North Carolina will face enormous challenges in the years to come as it prepares to meet the service needs of older adults and people with disabilities. By 2030, about 25% of the state’s population will be over age 60, dramatically affecting the resources required to meet the needs of an older population. Along with the projected growth of older North Carolinians, their increasing ethnic and racial diversity, rural living and poverty, the aging of individuals with physical and mental disabilities, and the slowed economy all create major challenges. Yet these challenges also present opportunities to find better, more efficient, and creative ways to meet the growing demands.

North Carolina has long been aware of the growing long-term service challenge. In 1981, the General Assembly established a long-term care policy (NCGS 143B-181.5) to address these issues. While recognizing family and friends as the primary resource for long-term care, the policy acknowledged that “the public interest would best be served by a broad array of long-term care services that support persons who need such services in the home or community whenever practicable.” In 1999, the General Assembly asked the Secretary of the Department of Health and Human Services to develop a long-term care system that could provide a continuum of care for older adults, people with disabilities, and their families, and to report its progress. A task force, facilitated by the North Carolina Institute of Medicine (NCIOM), produced A Long-Term Care Plan for North Carolina, which was submitted to the General Assembly in January 2001. The report noted that the fragmentation of many funding streams and oversight agencies makes it difficult for consumers to navigate the service system. It recognized the difficulties of moving from one type of service to another, identified inequities in funding and eligibility, and discussed workforce issues. It also examined the shortfalls of available data to monitor quality. The Task Force offered recommendations about entry into the long-term care system, availability and need for long-term care services, workforce, quality of care, and financing. These recommendations, as well as newer initiatives generated from the grassroots and federally, are guiding change in North Carolina’s long-term services and supports delivery system. These changes have been spurred by strong collaboration across the Department of Health and Human Services to maximize funding and plan for future needs.

One major federally-supported impetus for improving access to long-term services and supports is the Community Resource Connections program (CRC). CRCs create a “no wrong door” coordinated system of information and access through local agencies for people seeking long-term services and supports. CRCs aim to minimize confusion, enhance individual choices, and enable informed decision-making. Agencies collaborating in a CRC help consumers understand options, plan for future long-term service needs, and access public and private pay services. Supported through the Centers for Medicare and Medicaid Services (CMS) and the US Administration on Aging (AOA), North Carolina developed two pilot projects (then named Aging and Disability Resource Centers) in Surry and Forsyth counties in 2004 and 2005. With continued grant funding, the program now reaches 47% of the state’s population in 28 counties, with plans to develop several more local projects within the next two years and is moving toward statewide coverage within five years. Effective use of information technology is a key component of this initiative. As an example, NCcareLINK was developed to provide a statewide, web-
based information and referral system for consumers and providers (https://nccarelink.gov/).

In addition to better coordinated information and access, the state is working on initiatives to promote healthier lifestyles, support individuals to better manage their own health care needs, and connect individuals with primary health care providers in order to avoid—when possible—more expensive and restrictive services, including emergency room visits, hospital stays, and facility placements. One such initiative is the Living Healthy Program, funded through AOA grants. Based on the evidence-based Chronic Disease Self-Management Program curriculum developed at Stanford University, a Living Healthy participants attend workshops on (1) dealing with frustration, fatigue, pain, and isolation; (2) appropriate use of medications; (3) communicating effectively with friends, family, and health care providers; (4) appropriate exercise; (5) healthy eating; and (6) making informed treatment decisions.

A key platform for introducing many of these critical reforms and maximizing their effect is Community Care of North Carolina (CCNC). With 14 Community Care networks, comprised of community physicians, hospitals, health departments, and departments of social services, these established systems represent a patient-centered medical home for Medicaid recipients, who include people dually eligible for Medicare and Medicaid. North Carolina is one of only two states given permission by CMS to undertake a new Medicare 646 waiver demonstration for care of people with complex medical and social conditions that require a holistic and person-centered approach. The initiative’s success will depend largely on collaboration and integration among the variety of initiatives—including the CRC and the Living Healthy Program—that support seamless access to services, smooth transition of care among settings, and maximum consumer choice.

As the General Assembly noted in its long-term care policy, most long-term services and supports are provided informally. A priority recommendation of the NCIOM report was to “invest in family caregiving so that it can be sustained as the primary resource for long-term care, reducing the risk for needing formal, publicly-financed services.” Several initiatives are striving to meet this need.

Project CARE (“Caregiver Alternatives to Running on Empty”) provides consumer-directed respite to family caregivers of people with dementia. Its primary goals are to increase quality, access, choice, and use of respite and support services to low-income, rural, and minority families caring for a person with dementia at home. An estimated 70% of people with Alzheimer’s are cared for at home by unpaid family and friends. Research has shown that family caregivers needing and then receiving respite are more likely to postpone or avoid the care recipient’s institutional placement. Funded through federal and state funds, Project CARE has been successfully implemented in 22 counties, serving more than 3,800 families through 113 local provider agencies. There are efforts underway to expand to additional counties and, ultimately, statewide.

The Family Caregiver Support Program, funded under the federal Older Americans Act, began in 2001. It serves family caregivers providing care for an adult age 60 and older or for a person with Alzheimer’s Disease or related brain disorder (working with Project CARE when possible). It also provides services to caregivers age 55 and older who are raising a related child age 18 and under or caring for an adult with a disability. It leverages public and private resources to develop a multifaceted support system for caregivers, enabling them to better fulfill the caregiving role. Services include information; individual counseling; support groups; training in health, nutrition, and financial literacy; respite care; and supplemental services (e.g., home modifications, temporary home-delivered meals, and/or transportation) on a limited basis.

Most recently, North Carolina was selected as one of 12 states to develop a Lifespan Respite Program. Funded through a federal grant, it is intended to enhance and expand the quality and availability of respite services for all age groups via consumer and provider education and information, volunteer and provider training, and resource development. The objective is to create a more coordinated system of respite services by improving access and reducing barriers to respite care for people of all ages.

Strong coordination is especially critical as service needs grow and public resources are limited. Emerging service models that support greater collaboration and increased consumer choice will certainly become more important in efforts to help individuals remain in their own homes or even return home. Several consumer-directed care models are being tested and applied by the Division of Aging and Adult Services and the Division of Medical Assistance.

Among the growing array of new models are Money Follows the Person (MFP) and the Program of All-Inclusive Care for the Elderly (PACE). In MFP, individuals who have been in a qualified Medicaid facility for at least three months are eligible to return to a home-based or small group setting. MFP provides additional Medicaid funding and incentives to create systemic changes to make it easier for people to transition home. The PACE program integrates Medicare and Medicaid financing to provide social and medical services in an adult day health center supplemented with other services. For most PACE participants who would otherwise be eligible for nursing home placement, the service package permits them to continue living at home. There are currently two active PACE programs in North Carolina, at Elderhaus, Inc. in Wilmington and Piedmont Health Services, Inc. in Carrboro.

a. Information regarding this program is located at http://patienteducation.stanford.edu/programs/cdsmpl.html.
Driven in part by the aging baby boomers, the focus and definition of service quality is changing. Culture change toward more person-centered practices is encouraged through the service industries, as well as through the Department of Health and Human Services and federal funding agencies. These changes promote finding a balance between addressing what is important to individuals (as defined by the individuals themselves) while also attending to a person's health and safety. It shifts staff focus from the person's medical treatment or service needs to how these needs can be met in the context of what is important to the individual. Person-centered practices also support workplaces that are attentive to staff needs, recognizing that promoting more satisfied staff will result in more stable staff.

It is critical for the long-term services and supports system to have a well-qualified and stable workforce, as recognized by the NCIOM report. One result of developing consumer-directed programs is to create more options for hiring employees outside of a traditional agency, creating a larger potential workforce. There are also initiatives in the Department of Health and Human Services to develop continuing education, career opportunities, and incentives to promote stability for direct care staff. Two relatively new job categories, “Medication Aide” and “Geriatric Aide,” have been established for nurse aides working in nursing homes. Both provide opportunities for nurse aides to increase their knowledge and skill base and to help establish career advancement. WIN A STEP UP is a program implemented through a partnership with the North Carolina Institute on Aging at UNC Chapel Hill that aims to reduce turnover of nurse aides in nursing homes through training, education, and rewards.\(^b\) It upgrades skills, increases career commitment, improves retention of quality workers, and provides rewards and recognition.

The NCIOM recommendations included suggestions that agencies should be provided more incentives for developing quality programs that go above and beyond the minimum standards. North Carolina New Organizational Vision Award (NC NOVA) is a statewide, voluntary special licensure designated for nursing facilities, adult care homes, and home care agencies. It is a “raise-the-bar” workplace culture change program that addresses known causes of direct care staff turnover. Those achieving this designation have met a comprehensive, progressive set of criteria. In addition, the Division of Health Service Regulation has a new star rating system for adult care homes that allows for earning additional points for certain quality improvement programs above the minimum standards.

While acknowledging the challenges of the future demands for long-term services and supports, the Department of Health and Human Services is optimistic about the effect of changes underway. Its vision includes well-informed consumers who have support to plan for their futures; seamless access to coordinated primary health care and supportive services; an investment in families and other informal caregivers; services that are empowering, preventive, and person-centered; and a well-qualified workforce.

**REFERENCES**


\(^b\) More information about this program can be found at http://www.aging.unc.edu/research/winastepup/index.html.