Thursday, March 9, 2006
North Dakota Center for Persons with Disabilities
at Minot State University
Real Choice Rebalancing Grant
Testimony
North Dakota Legislative Council
Budget Committee on Human Services
Senator Dever, Chairman

Good afternoon, Chairman Dever and members of the Budget Committee on Human Services. I am Amy Armstrong, Project Director for the North Dakota Real Choice Rebalancing Grant at the North Dakota Center for Persons with Disabilities (NDCPD) at Minot State University. In September of 2004, this federal grant was awarded to the North Dakota Department of Human Services – Aging Services Division, and NDPCD has been contracted to facilitate this project. Thank you for the opportunity to present an overview and status report of the grant's important activities.

North Dakota's *Real Choice Rebalancing Grant* is a Real Choice Systems Change Grant funded by the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services. All Real Choice Systems Change Grants were implemented in order to assist states in complying with the Olmstead Decision and the President's New Freedom Initiative, which call upon states to improve access and choice of continuum of care services for the elderly and people with disabilities.

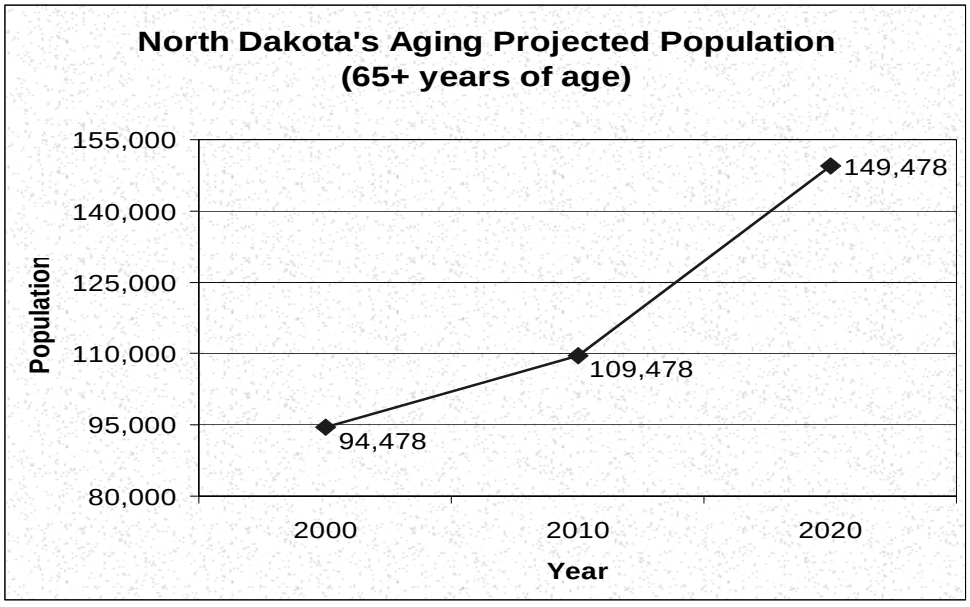
The United States Supreme Court's Olmstead v. L.C., Decision of 1999, calls upon states to integrate people with disabilities and to provide community-based services. On June 18, 2001, President Bush implemented the New Freedom Initiative which directed government

agencies to work together to "*tear down the barriers"* to community living for the elderly and people with disabilities. State agencies have been directed to:

- provide the supports necessary and administer their services in the least restrictive environment appropriate to the needs of the individual to learn and develop skills, engage in productive work, choose where to live, and fully participate in community life.
- provide new infrastructure to enable people who are elderly and/or have a disability to:
    - live in the most integrated community setting,
    - exercise meaningful choices, and
    - obtain quality services.

The *Real Choice Systems Change Grants* provide funding for states to build infrastructure that will result in effective and enduring improvements in community continuum of care support systems.

As you know, North Dakota is one of the states with the oldest population in America. ND is ranked first in the United States in the percentage of total population age 85 and older and fifth in the United States in the percentage of the total population age 75 to 84 (AARP Public Policy Institute, *Across the States: Profiles of Long-Term Care*, 2004). According to the *Needs Assessment of Long Term Care*, North Dakota's projected population will include approximately 149,000 people age 65 and older by 2020 (See graph below).



Needs Assessment of Long Term Care, North Dakota: 2002, Initial Report & Policy Recommendations, November 2002, NDSU

In a recent AARP survey, three in five ND AARP members expressed that they are extremely concerned with staying independent. (2004 AARP ND Member Survey: Support Services)

North Dakota's Real Choice Rebalancing Grant is working toward compliance with the Olmstead Decision and the President's New Freedom Initiative through the following goals:

- Develop a mechanism to balance state resources for continuum of care services, which includes all long-term and home and community based services. Rebalancing means adjusting a state's publicly funded long-term supports to increase community options and reduce reliance on institutions so the supply of available services reflects the preferences of older people and people with disabilities.
- Develop a system to provide a single point of entry for continuum of care services. A single point of entry system is one that provides consumers streamlined access to all continuum of care services through one agency or organization.

- Develop practical and sustainable public information services for all continuum of care services in North Dakota.

North Dakota's Real Choice Rebalancing grant will be funded through September of 2007. The project has accomplished a number of things during the first half of the grant period. With oversight from the North Dakota Department of Human Services – Aging Services Division, the grant's Planning Committee members serve as leaders who assist in developing, organizing, and planning the work of the grant. This committee includes Duane Houdek - Governor's Legal Counsel, Jim Moench - ND Disabilities Advocacy Consortium (NDDAC), Linda Wright - Aging Services Division, and Linda Wurtz – AARP.

Initially, the grant put much effort into developing and bringing together key state partners. These partners have formed the Steering Committee which has met six times since April of 2005. The Steering Committee has consistently provided the project with important input, recommendations, and guidance. This committee includes legislators, state officials, directors of county social services, consumers, family members, and representatives of continuum of care providers such as Easter Seals of North Dakota, North Dakota Association of Home Care, and the North Dakota Long Term Care Association (Membership list Appendix A).

One of the first things that the project did was look at research and reports that have been done in the past that relate to North Dakota's continuum of care system. Not surprisingly, much information has been gathered and studied in the past regarding this issue. Past studies considered include: *ND Report of the Task Force on Long-Term Care Planning 1996*; *ND Report of the Task Force on Long-Term Care Planning 1998*; *ND Report of the Task Force on Long-Term Care*

Planning 2000; *White Paper: Olmstead Workgroup November 6, 2000*; *Needs Assessment Of Long Term Care, North Dakota: 2002 Initial Report & Policy Recommendations,* November 2002; *2004 AARP ND Member Survey: Support Services*, June 2004; and many more (Report list and summary Appendix B). These past studies have served as a basis for what information we already know and have helped the project to consider what information was still necessary to gather as part of the grant's scope of work in order to progress toward the goals of the grant.

The Planning and Steering Committees identified the need to gather additional information from consumers of home and community based services, elderly nursing home residents, younger nursing home residents, family members of consumers of continuum of care services, and providers of continuum of care services. In order to gather input from these groups, recently, during October, November and December of 2005, the project assistant and I conducted a series of statewide focus groups and in-home personal interviews to identify current perceptions, patterns, themes, and suggestions for improving the choice and self-direction, quality and access to long term care supports, (i.e. home and community based services and nursing home care) for the elderly and persons with disabilities. This research was conducted to identify ways to develop a mechanism to balance state resources for services, and to identify elements for the design and structure of a single point of entry mechanism for all long term care supports for the elderly and people with disabilities in North Dakota. Combined, a total of forty focus groups and personal interviews were conducted throughout the eight human service regions in both rural and urban communities of North Dakota. Through this process and the information gathered, the grant will be able to build a plan that

reflects the needs and concerns expressed by the public. A final report of the findings of this research will be available later this spring.

Additional information is also being gathered from hospital discharge planners and additional consumers of continuum of care services through a survey mailing. Over 900 surveys are being mailed to approximately thirty-five continuum of care service providers for distribution to consumers.

Next steps for the Real Choice Rebalancing Grant include bringing together, later this month, over 100 Stakeholders from around the state to share and gather information. During this meeting the, group will be able to hear the grant's technical assistant from the National Association of State Units on Aging (NASUA), who will offer expert knowledge and vision for North Dakota. The Stakeholder meeting will work to build consensus regarding North Dakota's ideas for change and the development of a mechanism to balance state resources and development of a system to provide a single point of entry for continuum of care services

As part of the planning process, the Steering Committee will be meeting next month to develop a plan which will contain action steps, recommendations, and legislation for the 2007 session. This plan will be used for building system's change in North Dakota.

At this time, on behalf of the Steering Committee, I would like to invite all members of the Budget Committee on Human Services to attend an upcoming Real Choice Rebalancing Stakeholder Committee meeting. I have included the following meeting specifics

for your information. If you are interested in attending please contact me.

Once again, thank you for the opportunity to share this information. If you have any questions, I would be happy to answer them at this time.

Stakeholder Committee Meetings

We will be offering two meetings for your convenience, please choose the meeting that best fits your schedule, you do not need to attend both.

- Tuesday, March 21st, from 1:00 to 4:00 PM, Best Western Doublewood Inn, 1400 East Interchange Ave., Bismarck

or

- Wednesday, March 22nd, from 9AM to noon, Best Western Doublewood Inn, 3333 13th Ave. South, Fargo

Amy Armstrong, Project Director
Real Choice Rebalancing Grant
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Phone: 1-800-233-1737 or 701-858-3578

Appendix A
Real Choice Rebalancing
Steering Committee Members and Agencies

Steering Committee Members and Agencies

First	Last	Agency
Linda	Wurtz / Janis Cheney *	AARP North Dakota
Kathy	Hogan/DeLana Duffy-Aziz *	Cass County Social Services
Jane	Strommen	Circle of Care Cass County
Rodger	Wetzel	Community Health and Eldercare, St. Alexius Medical Center
Mark	Kolling	Developmental Disabilities Division (DD)
Carol	Olson / Tove Mandigo *	Dept. of Human Services, Director
Linda	Wright/Robin Schumacher *	DHS, Aging Services Division
Maggie	Anderson	DHS, Medical Services Division
Karin	Mongeon*	DHS, Medical Services Division
JoAnne	Hoesel	DHS, Mental Health and Substance Abuse Division
Gordon	Hauge / Marilyn Bender *	Easter Seals Goodwill of ND
Chuck	Stebbins / Mark Bourdon*	Freedom Resource CIL / Consumer
Amy	Clark	Governor's Committee on Aging
Duane	Houdek	Legal Counsel to the Governor
Cheryl	Kulas	Indian Affairs Commission
Theresa	Snyder	DHS / Tribal Liaison & Program Civil Rights Officer
Marcia	Sjulstad / Jo Burdick *	ND Association for Home Care
Darleen	Bartz	ND Dept. of Health, Division of Health Facility
James	Moench	NDDAC
Shelly	Peterson	ND Long Term Care Assoc.
Kurt	Stoner*	ND Long Term Care Assoc./ Bethel Lutheran Home
Tom	Alexander	ND Medicaid Infrastructure Grant/NDCPD
Bonnie	Selzler	Olmstead
Bruce	Murry / Teresa Larsen *	Protection and Advocacy
Amy	Armstrong / Kylene Kraft	Real Choice Rebalancing Grant/NDCPD
MariDon	Sorum / Sandy Arends*	Regional Aging Services Program Admin. North Ctrl. Human Ser. Ctr.-
Sandy	Arends / MariDon Sorum*	Regional Aging Services Program Admin.- SE Human Service Center
Gary	Kreidt	Representative
Richard	Dever	Senator
Joan	Campbell	South Central Adult Services, Inc
Bob	Puyear	Consumer
Shauna	Barth	Family Caregiver
	* Alternate	

Appendix B
North Dakota Studies & Reports Related to Aging Population and People with Disabilities

North Dakota Studies & Reports Related to Aging Population and People with Disabilities

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
Senate Bill 2330 Workgroup Final Report, December 2004 **Targeted Population:** Senate Workgroup of the ND Disabilities Advocacy Consortium	Identification of specific barriers to nursing homes providing home and community based services, Identify legal barriers to the "money following the client" and Exploration of the pros and cons of submitting a 1115 or 1915 Independence Plus Medicaid Waiver or modifying existing waivers and experiences of other states.	#1 barrier is an adequate payment system for individuals and agencies. The Individuals medical assistance funds must follow the individuals for whichever service option the individual selects. The growth of budget for institutional care cold potentially be curbed through enhancement of home and community based services. Develop a research document that will be distributed to various social service types of agencies. Develop a system that allows for a medical/social mix of services. Review the Nurse Practice Act. Review the $2400 cap on the Medicaid Waiver. Involve stakeholders in the expansion of the waivers while considering mutual planning between various groups and communicate with the Olmstead Commission.
2004 AARP ND Member Survey: Support Services, June 2004 **By:** David Cicero Survey **Targeted Population:** ND AARP members	Members' personal concerns? Views of AARP's role and activities at the state level? Opinions on legislative issues? Ideas concerning SS and unemployment benefits? And experiences with support services?	4/10 ND members used support services or family member who has in the past 5 years. Of these, half lived at home while receiving visits from health professionals and the other half lived in a nursing home. 1/7 report not at all easy to find support services that were needed. Information about personal care services was received from Health and Human Services and Senior Service providers. Half of the members are extremely concerned with having choices in long-term care. More than 3/4 members think it is very important to provide funding to make support services widely available, even if it means increasing taxes.
Final Report Real Choices Systems Change Grant Cultural Model May-June 2004 **By:** North Dakota Olmstead Commission Report Format **Targeted Population:** American Indian Elders and Native Disabled	Topics Discussed: Service delivery, information, intake process, funding, transportation, inter-agency collaboration and relationship building, staff training, self-advocacy. Questions: How do we develop service literacy among consumers and providers? How do we incorporate cultural input? How do we deal with cultural conflict upfront? In creating a culturally congruent model how do we impact systemic change? What are the best and most effective approaches? How can we help provider understand facts from myths? In your experience what are the difficulties in serving Native American or diverse populations in pre-services (enrollment, etc.)? In your	Provide transportation to elders, simplify language of service promotion materials (no acronyms), have cultural brokers to introduce consumer providers, use formats suitable for vision-impaired (materials), use alternative formats to deliver information (ex: audiocassettes), have culturally competent skilled workers, consider giving a more flexible funding scheme based on consumer needs, establish a system for providing funding for transportation of elders and disabled, trust building is a major factor in building client response and satisfaction, elder groups should be established and supported on every reservation.

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
	experience what are the difficulties in serving Native American or diverse populations in actual services? In your experience, what are the difficulties in serving Native American or diverse populations in evaluation? Describe exemplary programs, staff, services, etc. that have demonstrated cultural competency.	
Community of Care Olmstead Grant August 2003/2005 Final Report **By:** Good Samaritan Society and North Dakota Department of Human Services Report Format **Targeted Population:** Elderly and Disabled persons	Objectives: 1. Facilitate access and awareness of existing formal and informal support 2. Develop new and enhance existing needed formal and informal support services 3. Mobilize formal and informal organizations to work together in new and innovative ways to support needs of elderly/disabled persons in the community 4. Integrate private and public long-term care funding -lists unsuccessful initiatives and lessons learns as well as recommendations for future action in North Dakota	1. utilization of the resource center by community members and presentations to local civic groups has increased awareness and education of long-term care services and support 2. New services include the resource center, volunteer program, and caregiver support program; expanded services include the care companion program, the bereavement program and be friendlier ministry program; development of services have increased access to needed services 3. community of Care has increased awareness of needs of rural elderly/disabled people by developing and implementing a communication plan to reach a variety of audiences; community of care established numerous new relationships and partnerships with local health and human service providers, churches, businesses, etc. for promoting collaboration in meeting the needs of elderly/disabled 4. Preparational work has been done on the feasibility of either a rural PACE program or a social cooperative as potential components of a permanent community-based model of care as the intent of this objective is to further research appropriate funding mechanisms in Phase II **Unsuccessful initiatives-** case management system is not fully developed because steering committee planning process identified other issues more critical and the planning activities and other service development work required the majority of time delineated in the Olmstead grant and staff understanding of care coordination has changed and matured throughout the grant process **Lessons Learned-** long term care is fragmented and difficult to navigate; home and community based services are unaware of the value of collaborating with each other; community members are concerned about the welfare of their senior citizens and are willing to improve their quality of life; building community awareness and local owner ship is critical to the success of a rural program; care management is needed; need for information on long-term care

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
		issues is great
National Family Caregiver Support Program: ND American Indian Caregivers, June 2003 **By:** Center for Rural Health, UND School of Medicine & Health Services 2 Surveys, Family Caregiver & Older Relative Caregiver, conducted face-to-face **Targeted Population:** Five reservations in ND, caregivers from the ND American Indian Population	*Informal caregivers* (those who serve as informal caregivers to individuals 60 years of age or older) – questioned items reflecting caregiver characteristics, reasons for care giving, location of care, difficulties experienced by caregivers, availability and use of other informal caregivers, a series of items on specific services indicating availability, use, desire for access and evaluation of available services, characteristics of care supplied, types of information or services desired, impacts of care giving on caregiver's lives, and an invitation to become part of a caregiver registry. *Grandparents (older relative caregivers)* (individuals 60 years of age and older who serve as caregivers to persons 18 years of age and younger) – also characterized the caregivers and reasons for care giving. It also developed major categories of information on services that targeted the child such as tutoring and children's special needs and information on services that related directly to the caregivers themselves such as respite. Also the impacts of being a caregiver on the lives of the older relatives along with questions on availability, use and evaluation of services for services directed at both the child and the caregiver.	Reservations are rural, relatively isolated, and underserved by most long term care programs such as skilled nursing homes, assisted living, and home and community based services. Reliance on their strong traditions of extended family supports often represents the primary option for providing care to elders or for providing child care utilizing grandparents. When the results were compared to the State there were many differences between the two populations, i.e., different priorities, or different ratings of importance for some services or information types. NOTE: Researchers of this study conclude from the descriptive comparisons that one needs to look at the data from the reservation sample in order to adequately design activities or programs that will meet their needs. Items related to independent factors were different for the two populations. And in the Informal Caregivers survey, questions 7 & 8 dealing with difficulties experienced and sources of concern, the results from a factor analysis yielded three factors for the general population and four for the reservation sample. Similar results were obtained from the Grandparent Survey, using items 13 & 14, where the general population produced 7 factors or dimensions while the reservation sample produced 5. The underlying theme is that differences DO EXIST between the social world found on the reservations and those found in ND's towns and cities. They didn't find any significant differences between the five reservations to make note of at all.
Informal Caregivers: 2002 Phone Survey, May 2003 **By:** ND State Data Center @ NDSU Phone Survey **Targeted Population:** Households in ND to estimate the number of informal caregivers living in ND	Rating of difficulties experienced by caregiver, concerns associated with care giving, are services available to care recipient? Would they like them to be? Reasons why services are not used if they are available? Ratings of available services? Would caregiver like help providing the service? Financial difficulties caregivers' experience?	Nearly 46% of caregivers are caring for their mother or mother-in-law, top 2 reasons for needing services were the aging process and physical disabilities, 78% indicated they don't need monetary compensation for their care giving services Concerns: Serious difficulties are having to consistent help from other family members, emotional aspects, and having the responsibility for making major life decisions. 40% of caregivers indicated there are not other informal caregivers who provide care to the recipient. 2 most common reasons why others are not providing care are because they live farther away and/or have full-time jobs. Services available to

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
		care recipients: 3/4 of caregivers indicated that homemaker services and home health aides are available to recipient, at least 1/2 of caregivers said the following services are not available: pet service, parish nurse, adult day centers, outreach programs, and shopping assistance. If there were services unused the reason was always that the care recipient did not need it. Services available to caregivers: More than 62% said information about available services is available to them. At least 1/2 however indicate that respite care, caregiver training, counseling services, and support groups are NA to them. Most utilized service is assistance with accessing available services. More than 1/2 said other info or services that would be valuable is about the recipient's condition or disability, info-line, and someone to help arrange for services or assess the situation.
Informal Caregivers: 2002 Outreach Survey, May 2003 **By:** ND State Data Center @ NDSU Outreach Survey (Face to Face) **Targeted Population:** Residents in ND who serve as informal caregivers		More than 43% of caregivers are caring for their spouse and more than 93% indicated they don't receive monetary compensation for services. **Concerns:** Emotional aspects and lifestyle change are serious difficulties. It is also very difficult for caregivers to find and accept support or assistance, because of their duty of care giving. **Services Available to the recipient:** 3/4 of caregivers utilize meal services and home health aides. 1/2 have transportation services, outreach programs, visiting nurse and dietician services available to them. The most common reason a care recipient does not use a service was because they did not need it. **Services available to the informal caregiver:** 1/2 have info about respite care, assistance to access of available services and its' information. **Demographics:** Over half of caregivers are 65 years of age or older
Cost Containment Alternatives for ND Medicaid, November 1, 2002 **By:** David Ricks, Peterson Consulting 3 phases – first, analyzed ND expenditures to identify services and eligibility groups for which ND expenditures are higher, on a per capita basis, than those of other states. Then met with the management	ND, like most states, is facing budget difficulties because of decreased revenues and increased demand for services in the current recession. Despite many efforts to control expenditures, Medicaid costs continue to increase. The reasons for increasing costs include: • Increases in the number of eligible persons; • Increases in utilization of services; and • Increases in the costs of services.	Found that ND spends much more than most states on institutional services, especially nursing homes and institutions for the developmentally disabled. Expenditures are higher partly because ND has more elderly people in its population. However, elderly ND residents are also more likely to enter nursing homes than are elderly residents of other states. ND also pays higher daily rates to nursing homes than other states. ND spends a great deal for one state facility for the developmentally disabled. They identified several important opportunities for savings in restructuring institutional reimbursement. However, these would require legislative actions. They also found opportunities for savings in expanding managed care, strengthening the managed care enrollment process, and expanding alternatives to nursing home care. The savings from these actions

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
team of ND Medicaid program to discuss the current program, including cost containment initiatives that have been considered and those that have been implemented. And finally, probed a little deeper into the reasons for higher expenditures for certain services in ND. **Targeted Population:** ND asked Peterson Consulting to help identify initiatives that can help to achieve the Department's goal of approximately $17 million in total annual savings (approximately $6 million in state funds).		would not be as great as those from changing institutional reimbursement. Overall, the Medicaid program faces extraordinary challenges. If funding for nursing homes and ICF-MRs is to be maintained at present levels, then the savings must come from other services, and mostly cutting fees.
Needs Assessment Of Long Term Care, North Dakota: 2002, Initial Report & Policy Recommendations, November 2002 **By:** ND State Data Center @ NDSU 4 different needs assessments in regards to the issues of: Current and Future Elderly Population, Elderly Needs Profile, Availability and Demand for Elderly Services, Survey of Long Term Care (LTC) Administrators. Used mail, telephone, and 2000 Census data **Targeted Population:** Residents in ND aged 50 and older Data from the 2000 Census also provided detailed	The first component was to document the current and future distribution of elderly residents (those 65 years of age and older) in the state. This provided a backdrop for determining current and future demand for long term care. The second objective was to profile the physical capabilities of seniors in the state and highlight their functional limitations. By doing this, one can objectively estimate the amount of assistance seniors will need for daily functioning and in turn determine the demand that will be placed on the stated to provide formal, informal, and institutionalized care giving. The third objective was to explore what current institutional services are available for elderly in ND and to determine if there are critical shortages or specific areas of need. The last objective was to profile the current and future of labor force. This effort was to explore what challenges the state might face with regard to staffing facilities.	That state's population is aging rapidly, by 2020 the elderly population 65 years of age and over will have grown by 55,000 and will constitute 23% of the state's population. Nearly 2/3 of the state's 39 rural counties have 20% or more of their population base 65 years of age and over. By 2020 the proportion will jump to more than 30%. In 2000, nearly one in three seniors lived alone. More than one in three non-institutionalized seniors had a disability. ND's general population over age 55 report being healthier & having fewer chronic diseases than national averages. The major exceptions are those on the reservations. Number of seniors in ND with functional limitations, a measure of the level of assistance required for basic activities of living (bathing, eating, walking, and using the toilet), is higher than the national norm and indicates a greater demand for care giving. The number of senior service facilities is very limited and absent in a significant number of counties in ND. Sixteen of the state's 53 counties lack a hospital or clinic, four counties lack a senior center, and 35 of the counties lack a home health agency. LTC administrators did not appear alarmed over difficulties with recruitment or retention of staff at this time. The most successful tool for retaining workers appears to be flexible scheduling. Long term care staff in ND overall is quite stable. The average length of current employment is 8 years. CNAs report the

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
info regarding the current labor force and random ND households used to obtain info regarding current employment and future labor availability.		shortest avg. length of 6.7 year of employment and LPNs report the longest at 9.9 years. ND's workforce is concentrated largely in the state'
Report of the Task Force on Long-Term Care Planning June 2000 **By:** North Dakota Department of Health and North Dakota Department of Human Services Report Format **Targeted Population:** Elderly and Persons with Disabilities	Categories discussed: Nursing Facility Rate Equalization, Basic Care and Assisted Living, Personal Care Services, Senior Mill Levy Match, Native American Long Term Care Needs, Care Coordination/Case Management, Swing Bed Facilities, Statewide Needs Assessment.	Rate equalization should be continued and funding should be consistent as well as fairly and periodically reviewed. Talk about recommendations for assisted living and basic care. Establish a rent subsidy program for assisted living. Establish a licensing fee for basic care facilities. Repeal the moratorium on basic care beds. Recommends limiting personal care service options to certain provider types. Needs for Native Americans include: transportation, inter-agency communication, and increase public education. Expand SPED eligible recipients. They refer to the importance of a state wide needs assessment to determine funding that is needed and appropriate for assisted living units, nursing facilities, and basic care beds. Case Management needs to meet the arrangement, coordination, monitoring, and evaluation of services that satisfies the specific client's needs in the least restrictive environment. Tasks for state wide assessment include service area model, elderly demand model, labor demand model, elderly profile, provider and facilities profile.
White Paper: Olmstead Workgroup November 6, 2000 **By:** ND Department of Human Services Report Format **Targeted Population:** Mental health, aging, developmental disabilities, and physical disabilities	What groups of people are there an interest or involvement with? Awareness of community based services in your area? What types of services are missing? What do you see as an institution?	There is a need to schedule regular information/discussion sessions with regional stakeholders surrounding community-based services for persons with disabilities. There is also a need to develop a screening process prior to admission to a nursing facility to determine care needs and where their needs could best be obtained. The Dept. of Human Services should continue to encourage alternatives to nursing facility services.
Report of the Task Force on Long-Term Care Planning June 1998 **By:** ND Department of Health and Department of Human	Topics discussed include: Basic care rate equalization and rate-setting methods, Long-term care financing and Incentives, Alternative Services, Case Management, Moratorium on nursing facility and Basic care beds, Pilot Projects, Funding Sources, Swing Bed Facilities,	**Basic Care Rate Equalization and Rate-Setting Methods:** necessary changes must be made (pay direct care to 19th percentile, indirect care- 75th percentile, etc.), recommended 2 changes- basic care rate-setting system allow 3% on direct care costs and inclusion property costs as pass-through not subject to limitations, Recommendations include: Repeal basic care rate equalization. **Long-Term Care Financing**

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
Services Report Format **Targeted Population:** Residential providers, Geropsychiatric providers, Native American Long-Term care providers	Geropsychiatric services, Expanded case management, Service availability, Training of In-Home Care Providers.	**and Incentives:** Recommendations include- amend the definition of a private pay resident to include managed care entities as payers exempt from rate equalization, consider incentives package to reduce bed capacity and provide alternative long-term care to elderly, maybe expand NDCC 57-15-56 to enhance in-home and community-based services availability. **Alternative Services**: Redevelop rules, policies and procedures for current delivery system, actual implementation of a law. Case Management: Individuals eligible for Medicaid must access other services; obtain preadmission needs assessment, implement a targeted case management program for elderly/disabled, consider monitoring results. **Moratorium on Nursing Facility and Basic Care Beds:** continue current moratorium prohibiting increase in bed capacity, exception- permit facility for TBI population not to exceed 10 beds. **Pilot Projects:** authorize Department of Human Services to continue 3 Alzheimer's and Related Dementia pilot projects, Require monitoring by department. **Funding Sources:** restructure Department of Human Services. **Swing Bed Facilities:** study this process to determine needed changes. **Geropsychiatric Services:** explore expansion of psychiatric and geropsychiatric training at UND school of Medicine, Establish 14-bed geropsychiatric unit. **Expanded Case Management:** monitor progress of pilot projects. **Service Availability:** public formal services include regional human service centers, county social services, service payments for elderly and disabled (SPED), expanded SPED programs, older Americans act Title III and Title IV services, and medical assistance. **Training of In-Home Care Providers:** develop state wide model curriculum for in-home care certification/competency, investigate impact on in-home care training program. **Protection of Vulnerable Adults:** intervention provides opportunity for long-term savings
ND Report of the Task Force on Long-Term Care Planning 1996 **By:** North Dakota Department of Health and the North Dakota Department of Human Services Report Format	Topics Discussed: Hospital Swing Beds, Veterans Service Capacity, Alzheimer's and Related Dementia (ARD), Definitions of Services and Housing components, Native American Long-Term Care Access, Isolated Rural Elderly, Home and Community-Based Service Provider Availability, Training of qualified service providers, Geropsychiatric Service Adequacy, Pooling of	Swing beds are relatively unregulated compared to nursing homes, Veteran population is significantly younger with higher rate of chronic illnesses. Must create sufficient facilities for Alzheimer's and related dementia patients. The system should emphasize client involvement in care planning and choice of services. Case management services for elderly native Americans would be beneficial. QSP's are limited in rural areas and training of QSP's is also limited. This causes burnout which causes shortage of QSP's. We must promote long term care insurance to minimize reliance on Medicaid

Studies & Reports	Summary of Questions Asked	Summary of Data Collected
Targeted Population: Native Americans, aging population, people with disabilities, veterans	Service Reimbursement sources, Nursing Facility Payment Policy, Nursing Facility Bed Capacity, Managed Care, Long-Term Care Insurance, Transfer of Assets, Spousal Impoverishment, Case Management Definitions, Access and Standards, Client Assessment, Costs of Case Management,	Programs. There is a dilemma of transferring assets to qualify for Medicaid that should be addressed. Spousal impoverishment laws discourage married couples from choosing home and community-based services as an alternative to nursing home care. Policies may deter individuals from returning home from a nursing home because spouse would lose the asset exemption and the family would no longer qualify for Medicaid.