

A LONG-TERM CARE PLAN FOR NORTH CAROLINA: FINAL REPORT 2003 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)**

While the NC Department of Health and Human Services (DHHS) expects that this will be an ongoing goal, it has been able to make several important strides. First, the Department is developing an initiative for Consumer Directed Care (CDC) associated with the Real Choice grant.¹ Awarding a total of \$80,000, its initiative is supporting statewide and local pilot projects, which include: United Cerebral Palsy of North Carolina (statewide), Duplin Home Care & Hospice, Inc. (Duplin County), Community Partnerships, Inc. (Raleigh/Wake County), and Cabarrus County—joint proposal from Departments of Aging and Social Services. In support of the Real Choice grant, the Division of Medical Assistance has submitted a waiver to support consumer direction for Community Alternatives Program for Disabled Adults (CAP-DA) clients. Second, the Department supported a feasibility study for developing a statewide system for Information and Assistance. The Department is now moving forward to implement the feasibility study's recommendations. Third, the new Family Caregiver Support Program is contributing to this policy with its emphasis on providing information and access to 'flexible' services that are responsive to individual needs. In their implementation of the Caregiver Program, Area Agencies on Aging and their local providers are offering more choices to consumers.

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.**

Lynda McDaniel was appointed as Assistant Secretary for Long-Term Care and Family Services, and the Office of Long-Term Care and Olmstead was created. The Assistant Secretary created a Long-Term Care Cabinet, which includes all the Directors of the appropriate DHHS divisions to coordinate long-term care policies and the implementation of the Task Force recommendations. The Office of Long-Term Care uses a variety of means to involve consumers and other

¹ In 2001, the NC Department of Health and Human Services received a three year, \$1.6 million Real Choice grant from the Centers for Medicaid and Medicare Services to address direct care workforce issues. Major initiatives included in the project include: policy review, consumer directed care, public education/awareness and recruitment efforts, training and career ladder development, and development of a statewide association for direct care workers.

stakeholders, including use of the Real Choice Advisory Committee, the Senior Tarheel Legislature and the Governor's Advisory Council on Aging. Staff in the Office of Long-Term Care are primarily responsible for coordinating housing, transportation and direct care workforce initiatives across the Department in addition to other initiatives. The Department has also hired a Homeless Coordinator to coordinate with staff in the Office of Long Term Care and other Divisions to address homeless issues. In addition, the Department recently took the step of merging the Adult Services Section of the Division of Social Services with the Division of Aging.

ENTRY INTO THE LONG-TERM CARE SYSTEM

Note: A work group including all appropriate DHHS Divisions was established in September 2001 to develop a plan for implementing the seven recommendations addressing entry into the long-term care system. The work group submitted a report to the DHHS Long-Term Care Cabinet on the feasibility of implementing each of these recommendations. The work group's overarching conclusion, which was agreed upon by the DHHS Long-Term Care Cabinet in January 2002, was that without the availability of a statewide infrastructure of universal, automated assessment and care planning instruments, a uniform portal of entry is not feasible. It was also recognized that without sufficient funding from the NC General Assembly the automated assessment and care planning infrastructure could not be developed and implemented. Given the significant shortfall in the state budget, it was recognized that DHHS would not be able to move forward with requests for additional state funding to develop and implement the uniform portal of entry. The concept continues to be an effective approach to streamline access to the long-term care system. Once the state budget picture improves, DHHS will pursue development and implementation of a uniform portal of entry for long-term care services.

- 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 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, 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, by outstationing Division of Social Services Medicaid eligibility workers; collecting the financial information by other agencies; and transmitting it to DSS, or where possible, having 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)

DHHS is requesting \$800,000 from US Administration on Aging (AoA) and the Centers for Medicaid and Medicare Services (CMS) for a three-year period to support development of an Aging and Disability Resource Center Program to construct a locally integrated, visible network of resources to provide uniform information and access for seniors, younger persons with disabilities, family caregivers, and health and human service professionals. The State Divisions of Aging and Medical Assistance will be the principal implementers of this project, assisted by AARP-NC, the Research Triangle Institute, and many others. The Division of Aging will lead in developing a replicable and sustainable model of a Community Resource Center in Forsyth and Surry counties. In support of the Community Resource Centers, the Division of Aging will incorporate a new statewide Information and Assistance (I&A) infrastructure, expanded use of volunteer benefits counselors, a modified version of the National Council on Aging's Benefits Check Up, and the piloting of a uniform intake/screening tool. The Division of Medical Assistance will lead in developing a Chronic Care Management Project in a regional hospital in Forsyth, to complement the Community Resource Centers by providing essential functions to target the most complex long-term care populations reliant on public support. The Division of Medical Assistance will also pilot a simplified adult Medicaid mail-in application through the Resource Center Program.

In addition, the Division of Medical Assistance began initial work to simplify the Adult Medicaid application process for individuals in private living arrangements and the re-determination process for individuals in nursing homes. This work was curtailed due to the additional costs that would be incurred to make these changes when the state budget shortfall prohibited any additional, non-essential costs to be added to the Medicaid program.

- 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)**

Currently, the RAI-MDS instrument is automated and used by nursing homes. Development of the software for the RAI-Assisted Living (RAI-AL) instrument was curtailed when funding was discontinued by the NC General Assembly in June 2002. Software for the RAI-Home Care (RAI-HC) instrument was developed and is being used for the Special Assistance In-Home Program in a limited number of counties. This software is probably not useful for statewide implementation and would need to be re-written as an Internet application. It is not feasible for the Divisions of Social Services, Aging, and Medical Assistance to begin using these instruments until they are automated.

DHHS is conducting MDS assessments on a sample of adult care home residents for the purpose of providing needed information for the Adult Care Home Cost Modeling committee and process. In addition, a request for proposals (RFP) is being prepared to conduct MDS assessments on random sample of CAP/DA, adult day care, and adult day health recipients. The results of all the MDS assessments will be compiled and a report will be issued by the contractor comparing nursing facility patients, adult care home residents, CAP/DA recipients and adult day care and day health recipients. The Division of Medical Assistance is taking the lead on these studies.

- 6. The Office of Long-Term Care, within the 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 also 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)**

A paper version of a telephone screening tool was developed by a DHHS work group pursuant to the *2001 Long-Term Care Plan*, as part of the recommended uniform-portal-of-entry process to support information and assistance activities. The tool is based on items from RAI and includes questions to help refer people with mental illness, developmental disabilities, or substance abuse problems to appropriate programs. Pilot-testing of the tool in paper form is necessary to assess the tool's value before considering automation. This pilot will take place as part of the development of the Aging and Disability Resource Center if this funded by AoA/CMS. The RAI-AL and RAI-HC, once finalized and automated, will need to be piloted by the Divisions with a limited number of providers to assure their utility and to test the software application prior to mandating their use on a statewide basis.

There is little to no advantage to replacing paper instruments currently being used by these Divisions with *paper* RAI instruments. It would take additional resources to prepare and print the RAI paper instruments and train all local service providers on how to use them. No data would be collected. Multiple assessments would still be done by local agencies for the same

individual. Thus the goal is to eventually automate the telephone screening tool in conjunction with other RAI tools.

- 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 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)**

The Division of Aging led a feasibility study to determine how best to implement a centralized statewide Information and Assistance (I&A) infrastructure that would enable automated I&A service providers to respond more effectively to requests and provide citizens who search online for care provider information with a single access point that has a consistent look and feel. The Department supported the study from the Mental Health Trust Fund. Keane Consultants conducted the study that involved determining business and technical requirements for this system and designing a governance structure. An important component of the aforementioned Aging and Disability Resource Center Grant proposal is development of this statewide I&A infrastructure.

- 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.² Individuals not currently seeking publicly-funded long-term care services shall

² 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

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

The level of service assessment instrument has been completed. The instrument will need to be automated and piloted before it is used statewide by local agencies. It is not feasible to begin using this instrument on a statewide basis until level of service criteria have been established by DHHS for all settings of care and types of services. DHHS will prepare and issue an RFP to collect assessment data, using the RAI family of assessment instruments, on a random sample of individuals receiving care and services in various settings of care—including adult care homes, adult day care centers, and CAP/DA participants living at home. In addition to existing assessment data currently collected on the RAI-MDS instrument for nursing home patients and on the RAI-HC for Special Assistance In-Home Project participants, the data collected through the random sample process could be used to establish level of service criteria. Once the level of service criteria are established by DHHS, they could be used by the local uniform portal of entry agencies in administering the level of service assessment instrument to determine which level of service individuals need and are eligible to receive.

9. The Office of Long-Term Care, within the NC Department of Health and Human Services, 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

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.

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.

Policies and procedures that address completion of assessments in a timely manner and that prohibit inappropriate self-referral of clients by agencies conducting assessments will be developed by DHHS at the appropriate time in order to govern the access services that will be provided through the uniform portal of entry. Also, a budget and plan will be prepared for conducting “look-behind” assessments of a randomly selected subset to assure the reliability of the assessment instruments. The possibility of using Medicaid funds to help pay for the level of service assessments will be explored.

10. The NC General Assembly should appropriate \$3,888,000 in SFY 2002 and \$7,128,000 in SFY 2003 to the NC 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.

Under the current state budget crisis, the NC General Assembly did not appropriate new funds for care management services for non-Medicaid eligible adults with incomes below 200% of the federal poverty level who are at risk of institutionalization.

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 has developed tools to help evaluate 21 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). Each of these tools examines a service along six dimensions (i.e., existence, adequacy, accessibility, efficiency, equity, and quality/effectiveness). The Department used an interagency process to finalize these tools for use locally. In addition, the Office of Long-Term Care has expanded its purview to coordinate DHHS work on housing and transportation issues.

- 12. The Office of Long-Term Care, within the 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 secured more than one million dollars from the AoA to support a demonstration program (Project C.A.R.E.) to assist caregivers of persons with Alzheimer's disease. In addition, the Division has used approximately three million dollars annually in new federal monies under the 2000 Amendments to the Older Americans Act to support a Family Caregiver Resource Specialist at each Area Agency on Aging whose priority responsibilities include: "contributing significantly to helping the state implement the recommendations of the *Long-Term Care Plan*, including promotion of the availability of core services and the strengthening of local planning for aging and long-term care."

- 13. The NC 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 Division of Medical Assistance conducted a study and determined that there was not a need for a uniform payment rate at this time. However, the Division of Aging 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 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.

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

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

In support of the Communications and Coordination Initiative to Strengthen long-term care Services, the Division of Aging has convened an ad-hoc data group to identify, mine, and analyze data pertaining to local long-term care services that are available within the various DHHS divisions and offices. These client and program data will hopefully help counties assess their core long-term care services in terms of the following dimensions: existence, adequacy, accessibility, efficiency, equity, and quality/effectiveness.

In addition, the Division of Aging is currently revising the way that it maintains data on persons waiting for existing services under the Home and Community Care Block Grant (HCCBG), which should result in more reliable information. The Division of Aging also believes that the proposed computerized, statewide Information and Assistance system would aid in documenting unmet need.

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, HCCBG and 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, DHHS 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 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 DHHS to implement a communications and coordination initiative to support local coordination of long-term care and to pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. At the direction of the Long-Term Care Cabinet, the Division of Aging convened an inter-divisional State Team to lead in implementing this initiative, which involves several components: (1) development and piloting of evaluation tools for the core long-term care services; (2) selection of counties to voluntarily participate in the initiative; and (3) a process to ensure effective communication among the State Team and counties. Based on an RFP process, Mecklenburg and New Hanover counties were selected to participate in the initiative that should begin in January 2004. The goal is that the local long-term care coordination initiative will aid these two counties to further develop core services, coordinate local services, and streamline access to services. The initiative should also help to eliminate fragmentation and barriers to information and services; provide a seamless connection among state agencies and local entities, regardless of funding sources; and allow consumers to more effectively and efficiently navigate among long-term care services. (Sec. 10.8F of HB 397 of the 2003 Session).

LONG-TERM CARE WORKFORCE

17. The NC General Assembly should appropriate \$17,227,597 in 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 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)

For the last two budget cycles, DHHS submitted to the Governor's Office an expansion budget request to support a wage enhancement. The Study Commission on Aging also recommended funding for a labor enhancement in support of this recommendation. However, no action was taken on either of these proposals due to the state's budget crisis. However, the Office of Long Term Care, working with a broad-based Partner Team (including the NC Health Care Facilities Association, Association of Long Term Care Facilities, NC Assisted Living Association for Home and Hospice Care, and the NC Association of Nonprofit Homes for the Aging), is working to develop a special licensure designation for long-term care providers who voluntarily improve the workplace for nurse aides and other direct care workers. This effort is being funded through a Better Jobs/Better Care grant funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies. North Carolina's proposal was one of five projects Better Jobs/Better Care projects funded nationally. It is the intent of the Department and the Partner Team to tie any future labor enhancement effort that may be funded to this special licensure designation effort. The Better Jobs/Better Care effort in North Carolina will develop, pilot, and implement a uniform set of expectations and criteria for statewide use, on a voluntary basis across home care, adult care homes, and nursing facilities. The expectations will address issues such as: workplace culture, effective care teams, staff empowerment, effective coaching supervision, staff development and career ladder opportunities, and peer mentoring.

18. The NC General Assembly should appropriate \$1,406,029 in 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)

Building upon a pilot program implemented with funding from the Kate B. Reynolds Charitable Trust, the 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 participating in this program must complete certain training and complete a retention commitment in exchange for financial incentives. Participating employers must agree to pay a bonus or wage increase (employer incentives weighted toward a wage increase) when the nurse aide completes their training and retention commitment. The program will be expanded to include additional training modules and new job categories for direct care workers currently under development. The training modules developed for Win-A-Step-Up are available free of charge to any interested home care agency, adult care home or nursing facility. In 2003, the Study Commission on Aging recommended funding to support Win-Step-Up in adult care homes and home care agencies. No funding was authorized for these effort due to the state's budget problems.

19. The NC General Assembly should appropriate \$100,000 in 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 NC Center for Nursing, the NC 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)

DHHS has been working with the NC Board of Nursing, provider organizations, and other stakeholders to develop two new categories for direct care workers: a geriatric nurse aide and a medication aide. These new positions will respond to identified staffing needs by 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 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 UNC Institute on Aging to collect and analyze these data. (Priority)

Building upon data analysis efforts originally funded by the Kate B. Reynolds Charitable Trust, DHHS, in conjunction with the Institute on Aging at The University of North Carolina at Chapel Hill, systematically compiles and analyzes turnover rates in home care agencies, adult care homes and nursing facilities on an annual basis using a uniform methodology. Data efforts also include annually matching nurse aide registry data with Department of Labor data annually to examine wages, competing employment sectors, and job stability of active vs. inactive nurse aide registrants. The Institute on Aging also compiles a variety of wage, demographic and benefit data from nurse aide registrants through a survey process.

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) the Department of Health and Human Services implement initiatives to increase and promote the availability of nurse aide training and competency programs; 3) the Department of Health and Human Services work with the NC Board of Nursing, the Community College System and representatives from the NC Health Care Facilities Association to implement a pilot program using medication aides and geriatric aides in skilled nursing facilities; 4) the NC General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings. This was included in the 2003 report of the NC Legislative Study Commission on Aging.

- 22. The NC Department of Health and Human Services Office of Long-Term Care, along with the NC 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)**

DHHS convened a group of long-term care providers, the NC Department of Insurance and other interested individuals to explore ways to establish group health insurance purchasing arrangement for staff in long-term care organizations. The group was unable to identify any way to develop low-cost health insurance options that would meet the needs of direct care workers and other staff.

- 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 North Carolina, Developmental Disabilities Facilities Association, and the 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, or improve working conditions. Report(s) should be presented to the NC General Assembly no later than March 15, 2001. (Priority)**

The NC Health Care Facilities Association, NC Association of Long Term Care Facilities, NC Assisted Living Association for Home and Hospice Care, and the NC Association of Nonprofit Homes for the Aging are working with the Department to develop a special licensure designation for long-term care facilities that improve the workplace for nurse aides and other long-term care staff. It is intended that any future labor enhancements would be tied to this licensure designation. 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 other efforts to improve the retention and job satisfaction of direct care staff. In addition, all the aforementioned provider associations have collaborated with DHHS Real Choice grant funded efforts to increase public education and recruitment efforts including: development of recruitment materials, development of television ads, etc.

ASSURING QUALITY OF LONG-TERM CARE

- 24. Quality of care initiatives should become a major responsibility of the new NC Office of Long-Term Care within the NC 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 HCFA approval, and then, possibly in conjunction with North Carolina's Congressional delegation or with other states, request a HCFA 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 NC Department of Health and Human Services, in collaboration with the NC Institute of Medicine, Medical Review of North Carolina (MRNC), the NC Healthcare Facilities Association, NC NonProfit 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, to address the quality of care provided in nursing homes. The Committee has developed a brochure to help consumers understand the Quality Measures used in nursing homes and released by CMS in the fall of 2002. The work group has devoted attention to measuring resident and family satisfaction in nursing homes and is currently in the initial phase of developing modules for consumers, advocates, facilities and regulators to use in addressing particular quality of care issues affecting residents in nursing homes.

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 Medical Review of North Carolina (MRNC), to include 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)

MRNC is working with the Division of Facility Services to develop a set of best practices for long-term care quality of care. The initiative is focusing on falls and inappropriate wandering. MRNC is also addressing other quality initiatives in nursing homes in the areas of pain and restraints.

26. The Office of Long-Term Care, within the NC 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) consider 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 NC Department of Health and Human Services, should lead in 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) Partial implementation.

The Division of Facility Services has established a consultation program for Adult Care Homes. Dietary, nurse and/or pharmacy consultants provide on-site technical assistance. When case-mixed reimbursement goes into effect with Nursing Homes, the nursing homes will be required to initiate quality improvement programs. They will be allowed to choose from a wide variety of

programs including improved workplace initiatives. The Division of Medical Assistance will be the approval agency for the quality improvement programs. As part of the Contract between the Division of Facility Services and MRNC for best practices, technical assistance is provided to those nursing homes participating in the two programs.

FINANCING LONG-TERM CARE

28. The NC General Assembly should appropriate \$43,151,156 in 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)

No action taken.

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 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:**

The Division of Medical Assistance 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). The Division of Medical Assistance, which has state oversight for local management of CAP/DA, will work closely with local governments and lead agencies to ensure there is the capacity 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)

The NC General Assembly initially froze CAP/DA slots (2001), but reopened in 2002, and over 1,000 new slots were allocated to counties July 1, 2003. In addition, DHHS is also pursuing a consumer directed care waiver for CAP/DA. While this will not result in an increase in slots, it will offer CAP/DA recipients the choice of a consumer directed care option versus the traditional CAP/DA program. Consumer directed care also furthers the overall guiding principal of the Task Force to give consumers and their families more choice. It is hoped that the waiver will go into effect early in 2004. The CAP/MR-DD slots remain frozen.

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 is feasible under federal regulations, however 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 NC 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 NC 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, 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 covered by the other programs. (Priority)**

DHHS uses state SC/SA funds as state match for personal care services; there is an ongoing examination of whether there are other state monies that can be used as a match for Medicaid services. For example, DHHS is pursuing efforts to increase the use of state monies to draw down federal funds in the following areas:

- Vocational Rehabilitation is exploring whether it can use existing state funds to draw down Medicaid funds for Administrative Case Management; and
- The Division of Aging is exploring whether it can use existing state funds to draw down Medicaid funds to support the long-term care Ombudsman.

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 HCCBG. This 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, 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 SFY 04 and SFY 05. The state moved the three million dollars of state funds from purchase of home health to the Medicaid PCS budget. These funds will be 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.

35. The NC General Assembly should appropriate \$2.5 million in 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).

Funds have remained the same for the past three years.

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 NC Department of Insurance for private long-term care insurance outreach efforts. The NC Department of Insurance in conjunction with the NC Division of Aging; NC 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 offered in the community college system on estate and financial planning. Also the outreach should include information about the impartial counseling services offered by the NC Department of Insurance's SHIIP program. (Priority)

The Division of Aging, the Seniors' Health Insurance Information Program (SHIIP) in the Department of Insurance, and AARP are leading an effort to educate the public about Medicare, Medicaid, and long-term care financing options including long-term care insurance. A brochure entitled "It's About You, Your Children and Your Parents" was developed and distributed statewide, through support from a private grant.

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 NC 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.

The Assistant Secretary sent a letter sent to North Carolina's Congressional delegation in July 2002 encouraging them to support legislation promoting appropriate tax incentives. In addition, DHHS will encourage the NC General Assembly to take action to preserve the long-term care insurance tax credit.

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

The NC General Assembly increased restrictions on transfer of assets provisions in 2003-04 session; Sec. 10.26 of HB 397.

42. The Office of Long-Term Care, within the NC 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 HCCBG and SSBG 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 drafted a concept paper to revise its policies and procedures on cost-sharing arrangements in order to better target resources. With the recent merger of Adult Social Services with the Division of Aging, it will be easier to coordinate the implementation of cost-

sharing policies across the HCCBG and SSBG programs. July 2004 is the target date for revised cost-sharing policy and implementation of improved client screening process.

43. The Office of Long-Term Care, within the NC Department of Health and Human services, explore ways to invest in family caregiving so that it can be 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 AARP, NC Cooperative Extension, the Carolinas Center for Hospice and End of Life Care, the NC Association of Area Agencies on Aging, the Alzheimer's Association, the Duke Family Support Program, and others. The Division of Aging has established a State Caregiver Steering Team composed of leaders from the faith and business communities, foundations, senior advocacy groups, and other sources of information and influence.

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

At the request of Lynda McDaniel and the Long-Term Care Cabinet, the Division of Aging led an interagency/departamental initiative to develop an extensive web site on long-term care. Maintenance of this site is an ongoing initiative, which includes updating the Inventory of State Resources for Older Adults. This web site provides an important way to track the work of the

DHHS and Long-Term Care Cabinet in implementing the recommendations of the *Long-Term Care Plan*. See: <http://www.dhhs.state.nc.us/ltc/>

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 an RFP process for the consumer-directed care pilots and for the local communications and coordination initiative. Both included requirements for a clearly identified locus of local leadership, minimal local-level infrastructure and potential for sustainability. DHHS is also moving toward outcome-focused evaluation measures for all its contracts and agreements with outside parties. To the degree that funding is available to conduct outside, independent evaluations, the Department will engage such evaluators. The Special Assistance Demonstration began with 22 counties that expressed interest. Last session the NC General Assembly required that it become statewide to the degree possible with 800 slots.