TRAUMATIC BRAIN INJURY WAIVER
INTERIM REPORT

Session Law 2015-241, Section 12H.6.(b)

Department of Health and Human Services
Division of Medical Assistance
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services

December 1, 2015

Division of Medical Assistance
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Development of Traumatic Brain Injury Home and Community Based Services Waiver
Interim Report to the General Assembly
12/1/2015

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EXECUTIVE SUMMARY

Session Law 2015-241, SECTION 12H.6.(b) instructed the Department to report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid Traumatic Brain Injury (TBI) waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

(1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served;
(2) The expenditures to date and a forecast of future expenditures; and
(3) Any recommendations regarding expansion of the waiver.

The North Carolina General Assembly has appropriated $1,000,000 for fiscal year 2015-2016 and $2,000,000 for fiscal year 2016-2017 to fund the TBI Medicaid Waiver based on the recommendations from the Joint Legislative Oversight Committee on Health and Human Services. The Committee recommended the development of a home and community based services TBI waiver that: encompasses the needs of individuals with long-term care needs and more intensive rehabilitative needs; begins the TBI waiver in a specific geographic area; and phases the TBI waiver into other areas of the state after evaluating the program and making changes based on successes and lessons learned.

DHHS has worked with Stakeholders to draft a Waiver proposal for CMS. DHHS intends to post the final stakeholder review proposal by December 15th for the required 30 day public comment period. This will allow for submission to CMS no later than January 31st, 2016.

CURRENT STATE OF TBI IN NORTH CAROLINA

TBI is an alteration in brain function, or other evidence of brain pathology, caused by an external force. This force may include a blow to the head or a rapid acceleration-deceleration event. From prevalence data, we know that males are twice as likely as females to experience a TBI and that the leading causes of TBI are unintentional falls and motor vehicle accidents. We also know that Traumatic Brain Injuries are associated with increased rates of seizures, sleep disorders, fatigue, and behavioral or psychiatric disturbances. Centers for Disease Control and Prevention (CDC) prevalence data indicate that two percent of the general population have survived a Traumatic Brain Injury. In 2012, 76,708 North Carolina citizens sustained a traumatic brain injury.[1] There are approximately 190,000 survivors of traumatic brain injury in the State, and it is estimated that up to one-third of those individuals may need long-term care. 2010 Medicaid claims data show that approximately 30,000 individuals with traumatic brain injury received covered services.

[1] NC Disease Event Tracking & Epidemiologic Collection Tool (NC DETECT), analysis conducted by the Injury & Violence Prevention Branch, NC Division of Public Health.

The North Carolina General Assembly has authorized a biennium budget line item for the development of a TBI waiver that is consistent with DHHS' recommendation that the Waiver begin with a small number of beneficiaries and expand over time. It is important to continue to build service capacity for individuals with traumatic brain injury for the following reasons:

- The family and natural support networks for many adults with TBI are aging and unable to care for their family members.
- Many individuals with TBI do not qualify for Medicaid because of SSDI benefits from pre-injury employment.
- Many services for Individuals with Intellectual Disabilities (IDD), Mental Illness (MI), and Substance Use (SU) that people with TBI access are designed for other disability populations and do not effectively meet the needs of the TBI population.
- Individuals with TBI can only access Medicaid IDD services if they are injured prior to the age of 22.
- There are only three publicly funded Day Programs and ten publicly funded Residential Programs in the State that are designed for people with brain injuries (See Appendix E).
- TBI-specific group homes are currently at capacity (See Appendix E).

WAIVER PURPOSE

The waiver is designed to provide community based alternatives specifically for individuals with traumatic brain injuries who are currently in nursing facilities or specialty rehabilitation hospitals or who are in the community and at risk for facility placement.

WAIVER GOALS

The TBI waiver will:

1. Value and support individuals to be fully functioning members of their community
2. Promote rehabilitation, evidence-based practices, and promising practices
3. Offer person-centered service options to facilitate individuals' ability to live in homes of their choice, be employed, or engage in a purposeful day of their choice and achieve their life goals
4. Provide the opportunity for individuals to contribute to the development of their services
5. Provide training and support to foster the development of strong natural support networks that enable individuals to be less reliant on paid support systems
6. Ensure the well-being and safety of the people served
7. Maximize self-determination, self-advocacy, and self-sufficiency
8. Increase opportunities for community integration through work, life-long learning, recreation, and socialization
9. Provide quality services and improve outcomes

TARGET POPULATION

The target waiver population consists of adults with cognitive, behavioral, and physical support needs (See appendix C) who require supervised and supportive care. Most targeted individuals have either completed a course of intensive rehabilitation and need a less intensive rehabilitative schedule or are in need of long-term services and supports. Approximately 10 percent of the individuals served would benefit from a more intensive course of rehabilitation. The adults in the target population are Medicaid beneficiaries who:

1. Reside in the State of North Carolina;
2. Have a traumatic brain injury which occurred on or after their 22nd birthday;
3. Require a need for a combination and sequence of special interdisciplinary, or general care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated;
4. Meet admission criteria for placement in nursing facilities or specialty rehabilitation hospitals (see Appendix D for Nursing Facility admission criteria);
5. Have needs that would not be better met under the NC Innovations Waiver for individuals with intellectual disabilities or the Community Alternatives Program for Disabled Adults (CAP-DA) Waiver.

SERVICE ARRAY

The following service array was developed through a collaborative process between DMA, DMH/DD/SAS, and the Health Services Committee of the DHHS Traumatic Brain Injury Advisory Council. Some of the proposed waiver services are similar to services found under the NC Innovations Waiver for individuals with intellectual disabilities. However, under a TBI waiver, the service array is expanded to include a rehabilitation element. The waiver services would be covered in conjunction with any Medicaid State Plan services for which the beneficiary is eligible.

The TBI Services are categorized as follows:

1. Choosing where to live
2. Choosing how to spend the day
3. Choosing how to access the community
4. Opportunities for growth
5. Access to the environment

CHOOSING WHERE TO LIVE	
SERVICE	**DESCRIPTION**
Life Skills Training	Life Skills Training provides rehabilitation and skill building to enable the beneficiary to acquire and maintain skills that support independence.
Personal Care	Personal Care Services under North Carolina's State Medicaid Plan differ in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene, and other activities of daily living.
Residential Supports	Residential Supports provide individualized services and supports to enable a person to live successfully in a Group Home or Alternate Family Living setting of their choice and be an active participant in his or her community.
Respite Care (in-home or at a facility)	Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual with a TBI.
In-Home Intensive Supports	In- Home Intensive support is available to support beneficiaries in their private home, when they need extensive support and supervision.

CHOOSING HOW TO SPEND THE DAY	
SERVICE	**DECRIPTION**
Adult Day Health	This service is for beneficiaries who need a structured day program of activities and services with nursing supervision.
Day Supports	Day Supports is a group, facility-based service that provides assistance to the individual with rehabilitation, retention, or modification of socialization and daily living skills and is one option for a meaningful day.
Supported Employment	Provides assistance with choosing, acquiring, and maintaining a job when competitive employment has not been achieved or has been interrupted or intermittent. This includes pre job training, coaching, and long term follow along.

CHOOSING HOW TO ACCESS THE COMMUNITY	
SERVICE	**DESCRIPTION**
Community Networking	Community Networking services provide individualized day activities that support the beneficiary's definition of a meaningful day in an integrated community setting with persons who are not disabled.
Resource Facilitation	Resource Facilitation promotes the coordination of medical, behavioral, social and unpaid supports to address the beneficiary's needs. Resource Facilitation also informs the planning process with the team and assists beneficiaries with assuring coordinated supports, including direct services.

OPPORTUNITIES FOR GROWTH	
SERVICE	**DESCRIPTION**
Natural Supports Education	Natural Supports Education provides training to families and the beneficiary's natural support network in order to enhance the decision making capacity of the natural support network, provide orientation regarding the nature and impact of the TBI and its co-occurring disabilities upon the beneficiary, provide education and training on rehabilitation and/or compensatory intervention and strategies, and provide education and training in the use of specialized equipment and supplies.
Specialized Consultative Services	Specialized Consultative Services provide expertise, training and technical assistance in a specialty area (neuro/psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy, nutrition, and other licensed professionals who assist individuals with traumatic brain injury). These services help family members, support staff and other natural supports in assisting individuals with traumatic brain injury.
Extended Clinical Services	Physical therapy, occupational therapy, speech and language services, performed by credentialed professionals at a level higher than or not otherwise covered under the State Plan.
Cognitive Rehabilitation (CR)	Cognitive Rehabilitation is a one-on-one therapy used for the development of thinking skills to improve functional abilities including but not limited to: attention, memory, and problem solving, and to help identify impaired thinking. The initial goal of therapy is to improve cognitive functioning to the fullest extent possible. Compensatory strategies will be introduced as progress slows.

ACCESS TO THE ENVIRONMENT	
SERVICE	**DESCRIPTION**
Assistive Technology Equipment and Supplies	Technology and equipment used to increase, maintain, or improve functional capabilities of beneficiaries.
Home Modifications	Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the beneficiary or to enhance the beneficiary's level of independence.
Vehicle Modifications	Alterations to a vehicle include devices, service or controls that enable beneficiaries to increase their independence or physical safety by enabling their safe transport in and around the community.

QUALITY OUTCOMES

One of the primary waiver goals will be to maintain community placement and reduce the number of individuals who are admitted or readmitted to Skilled Nursing level of care. Outcomes associated with the Rehabilitative Level of Care will be rehabilitative gains and maximized independence. Outcomes associated with the Skilled Nursing Level of Care will be maintenance and improvement of quality of life and maximized independence. Individualized and measurable goals are included in each beneficiary's person centered plan. These goals are reviewed on a regular basis and the plan is updated as needed to add goals or to remove those that have been completed or found to not be effective. Quality will also be assured through the utilization of assessments normed for adults with TBI. The assessments will measure both rehabilitative and quality of life outcomes.

ESTIMATED WAIVER COST

To estimate the cost of the waiver, DHHS engaged Mercer to investigate the prevalence of TBI in North Carolina and the current Medicaid costs associated with individuals with TBI. The Department also researched cost reports in other states currently operating TBI waivers. Based on other states' experience, DHHS estimates the average cost per beneficiary in North Carolina would be $60,000 per year (State and federal funds combined).

Estimated Cost: North Carolina 3-year Projection

In order to support survivors of traumatic brain injury with long-term needs, North Carolina's TBI provider capacity must grow. DHHS recommends a maximum cumulative enrollment of 107 individuals over the first 3 years of the waiver based on the $1,000,000 and $2,000,000 appropriations by the General Assembly. DHHS continues to recommend developing a phased in waiver in a targeted area of the State. The intent is that the waiver could expand to other regions after initial three-year evaluation; implementation of any program modifications needed; development of trained community providers; and an increase in State appropriations.

The recommended DHHS Staffing projection for the TBI waiver will total two FTEs These two FTEs will be responsible for monitoring the waiver, developing policies and procedures, providing training and technical assistance, and assessing the TBI waiver on a regular basis to determine next steps for waiver expansion.

Table 1: Projected Waiver Service Costs*

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020
Number of Beneficiaries	49	99	107	139	156
Average annual cost per Beneficiary	$60,000	$60,000	$60,000	$60,000	$60,000
Total Cost	$2,920,715	$5,909,729	$6,460,000	$8,330,000	$9,350,000
Federal Share**	$1,920,715	$3,909,729	$4,279,104	$5.517,792	$6,193,440
State Appropriation	$1,000,000	$2,000,000	$2,180,896	$2,812,208	$3,156,560
FMAP***	0.6588	0.6624	0.6624	0.6624	0.6624

**The data contained in this table are in draft status. DHHS is continuing to work with Mercer to formalize these data.*
***Federal Medical Assistance Percentage (FMAP) is 100% for Indian Health services if Eastern Band of Cherokee Indians (EBCI) tribal members receive the Waiver services.*
****The State-specific FMAP is published annually and adjusted using a federal formula.*

Table 2: Projected Waiver Staffing Costs

	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020
Total Cost	$86,002	$171,803	$171,803	$171,803	$171,803
Federal Share	$43,001	$85,902	$85,902	$85,902	$85,902
State Share	$43,001	$85,901	$85,901	$85,901	$85,901
FMAP	0.50	0.50	0.50	0.50	0.50

Assumptions

1. A cumulative maximum of 107 Medicaid beneficiaries will be served in the waiver's three year period.
2. The maximum annual per capita cost will be $60,000, which is 30 percent less than the average institutional cost of $85,000.
3. The two FTE staff positions are assumed at a 50/50 administrative match with federal and State dollars.
4. The annually published Federal Medical Assistance Percentages (FMAPs) for Title XIX services, as shown in the table above, will be applied with the exception of a 100% FMAP for services provided to Eastern Band of Cherokee Indians tribal members.

Table 3 shows that for each year, the majority of individuals will be served at the Skilled Nursing Level of Care. A smaller number will be served at the Neurobehavioral or Rehabilitation level of Care. The assumption is that many of the individuals receiving the Neurobehavioral or Rehabilitation Level of Care will transition to the lower level Skilled Nursing Level of Care.

Table 3: Projected Transition of Waiver Participants to Lower Care Levels

Waiver Year	Number of Individuals	Hospital LOC	Nursing LOC
SFY2016	49	5	44
SFY2017	99	10	89
SFY2018	107	12	95
SFY2019	139	15	124
SFY2020	156	20	136

Cost Limitations / Requirements

Total program costs will be limited by the number of community care slots used each year and by costs per beneficiary. The payment structure will be a Capitated per Member per Month (PMPM) Payment and will be run concurrently with the 1915(b) North Carolina MH/DD/SAS waiver. The cost of providing care under a 1915(c) waiver will not exceed the cost of providing institutional care for those same beneficiaries. There will be no retroactive reimbursement of waiver services provided prior to program enrollment.

ACTIONS AND RECOMMENDATIONS

DHHS continues to recommend that the TBI waiver be implemented as follows:

1. Initially serve 107 individuals over a three-year period, evaluate metrics for success, and allow the population served to expand over time.
2. Initially serve adults. During future evaluation, DHHS will determine whether it is appropriate to expand the target population to include injuries sustained prior to the 22nd birthday. Individuals under 22 who have suffered a Traumatic Brain Injury are often eligible for the NC Innovations waiver.
3. Include the Eastern Band of Cherokee Indians in the TBI waiver and future waiver development.
4. Develop a trained and competent provider network that can support the TBI population as the waiver expands.
5. Assess the TBI waiver at regular intervals to ensure that it is meeting the needs of the beneficiaries, is cost neutral, and is sustainable.
6. Make informed recommendations to the General Assembly regarding appropriations needed to expand the TBI waiver to other areas of the State.
7. Plan for the transition of the TBI waiver to the 1115 Waiver for Medicaid reform in NC.

NEXT STEPS

December – January 2016

December 2015 – Staff will continue to work with Stakeholder groups and the North Carolina Traumatic Brain Injury Advisory Council to ensure that the waiver meets the needs of the TBI community. The waiver will be posted for public comment December 15th.
DHHS will work with the LME/ MCO to:

- Communicate plans for the TBI waiver with Alliance Behavioral Healthcare (Alliance)
- Provide key staff at Alliance (Clinical Director, Provider Network Director, I/DD Director, Medical Director, Finance Director) with a brief overview / training regarding the waiver's purpose and scope
- Begin question and answer (Q & A) document for waiver that captures Alliance's questions and concerns
- Add Alliance staff to State stakeholder group discussions as appropriate
- Submit DRAFT waiver to CMS.

January 2016 – Address public comments and submit final waiver to CMS by January 31st.
DHHS will:

- Make a formal announcement of waiver submission to CMS on the DMA website
- Begin developing LME/ MCO specific capitation payment for the number of individuals served
- Create a TBI page on the DMA website to include:
    - TBI draft Waiver
    - Q & A
    - DMA contact information
    - Links to Alliance and the TBI Advisory Council

DHHS will work with the LME/MCO and stakeholders to:

- Develop and support TBI specific provider networks
- Provide technical assistance and educational sessions to the providers, beneficiaries, and families on the TBI waiver
- Actively work through the Q&A document that captures the LME/MCO concerns

February – April 2016 – Work With CMS for Approval

February 2016
DHHS will work with the LME/MCO and stakeholders to:

- Provide training to Alliance staff on TBI waiver-specific operational procedures and policies
- Refine slot tracking and quality measures
- Provide technical assistance to Alliance during the RFA process for TBI waiver providers
- Update the DMA website as appropriate, including Q&A
- Review local communication strategies with the Alliance communications team
- Continue to provide technical assistance and educational sessions to providers, beneficiaries, and families on the TBI waiver

March 2016
DHHS will work with the LME/MCO and stakeholders to:

- Support Alliance to create a TBI stakeholder collaborative with State participation during the first year of implementation
- Engage existing stakeholder groups in discussion around implementation details
- Update the DMA website as appropriate, including Q & A
- Begin the waiver application process for individuals who want to enroll
- Collaborate with the TBI Advisory Council and NC Brain Injury Association on a stakeholder webinar (overview, services available, tiers, geographical limitations, application process)

April 2016
DHHS will work with the LME/MCO and stakeholders to:

- Provide technical assistance for Alliance waiver implementation
- Provide technical assistance to Alliance on reviewing waiver applications
- Solicit feedback from State stakeholder group and incorporate it as appropriate
- Update the DMA website as appropriate, including Q&A
- Continue to develop and support TBI-specific provider networks

<u>May 2016 and Beyond</u>

May 2016
DHHS will work with the LME/MCO and stakeholders to:

- Determine which individuals will be served during the first year of the TBI waiver
- Continue to provide technical assistance as needed
- Continue to solicit feedback from stakeholder groups
- Update the DMA website as appropriate, including Q&A

June 2016 – Waiver Implementation

- Update the DMA website to include data updates (number applied, number enrolled, etc.)
- Continue to update website Q&A
- Continue to provide technical assistance as needed
- Solicit feedback from Alliance TBI stakeholder collaborative on implementation issues

July 2016

- Provide quarterly updates to State stakeholder group and solicit feedback on implementation issues
- Solicit feedback from State stakeholder group on operational procedures, policies, etc. for Statewide implementation
- Use lessons learned to develop a plan for Statewide implementation
- Staff will continue to work with states with successful TBI programs and use lessons learned to refine operational and assessment tools and policies in NC.

Appendix A: Session Law 2015-241, Section 12H.6.

TRAUMATIC BRAIN INJURY MEDICAID WAIVER

SECTION 12H.6.(a) The Department of Health and Human Services, Division of Medical Assistance and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department), shall submit to the Centers for Medicare and Medicaid Services a request for approval of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that the Department designed pursuant to Section 12H.6 of S.L. 2014-100, which the Joint Legislative Oversight Committee on Health and Human Services recommended as part of its December 2014 report to the General Assembly, and which is further described in the Department's February 1, 2015, report to the General Assembly.

SECTION 12H.6.(b) The Department shall report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid TBI waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

(1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served.

(2) The expenditures to date and a forecast of future expenditures.

(3) Any recommendations regarding expansion of the waiver.

SECTION 12H.6.(c) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, one million dollars ($1,000,000) for fiscal year 2015-2016 and two million dollars ($2,000,000) for fiscal year 2016-2017 shall be used to fund the Medicaid TBI waiver.

SECTION 12H.6.(d) The waiver and any State Plan amendments required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

Appendix B: Existing State TBI waivers

TBI waivers in Other States:

23 states have a Home and Community Based Waiver that serves individuals with TBI.

STATES	Level of Care	Number of Beneficiaries Served	Waiver Cost (Factor D)*	Total Medicaid Costs
Colorado	Hospital & SNF	345	$54,773.91	$60,876.91
Florida	SNF	410	28,474.31	45,651.40
Illinois	SNF	4905	6,396.45	19,908.45
Indiana	SNF & ICF-IID	200 (146 SNF + 54 ICFIID)	31,407.46	65,279.36
Iowa	SNF & ICF-IID	1625 (1577 SNF + 48 ICFIID)	23,055.71	42,749.71
Kansas	(Hospital) Traumatic Brain Injury Rehabilitation Facility	804	22,998.02	33,362.02
Maryland	SNF & Hospital (Rehabilitative, Chronic, Specialty)	112	87,050.00	93,723.62
Massachusetts (3)	Hospital and SNF	100	107,302.28	143,821.08
Minnesota	Hospital (Neurobehavioral hospital) and SNF (services to support people with brain injury who have significant cognitive and behavioral needs)	2008 (542 Hospital + 1466 SNF)	76,955.02	93,008.02
Mississippi (TBI/SP)	SNF	3600	42,883.10	54,718.10
Nebraska	SNF	40	38,222.48	41,685.61
New York	SNF	3939	53,975.53	72,545.53
Pennsylvania	SNF	729	49,490.38	57,421.38
South Carolina (TBI/SP)	SNF & ICFIDD	1395 (1360 SNF +35 ICFIID)	41,820.70	53,808.70

**Factor D is the cost of waiver services per individual.*

States that have TBI services integrated within a waiver with broader levels of care:

State	Level of Care
Connecticut	TBI is incorporated into an Acquired Brain Injury Waiver
Delaware	TBI is incorporated in a Medicaid Waiver for the Elderly and Disabled)
Kentucky	TBI is incorporated into an Acquired Brain Injury Waiver
New Hampshire	TBI is incorporated into an Acquired Brain Injury Waiver
New Jersey	TBI is incorporated in a Comprehensive Medicaid Waiver that serves multiple disability populations
Utah	TBI is incorporated into an Acquired Brain Injury Waiver
Wisconsin	TBI is incorporated in a Medicaid Waiver that serves multiple disability populations
Wyoming	TBI is incorporated into an Acquired Brain Injury Waiver

Appendix C: Behavioral, Cognitive and Physical Deficits

Behavioral Deficits indicate support needs related to agitation, impulsivity, intrusiveness, legal involvement, susceptibility to victimization, verbal aggression, wandering, elopement, withdrawal, damage to property, inappropriate sexual activity, injury to self, injury to others, and physical aggression.

Cognitive Deficits indicate supported needs related to attention, concentration, learning, perceptions, task completion, awareness, communication, judgement, memory, and planning.

Physical Deficits indicate support needs related to speech, vision, hearing, headache, nausea, sleep disturbances, lack of coordination, and balance.

Appendix D: Nursing Level of Care criteria as found in NC Medicaid clinical coverage policy 2B-1, *Nursing Facilities.*

Nursing Facility Level of Care Criteria

The following criteria are not intended to be the only determinants of the resident's or beneficiary's need for nursing facility level of care. Professional judgment and a thorough evaluation of the resident's or beneficiary's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for nursing facility care and other health care alternatives. All professional services that are provided to the resident or beneficiary to maintain, monitor, and/or enhance the resident's or beneficiary's level of health must be addressed in the medical records and reflected on the medical eligibility assessment form.

b. Qualifying Conditions

Conditions that are considered when assessing a beneficiary for nursing facility level of care include the following:

1. Need for services that, by physician judgment, require:
    A. A registered nurse for a minimum of 8 hours daily and
    B. other personnel working under the supervision of a licensed nurse.

2. Need for daily licensed nurse observation and assessment of resident needs.

3. Need for administration and/or control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 13O.0202, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for supervision).

4. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities as much as possible; such measures may include, but are not limited to, the following:
    A. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transferring, and ambulation).
    B. Using preventive measures and devices, such as positioning and alignment, range of motion, handrolls, and positioning pillows, to prevent or retard the development of contractures.
    C. Training in ambulation and gait, with or without assistive devices.

5. Special therapeutic diets: nutritional needs under the supervision and monitoring of a registered dietician.

6. Nasogastric and gastrostomy tubes: requiring supervision and observation by licensed nurses.
    A. Tube with flushes.
    B. Medications administered through the tube.
    C. Supplemental bolus feedings.

7. Respiratory therapy: oxygen as a temporary or intermittent therapy or for residents who receive oxygen therapy continuously as a component of a stable treatment plan: A. Nebulizer usage.

B. Pulse oximetry.

C. Oral suctioning.

8. Wounds and care of decubitus ulcers or open areas.

9. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan.

10. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan.

11. Diabetes, when daily observation of dietary intake and/or medication administration is required for proper physiological control.

c. Conditions That Must be Present in Combination to Justify Nursing Facility Level of Care

The following conditions when in combination may justify nursing facility level of care placement:

1. **Need for teaching and counseling** related to a disease process, disability, diet, or medication.

2. **Adaptive programs:** training the resident to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must include the purpose of the resident's participation in the program and the resident's progress.

3. **Ancillary therapies:** supervision of resident performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts.

4. **Injections:** requiring administration and/or professional judgment by a licensed nurse.

5. **Treatments:** temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction.

6. **Psychosocial considerations:** psychosocial condition of each resident will be evaluated in relation to his or her medical condition when determining the need for nursing facility level of care; factors to consider along with the resident's medical needs include.

A. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or therapy notes).

B. Age.

C. Length of stay in current placement.

D. Location and condition of spouse.

E. Proximity of social support.

F. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning will help alleviate the fear and worry of transfer).

7. **Blindness.**

8. **Behavioral problems,** such as:

A. Wandering.

B. Verbal disruptiveness.

C. Combativeness.

D. Verbal or physical abusiveness.

E. Inappropriate behavior (when it can be properly managed at the nursing facility level of care).

9. **Frequent falls.**

10. **Chronic recurrent medical problems** that require daily observation by licensed personnel for prevention and/or treatment.

Appendix E: Publicly Funded TBI Specific Facilities in North Carolina

Publicly Funded Residential Options		
Organization		Location
ReNu Life Extended	ReNu Life	Goldsboro
Taylor Home	ReNu Life	Goldsboro
Pineview Home	ReNu Life	Goldsboro
Lakeview Home	ReNu Life	Goldsboro
Lippard Lodge	Luther Family Services of the Carolinas	Clemmons
TBI, Program #3	Person Co. Group Homes	Caswell Co
TBI, Program #1	Person Co. Group Homes	Caswell Co.
Gaston Residential Services	Gaston Residential Services	Gastonia
VOCA-Elm	VOCA-Elm	Hudson
Gail B. Hanks Home	Gail B. Hanks Home	Charlotte

Publicly Funded Day Support Options	
Organization	Location
Gateway Clubhouse	Raleigh
Hinds Feet Farm	Asheville
Hinds Feet Farm	Huntersville