculty and the medication aide trainee.[18] Training classes for medication aide faculty are to be taught by certified Master Teachers. Medication aide faculty training must take place in either the North Carolina Area Health Education Centers (AHEC) system or at North Carolina Community College System. Training has been in progress since the spring of 2006. Certified medication aide instructors may teach the medication aide course in a setting of their choice. Both the Board of Nursing and the Medical Care Commission have established rules related to the medication aide training, competency testing, and Medication Aide Registry requirements.[19] Information about the new medication aide training and competency, employer responsibilities, and registry requirements are available on the Internet.[20] The Medication Aide Registry became operational in October 2006. Medication aides also can be used in adult care facilities, but these aides must pass a separate exam administered by the Group Care Licensure Section in the Division of Facility Services.[20]

The geriatric aide specialist curriculum is undergoing refinement with projected completion in 2007. The Board of Nursing has not taken any formal action on the geriatric aide job description as it does not expand beyond the level of activities that a licensed nurse may delegate to unlicensed assistive personnel. Legislation will be needed to establish the geriatric aide specialist as a new job category. These new positions will respond to identified staffing needs by

[18] Available at http://facility-services.state.nc.us/NAICurricula2006.pdf.
[19] Board of Nursing rules: 21 NCAC §36.0403, 36.0406 (effective September 1, 2006).
[20] Available at http://www.ncnar.org/ncma.html.

providers and can provide a career and/or clinical ladder for direct care workers in the long-term care field.

20. The NC General Assembly should appropriate $50,000 in State Fiscal Year (SFY) 2002 and $50,000 in SFY 2003 to the Division of Facility Services to support on-going collection and analysis of data related to North Carolina's aide workforce. The analysis should include information on demographics, turnover and retention rates, wages/benefits, and comparison of active versus inactive nurse aide registrants with regard to job stability and wages. The Division may contract with the University of North Carolina Institute on Aging to collect and analyze these data. (Priority)

The North Carolina Department of Health and Human Services (DHHS), in conjunction with the Institute on Aging (IOA) at the University of North Carolina at Chapel Hill, compiles and analyzes annual turnover rates in home care agencies, adult care homes, and nursing facilities. This collaborative effort builds on a data analysis initiative originally funded by the Kate B. Reynolds Charitable Trust. Two series of data are reported in aggregate form:

1) Statewide average separation rates at the facility/agency level for direct care workers. In addition, beginning in 2005-06, DHHS/IOA collected data on the average length of tenure and turnover of administrators and directors of nursing (or comparable clinical supervisors in charge of staff) in nursing facilities, adult care homes, and home health/home care agencies. The statewide information is available on the Internet.[21]
2) Annual matches of all nurse aide I registrants with wage and employer information from the Labor Market Information Service data to examine wages, competing employment sectors, and job stability of active versus inactive nurse aide registrants. This information is also available on the Internet.[22]

Data collected show that the turnover rate for direct care workers in nursing facilities has increased since 2000 but decreased slightly in adult care homes and home health agencies.

Year	Nursing Facilities				Adult Care Homes				Home Health Agencies*			
	Separation Rates			Pct. Mgrs rating turn-over as problem	Separation Rates			Pct. Mgrs rating turn-over as problem	Separation Rates			Pct. Mgrs rating turn-over as problem
	Total (%)	Invol (%)	Vol (%)		Total (%)	Invol (%)	Vol (%)		Total (%)	Invol (%)	Vol (%)	
2000	100.3	31.2	70.8	90.7%	119.1	35.5	87.6	81.1%	50.4	18.1	33.6	54.3%
2001	102.6	35.7	68.2	75.8%	112.7	35.7	80.1	60.0%	50.4	12.2	38.8	43.0%
2002	94.8	34.8	60.6	74.3%	115.1	32.5	80.3	59.2%	37.2	9.6	28.7	36.6%
2003	105.3	38.8	66.9	68.0%	109.3	31.5	76.1	52.8%	48.7	13.6	36.2	39.5%
2004	107.1	39.3	71.9	65.7%	106.6	33.9	76.4	52.9%	40.7	11.1	30.0	38.0%
2005	116.5	41.0	75.8	81.1%	110.8	33.5	78.6	69.1%	45.9	14.1	33.4	46.1%

Source: Konrad TR, Morgan JC, Dill J. Descriptive Results from the State Turnover Survey. Conducted for the Office of Long Term Care of the Department of Health and Human Services, 2005. Institute on Aging. August 17, 2006. Available at http://www.aging.unc.edu/research/winastepup/reports/DFS2005_fnl.pdf (Accessed October 30,

[21] Available at http://www.aging.unc.edu/research/winastepup/reports/DFS2005_fnl.pdf.
[22] Available at http://www.aging.unc.edu/research/winastepup/reports/DOLexecutivesummaryfnl.pdf.

2006). *The Home Health Agency data includes turnover rates for both certified home health and licensed only home care agencies. This may mask differences in turnover rates among the two types of organizations.

Turnover rates were also higher in nursing facilities for administrative and clinical leaders than in adult care homes or home health agencies.

Level of Turnover of Administrative and Clinical Leaders, Long Term Care Organizations North Carolina, October 2004-September 2005						
	Nursing Homes		Adult Care Homes		Home Health/Care Agencies	
	(N=369)	(N=366)	(N=473)	(N=409)	(N=774)	(N=766)
Turnover Level in the last year	Administrator	Director of Nursing	Administrator	Resident Care Director	Administrator	Nurse Supervisor
Avg. Tenure of Administrators (years)	4.8 years	3.9 years	7.5 years	4.7 years	5.8 years	4.0 years
No Turnover (Only one incumbent in position during last year)	71.0%	61.2%	76.5%	66.5%	81.1%	69.1%
Moderate Turnover (Position had 2 incumbents during the last year)	19.2%	27.0%	20.5%	25.4%	18.0%	25.7%
High Turnover (Position had 3 or more incumbents during the last year)	9.8%	11.7%	3.0%	8.1%	0.9%	5.2%
Total	100%	100%	100%	100%	100%	100%

Source: Konrad TR, Morgan JC, Dill J. Descriptive Results from the State Turnover Survey. Conducted for the Office of Long Term Care of the North Carolina Department of Health and Human Services, 2005. Institute on Aging. August 17, 2006. Available at http://www.aging.unc.edu/research/winastepup/reports/DFS2005_fnl.pdf (Accessed October 30, 2006).

The Institute on Aging has used information from its ongoing collaborations with DHHS and the Win a Step Up implementation process to develop and post on its website two resources helpful to administrators and DHHS planners interested in measuring and reducing turnover. These are a turnover calculator and retention toolkit. The turnover calculator helps managers to measure turnover in their own direct care workforce and compare their turnover rates to industry benchmarks from peers across the state.[23] The retention toolkit provides information to facility managers and planners interested in Win A Step Up about how to improve retention of their direct care workforce and provides links to other national and state resources.[24]

21. The NC General Assembly should establish a Legislative Study Commission to examine workforce shortages among paraprofessionals and other professionals serving the population of older adults and persons with disabilities. (Priority)

The North Carolina Legislative Study Commission on Aging examined workforce issues and made a series of recommendations, including:

1) The NC General Assembly provide a workforce improvement program for direct care workers employed in adult care homes and home care situations;
2) DHHS implement initiatives to increase and promote the availability of nurse aide training and competency programs;

[23] Available at http://www.aging.unc.edu/research/winastepup/calculators/index.html.
[24] Available at http://www.aging.unc.edu/research/winastepup/reports/ToolkitReportAbstractredo041205.pdf.

3) DHHS work with the North Carolina Board of Nursing, the Community College System, and representatives from the North Carolina Health Care Facilities Association to implement a pilot program using medication aides and geriatric aides in skilled nursing facilities; and
4) The NC General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

These recommendations were included in the 2003 report of the NC Legislative Study Commission on Aging. The NC Legislative Study Commission on Aging continues to be interested in and follow this issue.

In addition to the NC Legislative Study Commission on Aging, there are two other groups that have examined workforce issues as they relate to older adults and persons with disabilities: the North Carolina Institute of Medicine (NC IOM) Task Force on the North Carolina Nursing Workforce and the House Select Committee on Health Care. The NC IOM's Task Force on the North Carolina Nursing Workforce Report also endorsed similar recommendations, including the creation of a special licensure designation, wage pass-through to enhance the salaries of nursing assistants, creation of the medication aide and geriatric aide classifications, and standardization of the Nurse Aide I competency evaluation program.[25] The House created a Select Committee on Health Care in 2005-2006. The Select Committee has a subcommittee which is charged with examining the health care workforce. This subcommittee made a number of recommendations during the 2006 session to address health care workforce shortages including nursing and direct care workers (among others). This subcommittee also endorsed the New Organizational Vision Award (NC NOVA) program.

22. The North Carolina Department of Health and Human Services Office of Long-Term Care, along with the North Carolina Department of Insurance, should explore ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and non-residential long-term care facilities and agencies. (Priority)

The Direct Care Workers Association of North Carolina conducted a study to determine the possibility of offering mini-medical health coverage to association members. An Association subcommittee is conducting a further examination of the top three coverage plans identified, with the expectation that the Board will select a plan(s) to offer as a benefit of membership to association members and their families.

In addition, the North Carolina Assisted Living Association and the North Carolina Long-Term Care Facilities Association has offered health care discount programs (not comprehensive insurance), as a benefit to their members. Most nursing facilities and many other long-term care organizations offer health insurance that is partially paid for by the employer to full-time employees.

[25] North Carolina Institute of Medicine Task Force on the North Carolina Nursing Workforce Report (May 2004). Available at http://www.nciom.org/projects/nursingworkforce/nursingreport.html. Recommendations 3.33, 3.34, 4.5, 4.9.

23. The NC Healthcare Facilities Association, NC Association of Long Term Care Facilities, NC Association of Nonprofit Homes for the Aging, NC Assisted Living Association, NC Association for Home and Hospice Care, NC Family Care Facilities Association, NC Adult Day Services Association, NC Association on Aging, Mental Health Association of NC, Developmental Disabilities Facilities Association, and NC Center for Nursing should develop a plan, either together or independently, to improve the retention rates among paraprofessional and professional staff in the North Carolina long-term care industry. These plans should include mechanisms to improve job satisfaction, increase pay, develop career paths, and improve working conditions. Report(s) should be presented to the NC General Assembly no later than March 15, 2001. (Priority)

The North Carolina Department of Health and Human Services (DHHS), NC Health Care Facilities Association, NC Association of Long Term Care Facilities, NC Assisted Living Association, Association for Home and Hospice Care of North Carolina, and the NC Association of Nonprofit Homes for the Aging, and numerous other organizations, worked collaboratively to create the NC NOVA special licensure program (See Rec. #17 above). The goal is to seek a reimbursement differential that is tied to this licensure designation.

All the aforementioned provider associations collaborated with DHHS to increase public education and recruitment efforts including the development of recruitment materials and television ads. The 30-second TV ads were shown as public service announcements in 2003 and are still available to consumer groups, providers, and other interested organizations to assist in recruitment and appreciation efforts.

In addition, many of the long-term care provider associations have initiated special programs to recognize outstanding nurse aides and other long-term care staff and have undertaken other efforts to improve the retention and job satisfaction of direct care staff. For example, the NC Healthcare Facilities Association (NCHCFA) conducts an annual recognition of 50 direct care workers from across the state in its Fabulous-50 program. This FAB-50 program culminates in the recognition of five top nursing assistants of the year with one receiving the top honor of the JR Garrett, Jr. Award. The NCHCFA also conducts a Nurse Leadership Institute focusing on relationships within nursing departments and effective coaching and supervision, as well as a Peer Review Meritorious Performer program that focuses intensely on staff support and mentoring. In conjunction with the University of North Carolina (UNC), NCHCFA is continuing in its fifth year of a Certification for Nurse Leaders in Long-Term-Care in an effort to improve the knowledge, ability, and skills of nurses leading care delivery in North Carolina skilled nursing facilities. The certification is awarded by the UNC School of Nursing, Department of Continuing Education.

The Association for Home & Hospice Care of North Carolina (AHHC) for the past thirteen years has sponsored an annual in-home aide recognition program where aides are nominated by agencies across the State. Each nominee must demonstrate the following qualities: a commitment to the industry by serving on internal agency committees or AHHC committees or other community involvement; an interest in professional growth through continuing education; excellence and commitment to patient care; and dedication to raising the level of

professionalism. In addition, the association for the past thirteen years has provided regional training twice a year to new home care nurses that emphasizes the collaborative working relationship of the nurse and nurse aide, appropriate nurse delegation and supervision, and training in transitioning from an institutional setting to a more autonomous in-home setting. The association also offers monthly teleconference in-services to in-home aides. AHHC provides training to help nurses prepare for several national certifications and works with AHEC to maintain the curriculum for the in-home PCS registered nurse certification. AHHC also employs a nurse who is a master certified trainer in coaching and supervision from the Para-Professional Healthcare Institute.

The North Carolina Association of Long Term Care Facilities (NCALTCF) also runs a recognition program for direct care workers. Each year, nine personal care aides are recognized from across the state for their exceptional service to the residents of Adult Care Homes. They are each recognized at the annual NCALTCF convention, where one wins the top recognition and a special honorarium.

ASSURING QUALITY OF LONG-TERM CARE

24. Quality of care initiatives should become a major responsibility of the new North Carolina Office of Long-Term Care within the North Carolina Department of Health and Human Services. Steps undertaken under the rubric of "quality" of long-term care should be coordinated by the Office of Long-Term Care with the direct involvement of the different Divisions involved in facility or program regulation.

The North Carolina Office of Long-Term Care should convene a Quality Standards Work Group with representatives from provider groups (nursing homes, adult care homes, and home care agencies), consumer groups, long-term care ombudsmen, state regulatory agencies, local Departments of Social Services, and academics. The purpose of this Quality Standards Work Group will be to:

- **(a) reach consensus around interpretations of current rules and quality measures;**
- **(b) develop broad multi-perspective definitions of quality for nursing homes, adult care homes, and/or home care and hospice agencies, including a consideration of resident case-mix in long-term care facilities;**
- **(c) facilitate separate discussions of quality of care for each of the three broad segments of the state's long-term care industry (viz., nursing homes, adult care homes and assisted living facilities, home health/home care/hospice)**
- **(d) explore what aspects of the quality assessment/monitoring process can be changed and/or modified under state authority, and make recommendations to the appropriate authority accordingly;**
- **(e) explore ways in which the standards and criteria for establishing the thresholds for key aspects of long-term care quality can be defined (e.g., for behavioral disruptions, gastric feeding, intractable incontinence);**

(f) explore those aspects of the quality assessment/ monitoring process that require the Center for Medicare and Medicaid (CMS) approval, and then, possibly in conjunction with North Carolina's Congressional delegation or with other states, request a CMS waiver to demonstrate a quality indicator approach or some such innovative approach to assuring and monitoring quality; and

(g) assure that state and county regulatory agencies are enabled to incorporate measures of consumer satisfaction with care and consumer choice in the quality assessment process for long-term care programs and facilities. (Priority)

The North Carolina Department of Health and Human Services, in collaboration with the North Carolina Institute of Medicine (NC IOM), The Carolinas Center for Medical Excellence (formerly Medical Review of North Carolina), the NC Healthcare Facilities Association, North Carolina Non Profit Homes for the Aging, AARP, Friends of Residents, Ombudsmen, providers, Board of Nursing, Duke School of Nursing, and Medical Directors Association, has created a Quality Standards Committee. The Committee's purpose is to address the quality of care provided in nursing homes. The Committee's first initiative was to develop a brochure to help consumers understand the Quality Measures used in nursing homes and released by CMS in the fall of 2002.

The Quality Standards Committee continued to focus on the dining experience in nursing homes, including issues related to nutritional status, therapeutic diets and their necessity, the flavor and attractiveness of food as a stimulus for nutritional intake, and steps to assure proper hydration. This effort culminated in an issue of the North Carolina Medical Journal (published by the NC IOM), on "Nutrition and the Elderly" (July/August 2005). This issue had articles concerning regulations, new and innovative dietary practices in nursing homes, clinical aspects of nutrition, and the elderly and family/resident perspectives of nutrition in a nursing home. There has been no activity since the work around nutrition.

25. Initial efforts to address quality issues in long-term care in North Carolina should include initiatives that can build upon the model quality improvement (QI) program developed by Carolina Center for Medical Excellence.[26] This program seeks provider/consumer input to problem selection, data analysis, measurements appropriate to particular dimensions of quality (indicators), intervention design, implementation, and evaluation. These quality improvement efforts should assure access for participants in these initiatives to the expertise housed in the state's public and private universities and community colleges. (Priority)

The Carolinas Center for Medical Excellence (CCME) has been working on several quality initiatives. Through its contract work with the North Carolina Division of Facility Services (DFS) it has established a website of best practice resources that include the following topics: pain management, falls reduction, medication safety, and reducing wandering.[27] CCME also has an initiative in process on improving Medication Safety looking at ensuring an accurate medication list is generated upon admission to the nursing home. Additionally, CCME is

[26] The Carolina Center for Medical Excellence (CCME) was formerly called Medical Review of North Carolina (MRNC).
[27] Available at http://www.mrnc.org/ncqic/.

contracting with the North Carolina DFS Nursing Home Licensure and Certification Branch to provide direct technical assistance to nursing homes through a Directed Plan of Correction for nursing homes that are out of compliance in areas such as accidents, pressure ulcers, restraints, and incontinence. The Nursing Home Licensure and Certification Branch will choose which facilities, based on compliance with the federal regulations, will be assisted by CCME to improve care in these areas. This is a year long project and started in August 2006. DFS in conjunction with CCME also has provided web based/ telephone based training to nursing homes in the areas of Abuse and Neglect in Nursing Homes and Pressure Ulcers and the Regulations in Nursing Homes.

DFS also helped organize trainings for nursing home administrators on restraints. The training included perspectives from the regulatory agency (DFS), NC Healthcare Facilities Association, CCME, and the Long-Term Care Ombudsman. DFS is helping organize another training in 2007 on Pain Management in Nursing Homes. (See Recommendation 27 below).

There also are several other initiatives that are aimed at improving medication safety and reducing unnecessary medication use. In 2003, the NC General Assembly directed DFS to develop a medication error reporting system for nursing facilities in order to help nursing facilities identify medication-related errors, evaluate the causes of the errors, and take appropriate actions to reduce these errors.[28] DFS contracted with the Cecil G. Sheps Center for Health Services Research to develop a reporting system. The system collects information on the number and types of medication-related errors and performs a root cause analysis of the errors and the staff level involved. The error system also includes the number and types of injuries caused. This information is collected and then provided to the nursing facility medication management advisory committee in order to take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing facility patients. In addition, DFS organized trainings for nursing home administrators that covered the Centers for Medicare and Medicaid Services (CMS) new medication guidelines. Specifically, the training focused on ways to reduce unnecessary medications, monitor potential adverse outcomes for patients taking multiple medications (9 or more), and require nursing home pharmacists to conduct appropriate medication reviews for nursing facility patients.

The NC General Assembly also directed the Division of Aging and Adult Services to create a Quality Improvement consulting program for Adult Care Homes (State Fiscal Year 2007). Funding was provided for eight new ombudsman positions and a contract to develop the quality improvement initiative. The Division is contracting with CCME to start implementation of the quality improvement initiative for Adult Care Homes. (See recommendation 27 below).

Private initiatives: The NC Healthcare Facilities Association has launched a new initiative to transform skilled nursing facilities into facilities that will better meet the demands of long-term care consumers and their families. The initiative, called Journey to National Best, is based around five dimensions: leadership, services that support and encourage autonomy and choice, resources grounded in evidence-based practices, innovation in technology and delivery systems, and renewed public trust.[29]

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[28] S1016. Session Law 2003-393.
[29] Information available at: http://www.nationalbestnc.org/html/home.html

26. The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should explore methods to improve and reward quality (and not limit their actions solely to imposing penalties for deficiencies) through such mechanisms as:

(a) extending the licensure period from one to two years or extending the survey period from two to six months for adult care homes with a good track record and in the absence of complaints;
(b) increasing the reimbursement rate for long-term care providers that consistently perform over and above the minimum standard of care;
(c) providing financial rewards for long-term care providers that demonstrate innovation in problem areas, such as maintaining low staff turnover and handling difficult behavior problems, as examples;
(d) providing financial rewards for long-term care providers that seek and gain accreditation from nationally recognized bodies, attesting to performance above the minimum standards of care;
(e) considering a cap on allowable indirect costs for adult care homes similar to that imposed on nursing homes, but allowing a higher capped, direct rate of reimbursement, so as to incentivize the provision of higher quality, direct care to residents of these facilities; and
(f) considering a different approach to setting reimbursement rates for adult care homes that would replace the current "state average" method in current use so that those facilities that operate more efficiently have some incentive to do so and can then reinvest these resources in higher quality care. (Priority)

See Recommendation 23 above. The special designation license for Nursing Homes, Adult Care Homes, and Home Care agencies is both an improved workplace initiative and a way to reward quality.

27. The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should lead the development of a Quality Improvement Consultation Program to assist providers in the development of quality improvement plans for each facility and program offering long-term care services to the public in North Carolina. (Priority)

Nursing Facilities: The Carolinas Center for Medical Excellence (CCME), formerly Medical Review of North Carolina, Inc.(MRNC), is involved in a number of quality improvement initiatives for nursing facilities, some of which are under contract with the Centers for Medicare and Medicaid Services (CMS) and others are under a contract with the North Carolina Division of Facility Services (DFS) (using civil penalty monies). As part of its CMS contract, CCME offers certain quality improvement efforts across the state, and CCME is working more closely with two identified participant groups. CMS's priority areas include reducing high risk pressure ulcers, decreasing the use of physical restraints, improving depression management, and improving chronic pain management.

CCME also has a three-year contract with DFS (2006 marks the third year of the current contract) to offer quality improvement assistance to nursing facilities. In this third year of the contract, CCME will work with volunteer nursing homes, within a collaborative group, to improve medication safety within facilities. The topic of medication safety was identified as a priority area based on the number of deficiencies issued to nursing homes and through discussions with state surveyors and the nursing home industry. Nursing homes learn best practice information related to the clinical topic from expert faculty within the North Carolina community, some of which are faculty members at North Carolina's private and public universities; facilities learn quality improvement tools and techniques from CCME staff. The collaborative work includes data analysis, measurements appropriate to particular dimensions of quality (indicators), intervention design, implementation, and evaluation. CCME also will be offering one-on-one consultation to a limited number of facilities identified by DFS as needing assistance with development of a Corrected Plan of Action under one of five topics areas including falls, pressure ulcers, therapeutic monitoring of medications, restraints, and incontinence. (Also, see Recommendation 25 above).

Home Health: As part of its CMS contract, CCME offers certain quality improvement efforts across the state, and is working more closely with two identified participant groups within the home health community. Priority areas include: reducing acute care hospitalizations and improving oral medication use as well as improving immunization assessment and organizational culture. CCME is working collaboratively with the Association of Home and Hospice Care of NC to engage agencies in quality improvement efforts.

Assisted Living (Adult Care Homes): Oversight and monitoring of Adult Care Homes is a joint endeavor between DFS and county Departments of Social Services (DSS). In 2005, the NC General Assembly mandated that the Division of Aging and Adult Services (DAAS) develop a Quality Improvement Consultation Program for Adult Care Homes.[30] This mandate is intended to promote better care and improve quality of life in a safe environment. DAAS has formed a project work group with representatives from Assisted Living providers, consumer advocates, county DSSs, professional organizations (e.g., NC NOVA), and other North Carolina Department of Health and Human Services agencies. DAAS is working with CCME to develop and pilot a model in up to four counties. The 2006 NC General Assembly appropriated $100,000 to support continued contractual services in design and implementation of this program. The initial focus will be on improving quality in medication management in adult care homes. On completion of the pilots, DAAS will make recommendations regarding the project to the DHHS Long Term Services and Support Cabinet, the North Carolina Study Commission on Aging, and the House and Senate Appropriations Subcommittees on Health and Human Services.

FINANCING LONG-TERM CARE

Background:

In 2005, Medicaid spent $1.8 billion on long-term services for older adults and people with

[30] Session Law 2005-6, section 10.40A.(p).

physical disabilities, out of a total Medicaid budget of $8.1 billion. Nursing facility outlays constituted 13.3 % of the state's total Medicaid service dollars and 59% of the state's total Medicaid long-term care spending for older adults and people with physical disabilities, while nursing facility residents made up 27% of long-term recipients in the same year.

As noted earlier, the Department hired the Lewin Group to determine whether an institutional bias exists in the financing or delivery of long-term care services.[31] The Lewin Group explicitly noted that its report was an update to the earlier North Carolina Institute of Medicine Long-Term Care Task Force report. In the "North Carolina Institutional Bias Study Combined Report" of April 2006, the Lewin Group wrote that "North Carolina's fifty-nine percent (59%) of Medicaid Long Term Care (LTC) spending for nursing facility care compares to a national average of 75 percent in Federal Fiscal Year 2004, placing North Carolina in the top 10 states with the lowest proportion of Medicaid LTC spending for nursing facility care."[32] While progress has been made, the Lewin report also identified ten areas where an institutional bias exists in the Medicaid program for aging and disabled. This report is under review by the Department and will help formulate future policy plans.

28. The NC General Assembly should appropriate $43,151,156 in State Fiscal Year (SFY) 2002 and $48,674,894 in SFY 2003 to the Division of Medical Assistance to increase the Medicaid medically needy income limits up to 100% of the federal poverty guidelines. (Priority)

The North Carolina Institute of Medicine (NC IOM) Long-Term Care Report found that the current Medicaid income eligibility rules created an institutional bias. Individuals with incomes that are slightly higher than the federal poverty guidelines can qualify for long-term services and supports if they live in an institutional setting (nursing home or ICF-MR) or in a group living setting (adult care homes). They would have a harder time qualifying for services living in the community. For example, in 2006, the income guidelines were as follows:

	Maximum Monthly Medicaid Income Limits (2006)
Nursing facility care	$3,385
Intermediate Care Facility for the Mentally Retarded (ICF-MR)	$5,747
State County Special Assistance for adult care homes	$1,164
Income limits for people receiving long-term services and supports in the community	$817 (individual) $1,100 (couple)
Income limits if income exceeds $817/$1,100	$242 (individual)

[31] The Lewin Group. North Carolina Institutional Bias Study Combined Report. Prepared for the North Carolina Department of Health and Human Services. April 2006. Available at http://www.ncdhhs.gov/dma/LTCReport.pdf.
[32] Ibid at p. 9.
[33] Individuals with incomes that exceed the regular income limits may be able to qualify for Medicaid if their medical bills exceed a deductible or "spend-down." The spend-down equals the difference between the person's countable income and the medically needy income limits. The amount of a person's spend-down will very, depending on their income. For example, an elderly individual with $942 in countable monthly income would have a $700/month spend-down. Medicaid eligibility is typically determined on a six-month basis, so the individual

(medically needy income limits)[33]	$317 (couple)

As with the NC IOM, the Lewin Group found an institutional bias in the Medicaid income eligibility process. Specifically, the Lewin Group noted two areas where an institutional bias exists in the Medicaid income eligibility process: 1) the low medically needy income limits and 2) the lack of spousal income protection for people residing in the community (called "spousal impoverishment" rules).

The Lewin Group noted that individuals can count the full cost of nursing facility care in meeting their Medicaid spend-down, whereas people living in the community can only count the costs of health care and allowable expenses (not room and board). The current Medicaid medically needy income limit of $242/month is not sufficient to enable a person to meet their housing, food, and other needs necessary to live in the community. Like the NC IOM report, the Lewin report also recommended that the state increase the medically needy income limits for the aged, blind, and disabled. However, Lewin only recommends that the state increase the income guidelines up to $414 for a single individual (the average for all the medically needy income limits across the country).[34]

In addition, the Lewin Group pointed out another bias in the eligibility determination process not specifically mentioned in the earlier NC IOM Task Force report. Specifically, under federal law, individuals who move into a nursing facility can protect some of their income and resources for the individual who is remaining in the community (community spouse). These same protections are not provided when both people are living in the community.[35] The report noted that this discrepancy can create a significant institutional bias, as the spouse of a person residing in a nursing facility can receive substantial portions of the institutional spouse's income to support his or her care in the community; whereas the same protections do not apply if a person receives CAP-DA services or needs home and community-based services while living at home. The Lewin Group recommended that the state align spousal impoverishment rules for long tTerm care beneficiaries in all settings.

29. The NC General Assembly should expand the number of CAP/DA and CAP-MR/DD allocations to help individuals, who would otherwise need institutionalization, remain in their homes or in the community. Expanding the number of CAP allocations would also assist the state in meeting Olmstead planning requirements.

- **CAP/DA: to increase the number of people served by CAP/DA from 12,234 in State Fiscal Year (SFY) 2001 to 13,750 in SFY 2002 and to 15,125 in SFY 2003**
- **CAP-MR/DD: to increase the number of people served by CAP-MR/DD from 6,527 in SFY 2001 to 7,527 in SFY 2002 and to 8,527 in SFY 2003**

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would have a $4,200 spend-down ($942-$242=$700 x 6 months = $4,200). Thus, the individual would need to incur $4,200 in medical expenses before Medicaid would begin paying for any additional services.
[34] Ibid at p. 25.
[35] Ibid. at p. 27.

> **The Division of Medical Assistance (DMA) should ensure the equitable distribution of any new "allocations" funded by the NC General Assembly in order to address some of the variations in the utilization of CAP allocations across the counties (See Chapter 4 and Appendix D). DMA, which has state oversight for local management of CAP/DA, will work closely with local governments and lead agencies to ensure the capacity exists to utilize additional service allocations from the NC General Assembly. In addition, DMA will work closely in this same capacity with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the agency charged with state oversight of the management of CAP-MR/DD by area mental health programs. (Priority)**

Community Alternative Placement for Disabled Adults (CAP/DA): The NC General Assembly initially froze CAP/DA slots (2001) but reopened the program in 2002 and subsequently expanded the number of people being served by CAP/DA. In 2004, the NC General Assembly expanded CAP/DA slots by 2,500. The new slots were allocated based on the ratio of current CAP slots per Medicaid aged and disabled individuals, so that the neediest counties (i.e., those with fewer existing CAP slots) received a higher proportion of the new allocations. In 2006, Congress passed the Deficit Reduction Act which gives states the authority to offer home and community-based services without a waiver to certain individuals with incomes below 150% of the federal poverty guidelines.[36] North Carolina still operates its home and community-based waiver programs (CAP/DA, CAP/MR-DD, CAP/C) through a waiver.

In addition, in 2006, the NC General Assembly directed the Division of Medical Assistance (DMA) to implement a case mix reimbursement methodology for the Community Alternatives Programs (exclusive of CAP/MR-DD). A report to the NC General Assembly was prepared and submitted describing case mix systems. DMA submitted a report, with a request to implement it in 2008.

The Lewin Group, in its study of Institutional Bias, examined the administration and financing of the CAP/DA program. It found:

- North Carolina's application of the CAP/DA waiver cost neutrality rules limited the CAP/DA program for individuals with more intensive needs, making it difficult for them to stay in the home or community.[37] The state sets individual caps on waiver services to ensure that no individual spends more on waiver services than they would have spent in an institutional setting. The federal law only requires an aggregate cap (e.g., that the state does not spend more on the CAP/DA program as a whole, as it would have done if everyone were in a nursing facility). The Lewin Group found that the state's individual cap "means that persons with the most intense needs (i.e., those that cost more than the

[36] Sec. 6086 of S. 1932. Deficit Reduction Act of 2005. The state need not submit a waiver to operate a home and community-based services program. Under this provision, the state can still limit the number of people who it will serve and can establish waiting lists. The state must establish needs-based criteria to determine eligibility for home and community-based services, and based on those criteria, what services the individual will receive. To qualify, an individual must be subject to an independent assessment that identifies the individual's support needs and capabilities.
[37] The Lewin Group. Ibid. Bias#5 at p. 31.

average) may be excluded from community-based services."[38] The Lewin Group recommended that the state institute a global program cap, rather than an individual cap.
- The enrollment cap in the CAP/DA program limited the availability of services.[39] The Lewin group recommended that the state consider options that would allow the North Carolina Department of Health and Human Services to expand the number of CAP/DA slots without needing legislative approval.
- The state does not have a statewide CAP/DA waiting list or a way of prioritizing those who have the greatest risk of institutionalization.[40] The Lewin Group recommended that the state crate a statewide system for managing access to CAP/DA services and give those people at risk of institutionalization a priority for services.

The allocation of CAP/DA slots across the county was one of the areas identified in the Lewin Medicaid Institutional Bias report. Specifically, the report found that the state's policy of allocating the new CAP/DA slots in 2004 to the counties that had proportionally fewer slots (compared to the county's Medicaid aged, blind, and disabled residents) lead to some inequities. While some of the counties with new slots were trying to fill the new slots, other counties had waiting lists. The criteria for being placed on the waiting list varied across counties. The Lewin Group recommended that the state explore the possibility of statewide management of waiver slots and the waiting list.[41]

The NC General Assembly directed the Department to examine the issues in the report, and submit a response to the North Carolina Study Commission on Aging on or before August 30, 2007.[42] Specifically, the report must include:

(1) Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years.

(2) A description of the CAP/DA slot allocation formula; a breakdown of slots by county, including the reallocation of any unused slots.

(3) Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists.

(4) Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This tool should include information on whether the lists should be prioritized by risk of institutionalization.

In addition to the regular CAP/DA program, the Department submitted a separate Medicaid community alternatives waiver to allow consumer directed care. The Department's CAP-Choice

[38] The Lewin Group. Ibid. Bias #5 at p. 32.
[39] The Lewin Group, Ibid. Bias #6 at p. 33.
[40] The Lewin Group. Ibid. Bias #7 at p. 34.
[41] The Lewin Group. Ibid. Bias #8 at p. 36.
[42] Session Law 2006-109 (SB 1276).

program was approved by the Centers for Medicare and Medicaid Services (CMS) and was implemented in two counties in January 2005 (Duplin and Cabarrus). Individuals who choose to enroll in the CAP-Choice program are allowed to direct their own care. Case managers serve as counselors and help clients develop a care plan and budget. (The case manager is still responsible for approving the care plan and the budget). Agencies serve as the fiscal agents, but clients have been given greater flexibility to hire their own direct care workers, including friends, neighbors, and family, but not their spouse (Medicaid prohibits paying spouses under this waiver). Clients also have more latitude to use funds to purchase services or items that can help them be more independent and may reduce their need for personal care services. The goal is to roll-out the CAP-choice program statewide by 2008, as part of the Medicaid long-term care transformation grant.

Other efforts to help older adults and people with disabilities remain in their home: In addition, the North Carolina Department of Health and Human Services (DHHS) is also piloting a consumer-directed care program in the Home and Community Care Block Grant program in Cabarrus County. (The CAP/DA and HCCBG programs will work together collaboratively in Cabarrus County). The goal is to evaluate the existing pilot to determine the feasibility of statewide implementation for self-direction in the HCCBG program by July 2007.

DMA also received a federal CMS Nursing Home Transition grant to help identify individuals living in nursing facilities who are interested in and who could appropriately be cared for in the community. DMA worked with the Division of Vocational Rehabilitation to assist with the transition. The Nursing Facilities Transitions Demonstration Project ended with 143 residents returned to the community setting. To continue and expand this effort, the Division recently submitted a Money Follows the Person grant (MFP). The proposed MFP grant is targeted at individuals who have resided in a facility for at least six months and wish to return to the community. The goal is to transition 300 individuals from nursing facilities, 225 people from public and private ICF-MRs, and 520 children from level 3 group homes between January 2007 and December 2012.

Additionally, the NC Department of Health and Human Services has developed an initiative targeting hospital discharge planning. In the past, many individuals who needed to be discharged from a hospital ended up in nursing facilities because they lacked the services and supports necessary to return to their homes. The current Medicaid eligibility process is too lengthy, and unresponsive to the needs of people who are at risk of nursing facility placement. This initiative, called the “Rebalancing Initiative,” targets individuals at risk of premature placement in a nursing facility, especially among non-elderly adults with physical disabilities. The Rebalancing Initiative is being led by the NC Division of Vocational Rehabilitation and will be tested in two counties: Forsyth and Surry. The pilot study will examine whether immediate availability of Medicaid funded services can prevent premature nursing facility placement among participants.

Community Alternatives Placement for People with Mental Retardation or Developmental Disabilities (CAP/MR-DD): The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) and the Division of Medical Assistance (DMA) developed a waiver to be submitted to CMS for consumer-directed choice waiver for the CAP/MR-DD program. This waiver submission will be coordinated with overall mental health

and developmental disability reform efforts. The plan is to obtain waiver permission from CMS sometime in the 2007-08 timeframe.

30. North Carolina should increase the Community Alternatives Program (CAP) income eligibility limits to 300% SSI (currently $1,536/month for an individual) and allow the individual to deduct an amount equal to 100% of the federal poverty guidelines to support the community spouse.

No action taken.

31. If permitted under federal law, North Carolina should increase the Medicaid income guidelines for older adults and people with disabilities up to the State-County Special Assistance income limits (currently $1,098/month for an individual).

No action taken.

DHHS has determined that this recommendation is feasible under federal regulations; however, the costs involved make it extremely difficult to pursue.

32. North Carolina has a strong public interest in maximizing the use of federal dollars to fund long-term care services. The North Carolina Department of Health and Human Services should ensure that Medicare pays for covered services for Medicare-eligible individuals by appealing the denials of Medicare coverage of long-term care services, including home health care. North Carolina should also maximize the use of Medicaid funds for long-term care services prior to using other more limited sources of state funds. (Priority)

Medicaid has changed its claims payments system to have Medicare and other third party insurance pay first before a claim can be filed for Medicaid.

33. The new Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should explore methods to use existing resources as the state's match in further Medicaid expansion to cover more older adults and people with disabilities, to cover additional long-term care services, or to pay for long-term care administrative costs. As part of its analysis, the Department should:

- **identify possible sources of state funds (e.g., state funds not required as federal match for HCCBG, SA) and**
- **determine whether the Medicaid expansion would cover the same eligibles and services as other programs. (Priority)**

The North Carolina Department of Health and Human Services continues to examine ways to use existing state resources as a Medicaid match. For example, the Department used state Special Assistance funds as state match for personal care services.

34. The NC General Assembly should appropriate $10,399,955 in both years of the biennium to the Division of Aging to expand the availability of home and community services for non-Medicaid eligible older adults. In December 2000, there were 8,126 identified service needs on the waiting list for services funded through the Home and Community Care Block Grant. This number includes people waiting for in-home aide services (3,729) and home delivered meals (2,920). The new appropriation would be used to meet the needs for additional in-home services, additional home delivered meals, and increased transportation services.

The NC General Assembly reduced state funds for the Home and Community Care Block Grant (HCCBG) by one million dollars in State Fiscal Year (SFY) 2004 and SFY 2005. The state moved three million dollars of state funds from purchase of home health to the Medicaid Personal Care Services (PCS) budget. These funds were used for PCS-Plus, designed as an enhancement to the PCS program. PCS-Plus funds are intended for private residence PCS recipients whose needs exceed the 3.5-hour per day limit and the 60-hour per month limit for regular PCS. Under PCS-Plus, individuals can obtain an additional 20 hours per month with prior approval from the Division of Medical Assistance.

In 2006, the NC General Assembly appropriated $4 million in recurring funds in SFY 2007 for the HCCBG. HCCBG supports such services as home-delivered meals, in-home aide services, adult day services, and transportation for persons 60 and older so that these individuals may stay in their homes. These funds also can be used to provide respite for family caregivers. As of June 2006, the wait list for HCCBG services exceeded 10,000. The Division of Aging and Adult Services expects to be able to reduce the waiting list for HCCBS by approximately 3,000 people.

35. The NC General Assembly should appropriate $2.5 million in State Fiscal Year (SFY) 2002 and $5 million in SFY 2003 to the Division of Social Services to expand the availability of home and community services for non-Medicaid eligible persons with disabilities between 18-59. These new funds would provide services to an additional 3,322 adults with disabilities in SFY 2002 and 6,644 in SFY 2003 through the State In-Home Funds program.

See recommendation number 34 above.

36. The NC General Assembly should appropriate $3,427,622 in both years of the biennium to the Division of Aging to expand the state Adult Day Services Fund to increase the availability of respite services for family caregivers. The new appropriations would cover an expansion of both the daily rate to cover the cost of daily care and transportation as well as a 45% increase in the number of people served (up to 1,923 people).

The number of adult day programs has steadily declined from 125 programs operating in 68 counties in 2000 to 105 programs in 56 counties four years later (2006). Partners in Caregiving, a national adult day services resource center, conducted a study and determined that 75% of North Carolina counties are underserved. The NC General Assembly responded in 2004, by

enhancing the daily rate for Adult Day Care and Adult Day Health Care services by $5.00.[43] In addition, the NC General Assembly directed the North Carolina Department of Health and Human Services to contract with a national adult day service resource center (Partners in Caregiving) to provide training and consultation to Adult Day providers and to study the reimbursement methodology.

In the 2006-07 Session, the NC General Assembly appropriated $1,043,750 to the Division of Aging and Adult Services (DAAS) to increase the daily rate for Adult Day Care and Adult Day Health Services by $5.00. The funds are to be allocated through the State Adult Day Care Fund and HCCBG. This per diem rate increase for adult day services was recommended by the 2006 Study Commission on Aging.

In addition, the NC General Assembly directed DAAS and the Division of Medical Assistance to provide education and training to ensure that case managers within the Community Alternatives Programs (CAP) were aware of adult day health services and to ensure that this option is considered when appropriate for specific clients.[44] DAAS was also directed to develop a reporting system to determine unit costs (which can be used for future rate changes). DAAS is in the process of refining a provider cost analysis/budgeting tool, which should be implemented statewide beginning July 1, 2007. DAAS also maintains a website and provides technical assistance to adult day programs.[45] In response to all of these efforts, DAAS expects an increase in adult day programs in North Carolina in the next year.

37. The Task Force does not recommend that the NC General Assembly rely on reverse mortgages as a means of financing long-term care services.

No action taken by NC General Assembly to encourage people to use reverse mortgages to finance long-term care.

38. The NC General Assembly should appropriate $268,000 in each year of the biennium to the North Carolina Department of Insurance (DOI) for private long-term care insurance outreach efforts. DOI in conjunction with the North Carolina Division of Aging, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other appropriate groups should develop an outreach strategy to inform the public about long-term care funding or payment options. The outreach effort should include information on what Medicare covers, what Medicaid covers, what individuals must pay on their own, and what private long-term care insurance can cover. Public education efforts should target employers, "baby-boomers," financial advisors, CPAs, banks, and the legal community. The state should develop multiple outreach strategies including community education, the Internet, and mass media. Further information on the long-term care options could be incorporated into the curricula of courses on estate and financial planning offered in the North

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[43] Section 5.1(a) of Session Law 2004-124.
[44] The North Carolina Department of Health and Human Services report to the North Carolina Study Commission on Aging (October 2006) is available at http://www.dhhs.state.nc.us/aging/ADCADH/PIC_Legislative_Report.pdf.
[45] Information available at http://www.dhhs.state.nc.us/aging/adcresources.htm.

Carolina Community College System. Also, the outreach should include information about the impartial counseling services offered by DOI's SHIIP program. ***(Priority)***

Public educational efforts about Medicare, Medicaid, and long-term care financing options have continued among the Division of Aging and Adult Services, the Senior Health Insurance Information Program (SHIIP), AARP, and others. More intense educational efforts are being planned for when North Carolina begins to offer a long-term care partnership program (see Recommendation 40 below).

39. The Task Force does not recommend that the NC General Assembly rely on Medical Savings Accounts as a means of financing long-term care services.

No action taken by NC General Assembly to expand the use of Medical Savings Accounts to finance long-term care.

40. The NC General Assembly should pass a resolution to encourage the North Carolina Congressional delegation to support federal incentives to purchase private long-term care insurance (such as federal tax credits or deductions, flexible savings accounts, or cafeteria plans) and to eliminate federal barriers to expansion of Medicaid long-term care partnership plans.

North Carolina had a state long-term care tax credit, which sunsetted in 2004. The 2006-07 NC General Assembly did not reinstate the state long-term care tax credit, even though the 2006 Study Commission on Aging recommended that they do so.

However, the NC General Assembly in the 2006 Session directed the North Carolina Department of Health and Human Services (DHHS) to develop a Public-Private Long-Term Care Partnership Program to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid. Partnership policies may be more attractive to middle-income individuals than other long-term care insurance. Individuals who purchase long-term care partnership plans may be able to exempt some assets from the Medicaid eligibility determination process, if they buy sufficient private long-term care coverage to pay for their services for a certain period of time (thus delaying dependence on Medicaid for long-term care services).[46] DHHS must submit the proposed partnership plan to the Senate Appropriations Subcommittee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and Fiscal Research before submitting this proposal to the federal government for final approval.

The Division of Medical Assistance (DMA) is currently working with the NC Department of Insurance (DOI) to explore long-term care partnership programs. DHHS is exploring the potential impact of these insurance products on the Medicaid program, and DOI is examining whether state insurance laws will need to be modified to accommodate the products in North

[46] Sec. 10.10 of Session Laws 2006-66.

Carolina.[47] DMA plans to submit a report to the NC General Assembly with the steps necessary to implement a long-term care partnership program by April 1, 2007.

41. The Task Force does not support further restrictions in Medicaid through tightening transfer of assets provisions or estate recovery.

Congress and the NC General Assembly enacted laws to further tighten transfer of assets and estate recovery provisions after publication of the North Carolina Institute of Medicine Long-Term Care Report. Specifically:

- Congress, in the Deficit Reduction Act of 2006, extended the look-back period for transfers of assets from three-years prior to five-years prior to applying for or becoming eligible for Medicaid. The penalty period begins on the date the person would have otherwise become eligible for Medicaid.[48] The NC General Assembly enacted new laws to implement the federal changes in the 2006 NC General Assembly.[49]
- North Carolina tightened the estate recovery provisions to apply the provisions to individuals 55 years old or older who are receiving home and community-based services effective July 1, 2006. The law continues to apply to a person of any age who is receiving institutional care.[50]

42. The Office of Long-Term Care, within the North Carolina Department of Health and Human Services, should explore the possibility of establishing a sliding scale fee based on an individual's ability to pay. This sliding scale fee should be imposed on long-term care services provided under the Home and Community Block Grant and the Social Services Block Grant programs. If a sliding scale fee is imposed, the Department should establish a mechanism to waive the fees for people who are unable to pay.

The Division of Aging and Adult Services developed a voluntary consumer contributions policy for all services provided through the Home and Community Block Grant (HCCBG) and the Social Services Block Grant.[51] This policy was implemented in September 2005. The state collects approximately $2.5 million annually in the HCCBG, which is used to expand the services provided to older adults.

43. The Office of Long-Term Care, within the North Carolina Department of Health and Human services, should explore ways to invest in family caregiving so that it can be

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[47] The National Association of Insurance Commissioners (NAIC) has develop model long-term care partnership laws which states can use in implementing long-term care partnership programs. The NC Department of Insurance believes that current state laws provide similar or better protections to the model long-term care partnership laws, so there will be little need for state insurance law changes.
[48] Crowley JS. Medicaid Long-Term Services Reform in the Deficit Reduction Act. Kaiser Commission on Medicaid and the Uninsured. April 2006. Available at http://www.kff.org/medicaid/upload/7486.pdf (October 25, 2006).
[49] Sec. 10.5 of Session Law 2006-66.
[50] NCGS §108A-70.5.
[51] Under the Older Americans Act, states were given the authority to choose between mandatory cost sharing for certain services and accepting voluntary contributions for other services. Only voluntary contributions may be accepted for nutrition services or from individuals with incomes below 100% of the federal poverty guidelines.

sustained as a primary resource for long-term care, reducing the risk for needing formal, publicly-financed services. (Priority)

North Carolina receives approximately three million dollars annually in federal caregiver support funds under the Older Americans Act. North Carolina has been viewed as a national leader in its use of these funds to develop a multi-faceted system of support for family caregivers. The Division of Aging has emphasized leveraging these funds and the development of partnerships (including with the AARP, North Carolina Cooperative Extension, Carolinas Center for Hospice and End of Life Care, North Carolina Association of Area Agencies on Aging, Alzheimer's Association, Duke Family Support Program, and others). The Division of Aging and Adult Services (DAAS) has established a State Caregiver Steering Team composed of leaders from the faith and business communities, foundations, senior advocacy groups, and other organizations involved in caregiver support. DAAS published a report that provides information on family caregivers in North Carolina and resources to obtain support and assistance.[52] (More information about DAAS' caregiver support initiatives is in Recommendation 12 above).

In terms of private initiatives, the Association for Home & Hospice Care of North Carolina has for the past thirteen years sponsored an annual Caregiver of the Year Award. This award is presented to a non-paid caregiver who goes above and beyond the call of duty to promote patient/client well-being and enhanced quality of life including but not limited to factors such as comfort, safety, and independence.

44. Special funds should be earmarked for one-time county "transition support" to enable counties to implement the recommendations of the Task Force on Long-Term Care and to make needed system improvements to conform to policies and procedures implemented by the new North Carolina Department of Health and Human Services Office of Long-Term Care. (Priority)

No action taken.

45. Special one-time "capacity-building" funds should be made available to small, rural counties to enable them to develop the infrastructure and capacity to implement statewide system changes. (Priority)

No action taken.

46. The Office of Long-Term Care should establish a clearinghouse to:

- **Gather information on the success and failure of long-term care initiatives, demonstrations, and system improvements in North Carolina and other states;**
- **Distribute such information to all local areas in North Carolina;**
- **Provide technical assistance for implementation of system improvements to counties that are not well-resourced; and**

[52] Available on the internet at http://www.dhhs.state.nc.us/aging/fcaregr/Statusreport2005final.pdf.

- **Provide a neutral forum for state and local leaders to come together to discuss continuous system improvement.**

The Division of Aging and Adult Services led an interagency/departmental initiative to develop an extensive website on long-term care.[53] Maintenance of this site is an ongoing initiative, which includes updating the Inventory of State Resources for Older Adults. This website provides an important way to track the work of the North Carolina Department of Health and Human Services and the Long-Term Services and Support Cabinet in implementing the recommendations of the *Long-Term Care Plan*.

47. Participation in any state-supported demonstration should be open to all counties and/or regions via a competitive RFP (Request for Proposal) process.

In any state-supported demonstration, the state should set parameters required of all participants in the demonstration; however, local communities should be allowed to meet specified parameters in a variety of ways that reflect differences in local agency structure, patterns of interaction, service, and governance.

In addition to demonstration project-specific guidelines and/or parameters, any state-supported demonstration should include the following features:

- **a clearly identified locus of county or regional leadership;**
- **minimal local level infrastructure; and**
- **local and/or regional potential for sustainability after the demonstration support.**

All state-supported demonstrations should be evaluated by an independent outside source and should include outcome-focused evaluation measures.

The Department used a Request for Proposal (RFP) process for the consumer-directed care pilots, the local communications and coordination initiative (ADRCs), and for community planning efforts. These RFPs included requirements for a clearly identified locus of local leadership, local-level infrastructure, and potential for sustainability. The North Carolina Department of Health and Human Services has also moved toward outcome-focused evaluation measures for all its contracts and agreements with outside parties.

OTHER LONG-TERM CARE INITIATIVES

Family Empowerment and Strategic Alliances for Elders in Long Term Care (SAFE-in-LTC). The Division of Aging and Adult Services' Elder Rights Division, Ombudsman Program has two initiatives intended to enhance the care provided to frail older adults and to prevent elder abuse. The Family Empowerment initiative helps to educate and support families to serve as more effective advocates for family members in long-term care. The intent is to help families

[53] Available on the internet at http://www.dhhs.state.nc.us/ltc/.

understand that they still serve an important role in shaping and influencing how care is provided in long-term care settings. SAFE-in-LTC (Strategic Alliances for Elders in Long Term Care) was implemented to carry out the Older Americans Act mandate to prevent elder abuse by coordinating services with law enforcement and the courts to prevent elder abuse. As part of this initiative, the North Carolina Ombudsman Program is working with law enforcement, adult protective services, long-term care providers, and other groups to discuss ways to prevent elder abuse. The group will review legislation to determine if additional changes are needed to protect frail elderly and will develop educational materials for the general public, long-term care providers, emergency service professionals, law enforcement, and the judicial system. The curricula will focus on 1) increasing awareness about elder abuse, 2) ensuring that when criminal acts occur in facilities, they are treated with the same sense of urgency as other crimes, and 3) that proper measures are taken to ensure that criminal acts are investigated and prosecuted to the full extent of the law.

Pilot Program to Evaluate Use of Telemonitoring Equipment in Home Care Services. The North Carolina Department of Health and Human Services Division of Medical Assistance may implement a pilot program to evaluate the use of telemonitoring equipment in home care services and community-based long-term care services.[54] This pilot program is based on a recommendation of the 2005-06 Study Commission on Aging.

Current Grants Used to Support North Carolina Department of Health and Human Services Long-Term Care Activities. Since the release of the North Carolina Institute of Medicine Task Force report, the Department has been very successful in obtaining federal and other grants to support the work of redesigning the state's long-term care system. Some of the current grants are listed below:

- *Aging and Disability Resource Center Grant*. The grant is a cooperative effort of the US Department on Aging and the Centers for Medicare and Medicaid Services. It is being used to help support the development of NC Care Link. In addition, the grant is being used to coordinate the work of the Aging and Disability Resource Centers in Forsyth and Surry Counties with Community Care of North Carolina in order to develop a system for managing the chronic care of the aged, blind, and disabled. (Grant completion date: September 2008).

- *Medicaid Long-Term Care Systems Transformation Grant*. Funding is provided by the Centers for Medicare and Medicaid Services. Funding is being used to support three primary goals: 1) improve access to long-term support services through the development of a one-stop system (through ADRCs and NC Care Link); 2) increase consumer choice and control through the development and enhancement of self-directed service delivery system; and 3) transform information technology (including level of services assessments, automated assessment and care planning tools) to support system change. (Grant completion date: September 2011)

- *Better Jobs Better Care Demonstration Grant*. This grant is a cooperative effort of the Robert Wood Johnson Foundation and the Atlantic Philanthropies and was used to help

[54] Section 10.9C of Session Law 2006-66.

develop the NC NOVA special licensure program for long-term care facilities and organizations (See Recommendations 17, 23 above). (Grant completion date: August 2007). More information about NC NOVA is available at http://www.dhhs.state.nc.us/ltc/bjobcare.htm.

- *Integrating Long Term Supports with Affordable Housing Grant.* This funding was part of the Centers for Medicare and Medicaid Services Real Choice grant and was used to hire three housing coordinators to integrate housing supported with the Low Income Housing Tax Credit with long-term supports to make these units accessible for people with disabilities. The Housing coordinators also provide technical assistance to expand the capacity of the human services system to encourage the development of appropriate housing for people with disabilities. (Grant completion: September 2007).

- *Medicaid Rebalancing Initiative Grant*. The grant, from the Centers for Medicare and Medicaid Services, is focused on improving hospital discharge planning for working-age and older, Medicaid-eligible adults with significant physical disabilities who are at risk of inappropriate placement in an institution or nursing home. The goal is to decrease reliance on institutional care and increase use of community based services. The grant will be piloted in Forsyth and Surry Counties. The project is (Grant completion date: September 2007, although the initiative may be continued through a no-cost extension).

- *Project Caregivers Running on Empty*. This money is a grant from the US Administration on Aging's Azheimer's Disease Demonstration Grants. It is being used to support three pilot sites serving ten counties: Winston-Salem (Forsyth, Stokes, and Surry), Asheville (Henderson, Madison, McDowell, Polk, Rutherford, and Transylvania), and Charlotte (Mecklenburg). The grant is used to provide individualized guidance, counseling, support, advocacy, and education to family caregivers and helps link (and pay) for respite and community services. (Grant completion date: June 2007).