Forsyth County Department of Social Services

Leading by Results

Volume II Number 1 Summer, 2007

Forsyth County

Serving our Community with Competence, Compassion and Commitment

"Published to enhance the community's knowledge of issues affecting children, families, older adults and the disabled in Forsyth County."

ViewPoint

Leading by Results

Joe Raymond, Director
Department of Social Services

Welcome to the Summer edition of ***Leading By Results.*** The issue marks the first year that the Forsyth County Department of Social Services will set performance targets for our benchmarks (see page 6). These targets represent our seriousness about performance improvement, and we believe we now have enough reliable data to set challenging but realistic benchmark targets. While these performance targets will increase our public "accountability," their ultimate value is more about continuous improvement toward important achievements that matter.

As North Carolina's counties adopted new budgets last month, the increasing cost of county expenditures of the Medicaid Program was front and center in the budget conversation. This issue of ***Leading By Results*** provides information about the Medicaid Program, including who actually receives Medicaid, what medical benefits are covered and how the Medicaid Program fits into the overall U. S. healthcare system.

Access to health care is a critical issue for Forsyth County residents. In Forsyth County, there are an estimated 48,000 residents who do not have health insurance. This is obviously problematic. Approximately 40,000 low-income residents are Medicaid recipients.

The number of Medicaid recipients has risen dramatically in the past 10 years, and program costs have risen. This has happened because eligibility criteria have expanded to serve more low-income children and older adults and benefits have expanded to improve health outcomes. At the same time, health care costs in general have increased tremendously and employers in both the private and public sector have cut employee health care benefits.

North Carolina is the last state to require counties to participate in the funding of the Federal Medicaid Program. As this issue goes to print, the North Carolina legislature has not decided whether the county share of Medicaid expenditures will be removed from county budgets. There is no doubt that NC counties have experienced financial pressures due to the local funding requirement. The NC Association of County Commissioners reports that the Forsyth County share of Medicaid expenditures was 4.6% of the total Forsyth County budget in FY 06 – 07.

This quarter's publication focuses on benchmarks from our five strategic goals. These benchmarks and goals include:

- Annual percentage of children who are adopted whose placement is not dissolved or disrupted,
- Annual percentage of Medicaid applicants (and NC Health choice applicants) whose applications are completed within 45 days, and
- Increasing Public Understanding of Social Issue and Building Effective Partnerships (the issue focused will be the Forsyth County Infant Mortality Reduction Coalition). A sincere thanks goes to Lynne Mitchell, of the Forsyth Public Health Department, who guest authored this article.
- Lastly, we address our Goal V: "Being Publicly Accountable for Efficient and Timely Use of Resources" by discussing program improvements DSS has made in its Family and Children's Medicaid Program.

Mr. Greg Bier, President, Forsyth Medical Center, is the focus of our interview (page 9) about the importance of the Medicaid Program to Forsyth County and the U.S. healthcare system. His insight on these issues is appreciated.

Finally, we wish thank Mr. John Sheldon, Chairman of the Forsyth County Board of Social Services who leaves board service after two consecutive three year terms. John's steady leadership and straightforward common sense have been extremely valuable. We wish John the best!

Thanks for reading ***Leading by Results***!

Publisher-Editor-in Chief
Joe Raymond, Director

Editor
Kay Albright, Human Services Planner

DSS Contributors

Dawn Perdue, Social Worker
Gail Stewart, Social Worker
Susan Thompson, Supervisor

Mission: Forsyth County DSS will serve and protect vulnerable children and adults; strengthen and preserve families; and enhance economic stability while encouraging personal responsibility.

"Serving Our Community with Competency, Compassion, and Commitment"

Please direct all correspondence regarding this publication to
Kay Albright,
Forsyth County Department of Social Services,
741 N. Highland Ave.,
Winston-Salem, NC 27101
336-703-3403
albrigkf@forsyth.cc

Goal I Improve the Safety, Quality of Life, and Well-Being of Children and Families

For children in the custody of DSS, adoption is one avenue to finding their "forever" families. After DSS has made diligent efforts to reunify children with birth parents or to place them with relatives, the juvenile court may sanction a plan for adoption to establish permanency for children. Some children become available for adoption when their parents relinquish their parental rights. Other children become free for adoption following court proceedings to terminate parental rights.

Once children are available for adoption, prospective families petition the court to adopt. Later they go through the court to have the adoption legally finalized. Often children are adopted by relatives or foster parents with whom they have been living prior to relinquishments or termination of parental rights.

Benchmark Spotlight On: *Annual percent of children who are adopted whose placement is not disrupted/ dissolved.*

What is disruption or dissolution of an adoption?

The goal of adoption is to establish legal permanence for children. In the vast majority of adoptions, this goal is achieved. Rarely do adoptive placements experience disruption or dissolution. Disruption occurs when there is a break-down during the adoptive process after the family has filed the petition to adopt, but prior to the legal finalization of the adoption. Dissolution occurs when there is a disintegration of the placement after the legal finalization of the adoption. In either case, the child involved returns to the foster care system and remains in the legal custody of DSS.

What does the data show?

Over the last 10 years, DSS has placed almost 500 children (480) in adoptive families. Of that number, 29 or 6% have either been disrupted (before the adoption was finalized) or dissolved (after it was finalized). Of the 48 adoptions during the FY 05-06, one adoption disrupted (2%) and one adoption ended in dissolution (2%). These data indicate that 96% of the placements of children adopted during FY 05-06 did not experience disruption or dissolution.

What is DSS or the community doing to prevent disruption or dissolution of adoptions?

Our community is key to ensuring a permanent home for a child and many individuals and activities assist in that effort. First among these are the recruitment, education, and training of prospective adoptive families. Current foster/adoptive parents provide an excellent source of recruitment. To be licensed as foster/adoptive parents, completion of a 30-hour training program is required. This training is followed by home evaluations, and criminal background checks including finger-printing, of all adults in the home.

Following licensure, a period of waiting often ensues for the placement of a child. While this period may be frustrating for prospective parents, the job of matching the child with foster/adoptive parents is essential to the high rates of successful, enduring adoptions reflected in our low rates of disruption/dissolution.

Once children are placed with prospective adoptive parents, the family continues to have access to services from an adoptions social worker. Post-adoption services are available through DSS following the finalization of the adoption. These services may include Medicaid for the child, financial assistance for families adopting children deemed to have certain special needs, case management to make referrals to access services needed to support the family and maintain the child's placement, and support groups for adopted children and parents.

Our community plays an integral role in supporting adoptive families. Churches and businesses provide support. Additional support is being provided by these and other groups through mentoring of adolescents and scholarships allowing children to participate in sports, the arts, and other camps.

Additional opportunities to enhance support for adoptive families include:

- Developing more respite options for families and children;
- Providing increased community education about adoption and the needs of members of adoptive families;
- Offering affordable educational remediation for adopted children who may be behind in school;
- Improving access to mental health services; and
- Increasing safe recreational resources for children and youth.

"Our community plays an integral role in supporting adoptive families."

Goal II Improve the Safety, Well-Being, and Quality of Life of Older Adults and Adults with Disabilities

Goal III Enhance the Economic Stability of Individuals and Families

In this issue, ***Leading by Results*** combines Goals II and III to write about the Medicaid insurance program.

Access to health care is fundamental to assuring good health in America. Historically, most people have obtained health insurance through their employers, but many low-income families and individuals must increasingly rely on public health insurance through the Medicaid program. Medicaid is an insurance program that provides benefits to individuals and families. Payments for services go to doctors, dentists, pharmacists and hospitals. The role of the Department of Social Services is to determine eligibility for the programs.

Benchmark Spotlight On: Annual percent of Adult and Family and Children's Medicaid applicants whose applications are completed within the 45 day (Medical Assistance for the Aged) or 90 day (Medical Assistance for the Disabled) standard.

What is Medicaid and NC Health Choice?

Medicaid is made up of many individual programs, each with specific eligibility guidelines. It is available only to certain low-income families or individuals who fit into a group recognized by federal law and state eligibility standards. Overall, eligibility includes U.S. citizenship, residency, age, whether you are blind, or disabled, income, and resources (such as bank accounts, property, etc.). People who receive SSI or Work First Cash Assistance are automatically eligible as well as people receiving foster or adoption assistance. People who have unmet medical bills which they can not pay may also be eligible. Medicaid is financed by federal, state, and county funds.

Programs for Families and Children

Family and Children's Medicaid is made up of programs that target specific populations who meet income limits. Major programs include those that target:

- Single parents or couples with children under age 19 in their household or for children ages 19-20;
- Children under age 19; and
- Pregnant women.

NC Health Choice for Children was established in 1998 to fill the gap in health coverage for children whose families had too much income to be eligible for Medicaid, but too little to afford the cost of private health insurance. To be eligible for NCHC, a child cannot be eligible for full Medicaid benefits nor have comprehensive private health insurance. Families do not have to meet an asset test as with other Medicaid programs. Unlike Medicaid, Health Choice is not an entitlement. It is limited by the availability of funds. This means that children are served on a first-come, first-served basis as long as funds are available.

The maximum income level to receive NCHC coverage is 200% of the federal poverty level. Families whose income falls between 150% and 200% of the federal poverty level must pay a modest annual enrollment fee.

Health Choice now targets children ages 6-18. In 2006, the NC General Assembly made a change to Medicaid to make younger children eligible for Medicaid who had formerly only been eligible for NCHC. This allowed more children to be served for Health Choice.

Programs for Adults and the Disabled

What is known as "Adult Medicaid" is made up of three programs for individuals who meet income limits. Target groups include:

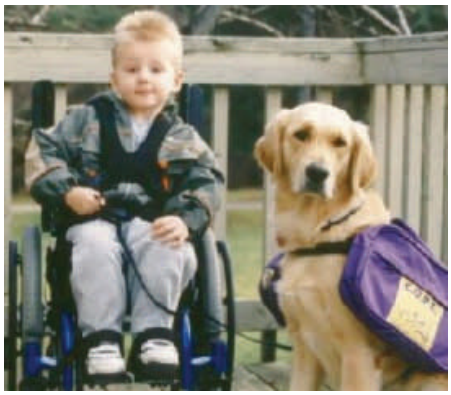
- People age 65 or older;
- Blind or visually impaired people of any age who meet the Social Security Administration definition of blindness, and
- People of any age who are unable to work due to a disability that is expected to last at least one year.

For most types of Medicaid programs, applicants must bring proof of income and information on their assets as part of the application process. If children are involved, parents must bring their children's birth certificates.

Benefits

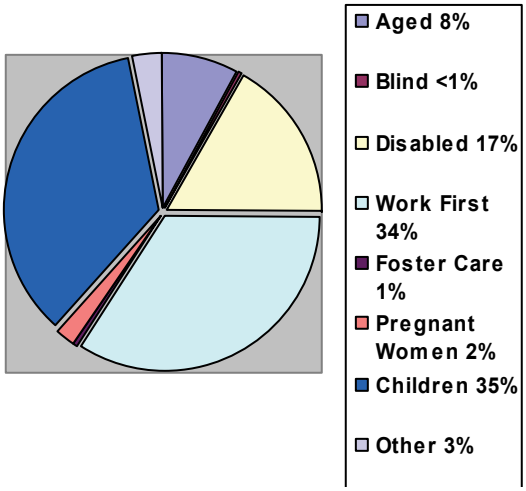
Some of the benefits provided by Medicaid include doctor's visits, hospital care, prescription drugs, laboratory and x-ray services, payment of Medicare premiums (elderly), durable medical equipment, dental care, licensed home health care, nursing and hospice care, and medical transportation.

In Forsyth County, the number of individuals who receive Medicaid is growing. Since 1998, the number of



overall Medicaid recipients in all programs has grown by 68 percent—from 25,442 to 42,666 recipients (June,2007). The number of Health Choice recipients had increased by 116% although the numbers are much smaller (3,377 in June, 2006).

FC Medicaid by Program Type: FY 2006



In 2006 in North Carolina, the elderly and disabled comprised about 28% of the Medicaid population, but accounted for 69% of all expenditures according to state reports. These two groups received a greater number of services, and services that were more expensive per unit.

Why are time standards for applications important?

People want to receive their Medicaid card as quickly as possible so that they can receive benefits. It is FCDSS's intention to provide benefits in a timely fashion. The state has set standards for counties to process applications for all programs within 45 days except Medicaid for the Disabled.

This Medicaid program allows 90 days for processing these applications because part of the process of being declared disabled is completed by the State Division of Disability Determination.

The application process can be time-consuming. The application is about 10 pages and applicants must bring documentation for all information. Then DSS staff must verify income, employment, asset information, citizenship, residency, birth certificates of children (if applicable), a doctor's statement (if pregnant), receipt of other public benefits, etc. If an applicant forgets some information, they have a set amount of time to bring the information in. The same information is entered into a computer repeated times. A case file is often several inches thick of verification information and other paper forms.

How are we doing on meeting the time standards?

The Department takes the time standards seriously and works hard to be in compliance. Adult Medicaid programs have done particularly well in meeting standards for some time.

The largest set of programs, Family and Children's Medicaid and NC Health Choice, have improved in recent years. While more staff work in Family and Children's Medicaid and Health Choice for Children, these programs also have the most applications. Adult Medicaid has about 28 staff members. Family and Children's Medicaid and Health Choice have about 87 staff. Caseloads are very high for all programs—averaging close to 500 cases per worker. While all programs use computers, none use integrated technology to assist workers. Paperwork is a constant issue.

Program	FY 05-06	FY 06-07 (through April)
Adult Medicaid	96%	93%
Family and Children's Medicaid	88%	90%
NC Health Choice	88%	90%

What needs to be improved?

The issue of making health care more readily available to consumers goes well beyond time standards and efficiency in programs. At the national and state level, policy changes are needed. Some of these include:

- Assuring access to health care for as many people as possible, particularly children. According to NC's Action for Children, North Carolina has the second largest decline in employer-provided health insurance in the country. Their 2006 Child Health Report Card showed that the number of uninsured children in NC was increasing (up 17.8% in five years).
- Simplifying applications, policies, and documentation requirements at the state level to make applications easier for consumers.
- Providing more funds for NC Health Choice to expand coverage.

Locally, the Department will improve access to health care by continuing to work on outreach to eligible individuals. To ensure that customers have timely access to services, performance on benchmarks will be tracked. To ensure progress, the Department needs:

- Additional staff to process applications and reduce caseloads (six positions have been added to this program in four years; however four positions were used to create the verifications unit);
- Additional technology to assist staff and reduced paperwork; and
- Creative ways to reach more eligible individuals.

"Since 1998, the number of overall Medicaid recipients has grown by 68 percent—from 25,442 to 42,666 recipients."

FCDSS Benchmarks

All targets are intended to be achieved by 6/30/08.

Goal I: Improve the safety, well-being and quality of life of children and families/Benchmarks:	
1.1	The annual percent of children in DSS custody who achieve permanence within one year to through reunification, guardianship to a court approved caregiver, or adoption will increase from 38% to 50%.
1.2	The annual percent of children who have been in foster care more than one year who leave foster care will increase (data not available).
1.3	The annual percent of maltreated children who are not repeat (within 6 months of their maltreatment) victims of substantiated maltreatment (data not available, no target set).
1.4	The annual percent of children who are adopted within a year of having a permanent plan of adoption will increase from 45% to 50%.
1.5	The annual percent of children who are adopted whose placement is not disrupted or dissolved will be 100%.
1.6	The annual percent of children in foster or facility care who have not been maltreated by a foster parent or facility staff will be 100%.
1.7	The annual percent of foster youth who are in care at age 18 and who are employed or enrolled in post-secondary education from the age of 18-23 (data not available, target not set).
Goal II: Improve the safety, well-being and quality of life for older adults and adults with disabilities/Benchmarks:	
2.1	The annual percent of older adults and adults with disabilities who request In-Home Aide Assistance and receive it will increase from 72.5% to 79%.
2.2	The annual percent of older adults and adults with disabilities served by DSS (Adult Services) who live in the least restrictive, most appropriate setting (data not available, no target yet)
2.3	The annual percent of Adult Medicaid applicants whose applications are completed within the 45 day (Medical Assistance for the Aged) or 90 day (Medical Assistance for the Disabled) standard will increase from 93% to 95%.
2.4	The annual percent of older and disabled adults who are not abused, neglected or exploited while living in licensed care facilities will be 100%.
2.5	The annual percent of older and disabled adults served who are not found to be repeat victims of abuse, neglect or exploitation will be 100%.
Goal III: Enhance the economic stability of individuals and families /Benchmarks:	
3.1	The annual Child Support Enforcement collection rate will increase from 61.4% to 73.2%.
3.2	The annual percent of Child Support cases with court orders will increase from 79% to 81.8%.
3.3	The Child Support Enforcement Program will meet its collections goal (target yet to be defined by state).
3.4	The annual percent of Child and Family Medicaid and Health Choice applicants whose applications are completed within 45 days will increase from 90% to 91%.
3.5	The annual percent of Work First participants who meet the Federal participation rate will increase from 37% to 50%.
3.6	The total number of Work First participants who obtain employment will be 400.
3.7	The annual percent of Work First participants who obtain employment at a living wage of $8.50 per hour or higher will increase from 3% to 10%.
3.8	The annual percent of Work First participants who obtained a GED/High School diplomat or vocational certificate. (no data/no target set).
3.9	The annual percent of individuals potentially eligible for Food and Nutritional services who receive them will be 60% or better.
Goal IV: Increase public understanding of relevant social issues and build effective community partnerships/Benchmarks *Data not available, no targets have been set: (**These benchmarks will be linked to Forsyth Futures work**)	
4.1	The annual percent of children potentially eligible for the child care subsidy and receive it.*
4.2	The annual percent of residents who have access to private health insurance or publicly funded health care.*
4.3	The annual percent of children and adults in need of mental health services who have access to timely services.*
4.4	The annual percent of 9th graders who start the 9th grade and complete high school.*
4.5	The annual percent of child abuse and child neglect.*
4.6	The annual percent of older adults and adults with disabilities who are not abused, neglected or exploited.*
4.7	The annual percent of maltreated children who are not repeat victims of substantiated maltreatment will increase from 71.8% to 75%.
Goal V: Be publicly accountable for efficient use of resources and timely delivery of services /Benchmarks	
5.1	The annual employee departure rate will decrease from 10.2% to 7.5% or less.
5.2	The number of 18 core DSS programs not in program improvement status will decrease from 3 to 0.
5.3	The annual percent of customers who report that they were treated with respect will be maintained at 90% or higher.
5.4	The annual amount of dollars recovered through program integrity efforts will be $75,000 or more.

What's New at the Department of Social Services

- **Thanks John Sheldon:** John Sheldon of the Winston-Salem/ Forsyth County School System left the DSS Board after 6 years of service, the last as DSS Chair. Thanks, John, for a job well done.

- **Michael Wells Joins DSS Board**: Michael Wells of Wells Jenkins Attorneys-at-Law is joining the DSS Board. Mr. Wells is active in the community and serves on many local boards including NC Baptist Hospital Board of Trustees, and the Greater Winston-Salem Chamber of Commerce. His varied law practice includes an interest in elder law.

- **FY 07-08 Budget:** Forsyth County Commissioner's adopted a new budget for Fiscal Year 07-08 that included six new positions for the Department. Three of these positions are in Medicaid while the others are spread throughout the agency.

- **Accuracy Counts:** In most government programs, ensuring accuracy of services is important and many

Food Stamp staff

programs have high standards that counties must meet. The Food Assistance Program (formerly known as Food Stamps) has both timeliness and payment accuracy standards. Nationally, NC won over $8 million in awards for FY 2005 and ranked 5th in the nation in a combined score of accuracy and timeliness of food assistance benefits. Forsyth County DSS was recognized for an outstanding job of 99.34% accuracy for FY 2006. Congratulations to the employees of the Food Assistance Program!

- **Relatives as Parents (RAPP) Grant:** DSS has received an additional two-year grant from the Brookdale Foundation of New York. The foundation's mission is to enhance the quality of life for senior citizens… It encourages and promotes services for grandparents and other relatives who have taken on the role of surrogate parenting. This is the second grant DSS has received since 2003. The grant will be utilized to offer monthly support group meetings, bi-monthly family night activities and other functions as determined by the group participants.

  Children of all ages are likely to live with relatives because their biological parents are incarcerated, deceased, battle addictions or have mental health concerns that prohibit them from providing the basic needs for their children. Many times relative caregivers begin parenting children to avoid foster care.

- **Foster Parents Appreciation:** Forsyth County DSS held its 6th annual appreciation picnic to honor foster and adoptive picnic on May 17th. Over 250 parents, children, and DSS staff attended this year's picnic. Currently, DSS has almost 80 licensed foster families. Our community always needs individuals and families who are willing to provide a loving home for a child who needs a family. To learn more about becoming a foster parent, call 703-CHILD (703-2443).

Tanya McDougal, Director, Family and Children's' Services addresses the crowd at the Foster Parents Picnic.

- **Aging Services Planning Committee:** The Forsyth County Aging Services Committee is made of representatives from local agencies, including DSS, and community volunteers, working together to ensure that efficient and high quality services are available to meet the needs of older adults and adults with disabilities.

  They work to educate the public on the needs of older adults, identify program gaps, and support the development of an aging prepared community.

  They have also sponsored events to bring attention to the needs of older citizens. Recently, in coordination with the Mayor's Council, the Mayor's Fitness Day was held in three locations, Salemtowne, Wake Forest University, and Winston Salem State University.

L. to R. Ed Brewer, Mayor of Clemmons; Aldine Ebert, resident of Salemtowne; Allen Joines, Mayor of Winston-Salem at Fitness Day

Goal IV Increase Public Understanding of Relevant Social Issues and Build Effective Community Partnerships

Forsyth County Infant Mortality Reduction Coalition

By Lynne Mitchell, Preventive Health Services Director, FC Health Department

In this issue, ***Leading by Results,*** focuses on an issue important to our community, the high incidents of infant deaths.

The rate of infants who die before their first birthday in Forsyth County is 8.5 per thousand. NC is ranked 40th in infant deaths (meaning 9 states have an infant death problem worse than ours).

What is the Infant Mortality Reduction Coalition and how does it do its work?

The Infant Mortality Reduction Coalition is a community partnership housed at the Forsyth County Department of Public Health that was started in 1996. The coalition is a partnership of individuals and organizations that work together to reduce infant mortality. Infant mortality is defined as the death of an infant before their first birthday. Coalition members come from the business community, civic and community organizations, the faith community, as well as universities, hospitals, human service organizations, and local neighborhoods. Coalition members work on campaigns targeting policies and systems to create a community environment that supports women's health. Campaigns include:

Smoking and Babies Just Don't Mix

The Coalition did a community-wide media campaign to raise awareness about the dangers of smoking and secondhand smoke while pregnant. Women who smoke while pregnant are twice as likely to have a baby die as women who don't smoke.

This campaign also focused on increasing the number of restaurants in Forsyth County that are smoke-free. Currently, there are over 250 smoke-free restaurants listed on the coalition website and the number is growing!

Preventing Unplanned Pregnancy

The coalition worked this past year to teach doctors and nurses about emergency contraception pills and how they work to prevent pregnancy. Emergency contraception can help prevent pregnancy after unprotected sex or a birth control emergency.

Emergency contraception is *not* the abortion pill and has the best chance of preventing pregnancy if taken within 24 hours after unprotected sex but may work for up to 5 days. The campaign also encouraged doctors and medical personnel to follow new national standards of care by educating all of their sexually active patients about emergency contraception.

What does the data show?

The good news is that the infant death rate is *slowly* declining in our community. Between 1995-2005, the rate declined by 28%. However, as a community, we rank 4th worst out of the 5 urban counties in our state. Most alarming is our problem with disparities – or infant death rates that are substantially higher for racial minorities. In our community, black babies are 2-3 times more likely to die than white babies. This disparity is unacceptable, and the coalition is working to implement strategies to reduce these disparities. As a community, we need to understand and address issues around poverty, racism and social injustice as a means to eliminate the health inequalities we see in our infant mortality rates. It is a difficult conversation - but a necessary one.

Why do babies continue to die?

Although our community has excellent hospitals and medical care facilities, our rates of infant mortality are still high. The leading cause of infant death is premature birth and low birth weight. Three-fourths of Forsyth County infants that died in 2005 were born premature – most were born 2-3 months too early. Babies born too early and weighing too little are at higher risk of dying.

Some other causes of infant mortality are not obvious, such as racism and poverty. Other factors that negatively impact births include smoking during pregnancy, chronic stress, stress of pregnancy, STDs, and the use of alcohol and/or drugs.

What is the overall cost of not addressing infant deaths and what can the community do to help?

The financial, emotional, and long-term costs to our community are high. It costs about $2,000 a day to care for a baby in the Neonatal Intensive Care Unit (NICU). The average length of stay for a "preemie" in the NICU is 21 days. That is about $42,000 for a baby born prematurely. With hundreds of babies born prematurely each year, the cost quickly rises into millions of dollars and this doesn't include the cost of lifelong chronic health conditions and learning disabilities that may be due to premature birth.

As a community, we need to focus on improving women's health before a woman becomes pregnant or pregnant again. Prevention is the key! For more information go to www.HelpOurBabies.org or call 703-3260.

Goal V Be Publicly Accountable for Efficient Use of Resources and Timely Delivery of Services

In this issue of ***Leading by Results***, we have discussed the complex health insurance programs called "Medicaid." The specific benchmarks chosen for the Medicaid program speak to our concern for meeting DSS' commitment to our customers to provide health insurance as quickly as possible for those who are eligible and to meeting the state standards on the timely delivery of this service.

Rather than write about a specific benchmark for this goal of being publicly accountable, ***Leading by Results*** has chosen to discuss the Department's efforts to make this program more efficient and services timelier.

A few years ago, the Family and Children's Medicaid program was struggling to meet the state time standards for this program. The Adult Medicaid program had been meeting state timeliness standards for many years. This is the story of how the agency was able to turn that benchmark around for the largest segment of the Medicaid population. The Department went from 79% to 94% of customers whose applications for Family and Children's Medicaid are completed within 45 days.

What are the key resources available to meet the time standards ?

Medicaid policy is made at the federal and state level, so local DSS organizations are left with three primary resources to ensure efficient and timely delivery of services:

- Staff—workers and supervisors who are well-trained and knowledgeable about program rules and dedicated to serving the public;
- Technology—to support staff to work smart whenever possible and not have to handle paper unnecessarily; and
- Work processes—work must be organized so that staff is utilized most efficiently and that services are provided in the most effective manner.

Staff are our most valuable resources. DSS staff is largely dedicated to providing good service to customers, but often they have very high work loads and insufficient tools to simplify their jobs. While all staff has computers, few of the multiple data programs are integrated and double data entry is common.

Why wasn't the agency meeting the standards and what action have been taken to improve?

The Medicaid program at the county level is about gathering applicant eligibility information and processing it in a timely manner. Staff are also responsible for periodic reviews of eligibility and keeping records up to date. In any one month, about 1/3 of all active applicants (over 35,000 in June, 2007) have some sort of case action—anything from an address change to a required review. The Family and Children's Medicaid program has experienced the most growth of any of the programs administered by the County. Over the last ten years, the state added NC Health Choice to expand health coverage to families. While this was great for families and children, the program expansion came with no additional staff.

Over this time period, the number of people served increased by 106% (Family and Children's Medicaid only), but the number of staff did not increase. Instead, staff had to learn a new program—NC Health Choice. In 2004-05 a debilitating county-wide hiring freeze was imposed that contributed to excessive employee turnover and an operating staff strength reduction of 40%. Staff were overworked and frustrated. Work loads per staff were too high.

The most important actions taken by program management and supervisory staff were reorganization of work. The program instituted a specialized unit within Family and Children's Medicaid to handle some of the verification work for staff and to process all Medicaid transportation requests. One unit also does all mail-in applications which are more complicated since the applicant is not there in person to ask and answer questions. In addition, DSS got two new Family and Children Medicaid positions in 4 years (plus 4 clerical positions). Little by little, turnover stabilized and as staff became more experienced, new work processes had the desired effect.

What's needed now to offer more efficient use of staff resources and more timely delivery of services?

Today Forsyth County is meeting the minimum timeliness standards for Family and Children's Medicaid but wants to go beyond just meeting the state standards. To do that, better technological solutions are needed to help staff work smarter. More staff are still needed. This program still has some of the highest work loads in the agency. Medicaid is only expected to grow as the needs of the uninsured increase.

"The Medicaid program at the county level is about gathering eligibility information from the public and processing it in a timely manner."

A Conversation about Medicaid with Greg Beier

Greg Beier, President
Forsyth Medical Center

How does access to health care or lack of access to health care impact individual patients and their families?

Often when a patient does not have financial coverage, they will not access the health care system in a timely way, particularly for preventive care and early diagnosis of treatable disease. Then when they have acute problems, they will enter the system through the hospital Emergency Room which is more expensive and not the best setting for these services. Their disease may also be at an advanced stage and less likely to have as good of an outcome.

How does access or lack of access to health care impact our overall community?

It creates stress on the Emergency Departments of the hospitals and creates delays for those truly in need of emergency care. It also causes the cost of health care to be high for everyone in order to pay for the expenses of patients without coverage.

Why is access to health care such a problem in our nation and state?

Many employers are not providing coverage and see health as a cost that makes it difficult to compete in the world market (American consumers are not willing to pay more for consumer purchases to include higher health care costs then when they are produced in countries without comparable health care). A lot of individuals either do not have the means to provide their own coverage or choose to go uninsured. While most physicians and hospitals provide access to patients who are unable to pay, the cost of doing so is substantial. Many insurance companies have negotiated rates with hospitals and physicians that are too low to cover these costs. Our nation's health care system is a complicated system of regulation and competition with cross subsidies by private patients, government, and the uninsured. With this type of system, we have higher average access to technology, hospitals, drogues, and physicians than any country in the world, but it is not always equally available to everyone.

Is Medicaid an important part of the overall health care landscape? Is so, why?

It is a very important program to provide better access to the poorest of the poor. While it does not cover all services or all costs of care for those who are eligible, without it, many women and children and fragile elderly would have less access to care.

How does the Medicaid program affect the provision of health care at your hospital?

It provides partial payment for the costs of care to those who are eligible. Without payment, it would be more difficult to provide care and afford the nurses, physicians, and supplies needed to serve the needs.

Why are Medicaid costs increasing?

The costs for personnel, technology, drugs, information systems, and programs are increasing. The advances in medical care have significantly increased life expectancy but at a higher costs. The number of people being served is increasing and the amount of care needed, as the population ages, is increasing. This all contributes to the rise in Medicaid costs.

How serious are these increases and what might be done to lower costs?

The cost increases are quite serious and because of the aging of the Baby Boomers are expected to increase even more. This will strain our entire economy and is projected to impact all services and all populations in America. Several things can be done to address the increase. First and foremost, healthy lifestyles and personal behavior will reduce the need for care (I read a study that concluded that more than 30% of the increase in health care cost was directly attributable to obesity). Other studies show the consequences of a sedentary lifestyle, smoking, etc. Preventive care and early detection of disease also lowers the cost of treatment and would be more available with better health care coverage. Several experiments with how incentives are aligned between individuals, government, employers, and health care providers are taking place in a quest to improve our country's health care system. No one would design our system to look like it does today, but redesigning it will require all of us to consider change. Changing the health care system is much like changing the social security system. Both need to be changed but take enormous political capital to get it done.

"The advances in medical care have significantly increased life expectancy but at a higher costs."

Financing Medicaid: Who Pays for What

Taxpayers pay for this important health insurance program. Program finances are not simple and changes have been proposed in NC recently that would change Medicaid financing. Like all health care costs, Medicaid costs continue to rise as the cost of prescription drugs, hospital, and doctors' services increase.

Who finances Medicaid?

Federal, state, and county government jointly finance Medicaid in NC. North Carolina is the only state requiring a county contribution. The federal government does not require a county contribution. The federal government pays the largest share which is based on the most recent three-year average per capita income.

Currently, NC counties contribute 15% of the non-federal share. In 2006, 21.5% of NC's population was eligible for Medicaid. In Forsyth County, that percentage was 19.57%. Over the past five years, county Medicaid costs have increased an average of 10% each year. The property tax base for counties increased only 7.7% during this period.

In 2006-2007, counties were expected to spend more than $517 million for Medicaid services, a 96 percent increase since 2000. Six counties spend more on Medicaid than for their public schools' current expenses. Fifty counties spend more than on public school construction and other capital expenses. The burden is felt most by poorer counties.

What does Medicaid cost Forsyth County?

Forsyth County's share of Medicaid costs for FY 2007-2008 is estimated to be $18,228,613 up 109% since 2000. This is a per person expenditure of $55.86. Medicaid accounts for 4.6% of the County budget.

Where does the money go?

For years, long-term care has been the most expensive Medicaid service. In FY 2006 it accounted for about 33% of all costs. Prescription drugs accounted was the second most expensive services (about 20% of remaining costs. Medicaid pays for about 37% of all births in NC. 90% of all Medicaid recipients see a physician at least once a year.
Medicaid recipients in NC are 44% Caucasian; 40% Black; and 16% other. The majority are female (61%). Only 13% are over age 65. Most are children or youth between the ages of birth and age 20 (55%).

Who sets Medicaid rates and determines services?

The federal government determines basic services to be offered and allows states to add additional services. Counties have no control over benefits offered, Medicaid policy, provider rates, or how many people are eligible. Local DSS offices administer eligibility for the program.

NC Medicaid Expenditures/ FY 2006

Category of Service	2006 Expenditures	Percent
Prescription Drugs	$1,385,039,301	16%
Inpatient Hospital	$1,024,293,989	12%
Physician	$817,055,723	10%
Outpatient Hospital	$599,306,708	7%
Mental Health	$472,785,462	6%
Medicare Part B Premiums	$228,234,475	2%
Dental	$217,965,9881	2%
Other Non-Long-Term	$1,004,919,238	12%
Total Non- Long Term	**$ 5,749,600,779**	**67%**
Total Long-Term	**$2,833,862,694**	**33%**
Grand Total	**$8,538,463,472**	**100%**

Source: NC Division of Medical Assistance Assistance, 2006 Annual Report

What changes are being proposed in NC to Medicaid financing?

The number one legislative goal for the NC Association of County Commissioners this year is Medicaid Relief. The Blue Ribbon Commission on Medicaid created by the NC General Assembly in 2003 has made several recommendations aimed at a state takeover of the county share of costs. These include a phase out of the county share, capping the county costs at 2004-05 levels, and providing targeted relief to the state's hardest hit counties. While several bills have been introduced in the General Assembly, no final action has been taken when ***Leading by Results*** went to press.

Sources: NC Department of Health and Human Service, Division of Medical Assistant; NC Policy Watch; and the NC Association of County Commissioners

"In 2006-2007, counties were expected to spend more than $517 million for Medicaid services, a 96 percent increase since 2000."

"In the Next Issue"

*In the Fall issue of **Leading by Results**, the Department of Social Services will report on specific benchmarks associated with each goal. The newsletter will also include an interview on a topic of interest related to these benchmarks.*

Forsyth County

Serving our Community with Competence, Compassion and Commitment

---

Department of Social Services
741 N. Highland Ave.
Winston-Salem, NC 27101

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
Winston-Salem, NC
Permit No. 714