2004

AGING STUDY COMMISSION

MINUTES

ARTICLE 21.
The North Carolina Study Commission on Aging.

Sec.

120-180. Commission; creation.
120-181. Commission; duties.
120-182. Commission; membership.
120-183. Commission; meetings.
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120-185. Commission; public hearings.
120-186. Commission; authority.
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120-188. Commission; staff; meeting place.

§ 120-180. Commission; creation.

The North Carolina Study Commission on Aging is created to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults. This study shall be a continuing one and the evaluation ongoing, as the population of older citizens grows and as old problems faced by older citizens magnify and are augmented by new problems.

§ 120-181. Commission; duties.

The Commission shall study the issues of availability and accessibility of health, mental health, social, and other services needed by older adults. In making this study the Commission shall:

(1) Study the needs of older adults in North Carolina;

(2) Assess the current status of the adequacy and of the delivery of health, mental health, social, and other services to older adults;

(3) Collect current and long range data on the older adult population and disseminate this data on an ongoing basis to agencies and organizations that are concerned with the needs of older adults;

(4) Develop a comprehensive data base relating to older adults, which may be used to facilitate both short and long range agency planning for services for older adults and for delivery of these services;

(5) Document and review requests of federal, State, regional, and local governments for legislation or appropriations for services for older adults, and make recommendations after review;

(6) Evaluate long-term health care and its non-institutional alternatives;

(7) Propose a plan for the development and delivery of State services for older adults that, if implemented, would, over 10 years, result in a comprehensive, cost-effective system of services for older adults;

(8) Study all issues and aspects of gerontological concerns and problems, including but not limited to Alzheimer's Disease; and

(9) Carry out any other evaluations the Commission considers necessary to perform its mandate.

§ 120-182. Commission; membership.

The Commission shall consist of 17 members, as follows:

(1) The Secretary of the Department of Health and Human Services or his delegate shall serve ex officio as a non-voting member;

(2) Eight shall be appointed by the Speaker of the House of Representatives, five being members of the House of Representatives at the time of their appointment, and at least two being planners for or providers of health, mental health, or social services to older adults; and

(3) Eight shall be appointed by the President Pro Tempore of the Senate, five being members of the Senate at the time of their appointment, and at least two being planners for or providers of health, mental health, or social services to older adults.

Any vacancy shall be filled by the appointing authority who made the initial appointment and by a person having the same qualifications. All initial appointments shall be made within one calendar month from the effective date of this Article. Members' terms shall last for two years. Members may be reappointed for two consecutive terms and may be appointed again after having been off the Commission for two years.

§ 120-183. Commission; meetings.
The Commission shall have its initial meeting no later than October 1, 1987, at the call of the President of the Senate and Speaker of the House. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall appoint a cochairman each from the membership of the Commission. The Commission shall meet upon the call of the cochairmen.

§ 120-184. Commission; reimbursement.
The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, G.S. 138-5 and G.S. 138-6, as applicable.

§ 120-185. Commission; public hearings.
The Commission may hold public meetings across the State to solicit public input with respect to the issues of aging in North Carolina.

§ 120-186. Commission; authority.
The Commission has the authority to obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duties, pursuant to the provisions of G.S. 120-19, as if it were a committee of the General Assembly. The Commission shall also have the authority to call witnesses, compel testimony relevant to any matter properly before the Commission, and subpoena records and documents, provided that any patient record shall have patient identifying information removed. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission as if it were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this section, the subpoena shall also be signed by the cochairmen of the Commission. Any cost of providing information to the Commission not covered by G.S. 120-19.3 may be reimbursed by the Commission from funds appropriated to it for its continuing study.

§ 120-186.1. Commission; Alzheimer's Subcommittee, Long-Term Care Subcommittee, and other subcommittees.
(a) The Commission cochairs shall appoint subcommittees as needed to assist with the completion of the work of the Commission. These subcommittees may include an Alzheimer's Subcommittee, a Long-Term Care Subcommittee, or other special subject subcommittees. The cochairs shall appoint as members of any subcommittee not more than four Commission members and at least four but no more than eight non-Commission members.
(b) The Commission cochairs shall prescribe the duties of any subcommittee created. Duties of the Alzheimer's Subcommittee may include conducting studies on the availability and efficacy of currently existing geriatric or memory disorder services and programs, advising the Commission on matters regarding Alzheimer's services and programs, and recommending to the Commission solutions to related problems. Duties of the Long-Term Care Subcommittee may include developing a long-term care policy for the State that has at least the following elements:
(1) Promotes elder independence, choice, and dignity;
(2) Provides a seamless, uniform system of flexible and responsive services;
(3) Provides single-entry access;
(4) Includes a wide range of home and community-based services available to all elderly who need them but targeted primarily to the most frail, needy elderly;
(5) Provides care and services at the least expense in the least confusing manner and based on the desires of the elder population and their families;
(6) Expands Medicaid income eligibility to allow more services in the home and community;
(7) Creates a single agency and budget stream to administer services to the elderly; and
(8) Approaches long-term care within the context of the entire health care system.

§ 120-187. Commission; reports.
The Commission shall report to the General Assembly and the Governor the results of its study and recommendations. A written report shall be submitted to each biennial session of the General Assembly at its convening.

§ 120-188. Commission; staff; meeting place.
The Commission may contract for clerical or professional staff or for any other services it may require in the course of its on-going study. At the request of the Commission, the Legislative Services Commission may supply members of the staff of the Legislative Services Office and clerical assistance to the Commission as the Legislative Services Commission considers appropriate.

The Commission may, with the approval of the Legislative Services Commission, meet in the State Legislative Building or the Legislative Office Building.

§§ 120-189 through 120-194: Reserved for future codification purposes.

NORTH CAROLINA STUDY COMMISSION ON AGING

2004 COMMISSION BUDGET ESTIMATE

1.	Legislative Members Subsistence $104 x 10 (*number of legislative members*) x 1 ½ (*Half of members using two days subsistence*) x 5 (*number of meetings*)	$7,800
2.	Non-Legislative Members Subsistence $102.75 x 6 (*number of non-legislative members*) x 1 ½ (*Half of members using two days subsistence*) x 5 (*number of meetings*)	$4,624
3.	Travel Expenses $58.00 * x 10 (*number of GA members*) x 5 (*number of meetings*) $50.00 ** x 6 (*number of public members*) x 5 (*number of meetings*) * Average 200 miles round trip x $.29 = $58.00 ** Average 200 miles round trip x $.25 = $50.00	$4,400
4.	Clerical Staff Average of $613 ** x 5 (*number of meetings*) ** $613 = average salary with benefits for 5 day work week	$3,065
5.	Professional Staff (To be used if other than legislative professional staff is employed)	$0
6.	Special Travel and Expenses	$500
7.	Postage and Telephone	$500
8.	Supplies	$250
9.	Copying and Printing	$1,000
10.	Reserve	$27,861
TOTAL		**$50,000**

Rev. 1/30/04

ATTENDANCE

North Carolina Study Commission on Aging

(Name of Committee)

DATES **MEMBERSHIP**	2-10-04	3-9-04	3-23-04	4-13-04	4-27-04	10-21-04	10-26-04	10-27-04	11-10-04	12-1-04	1-20-05				
Representative Debbie Clary, Co-Chair	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓				
Rep. Edd Nye, Co-Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Senator A. B. Swindell, Co-Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓						
Senator Austin Allran, ~~Co-Chair~~	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓				
Senator Charlie Dannelly		✓	✓	✓		✓	✓	✓	✓	✓	✓				
Senator Tony Moore	✓	✓		✓	✓				✓						
Senator Joe Sam Queen				✓	✓						✓				
Representative David Lewis	✓				✓			✓	✓	✓	✓				
Rep. Jennifer Weiss	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓				
Representative Gene Wilson.			✓	✓	✓			✓	✓	✓	✓				
Representative Beverly Earle		✓	✓						✓		✓				
Public Members															
Mr. Brad Allen	✓	✓	✓	✓	✓		✓		✓	✓	✓				
Ms. Josephine Elliot	✓	✓	✓	✓	✓	✓		✓	✓	✓					
Ms. Katherine Fox Price	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓				
Mr. Sam Marsh	✓	✓	✓	✓	✓				✓		✓				
Ms. Florence Soltys		✓	✓		✓			✓	✓	✓					
Ms. Linda Howard		✓	✓		✓			✓	✓	✓	✓				
Ex Officio Member															
Jackie Sheppard	✓	✓	✓	✓			✓		✓	✓	✓				
Staff (Research)															
Theresa Matula	✓	✓	✓	✓	✓	✓			✓	✓					
Dianna Jessup	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					
Shawn Parker						✓	✓	✓	✓	✓					
Staff (Fiscal) Susan Morgan	✓	✓	✓	✓	✓										
Cmte/Asst. Jo Bobbitt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					

North Carolina General Assembly

North Carolina Study Commission on Aging

UnExpired Positions Only

G.S. 120-182

Pro Tem's Appointments

Sen. Albin B. Swindell IV — Co-Chair
NC General Assembly
Legislative Office Building, Rm 629
Raleigh, NC 27601-2808
(919) 733-3030

Sen. Austin Murphy Allran — Member
NC General Assembly
Legislative Office Building, Room 516
Raleigh, NC 27601-2808
(919) 733-5876

Sen. Charlie Smith Dannelly — Member
NC General Assembly
Legislative Building, Room 2010
Raleigh, NC 27601-2808
(919) 733-5955

Sen. Tony P. Moore — Member
N.C. General Assembly
Legislative Office Building, Rm 622
Raleigh, NC 27601
(919) 715-8363

Sen. Joe Sam Queen — Member
N.C. General Assembly
Legislative Building, Rm 2111
Raleigh, NC 27601
(919) 733-3460

Mr. Brad Allen — Public Member
317 Windsor Road
Lumberton, NC 28358

Ms. Jan Elliott — Public Member
1302 Franklin Ave
Laurinburg, NC 28352
(910) 277-2501
email: jelliott@scotlandcounty.org

Speaker's Appointments

Rep. Debbie A. Clary — Co-Chair
NC General Assembly
Legislative Building, Room 1211
Raleigh, NC 27601
(919) 733-5654

Rep. Edd Nye — Co-Chair
NC General Assembly
Legislative Office Building Room 639
Raleigh, NC 27601-1096
(919) 733-5477

Rep. David R. Lewis — Member
North Carolina General Assembly
Legislative Office Building, Rm 509
Raleigh, NC 27603-5925

Rep. Jennifer Weiss — Member
NC General Assembly
Legislative Building, Room 2221
Raleigh, NC 27601
(919) 733-5871

Rep. William Eugene Wilson — Member
NC General Assembly
Legislative Building, Rm 1109
Raleigh, NC 27601-5925
(919) 733-7727

Ms. Katherine Fox Price RN — Public Member
1760 Whispering Pine Drive
Lincolnton, NC 28092-0937

North Carolina Study Commission on Aging

UnExpired Positions Only

Mr. Sam Marsh
1202 Tavern Landing
Rocky Mount, NC 27804

Public Member

Ms. Florence Gray Soltys
707 Greenwood Road
Chapel Hill, NC 27599-3550
919.929.4412
FGSOLTYS@email.unc.edu

Ms. Linda Howard, Administrator
Carrington Place
600 Fullwood Lane
Matthews, NC 28105
704.841.4920
CARPLACE@trellis.net

Ex Officio Member

Mr. Jackie Sheppard
Asst. Secretary/ Long Term Care/Family Services
2001 Mail Service Center
Raleigh, NC 27699
(919) 733-4534

Staff to Committee

Dianna Jessup, Research Division
Theresa Matula

(919) 733-2578

Contact

Jo Bobbitt

(919) 733-5477

February 9, 2004

MEMORANDUM

TO: Members, NORTH CAROLINA STUDY COMMISSION ON AGING

FROM: Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NORTH CAROLINA STUDY COMMISSION ON AGING:

DAY:	Tuesday	TIME:	10:00 A.M.
DATE:	February 10, 2004		
LOCATION:	Room 643, LOB		

Please advise Jo Bobbitt, Committee Assistant, at (919) 733-5477, or e-mail nyela@ncleg.net if you will be unable to attend.
For planning purposes, the following meeting dates have been scheduled for future meetings: March 9, 2004, April 13, 2004, and April 27, 2004

Posted: January 28, 2004

cc: Committee Record _____
Interested Parties _____

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Tuesday, February 10, 2004
10:00 A. M.
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, February 10, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Edd Nye, Co-Chair, presided. Members also in attendance were Co-Chairs Rep. Debbie Clary and Senator A. B. Swindell; Senators Allran and Moore; Representatives Lewis and Weiss; public members Allen, Elliott, Price, Marsh, and Sheppard.

Theresa Matula, Dianna Jessup, and Susan Morgan provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes (See Attachment 1).

Rep. Nye called the meeting to order at 10 a. m. and welcomed members, staff and visitors. He asked the members to briefly introduce themselves to the other members of the Commission. He then recognized Theresa Matula, Commission Staff, Research Division, NCGA, to come forward to give the Commission an overview of their responsibilities. She gave a brief overview of the Commission's responsibilities, the number of members that are to be appointed, and how they are appointed. She next reviewed the meeting dates explained the budget for the Commission. A motion was made by Senator Moore that the budget be approved. The members voted and the motion carried.

Theresa Matula and Dianna Jessup, Commission Staff, Research Division, NCGA, addressed the members and reviewed the *2003 Legislation & Status of 2003 Aging Study Commission Recommendation* (See Attachment). The handout included a summary of substantive legislation relating to aging and a status of 2003 recommendations from the Study Commission on Aging. Ms. Matula reviewed the status of the previous Commission's recommendations and Ms. Jessup reviewed the legislation. Items Ms. Jessup mentioned included: the Continuing Care Retirement/Technical Changes; the effective date of long-term criminal record checks moratorium that was put on that requirement a couple of years ago and has been continued until January 1, 2005; the renaming of the NC Heart Disease and Stroke Prevention Task Force to the Justus-Warren Heart Disease and Stroke Prevention Task Force; the continuation of the Special Assistance In-Home Program pilot; and SB1016, Nursing Home/Medication Errors which was a substantial piece of legislation that requires nursing homes to undertake certain activities aimed at decreasing Medicaid related errors.

Theresa Matula was again recognized and stated there were 16 recommendations and she reviewed the results of each one with the members. The handout lists the results. She pointed out the recommendation for the tax credit for long-term care insurance and the recommendation to establish a legislative study commission to study state guardianship. The bills for this particular recommendation did not advance during the 2003 session, but the current Co-Chairs feel this issue is important so staff has scheduled them for study and presenters will be addressing the Commission later in the meeting.

Representative Nye recognized Karen Gottovi, Director, Division of Aging, DHHS, to address the Commission.

OVERVIEW OF AGING SERVICES AND STATE AGING PLAN

Karen Gottovi presented the members a handout and used a slide presentation (See Attachment). Adult Services has been added to the Division of Aging. They are now one agency that deals with both aging and the disabled from 18 years of age and up. It is a combination recommended by the 1997 Study Commission on Aging and Secretary Hooker Odom made the change the beginning of September. They now have fifty-four employees with the addition of Adult Services. They are going forward with a name change for the Division of Aging and it will become the Division of Aging and Adult Services. She pointed out the members had been given a copy of the State Aging Plan. She noted that Jackie Sheppard, a member of the Commission, is Assistant Secretary for Long Term Care and Family Services. He oversees a number of these divisions and services. There are 969,000 citizens of NC age 65 or older. The long term plan aims to provide more services in the community and in the home. There are statewide "baby boomers" that represent more than one in four NC citizens (28%). The state should be concerned because 178,000 between the ages of 55 and 65 are not insured. Only 40% of "boomers" will get any pensions. There is a need to build senior-friendly communities. Representative Nye called for questions and after discussion and questions; he thanked her for her report.

GUARDIANSHIP

John Saxon, Professor of Public Law and Government, UNC Chapel Hill (See Attachment). Mr. Saxon used a PowerPoint presentation in his address to the members. He reviewed the legal history of guardianship reform. Much of what is in the law today dates back 200 or more years. He briefly discussed the current law and the current issues. He suggested they repeal the NC guardianship law and use the Uniform Guardianship and Protective Proceedings Act. Chairman Nye thanked him for his presentation and then announced there would be a break for lunch.

Representative Nye brought the meeting back to order after lunch and asked for the next presenter.

LONG TERM CARE INSURANCE TAX CREDIT

Carla Obiol, Seniors' Health Insurance Information Program (SHIIP), Department of Insurance. Ms. Obiol specifically works with the seniors' Health Insurance Information Program. They provide information, education and assistance to primarily Medicare beneficiaries in the state with regard to Medicaid, Medicare Supplement, Managed Care, and also Long Term Care Insurance. Long Term Care Insurance is a private insurance policy designed to pay for the cost of long term care. This insurance is no longer just nursing home insurance. They must provide benefits for at least 12 months and both skilled care and personal care both are included. It is primarily an indemnity policy. They are seeing that people usually select from $100 to $200 per day benefits. Individuals must decide the length of coverage and deductible period. The Department does not endorse a particular company. People need to pick a plan that fits their particular situation. There was a period of discussion and questions from the members.

Nancy Pomeranz, Personal Taxes Division, Department of Revenue. Ms. Pomeranz was asked by staff to present to the members some information on the Long Term Care Insurance tax credit and how they administer the credit and some of the compliance issues they have had in the past. The credit was enacted in 1999 and expired at the end of last year. The credit is 15% of the

premiums paid, but cannot exceed $350.00 per contract. Claims can include a contract for ones self, spouse, or another dependent. There was a lot of confusion by taxpayers due to this tax credit. Some people thought there was a credit on regular health insurance. The Department has taken steps to reduce the error rates and they are looking at additional suggestions to help with this if the tax credit is reinstated. They do continue to see error rates on returns and would welcome suggestions from the members of the Commission.

Karl Knapp, Tax Research Division, Department of Revenue. Mr. Knapp's presentation compares North Carolina to other states and reviewed a sampling of how other states are doing. In Maine and Oregon, employers can take tax credit as an incentive to encourage companies to offer this insurance to employers. When looking at the 2002 tax returns, the bulk of the credits were taken by married, filing jointly, or widowed taxpayers. Representative Clary pointed out this insurance isn't just for high-income citizens. Premiums are affordable for middle-income citizens as well. She stressed the need to encourage citizens to purchase Long Term Care Insurance.

ADULT CARE HOMES RULES AND CARING FOR THE MENTALLY ILL

Jim Upchurch, Division of Facility Services, DHHS (See Attachment). Mr. Upchurch stated he was asked to briefly discuss the rules and regulations regarding the mentally ill and adult care homes in North Carolina. The most notable thing regarding the subject is the lack of rules and regulations specifically to the mentally ill residence in these facilities. Since the 1960's, the mentally ill have been placed into adult care homes in the state. In recent years, mixing these younger, mentally ill patients with the elderly in these facilities has become an issue in a lot of areas. The frail elderly often are mixed in with the population in the adult care home. This has become a larger issue in recent years and in recent weeks, there have been some assaults by the mentally ill residents on other residents and two or three deaths have been reported. These are currently being investigated. This is a behavior issue with the younger mentally ill. Most facilities do a very good job of taking care of the mentally ill as well as the other residents in the home, but there are other issues that other presenters will address concerning reported lack of services for the residents in these facilities. Some of the larger facilities specialize in taking residents with mental illness. Some of these facilities have done a good job over the years in providing care and supervision for these residents. There are no rules and regulations about mixing these populations in the adult care homes. In NC there are two types of facilities: Adult Care Homes are facilities with seven or more beds, and Family Care Homes are facilities with two to six beds. Of the larger facilities, 71% report they serve some mentally ill residents. The mentally ill represent 20% of residents in facilities in the state. In Family Care Homes, they report 63% in the state have some mentally ill residents in their facility. They represent 43% of all residents in family care homes. He ended his presentation by emphasizing that from a regulatory standpoint many facilities in the state have residents with mental illness and most provide very good care to them with out any additional payments.

Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI)
Ms. Harrison addressed the members saying the facilities are not "age appropriate" and the also are not disability appropriate facilities. These residents are there because there are no other housing options. Evidenced Based Best Practices for person with severe mental illness have evolved from years of research and better medications that are now available. They know that recovery from these disorders is possible. Recovery is not to be confused with a cure. The

recovery model of care, when adhered to, means the improvement of optimal level of functioning.

Lou Wilson, NC Association Long Term Care Facilities. Ms. Wilson briefly discussed the barriers that adult care homes have in providing care for the mentally ill. She stated the state has no expectations and pointed out that in the presentation by Mr. Upchurch, he stated the State only has two rules. There are no state guidelines. Providers are not held accountable for knowing or meeting the needs of the mentally ill in facilities. The Division of Mental Health has failed to develop programs or services for people with mental illness that live in adult care homes until 2003. Last year, Geriatric Specialty Teams were developed which are supposed to serve people age 60 or older. The State has provided very little guidance for area mental health programs as to how the teams should be operated, thus the program has floundered in many areas of the state. Most providers have been left with little support and residents have been left with few opportunities for the level of services provided for the mentally ill who live in other settings. She stated there should be special regulations. The State should have some expectation of what kind of care is to be provided. She has made the recommendation that they create a new licensure law and develop rules that are more realistic than the rules that are on the books. The majority of persons in adult care homes who are mentally ill are Medicaid eligible and a lot of them have no families or support system. They do not have enough support to live outside of an institutional setting. The mentally ill have been in adult care homes in NC for 30 years. People need to be supported to live as independently as possible where ever they are. Representative Nye thanked her for her presentation and asked for question or comments. Representative Clary stated that she agreed there needed to be changes made and they need to work hard toward making those changes, such as changing the licensure law.

In closing, Representative Nye expressed his appreciation to members for their attendance and adjourned the meeting.

Representative Edd Nye, Co-Chair

Jo Bobbitt, Committee Assistant

Representative Debbie Clary, Co-Chair
Senator A. B. Swindell, Co-Chair

DRAFT

Agenda

North Carolina Study Commission on Aging

Tuesday, February 10, 2004
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair
Senator AB Swindell, Cochair

II. Overview of Commission Responsibilities

Theresa Matula, Commission Staff, Research Division, NCGA

2004 Meeting Dates and Commission Budget

Commission Cochairs

III. 2003 Legislation & Status of 2003 Aging Study Commission Recommendations

Dianna Jessup, Commission Staff, Research Division, NCGA
Theresa Matula, Commission Staff, Research Division, NCGA

IV. Overview of Aging Services & State Aging Plan

Karen Gottovi, Director, Division of Aging, Department of Health and Human Services(DHHS)

V. Guardianship

John Saxon, Professor of Public Law and Government, UNC Chapel Hill

VI. Long Term Care Insurance Tax Credit

Carla Obiol, Seniors' Health Insurance Information Program (SHIIP),Department of Insurance
Karl Knapp, Tax Research Division, Department of Revenue
Nancy Pomeranz, Personal Taxes Division, Department of Revenue

VII. Adult Care Home Rules & Caring for the Mentally Ill

Jim Upchurch, Division of Facility Services, DHHS
Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI)
Lou Wilson, NC Association Long Term Care Facilities

VIII Next Meeting:

March 9, 2004 at 10:00 a.m. in Room 643

1.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **February 10, 2004**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thomas A. Deal	
Richard C. Hatch	AARP / NC Coalition on Aging
Olene Ogles	AARP / NC Coalition on Aging
Yoko Crome	NC Division of Aging
John Saxon	UNC Institute of Government
Polly Williams	NC Justice + Community Dev. / Coalition on Aging
Suzanne Merrill	NC Division of Aging + Adult Services
Rosalyn Pettyford	NC Division of Aging & Adult Services
Larry Johnson	Rockingham County Dept. of Social Services
Karen George	NC Assoc of County Dir of Social Services
Jerry Cooper	NC Assisted Living Assoc.
Jim Rogers	Assoc. for Home & Hospice Care-NC
Ann B. Johnson	Gov. Advisory Council
Lynne Berry	Dir. of Aging
Abby C. Emanuelson	National MS Society
Robert Jackson	AARP
Lon Wilson	NCALTCF
BILL HALE	ACLI
Rofane Bryg-Cook	NCADA, Franklin Co Dept Aging 122 Shannon Valley Loop
Jean Reaves	NCOA PO Box 127 Welcome NC 27374
Debra A. Yancey	Friends of Residents in Long Term Care
Sheila McInnis	NC DHHS
Nancy Pomeranz	NC DOR
Michelle Frazier	NC Bar Assn
Bob Hensley	NC BCBS
Ed Regan	NCREA
Elizabeth Dalton	Bone Assoc.

2.

2.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **February 10, 2004**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dorothea Harrison	NAMI N.C.
Phyllis T. Daw	DFS
Jim Upchurch	DHHS/DFS
Bill Krueger	N+O
Jean Keary	NCCOA 127 Weldon NC 27890
ETHAN HYMAN	N+O

6/33

ATTACHMENT 1

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2003 Session

Prepared by Staff for the:
North Carolina Study Commission on Aging

February 10, 2004

Enacted Legislation

Continuing Care Retirement/Technical Changes

S.L. 2003-193 (HB 253) makes various technical changes to the statutes that regulate continuing care retirement communities (CCRCs). These facilities provide housing and health-related services either for life or for a period in excess of one year. CCRCs provide independent living and also offer nursing home or adult care home level of care. Because CCRCs include contractual requirements where, for certain fees, the facility agrees to provide health care coverage over a given period of time, they are considered an insurance product and are regulated by the Department of Insurance under Article 64 of Chapter 58.

The act makes the following changes to the statutes:

- Repeals an unused, and likely unusable, provision allowing for a continuing care retirement facility that is accredited under a process approved by the Commissioner to be issued a license based on that accreditation.
- Replaces the word "facility" with "provider" to clarify that it is the provider that operates the facility that is responsible for meeting the various statutory requirements.
- Clarifies language governing operating reserves for continuing care retirement facilities and providers, including:
  - Changing the wording to reflect the fact that a provider is to calculate and maintain a separate operating reserve for each continuing care facility operated by the provider.
  - Changing the words "annual statement" to "disclosure statement."
  - Changing the words "invested cash" to "cash equivalents."
- Makes the following changes governing the rights of residents of continuing care retirement facilities to organize:
  - Changes "registered under this Article" to "operated by a provider licensed under this Article" in G.S. 58-64-40(a). No entity is "registered" under G.S. 58-64.
  - Makes gender neutral corrections.
  - Clarifies that the governing body of a provider must hold semi-annual meetings with the residents of each facility operated by the provider.
- Makes various changes governing supervision, rehabilitation and liquidation of continuing care retirement providers including:
  - Replacing the word "projected" with "forecasted".
  - Amending the statute as necessary to accommodate the fact that a provider can own or operate more than one facility.
- Amends the provision on receiverships, to reflect the fact that the Commissioner would be appointed as receiver for a provider not a facility.
- Replaces the word "agreements" with "contracts" for consistency of wording within Article 64.
- Removes unnecessary language to conform with the removal of the "accredited facility" provision.
- Amends the provision, governing civil liability, to:
  - Remove the misleading words "facility, or person violating this Article" because the provider is the entity entering into a contract for continuing care, not the facility or other person.
  - Remove the words "or person liable" because the provider is the only entity that is required to deliver a disclosure statement to the contracting party.
  - Remove the words "facility, or person" since payment is made to the provider, and the provider is the entity responsible for the dissemination of the disclosure statement.

  This act became effective June 12, 2003.

Senior Cares Program Administration

S.L. 2003-284, Sec. 10.5 (HB 397, Sec. 10.5) provides that the Department of Health and Human Services may administer the "Senior Cares" prescription drug access program approved by the Health and Wellness Trust Fund Commission and funded from the Health and Wellness Trust Fund.

This section became effective July 1, 2003.

Effective Date of Long-Term Care Criminal Record Checks for Employment Positions

S.L. 2003-284, Sec. 10.8E (HB 397, Sec. 10.8E) continues the suspension of the requirements of G.S. 131E-265 for nursing homes and G.S. 131D-2 for adult care homes to conduct national criminal history checks for certain employees until January 1, 2005. These requirements were also suspended during the last biennium.

This section became effective July 1, 2003.

Implement a Pilot Project for Long-Term Care Community Service Coordination

S.L. 2003-284, Sec. 10.8F (HB 397, Sec. 10.8F) requires the Department of Health and Human Services to implement a communications and coordination initiative to support local coordination of long-term care, and to pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. The initiative must eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services. For those counties that voluntarily participate, the local long-term care coordination initiative must aid in the development of core services, coordinate local services, and streamline access to services. The Department of Health and Human Services must submit an interim report on the pilot project for local long-term care coordination to the North Carolina Study Commission on Aging by October 1, 2004 and a final report by October 1, 2005.

The Institute of Medicine Long-Term Care Task Force found that "long-term care services are often fragmented, duplicative, complex, and not consumer-friendly and that many counties lack needed core long-term care services." In response to this finding, and a report presented in accordance with S.L. 2001-491, Part XXII, the North Carolina Study Commission on Aging's 2003 report to the General Assembly and the Governor made a recommendation that the General Assembly fund a pilot project on long-term care local lead agencies. This provision is in response to that recommendation.

This section became effective July 1, 2003.

Medicare Enrollment Required

S.L. 2003-284, Sec. 10.27 (HB 397, Sec. 10.27) directs the Department of Health and Human Services to require Medicaid recipients who qualify for Medicare to enroll in Medicare in order to pay medical expenses that qualify for payment under Medicare Part B. Medicare is the federally sponsored health insurance program for persons aged 65 or older and for certain disabled persons under age 65. Medicare Part B pays for doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. In order to obtain coverage under Medicare Part B, an eligible person must pay a premium. Requiring eligible persons to enroll in Medicare will shift health care costs from the Medicaid program (which is paid in part with State and local funds) to the Medicare program (which is paid entirely with federal funds).

This section became effective July 1, 2003.

Medicaid Assessment Program for Skilled Nursing Facilities

S.L. 2003-284, Sec. 10.28 (HB 397, Sec. 10.28) directs the Secretary of Health and Human Services to implement a Medicaid assessment program for skilled nursing facilities effective October 1, 2003. The assessment program applies to skilled nursing facilities licensed under Chapter 131E of the General Statutes and must be imposed in a manner consistent with federal regulations under 42 C.F.R. Part 433, Subpart B. Funds realized from assessments imposed shall:

- Be used only to draw down federal Medicaid matching funds for implementing the new reimbursement plan for nursing homes and for increasing nursing facility rates in accordance with the plan,
- Be used to pay 100% of the nonfederal share for the new reimbursement plan for nursing homes; and
- Not be used to supplant State funds appropriated for nursing facility services.

This section became effective July 1, 2003.

Rename North Carolina Heart Disease and Stroke Prevention Task Force

S.L. 2003-284, Sec. 10.33B (HB 397, Sec. 10.33B) renames the North Carolina Heart Disease and Stroke Prevention Task Force. The new name is the Justus-Warren Heart Disease and Stroke Prevention Task Force.

This section became effective July 1, 2003.

Senior Center Outreach

S.L. 2003-284, Sec. 10.42 (HB 397, Sec. 10.42) provides that the funds appropriated to the Department of Health and Human Services, Division of Aging, for the 2003-2005 fiscal biennium, shall be allocated by October 1 of each fiscal year and used by the Division of Aging to enhance senior center programs in the following ways:

- To expand the outreach capacity of senior centers to reach unserved or underserved areas; or
- To provide start-up funds for new senior centers. However, prior to funds being allocated for start-up funds for a new senior center, the county commissioners of the county in which the new center will be located shall:
  - Formally endorse the need for such a center;
  - Formally agree on the sponsoring agency for the center; and
  - Make a formal commitment to use local funds to support the ongoing operation of the center.

Additionally, State funding shall not exceed 75% of reimbursable costs.

This section became effective July 1, 2003.

Adult Care Home Model for Community-Based Services

S.L. 2003-284, Sec. 10.43 (HB 397, Sec. 10.43) requires the Department of Health and Human Services to develop a model project for delivering community-based mental health, developmental disabilities, and substance abuse housing and services through adult care homes that have excess capacity. The model must be designed for implementation on a pilot basis and address the following:

- Services that will be provided by the facility or under contract with the facility, including assistance with daily medication.

- Access of clients to mental health, developmental disabilities, and substance abuse services provided in the community, including transportation to services outside of the client's residence in the adult care home facility.
- Physical plant additions or changes necessary to provide for independent living of residents.
- Methods for assuring quality of services, resident safety, and cost-effectiveness.
- Consistency with the Department's Olmstead plan, other policies on community-integration, and disability plans adopted by the State.

The Department must submit a final report on the development of the model to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on or before March 1, 2004. The report shall address the following:

- Proposed time and location for implementation of the pilot.
- Proposed number of residents to be placed and services to be provided directly by the facility or under contract with the facility.
- Method for evaluating the pilot, including services provided, on a regular basis.
- A description of the living environment for each resident and a comparison of how the living environment compares to that of other residents in the adult care home.
- Changes to State law necessary to implement the pilot.
- Projected cost to the State for pilot and statewide implementation.

This section provides that the development of this model is in response to the State policy to provide appropriate services to clients in the least restrictive and most appropriate environment and with the United States Supreme Court Decision in Olmstead vs. L.C. & E.W.

This section became effective July 1, 2003.

Special Assistance In-Home Program

S.L. 2003-284, Sec. 10.51 (HB 397, Sec. 10.51) allows the Department of Health and Human Services to use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals with in-home living arrangements. These payments may be made for up to 800 individuals during the 2003-2004 fiscal year and the 2004-2005 fiscal year. The standard monthly payment to individuals enrolled in the Special Assistance in-home program shall be 50% of the monthly payment the individual would receive, if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. For State fiscal year 2003-2004, qualified individuals shall not receive payments at rates less than they would have been eligible to receive in State fiscal year 2002-2003. The Department must implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program, would seek placement in an adult care home facility; and shall include the use of a functional assessment. This in-home option must be available to all counties on a voluntary basis; and to the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State.

The Department is required to report on or before January 1, 2004, and on or before January 1, 2005, to the cochairs of the House of Representatives Appropriations Committee, the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the cochairs of the Senate Appropriations Committee on Health and Human Services. This report shall include the following information:

- A description of cost savings that result from allowing individuals eligible for State-County Special Assistance the option of remaining in the home.
- A complete fiscal analysis of the in-home option to include all federal, State, and local funds expended.
- How much case management is needed and which types of individuals are most in need of case management.
- The geographic location of individuals receiving payments under this section.
- A description of the services purchased with these payments.

- A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.
- Findings and recommendations as to the feasibility of continuing or expanding the in-home program.
- The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes.

Additionally, the Department shall incorporate data collection tools designed to compare quality of life among institutionalized versus noninstitutionalized populations (i.e., an individual's perception of his or her own health and well-being, years of healthy life, and activity limitations). To the extent national standards are available, the Department shall utilize those standards. These provisions are based on recommendations from the North Carolina Study Commission on Aging.

This section became effective July 1, 2003.

State/County Special Assistance Transfer of Assets

S.L. 2003-284, Sec. 10.53 (HB 397, Sec. 10.53) codifies the provision adopted in last year's budget providing that Supplemental Security Income (SSI) policy concerning transfer of assets and estate recovery applies to applicants for State-county Special Assistance and repeals current codified law on the issue. The provision also requires the Department of Health and Human Services to continue reviewing whether policy for State-county Special Assistance should be changed to permit an assisted living facility to accept from a family member of a resident who qualifies for State-county Special Assistance payment for the difference in the monthly rate for room, board, and services available. The Department must report its activities on this policy review by March 1, 2004 to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

This section became effective July 1, 2003.

Social Services Commission Rules on Rate-Setting For Adult Day Centers and Adult Day Health Centers

S.L. 2003-284, Sec. 10.58 (HB 397, Sec. 10.58) provides that the Social Services Commission shall consider adopting rules increasing the rates for adult day centers and adult day health centers and that any rate increase shall be implemented within existing funds.

This section became effective July 1, 2003.

Nursing Home/Medication Errors

S.L. 2003-393 (SB 1016) requires every nursing home to establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The Advisory Committee will have the following duties:

- Assess the facility's pharmaceutical management system and practices and identify areas at high risk for medication-related errors.
- Review the facility's pharmaceutical management goals and ensure these goals are being met.
- Review, investigate, and respond to facility incident reports and resident grievances.
- Identify goals and recommendations for the implementation of best practices.
- Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system.
- Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the NC Nursing Practice Act.

- Develop specifications for self-administration of drugs by qualified patients in accordance with law.

As part of its requirement to minimize risk of medication-related error, the act requires every nursing home quality assurance committee to undertake the following:

- Educate and make the patient and the patient's family members aware of all the medications the patient is using.
- Increase prescription legibility.
- Minimize confusion in prescription drug labeling and packaging.
- Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.
- To the extent practicable, implement proven medication safety practices.
- Educate facility staff engaged in medication administration.
- Implement a system to accurately identify recipients before any drug is administered.
- Implement policies and procedures designed to improve accuracy in medication administration and in documentation.
- Implement policies and procedures for the self-administration of medication.
- Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.
- Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

The act also requires nursing home to provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors for all nonphysician personnel involved in direct patient care.

A new statute enacted in this act requires consultant pharmacists of nursing homes to undertake certain drug regimen reviews, make reports concerning drug irregularities, drug product defects and adverse drug reactions, ensure proper documentation of allergies and adverse effects, and ensure that drugs that are not specifically limited as to duration of use or number of doses are controlled by automatic stop orders.

Finally, the act requires the Secretary of Health and Human Services to contract with a public or private entity to develop and implement a Medication Error Quality Initiative. As part of the Initiative, each nursing home must report annually on the nursing home's medication-related errors. The report submitted by each nursing home would not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The contracting entity would analyze the reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor would retain its confidentiality and would not be subject to discovery or use in any civil action as provided under the act.

This act became effective January 1, 2004.

Audit of CAP/DA Programs by State Auditor

S.L. 2003-284, Sec. 10.29B (HB 397, Sec. 10.29B) directs the State Auditor to perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA), provided that State funds are appropriated for this purpose. The audit shall build upon the results of the study conducted by the North Carolina Institute of Medicine, in accordance with Section 10.16(c) of S.L. 2002-126, and provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor shall report the results of the audit to the North Carolina Study Commission on Aging by January 1, 2004.

This section also directs the Department of Health and Human Services to review, on a pilot basis, a selected number of CAP/DA programs to determine compliance with eligibility requirements for the program. Additionally, the Department shall continue to examine aspects of CAP/DA including: the current assessment process; an analysis of per-client costs in CAP/DA to per-client costs in nursing homes and adult care homes; per-participant costs for the State-County In-Home Program; an analysis of per-person costs for personal care services through Medicaid; the monitoring of quality of care for

CAP/DA clients; the current waiting list procedures. The Department is required to make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004.

This section became effective July 1, 2003.

Studies and Reports Related to Aging

Study/Report	Entities Involved	Reporting Date	Reference
Report on the pilot project for local long-term care coordination.	DHHS to Aging Study Commission	Interim report 10/1/04 Final report 10/1/05	S.L. 2003-284 (HB 397), Sec. 10.8.F.(b)
Report on examination of CAP/DA that includes certain cost comparisons	DHHS to Aging Study Commission	1/1/04	S.L. 2003-284 (HB 397), Sec. 10.29B.
Report on development of the adult care home model for community-based services	DHHS to HHS and FRD	3/1/04	S.L. 2003-284 (HB 397), Sec. 10.43.(b)
Report on the Special Assistance In-Home Demonstration Program	DHHS to HHS	1/1/04 and 1/1/05	S.L. 2003-284 (HB 397), Sec. 10.51(b)
DHHS to review whether policy for Special Assistance should be changed to permit an assisted living facility to accept from a family member of a resident who qualifies for the program payment for the difference in the monthly rate.	DHHS to HHS and FRD	3/1/04	S.L. 2003-284 (HB 397), Sec. 10.53(c)
DHHS to review activities and costs related to the provision of care in adult care homes and determine what costs may be considered to properly maximize allowable reimbursement available through Medicaid and may transfer funds from DSS to DMA to draw down federal Medicaid funds.	DHHS to HHS and FRD	As funds are transferred and rates are modified	

Abbreviations:
DHHS: the Department of Health & Human Services
FRD: Fiscal Research Division
HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services

ATTACHMENT 2

2003 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2003 North Carolina General Assembly, 2003 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

February 9, 2004

2003 *Recommendation Status Report*
North Carolina Study Commission on Aging

LONG-TERM CARE WORKFORCE RELATED ISSUES	
RECOMMENDATIONS	**RESULTS**
RECOMMENDATION 1 **The Commission recommends that the General Assembly provide a workforce improvement program for direct care workers employed in adult care homes and home care situations.**	House Bill 155 was introduced, received a favorable report from the Committee on Health, and was re-referred to the Committee on Appropriations. Senate Bill 255 was introduced and referred to the Health and Human Resources Committee; if favorable, Appropriations/Base Budget Committee.
RECOMMENDATION 2 **The Commission recommends that the Department of Health and Human Services implement initiatives to increase and promote the availability of nurse aide training and competency programs.**	The Department of Health and Human Services reports the following: a net increase of 16,783 nurse aides listed on the Nurse Aide I Registry over the past three and one half years; modest growth in the number of Nurse Aide I training programs (particularly in high schools), though no major growth in other sectors due to the lack of qualified faculty and adequate facility space to expand programs; the Nurse Aide I Training Model Curriculum was revised; revisions to competency evaluations due May 2004; distance e-learning opportunities are being explored; and increased opportunities for nurse aide training feedback are planned through 2004. Additionally, "Project Health," a combined effort of a number of State departments and interested organizations, is a proposal to address the shortages of registered nurses and direct care workers in hospitals and long term care settings. The grant will include pilot projects targeted in the Western, Piedmont and Eastern regions of the state. Major goals with regard to direct care workers include: expanding the faculty capacity to offer nurse aide training; implementing on-line and distance learning training opportunities; pre-employment skills training; and providing needs based stipends and other supports to ensure student completion of training. A funding decision is expected by mid-February 2004. A total of $2 million is requested for the total grant effort over a two -year period.

RECOMMENDATION 3 **The Commission recommends that the Department of Health and Human Services work with the NC Board of Nursing, the Community College System and representatives from the NC Health Care Facilities Association to implement a pilot program using medication aides and geriatric aides in skilled nursing facilities.**	Medication Aide: The Department of Health and Human Services reports that the curriculum for the medication aide category is almost complete along with accompanying teaching tools (faculty and student manuals, training video, and toolbox). The Department anticipates being ready to pilot test the medication aide curricula and related training materials this Spring. The competency testing and registry procedures will be the next major focus area. Geriatric Aide: The Department reports that the curriculum for the geriatric aide is currently under development. They anticipate having the curricula and related training materials ready for review by June 2004, and pilot testing should commence this fall. The Department expects both job categories to be implemented in 2005.
RECOMMENDATION 4 **The Commission recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.**	House Bill 308 was introduced and referred to the Committee on Appropriations. Senate Bill 205 was introduced and referred to the Committee on Appropriations/Base Budget.
COMMUNITY BASED INITIATIVES	
RECOMMENDATIONS	**RESULTS**
RECOMMENDATION 5 **The Commission recommends that the General Assembly fund the Community Alternatives Program for Disabled Adults (CAP/DA) at a level sufficient to preserve the availability of community-based services offered through the program.**	According to the General Assembly's Fiscal Research Division, CAP-DA was not expanded nor was it reduced for SFY 2003-04. The Department of Health and Human Services reports that the authorized budget for CAP/DA is $217,791,639. Additionally, they report that counties are still in the process of "building" the program and the participation. Additional slots have been allocated and utilization is being monitored. It is anticipated that participation rates should return to the pre-freeze level, or over, within the next six months.

RECOMMENDATION 6 **The Commission recommends that the General Assembly direct the Office of the State Auditor to conduct a full audit of the CAP/DA program.**	Provisions of House Bill 310 and Senate Bill 252 were incorporated into S.L. 2003-284, Sec. 10.29B (a) (HB 397, Sec. 10.29B(a)) which provides that if State funds are appropriated to the Office of State Auditor for this purpose, then the State Auditor shall perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA). The audit shall build upon the results of the study conducted in accordance with Section 10.16(c) of S.L. 2002-126, by the North Carolina Institute of Medicine and shall provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor is required to report the results of the audit to the North Carolina Study Commission on Aging by January 1, 2004. General Assembly Fiscal Staff reports that the audit was not funded. However, the Office of the State Auditor reports that they intend to perform an analysis of the CAP/DA program.
RECOMMENDATION 7 **The Commission recommends that the General Assembly direct the Department of Health and Human Services to continue its examination of the CAP/DA program.**	Provisions of House Bill 310 and Senate Bill 252 were incorporated into S.L. 2003-284, Sec. 10.29B (b) (House Bill 397, Sec. 10.29B (b)) which requires the Department of Health and Human Services to examine CAP/DA including: (1) A review of the current assessment process for CAP/DA clients. (2) A description of total program costs to the State and counties for clients receiving CAP/DA payments and an analysis of per-client costs in CAP/DA to per-client costs in nursing homes and adult care homes. (3) A description of total program costs and an analysis of per-participant costs for individuals in the State-County In-Home Program. (4) A description of total program costs and an analysis of per-person costs for persons receiving personal care services through the Medicaid program. (5) A description of the monitoring of quality of care for CAP/DA clients. (6) An evaluation of the current waiting list procedures. Additionally, S.L. 2003-284, Sec. 10.29B.(c) requires the Department of Health and Human Services to review, on a pilot basis, a selected number of CAP/DA programs to determine compliance with eligibility requirements for the program. The Department of Health and Human Services was directed to include the results of the review in Section 10.29B.(c), and its findings under Section 10.29B(b), in a report to the North Carolina Study Commission on Aging by January 1, 2004. *(Note: The Department has requested a sixty-day extension, with a reporting date no later than March 1, 2004.)*

RECOMMENDATION 8 **The Commission recommends that the General Assembly fund a pilot project on long-term care local lead agencies.**	Provisions of House Bill 172 and Senate Bill 204 were incorporated into S.L. 2003-284, Sec. 10.8F (HB 397, Sec. 10.8F) which requires the Department of Health and Human Services to implement an initiative to support local coordination of long-term care and to pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. For those counties that voluntarily participate, the local long-term care coordination initiative shall aid in the development of core services, coordinate local services, and streamline access to services. The initiative shall eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services. The Department is required to submit an interim report on the pilot project for local long-term care coordination to the North Carolina Study Commission on Aging by October 1, 2004, and a final report by October 1, 2005.
RECOMMENDATION 9 **The Commission recommends that the General Assembly maintain the Home and Community Care Block Grant services for impaired older adults at the current level and under the current administrative structure that allows flexibility to counties to offer those services chosen by the county.**	According to the General Assembly Fiscal Research Division, the Home and Community Care Block Grant was cut by $1,000,000; the administrative structure remained the same.

RECOMMENDATION 10 **The Commission recommends that the General Assembly expand the State/County Special Assistance in-home component by permitting the Department of Health and Human Services to increase the number of individuals who may be enrolled in the project. The Commission also recommends that the project be made available to all counties on a voluntary basis.**	Provisions of House Bill 170 and Senate Bill 253 were incorporated into S.L. 2003-284, Sec. 10.51(HB 397, Sec. 10.51) that allows the Department of Health and Human Services to use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to 800 individuals during the 2003-2004 fiscal year and the 2004-2005 fiscal year. The standard monthly payment to individuals enrolled in the Special Assistance in-home program shall be fifty percent (50%) of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. For State fiscal year 2003-2004, qualified individuals shall not receive payments at rates less than they would have been eligible to receive in State fiscal year 2002-2003. The Department is required to implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program, would seek placement in an adult care home facility. The Department's policies and procedures must include the use of a functional assessment. The Department must make this in-home option available to all counties on a voluntary basis; and must consider geographic balance in the dispersion of payments to individuals across the State. The Department is required to report on or before January 1, 2004, and on or before January 1, 2005, to the cochairs of the House of Representatives Appropriations Committee, the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the cochairs of the Senate Appropriations Committee on Health and Human Services. The report shall include the following information: (1) A description of cost savings. (2) A complete fiscal analysis of the in-home option. (3) How much case management is needed and which types of individuals need the most. (4) The geographic location of individuals receiving payments under this section. (5) A description of the services purchased with these payments. (6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program. (7) Findings and recommendations as to the feasibility of continuing or expanding the in-home program. (8) The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes. Additionally, the Department shall incorporate data collection tools to compare quality of life among institutionalized versus noninstitutionalized populations.

LONG-TERM CARE FACILITIES

RECOMMENDATIONS	RESULTS
RECOMMENDATION 11 **The Commission recommends that the Department of Health and Human Services study the implementation of a remediation program similar to the Collaborative Remediation Project in Michigan.**	House Bill 309 was introduced and referred to the Committee on Rules, Calendar, and Operations of the House. Senate Bill 206 was introduced and referred to the Committee on Rules and Operations of the Senate.
RECOMMENDATION 12 **The Commission recommends that a group within the Department of Health and Human Services be established to ensure that felons are not employed by long-term care facilities and home care agencies and that the moratorium on the effective date of long-term care criminal checks established in S.L. 2002-126, Section 10.10C be repealed.**	House Bill 171 was introduced and referred to the Committee on Health. Senate Bill 254 was introduced and referred to the Judiciary I Committee. S.L. 2003-284, Sec. 10.8E (HB 397, Sec. 10.8E) provides that notwithstanding any other provision of law to the contrary, the requirements of G.S. 131E-265 for nursing homes to conduct national criminal history record checks for employment positions other than those involving direct patient care shall become effective no earlier than January 1, 2005. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131D-2 for adult care homes to conduct national criminal records checks for all staff positions shall become effective no earlier than January 1, 2005.

ADDITIONAL ISSUES

RECOMMENDATIONS	RESULTS
RECOMMENDATION 13 **The Commission recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.**	House Bill 156 was introduced and referred to the Committee on Rules, Calendar, and Operations of the House. Senate Bill 273 was introduced and referred to the Committee on Rules and Operations of the Senate.

RECOMMENDATION 14 **The Commission recommends that the Secretary of the Department of Health and Human Services define the duties and responsibilities of the Assistant Secretary of Long-Term Care and Family Services to include only those responsibilities related to long-term care.**	The Department of Health and Human Services is formulating a response to this recommendation.
RECOMMENDATION 15 **The Commission recommends that the Secretary of the Department of Health and Human Services continue efforts to coordinate and simplify public access to the myriad drug prescription programs for low and moderate income older adults.**	The Department of Health and Human Services is formulating a response to this recommendation. The Medicare prescription drug changes will have an impact on this recommendation.
RECOMMENDATION 16 **The Commission recommends that the tax credit for long-term care insurance be made permanent.**	House Bill 157 was introduced and referred to the House Committee on Finance. Senate Bill 346 was introduced and referred to Senate Committee on Commerce.

ATTACHMENT 3

Table III-B
SFY 02-03

Schedule of Reported Expenditures by Agency and Major Service Category

Agency	Adult Care Homes	Economic Support	Hospitals, Physicians & Other Health Care	Home Health & In-Home Care	Institutional Care	Social Supportive Services	Division Totals[1]	Agency Percent
Division of Aging			$1,708,063	$33,495,413		$25,076,338	$60,279,814	2.38%
Division of Medical Assistance	$80,473,612	$156,402,718	$620,168,700	$354,171,172	$917,475,779		$2,128,691,981	84.01%
Division of Mental Health/Developmental Disabilities/Substance Abuse Services			$10,179,080		$160,795,528		$170,974,608	6.75%
Division of Services for the Blind[2]	$29,579		$1,104,848	$527,862		$132,886	$1,795,175	0.07%
Division of Social Services	$89,423,812	$46,223,698		$8,470,912		$18,223,210	$162,341,632	6.41%
Division of Vocational Rehabilitation			$3,009,271			$1,162,430	$4,171,701	0.16%
Department of Transportation[3]						$5,652,358	$5,652,358	0.22%
Totals	$169,927,003	$202,626,416	$636,169,962	$396,665,359	$1,078,271,307	$50,247,222	$2,533,907,269	100.00%
Percent	6.71%	8.00%	25.11%	15.65%	42.55%	1.98%	100.00%	

[1] Rounding has led to slight discrepancies.
[2] The expenditures for these services are under reported.
[3] These expenditures also include those for persons with disabilities.

Attachment #5

Inventory of State Resources for Older Adults

This inventory lists many of the services and programs administered for older North Carolinians by agencies within state government, and especially among the divisions and offices of the Department of Health and Human Services (DHHS).

The Department of Health and Human Services

(http://www.dhhs.state.nc.us)
Listed below are the divisions and offices within DHHS that provide some service to older adults and their families.

Divisions:

Aging [pages 1-8]
Facility Services [pages 8-9]
Medical Assistance [9-12]
Mental Health, Developmental Disabilities, and Substance Abuse [pages 12-13]
Public Health [pages 13-14]
Services for the Blind [page 14]
Services for the Deaf and Hard of Hearing [page 14]
Social Services [pages 14-15]
Vocational Rehabilitation [page 15]

Offices:

Citizen Services [pages 15-16]
Economic Opportunity [page 16]
Long Term Care & Olmstead [pages 16-17]
Research, Demonstrations, and Rural Health Development [page 17]

DHHS (http://www.dhhs.state.nc.us/) advocates for citizens age 60 and older and their families and helps younger generations prepare to enjoy their later years. Its divisions and offices enrich the lives of older North Carolinians by:

- supporting safe and stable living arrangements
- enhancing self-sufficiency
- enhancing quality of life
- safeguarding the rights and interests of older people
- promoting health care for older people
- promoting independent living.

Division of Aging

(http://www.dhhs.state.nc.us/aging/home.htm)

Home and Community Services

Working with 17 Area Agencies on Aging (AAAs) and more than 430 public and private local organizations, the Division of Aging supports a wide range of home and community-based services. The division also helps develop and strengthen senior centers as resources for communities all across the state. The array of services and programs offered varies from one county to another based on local need and other factors particular to a county. Described below are the various services that are available under the state's Home and Community Care Block Grant [NCGS 143B-181.1(a)(11).]

Adult Day Care and **Adult Day Health Care** provide organized programs of services during the day in community group settings for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being. Programs must offer a variety of activities designed to meet the individual needs and interests of the participants, including referral to and assistance in using other community resources. In addition, providers of adult day health services, as the name implies, offer health care services to meet the needs of individual participants. These two adult day services are considered to be "core long-term care services." Providers of adult day care must meet North Carolina State Standards for Certification, which are administrative rules (10 NCAC 42E) set by the Social Services Commission and enforced by the Division of Aging. Providers of adult day health care must similarly meet administrative rules set by the Social Services Commission (10 NCAC 42Z) and enforced by the Division of Aging. Routine monitoring of compliance is performed by Adult Day Care Coordinators located at county departments of social services. Centers may be certified to provide adult day care, adult day health care, or both types of care. As of January 1, 2004, there were 55 centers certified to provide both adult day care and adult day health care (down from 59 in February 2002), 57 centers certified to provide only adult day care (same as in February 2002), and 2 centers certified to provide only adult day health care. A

total of 60 counties (three less than in February) had at least one center offering adult day services. In SFY 2002-03, the Division of Aging supported 652 adult day care participants through the HCCBG in 41counties (as compared to 587 participants in 42 counties in SFY 01-02), and 516 adult day health care participants in 31 counties (up from 446 participants in 28 counties in SFY 01-02.) As of February 2004, there were 55 older adults reportedly waiting for adult day care services under the HCCBG, and 24 waiting for adult day health services.

Another funding source for adult day services is the State Adult Day Care Fund, which is budgeted through the Division of Social Services and administered by the Division of Aging. In SFY 2002-03, 65 county departments of social services spent nearly $2.8 million from the State Adult Day Care Fund to support 1,053 older and disabled clients of adult day care and 367 clients of adult day health. In SFY 01-02, 1,102 clients received adult day care services and 325 clients received adult day health services, through 69 county DSSs.

Care Management, a "core long-term care service," is a coordinated care function that incorporates case finding, assessment, care planning, negotiation, care plan implementation, monitoring, and advocacy to assist clients and their families with complex needs in obtaining appropriate services. Most counties in North Carolina have at least one agency that can help manage the care of frail older adults living in the community. In SFY 2002-03, 10 counties chose to offer care management using their HCCBG, assisting 266 persons. As of February 2004, 73 older adults were waiting for care management services.

Congregate Nutrition provides a meal (typically lunch) offering one-third of the Recommended Dietary Allowances in a group setting to persons age 60 and older and their spouses. In SFY 2002-03, 27,844 people (down from 28,591 in SFY 01-02) were served an average of 81 meals during the year. Participants contributed a total of $1,027,078, which helped extend the service to others. As of February 2004, congregate nutrition services had a waiting list of 179 older adults. The Division of Aging is also working with the Division of Public Health and the North Carolina Department of Agriculture to operate the Senior Farmers' Market Nutrition Program that provided about 3,400 low-income congregate participants with free fruit and vegetables. The program is underway in 20 counties.

Group Respite utilizes professional management and trained volunteers to offer temporary, part-time relief to unpaid, primary caregivers of cognitively or physically impaired older adults and to provide meaningful social and recreational activities for those receiving care. Sometimes called "Caregiver's Day Out," group respite programs must be open a minimum of one day a week for at least 3 hours and the programs may not exceed 4 days a week for 5 hours per day without being certified as an adult day care center. It became a reimbursable service under the state's HCCBG in July 1996, and in SFY 2002-03, 50 people in 8 counties were served along with their family caregivers. Respite is considered to be a "core long-term care service."

Health Screening offers general medical testing, screening, and referral for the purpose of promoting the early detection and prevention of health problems in older adults. In SFY 2002-03, 2 counties used some of their HCCBG to offer health screening. In addition, under Title III-D of the Older Americans Act, $655,755 was spent for **Health Promotion and Disease Prevention** programs that support a broad array of activities to assist older adults in maintaining and improving their health and wellness. Health promotion and disease prevention programs also help older adults identify health problems or potential problems and offer effective interventions to address these problems. Funding for Title III-D is made available to AAAs who contract with local service providers. At least 23.62% of the health promotion and disease prevention funds must be used for medication management programs. Other common services funded by health promotion and disease prevention funds include health screening, nutrition education, and exercise classes.

Home-Delivered Meals, a "core long-term care service," provides a meal (typically lunch) to homebound older adults, offering one-third of the Recommended Dietary Allowances. In SFY 2002-03, 18,490 people (up from 18,230 in SFY 01-02) were served an average of 152 meals during the year. Participants contributed a total of $755,822 which helped extend the service to others. Across the state, 1,995 older adults were

waiting for home-delivered meals as of February 2004.

Home Health, a "core long-term care service," is skilled health care prescribed by a physician that is provided in the home of an older adult in need of medical care. Allowable services include skilled nursing; physical, occupational, and/or speech therapy; medical social services; and nutrition care. In SFY 2002-03, only 1 county chose to use some of its HCCBG to offer home health skilled nursing care to 25 older persons.

Housing and Home Improvement, a "core long-term care service," assists older adults with obtaining or retaining adequate housing and basic furnishings. Types of assistance include providing information about available options for housing, and housing with services and how to finance them; helping to improve landlord/tenant relations; identifying substandard housing; securing correction of housing code violations; assisting with finding and relocating to alternative housing; and providing labor and/or materials for minor renovations and/or repair of dwellings to remedy conditions that create a risk to the personal health and safety of older adults. In SFY 2002-03, 39 helped 987 older households through the HCCBG (down from 1,142 in SFY 01-02.) As of February 2004, 650 older adults were waiting for housing and home improvement services under the HCCBG.

Information and Assistance, a "core long-term care service," helps older adults, their families, and others acting on their behalf, in acquiring information about programs and services and accessing them as appropriate. In SFY 2002-03, 40 counties chose to use $1.7 million in HCCBG funds to offer information and assistance.

In-Home Aide Services, a "core long-term care service," involves the provision of paraprofessional services that assist functionally impaired older adults and/or their families with essential home management and personal care and/or supervision to enable the older adult to remain at home as long as possible. In SFY 2002-03, counties expended $17.7 million from the HCCBG to provide in-home aide services to 8,022 older persons (up from 7,904 persons in SFY 01-02.) As of February 2004, 2,758 older adults were waiting for in-home aide services under the HCCBG.

Institutional Respite Care temporarily places older adults, who require constant care and/or supervision, out of their homes to provide their unpaid, primary caregiver with relief from caregiving responsibilities. In SFY 2002-03, 3 counties chose to use some of their HCCBG to offer institutional respite care and served a total of 85 older persons (down from 89 in SFY 01-02.) Respite is considered to be a "core long-term care service."

Legal Services provides help to older persons with the greatest economic and social need who are not otherwise eligible for assistance. The Division of Aging and AAAs allocate a percentage of the Older Americans Act funds to provide such legal services. During SFY 02-03, 6,400 older persons were served (up from 5,708 in SFY 01-02.)

Mental Health Counseling incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems. In SFY 2001-02, no county chose to use HCCBG monies to offer mental health counseling.

Senior Center Operations and Development supports the operationof multipurpose senior centers as well as acquisition, construction, expansion, renovation, and the purchase of equipment for a multipurpose senior center. The term multipurpose senior center means a community facility for the organization and provision of a broad spectrum of services, which include health, social, nutritional, and educational services and recreation activities. The primary objectives of a multipurpose senior center are to centralize provision of services that address the special needs of older adults; provide opportunities for older adults to become more involved in the community; and prevent loneliness and premature institutionalization by promoting personal independence and wellness. The Division of Aging administers three areas of funding for Senior Centers—state funding for Senior Center Outreach, state funding for Senior Center General Purpose, and Senior Center Operations, under the HCCBG and funded by the Older Americans Act. For SFY 2002-03, $100,000 was allocated for Senior Center Outreach and $862,316 for Senior Center General Purpose. This funding goes to 158 centers in 95 counties [5 counties do not have a senior center]. The SFY 02-03 expenditure for Senior Center Operations, under the HCCBG

and funded by the Older Americans Act, was $2,592,463. Currently the Division has certified 30 centers—22 Senior Centers of Excellence and 8 Senior Centers of Merit—through a voluntary state certification process designed to strengthen and reward quality senior centers.

Senior Companion Program offers a part-time, volunteer opportunity with a stipend for people age 60 or older with low incomes who are interested in community service. Senior companions provide support, task assistance, and/or companionship to adults with exceptional needs (developmental disabilities, functional impairments, or persons who have other special needs for companionship). In SFY 2002-03, 7 counties chose to use some of their HCCBG for the senior companion program, totaling $117,365 to serve 54 seniors with special needs.

Transportation, a "core long-term care service," provides travel to and/or from community resources such as medical appointments and nutrition sites or other designated areas for older adults needing access to services and activities necessary for daily living. In SFY 2002-03, about $6.2 million in HCCBG funds were used to provide more than 1.2 million trips for 14,570 older persons (down from 15,284 persons in SFY 01-02 and 16,302 in SFY 00-01.) As of February 2004, 20 older adults were on waiting lists for medical transportation and 68 for general transportation under the HCCBG.

Volunteer Program Development supports development and operation of a systematic program for volunteer participation, involving volunteers of all ages in serving older adults while also providing older adults with opportunities for community service. In SFY 2002-03, 9 counties (up from 6 in SFY 01-02) chose to use some of their HCCBG for development of volunteer programs, totaling $187,725.

Family Caregiving

The Division of Aging received $2,916,628 in 2001 to start the Family Caregiver Support Program under the Older Americans Act, as amended in 2000. North Carolina served more than 9,100 caregivers in the first year. For FFY 2002-03, these federal funds increased to $3,326,460 and the program served nearly 22,000 caregivers. In implementing the Family Caregiver Support Program, North Carolina has focused on partnering and leveraging the somewhat limited caregiver funds. In working through the state's 17 AAAs, the NC Division of Aging has set several statewide goals for the first three years of the program:

1. There will be an adequate infrastructure at the AAA and State levels to serve as a platform for future enhancement of support for family caregivers.
2. Every region will have an Information & Assistance (I&A) system that meets the recommendations of the Division's Task Force on I&A.
3. Family caregivers in every county will have access to respite care, counseling and training.
4. AAAs and the Division will know the unmet needs of caregivers for purposes of planning and program development.
5. AAAs and the Division will have contributed significantly to helping the State implement recommendations of the N.C. Institute of Medicine Task Force on Long Term Care, including promotion of the availability of core services and the strengthening of local planning for aging and long term care.

The North Carolina Division of Aging envisions a future in which families enter into caregiving with the knowledge and assurance that they can call upon the business, faith, and health and human service communities to assist with information, counseling, problem solving, respite, and formal services when needed. Families are respected as the decision-makers and have access to tools to aid their problem solving. The contribution of family caregiving is acknowledged and supported through enlightened public policies. The role of the family remains strong regardless of the care setting or arrangement.

Elder Rights and Special Initiatives

Protecting and securing the rights and benefits of older adults is central to the work performed by the aging network. Through its elder rights activities, the Division of Aging seeks to help vulnerable older adults to understand their rights, secure benefits, exercise choice, and maintain autonomy and independence. This work is achieved through a variety of programs and services.

The Long-Term Care Ombudsman. North Carolina's Long-Term Care Ombudsman Program consists of state and regional

ombudsmen who help residents of long-term care facilities exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff members about rights and help resolve grievances between residents/families and facilities. In 2002, the state and regional ombudsmen handled 3,742 complaints and resolved 76% of them solely without referral to another agency. The Ombudsman Program also provided technical assistance to 16,427 individuals on long-term care issues. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (NCGS 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in nursing homes and adult care homes. There are more than 1,310 such volunteers statewide, with committees in each county.

Elder Abuse, Neglect, and Exploitation Prevention Education. Working with the county departments of social services and other local and state agencies, the Division of Aging and the Area Agencies on Aging provide educational seminars, materials, and technical assistance on the prevention of elder abuse, neglect, and exploitation. Examples of initiatives within the state include the TRIAD Program, the First Responders Program, sensitivity training programs, and missing persons programs.

Legal Resource Center. The Legal Resource Center of the Division of Aging offers a variety of services that include: (1) oversight of the legal assistance provided to older adults across the state through Older Americans Act funding; (2) provision of technical assistance and referral to older adults, professionals and the aging network on legal issues affecting older adults; (3) assembly and development of elder law educational and informational material for distribution to older adults, professionals, and the aging network; (4) provision of education and training across the state on relevant elder law issues; (5) work with the private bar, the Legal Services Corporation, law schools, and other agencies to improve and address the legal needs of older adults; and (6) serve on policy and program commissions, task forces, and boards to act as a resource and to represent the needs of older adults.

Consumer Fraud Protection. In 1998, the Division of Aging joined with AARP and the Attorney General's Office to establish the NC Senior Consumer Fraud Task Force, with representatives from federal, state, and local law enforcement agencies, aging advocates, the aging network, state and local Better Business Bureaus, and crime prevention agencies. An important goal of the Task Force is to educate consumers about fraud and other deceptive practices that target seniors. The Task Force has worked closely with others to get consumer protection legislation passed such as the NC Predatory Lending Law of 1999.

Volunteer Coordination. The Senior Education Corps is an example of the Division's efforts to establish intergenerational partnerships linking the experience, talent and cultural awareness of senior volunteers with the priority needs of North Carolina schools. Currently, the Senior Education Corps operates in 82 counties. Both seniors and school children benefit from this intergenerational program.

Senior Community Service Employment Program. The Division of Aging administers the Senior Community Service Employment Program (SCSEP) through seven (7) area agencies on aging in 34 counties. National sponsors administer the Program in the remaining 66 counties. Over 2,000 older workers participate in the program (state and national). Funded through Title V of the Older Americans Act, the program places eligible individuals into useful part-time community service programs while helping them transition into unsubsidized employment.

Seniors Plus Program. The Division of Aging offers public benefits training to interested volunteers across the state to provide assistance to seniors who may be eligible for additional sources of income due to their limited resources. As of February 2002, the Seniors Plus Program has over 320 volunteers in 80 counties working to assist older adults.

Medicare Lookout. In 2000, the Division of Aging received a three-year grant from the U.S. Administration on Aging to provide education and outreach to Medicare beneficiaries. This grant was part of an ongoing federal, state, and

local initiative called Operation Restore Trust, designed to prevent improper payments in the Medicare and Medicaid programs and to preserve these public health programs for future generations. The Division of Aging administered the project in partnership with AAAs, SHIIP, CARE-LINE, providers, public and private agencies, and consumer groups. In the fall of 2003, the Division began transferring responsibility for Medicare Lookout to the Seniors' Health Insurance Information Program (SHIIP) in the Department of Insurance. SHIIP has secured a new three-year grant to administer this project and the Division is continuing its support as a partner. The Medicare Lookout program uses a dedicated core of volunteers to assist Medicare beneficiaries in understanding the general provisions of Medicare and Medicaid, recognizing and reporting discrepancies in their health care delivery that may be caused by simple error or by fraud, abuse, or waste, and becoming active participants in their own health care delivery.

Advocacy

The Division of Aging supports several bodies that are effective advisors and advocates on aging issues. These include the Governor's Advisory Council on Aging and the North Carolina Senior Tar Heel Legislature.

The **Governor's Advisory Council on Aging** is authorized by state legislation to make recommendations to the Governor and the Secretary of the Department of Health and Human Services for improving human services to older people, including improved coordination among state agencies. The council also studies and recommends how best to promote public understanding of problems affecting older adults and considers the need for new state programs to address these problems. It is comprised of 33 members, with 29 people appointed by the Governor, and 2 each appointed by the President Pro Tempore of the state Senate and the speaker of the state House of Representatives. Among these 33 are 19 at-large members, who arecitizens knowledgeable about services supported through the Older Americans Act, and 14 representatives of state agencies or organizations serving older people.

The **North Carolina Senior Tar Heel Legislature** was created by the state General Assembly in July 1993 to provide information to older adults on the legislative process and matters being considered by the General Assembly, promote citizen involvement and advocacy about aging issues, and assess the legislative needs of older adults by convening a forum modeled after the General Assembly. Each county has one delegate and many counties also have an alternate delegate to the Senior Tar Heel Legislature. Delegates and alternates must be age 60 or older.

In addition, the Division of Aging is responsible for developing the *North Carolina Aging Services Plan*, which is required by state and federal statutes. See http://www.dhhs.state.nc.us/aging/plan.htm for the State Plan.

Adult Services

Working with the 100 County Departments of Social Services, the Division of Aging oversees vital social services programs for older and disabled adults and their families.

Adult Placement Services. All 100 county departments of social services help aging or disabled adults find appropriate living and health care arrangements when their health, safety, and wellbeing can no longer be maintained at home. Placement arrangements are made in adult care homes, nursing homes, and other congregate settings with available services. Adults and their families are counseled to help determine the need for placement, helped to complete medical evaluations and financial applications, and locate and move to new settings. They also may receive counseling to help them adjust to the change. Adult Placement services also include assisting older adults, when requested, to return to more independent settings in the community or to relocate to more appropriate settings when new levels of care are needed. For SFY 2002-03, 888 clients age 60 and older were assisted through Adult Placement services.

Adult Protective Services. North Carolina has been providing protective services to adults through its 100 county departments of social services since 1975. This was one of the nation's first initiatives to recognize the needs of older and disabled adults who had been abused, neglected, and/or exploited and to develop a protective services program to address their needs. North Carolina's Adult Protective Services statute (NCGS 108A, Sec. 6) provides for services to all adults who are incapacitated by a physical or mental disability. It authorizes the

county departments of social services (DSS) to evaluate a disabled adult's need for protective services and to provide or arrange for services when necessary. Services include a thorough assessment of needs, referral to appropriate services, and counseling for the adult and the adult's family. Protective Services are provided with the adult's consent and in the least restrictive and intrusive manner possible. For SFY 2002-03, 5,475 clients age 60 and older were assisted through Adult Protective Services.

Foster Care Services for Adults. Foster care services for adults involve recruiting, developing, and evaluating adult care homes to determine if they meet the needs of residents and to help them improve their service. Adult care homes provide 24-hour supervision and must be licensed by the state in order to operate legally. Adult care homes are not nursing homes, although designated staff can administer medications and provide personal care services (such as assistance with bathing, eating, and dressing). All county departments of social services provide this service.

Guardianship Services. All 100 county departments of social services provide public agent guardians to make legal and living arrangement decisions for adults who have been deemed incompetent to handle their own affairs. Guardianship may be appropriate for adults who are incompetent to manage their affairs and take care of themselves. Public Agent Guardians, such as social services and mental health directors, may be appointed when friends, relatives, or corporations are not available and when it is considered necessary by the Clerk of the Superior Court. The Division of Social Services manages the DHHS public agent guardian program. Training for all public agent guardians, including county departments of social services, area mental health programs, local health departments, and county departments of aging, is provided by the Division of Social Services. The DHHS Blanket Bond Data Base for all incompetent adults with a public agent guardian is also managed by the Division of Social Services. For SFY 2002-03, 1,803 clients age 60 and older were assisted with guardianship services through the DSS system.

At-Risk Case Management Services. County departments of social services assist Medicaid-eligible older adults who are at risk of or show evidence of abuse, neglect, or exploitation in gaining access to needed medical, social, educational, or other services. These case management activities are directed toward preventing abuse, neglect, or exploitation, or preventing further mistreatment when it has already occurred. Included in the service is an evaluation of the situation, assessment of service needs, development of a comprehensive service plan, assisting the client in locating and accessing services, coordinating service delivery, and monitoring service provision to ensure that they are delivered, are adequate, and are consistent with quality care. For SFY 2002-03, 2,089 clients age 60 and older received at-risk case management.

Adult Care Home Case Management Services. County departments of social services provide a case manager to work in partnership with residents, residents' families, significant others, adult care homes, and community service providers to assure that the needs and preferences of heavy care residents living in adult care homes are being met. Case managers have important and diverse roles with these residents, such as responsibility for conducting broad assessments that can identify the need for other health and social services that might benefit residents. Case managers develop service plans and monitor these plans. The service plans outline the primary problems and concerns as identified by residents, residents' families, significant others, adult care homes, and case managers. Service plans identify activities that are intended to address these problems, ultimately improving the quality of care for residents. For SFY 2002-03, 5,267 clients age 60 and older received this service.

Transportation. All 100 county departments of social services provide transportation services to eligible Medicaid recipients for the purpose of accessing medical services, and they offer transportation to other individuals, for other purposes, on an optional basis. County DSSs that elect to provide non-Medicaid transportation offer it as part of a services plan to enable individuals for whom transportation is not otherwise available to have access to medical and health resources; shopping facilities; education, recreational and employment opportunities; and other community facilities, resources, and social services. For SFY 2002-03, 6,406 clients age 60 and older were provided transportation.

Special Assistance. The division administers the State/County Special Assistance for Adults program that provides a cash supplement to help pay for the care of eligible low-income persons residing in adult care homes. For SFY 2002-03, 18,495 clients age 60 and older were assisted through Special Assistance at a cost of $87,479,695.

Special Assistance In-Home Program. The Special Assistance (SA) In-Home program provides an option for in-home care for elderly and disabled adults who are at risk of placement in an adult care home but who desire to live in a private living setting. Currently, this option is available in 61 counties. To qualify, the individual must meet the eligibility criteria for Medicaid and meet all other SA eligibility requirements. For SFY 2002-03, 262 clients age 60 and older were assisted through the SA In-Home program at a cost of $662,033.

Division of Facility Services

(http://facility-services.state.nc.us/)

The Division of Facility Services (DFS) inspects, certifies, registers and licenses hospitals, nursing homes, adult care homes, mental health facilities, home care programs, and other health facilities. It determines the need for many of these health facilities and services across the state and develops a plan to meet that need. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a long-term care facility. The Division of Facility Services also maintains the Nurse Aide Registry, as required by state statute.

The State Health Coordinating Council

The Medical Facilities Planning Section of the Division of Facility Services provides staff support to the State Health Coordinating Council, a 27 member body appointed by the Governor. The Council and the division are charged by state law with developing policy, criteria, and standards for health service facilities planning; making a determination of need for health services facilities; and developing an annual state Medical Facilities Plan. One of the Council's three working committees is focused on long-term care, which includes determining the need for nursing home beds.

Certificate of Need Section

State law requires any person or entity wanting to establish a health care facility, including nursing homes and adult care homes, to first make application for a certificate of need (CON). The Certificate of Need Section within the Division of Facility Services reviews and evaluates the applications in terms of such criteria as need, cost of services, accessibility to services, quality of care, and feasibility.

Health Care Personnel Registry Section

The Health Care Personnel Registry Section provides a registry of all persons who have met the federal and state training and competency requirements to perform Nurse Aide I functions. The Registry Section also maintains a list of unlicensed assistive personnel who have been accused of harming, or been found to have harmed, a resident of a facility.

Licensure and Certification Section

The Licensure and Certification Section is responsible for assuring the health, safety, and well-being of persons receiving services in hospitals, nursing homes, and other facilities and services licensed by the state and certified by the federal government to receive Medicare and Medicaid. Staff members of the section conduct inspections and investigate complaints of health care facilities to track compliance with regulations. The section also provides consultation and training to encourage compliance and improve the quality of care in these facilities.

Construction Section

The Construction Section reviews building plans and specifications for applicants wanting to be licensed or certified by the Division of Facility Services. The section also conducts physical plant inspections and offers training for architects, engineers, and contractors involved in the construction of medical facilities.

Medical Care Commission

The Medical Care Commission, composed of 17 members appointed by the Governor, establishes rules for regulating health care and related facilities, including nursing homes and home

care agencies. The Division of Facility Services provides staff support to the Commission.

Acute and Home Care Section

The Acute and Home Care Section is responsible for the oversight of home care agencies, which must be licensed under state law. This includes the investigation of complaints.

Adult Care Licensure Section

The Adult Care Licensure Section is responsible for licensing all adult care homes and mental health facilities in the state. The section coordinates its oversight with adult homes specialists who work at county departments of social services.

Mental Health Licensure & Certification Section

The Mental Health Licensure and Certification Section inspects and licenses psychiatric hospitals and psychiatric units of acute care hospitals, intermediate care facilities for mentally retarded (ICF/MR), and all other mental health group homes and treatment facilities.

Division of Medical Assistance

(http://www.dhhs.state.nc.us/dma/)

Mandatory Services

At a minimum, all state Medicaid programs must cover a core of health services. The following mandatory services are provided for Medicaid recipients in North Carolina:

Inpatient Hospital Services. Medicaid covers hospital inpatient services without a limitation on the length of stay. Selected inpatient procedures require pre-admission certification to ensure that the stay is medically necessary and that the procedure is most appropriately performed in an inpatient rather than an outpatient setting. Special restrictions apply to abortions, hysterectomies, and sterilization. As of January 1, 1995, hospital services are paid on the basis of diagnostic-related groupings (DRGs). For SFY 2002-03, $75,958,520 was paid for inpatient hospital services for Medicaid eligible persons age 60 and older.

Hospital Outpatient Services. Outpatient services are covered subject to Medicaid's annual 24 physician-visit limitation, except for emergency room visits, which have no limits. A $3.00 per visit co-payment applies except for certain exempt groups and services. Hospital outpatient services are paid to the provider at 80 percent of actual operating costs. For SFY 2002-03, $62,450,167 was paid for outpatient hospital services for Medicaid eligible persons age 60 and older.)

Other Laboratory and X-ray. Laboratory and X-ray services are covered when ordered by a physician. These services are covered in a variety of settings. Payment for these services is based on a statewide fee schedule.

Nursing Facility. Nursing facility (NF) services are mandatory for recipients aged 21and older. The state also has chosen a federal option to cover NF services for people under age 21. Patients must be certified by a physician to require nursing facility care and be approved by Medicaid prior to admission. Nursing facility services are paid on a prospective per diem rate. The Omnibus Budget Reconciliation Act (OBRA) of 1987 and later amendments, effective October 1, 1990, established uniform requirements for institutions that formerly were identified as Medicaid skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Now, all Medicaid SNFs and ICFs are called NFs and must provide both skilled nursing (SN) and intermediate care (IC) service. Reimbursement rates, however, continue to differ based on whether the patient requires skilled or intermediate care. For SFY 2002-03, $794,438,864 was paid for nursing home care for Medicaid-eligible persons age 60 and older.

Physician Services. Physician services are covered subject to an annual 24-visit limit. Selected surgical procedures require prior approval. A $3.00 copayment is required for physician services except for certain exempt groups. Payment is made based on the lower of the physician's actual charges or the statewide Medicaid fee schedule amount.

Home Health Services. Medicaid covers visits provided by certified home health agencies for skilled nursing services, physical therapy, speech-language pathology services, and home health aide services when the service is medically necessary and the patient's home is the most appropriate setting for the care. Under Home Health, Medicaid also pays for medical

supplies. Home Health agencies are paid the lower of their customary charges to the general public or a maximum per visit rate established by DMA for each type of service. For SFY 2002-03, $44,445,222 million was paid for home health services for Medicaid-eligible persons age 60 and older.

Durable Medical Equipment. Durable medical equipment suitable for use in the home is reimbursed via a fee schedule.

Medical Transportation. The federal requirement for coverage of transportation for medical care services is met in three ways:

1. Medically necessary ambulance transportation is a covered benefit.

2. County departments of social services establish a local transportation network that may range from providing bus tokens to using county employees in county-owned vehicles to transport Medicaid recipients. These county transportation costs may be billed as a benefit cost or as an administrative cost, depending on how the service is delivered. Federal and state funds are then used to match the county expenditure.

3. Medicaid-eligible residents of nursing facilities and adult care facilities receive Medicaid-authorized transportation from the facilities in which they reside (other than medically necessary ambulance services). Medicaid makes a per diem payment to the facility on behalf of each Medicaid-eligible resident in order to reimburse the nursing facilities for these transportation costs.

Optional Services

Federal law permits states to cover additional services at their option. The following are optional services that North Carolina Medicaid covers:

Intermediate Care Facilities for the Mentally Retarded (ICF-MR). Services in ICF-MRs are covered for those who are mentally retarded or who have a related condition. ICF-MR facilities must meet certification requirements relating to provision of habilitation services as well as basic intermediate care services. Intermediate care facilities for the mentally retarded are paid prospective per diem rates. For SFY 2002-03, $39,798,357 million was paid for ICF-MR for Medicaid-eligible persons age 60 and older.

Personal Care Services. Medicaid Personal Care Services (PCS) cover personal aide services in private residences to perform personal care tasks for patients who, due to a debilitating medical condition, need help with such basic personal activities as bathing, toileting, moving about, and keeping track of vital signs. It may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. PCS is provided for the patient according to a physician's authorized plan of care. As of December 2002, a patient in a private residence may receive no more than three and a half hours per day and a total of no more than 60 hours of PCS in a calendar month. The PCS provider is paid the lower of the provider's customary charges for the service or the Medicaid maximum allowable rate. During the 1995 legislative session, coverage of personal care services to persons living in adult care homes was authorized to begin in SFY 1996-97. Along with PCS coverage, a program of independent assessment and case management for heavy care residents of adult care homes was implemented in SFY 1996-97, with the county departments of social services and area mental health programs providing this service. For SFY 2002-03, $137,328,657 was paid for personal care service in private residences for Medicaid eligible persons age 60 and older. Another $77,556,578 was paid for personal care in adult care homes.

On November 1, 2003, Medicaid implemented the new Personal Care Services-Plus (PCS-Plus) program. The program is designed to enhance the current Personal Care Services (PCS) program by providing up to 20 additional hours of PCS each month to eligible recipients. After the monthly limit on PCS hours was reduced from 80 hours to 60 hours in December 2002, it became evident that there were many PCS clients that needed more than 60 hours of PCS a month in order to remain at home. To qualify for PCS-Plus, a Medicaid recipient must be eligible for PCS and meet one of the following three criteria: at a minimum, require extensive assistance in four or more activities of daily living (ADLs); at a minimum, require extensive assistance in three or more ADLs and need the in-home aide to perform at least one task at the Nurse Aide II

level; or at a minimum, require extensive assistance in three or more ADLs and have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks. All requests for PCS-Plus must be prior approved by DMA.

Prescription Drugs. Medicaid covers most prescription drugs as well as insulin for diabetic patients. Drug coverage is limited to six prescriptions per month unless it is shown that additional medication is needed for treatment of a life-threatening illness or disease. In addition, recipients may use only one pharmacist per month except in an emergency. A $1.00 per prescription co-payment applies, except for certain exempt groups. Payment for drugs is based on the average wholesale price less 10 percent plus either a $5.60 dispensing fee for generic drugs or a $4.00 dispensing fee for name brand drugs or the usual and customary charge to the public, whichever is less. For SFY 2002-03, $461,816,801 was paid for prescription drugs for Medicaid-eligible persons age 60 and older.

Dental Services. Most general dental services are covered, such as exams, cleanings, fillings, X-rays, and dentures. Prior approval is required for some dental services. A per visit co-payment of $3.00 applies for all recipients, except for the exempt groups. Payment is made on the basis of a statewide fee schedule. For SFY 2002-03, $9,788,862 was paid for dental services for Medicaid-eligible persons age 60 and older.

Eye Care Services. Medicaid covers medical eye examinations to determine refractive errors and covers corrective lenses, eyeglasses, and other visual aids. Prior approval is required for some optical services, all visual aids, and frequency of visit limitations apply. A $3.00 copayment applies to physician visits; a $2.00 copayment applies to optometrist visits; and a $2.00 copayment is charged for new eyeglasses and eyeglass repairs. Copayments do not apply to certain exempt groups.

Mental Health Services. Patients who have a plan of treatment developed by and on file with an area program center are offered outpatient mental health services, partial hospitalization, and emergency services through Mental Health, Developmental Disabilities, and Substance Abuse Services. Visits do not count against the annual 24-visit outpatient limit. Area Program centers are paid a negotiated rate, not to exceed costs, for services. Visits to independent psychiatrists and physicians are covered for mental health services, as well. Prior approval is required for outpatient visits after the first two are completed. Visits to a private practice psychiatrist count against the annual 24 visit outpatient limit and a $3.00 copayment applies, except to the exempt groups. Payment is made on a fee-schedule basis for outpatient visits. Inpatient state and private mental hospital services are covered for recipients over age 64 or under age 21. Payments to psychiatric hospitals are based on each hospital's actual allowable and reasonable costs.

Other Optional Services. A variety of other optional services are provided by North Carolina's Medicaid program. Limited services by chiropractors and podiatrists are covered and paid on the basis of a statewide fee schedule. Other optional services provided by Medicaid include hospice, private duty nursing, ambulance transportation, and case management services to meet the needs of specific groups of people eligible for Medicaid.

Special Community Alternatives Programs

The Division of Medical Assistance operates four programs to provide home and community care as a cost-effective alternative to institutionalization. These community alternatives programs are for Disabled Adults (CAP/DA), for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD), for children (CAP/C), and for persons with AIDS (CAP/AIDS). They are known as "waiver" programs because standard program requirements are waived to allow the program to operate. These waiver programs provide some services that otherwise are not covered under Medicaid.

Community Alternatives Program for Disabled Adults. The CAP/DA program provides services that allow adults (ages 18 and above) who require care in a nursing facility to remain in the community. By October 1996, all 100 of North Carolina's counties offered CAP/DA. Funding from the Kate B. Reynolds Charitable Trust through the Duke University Long Term Care Resources Program was instrumental in expanding CAP/DA statewide. For SFY 2002-03, $146,075,501 was paid for CAP-DA services for 8,406 Medicaid-eligible persons age 60 and older.

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities. The CAP-MR/DD program provides services to individuals of any age who normally would require care in an intermediate care facility for the mentally retarded. All 100 counties had access to the CAP-MR/DD program. For SFY 2002-03, $10,026,262 was paid for CAP-MR services for 210 Medicaid eligible persons age 60 and older.

Other Medicaid Benefits Associated with Older People

Since February 1989, North Carolina has operated a program of health care financing assistance to older and disabled Medicare beneficiaries, as mandated by federal law. Depending on a person's income and resources the coverage may include (1) full Medicaid plan benefits, (2) payment of Medicare premiums, coinsurance, and deductibles, (3) payment of Medicare Part B premiums only, or (4) payment of a portion of the Medicare Part B premium. For SFY 2002-03, $155,911,947 was paid for Medicare Part A and B premiums for Medicaid-eligible persons age 60 and older.

Managed Care and Medicaid

Managed care options for Medicaid recipients are now available in all 100 counties. Options include Carolina ACCESS, ACCESS II, ACCESS III and Risk Contracting with State-licensed health maintenance organizations (HMOs). All managed care options operate under the authority of 1915(b) of the Social Security Act. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid who are dually eligible for Medicaid and Medicare are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan.

Carolina ACCESS-North Carolina's Patient Access and Coordinated Care Program-continues to be the cornerstone of managed care development for North Carolina's Medicaid eligible population. Carolina ACCESS, a primary care case management model characterized by a primary care physician gatekeeper, is designed to provide a more efficient and effective health care delivery system for Medicaid recipients. It brings a system of coordinated care to the Medicaid program by linking each eligible recipient with a primary care provider (PCP) who has agreed to provide or arrange for his or her health care services. By improving access to primary care and encouraging a stable doctor-patient relationship, the program helps to promote continuity of care, while reducing inappropriate utilization and controlling costs. ACCESS II and III are programs that build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of health care. ACCESS II and ACCESS III, originally created as a health care demonstration project by the N.C. Office of Research, Demonstrations, and Rural Health Development, are currently a joint collaborative effort between DMA and this office. Lastly, DMA contracts with HMOs in selected areas to provide and coordinate medical services for certain Medicaid eligibles on a full risk-capitated basis. In these areas, recipients may choose between a participating HMO and Carolina ACCESS. The State must license all HMOs that contract with DMA.

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

(http://www.dhhs.state.nc.us/mhddsas/)

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services offers help and support to North Carolinians and their families suffering from mental illness, struggling with a drug or alcohol addiction, or coping with a developmental disability. The division operates four regional psychiatric hospitals for those who need inpatient psychiatric services, and oversees a network of mental health programs in communities across the state. It operates a special care center for older people with serious medical and mental problems. The division provides residential services at five regional mental retardation centers, which provide a wide range of services to people with severe and profound mental retardation and other related disabilities. The Black Mountain Center in the Western Region operates a unit for Alzheimer's patients who have entered the combative stage of the disease, and it is being reorganized as a skilled nursing facility

for people with cognitive disabilities who are aging. The Division also oversees residential and outpatient treatment at three alcohol and drug abuse treatment centers.

The Division has provided funding for the development of 20 Geriatric Specialty Teams. Each team consists of at least a registered nurse and master level social worker both with expertise working with older individuals with mental illness. The teams will perform activities to increase the capacity for communities to serve these individuals as they are discharged from the State Psychiatric Hospitals. The teams will provide technical support and training to the staff working at nursing homes and adult care homes that will serve the older individuals discharged from the psychiatric hospital.

Through a contract with the Arc/NC, the Division supports the *LIFEGuardianship* program that assists individuals with cognitive disabilities to secure guardians. This program serves a number of older citizens.

Division of Public Health

(http://www.dhhs.state.nc.us/dph/)

Older Adult Health Branch

The mission of the Older Adult Health Branch is to protect, promote and preserve the health of North Carolinians through ethical, compassionate and evidence-based public health practice. The goals are to: 1) ensure that communities are healthy places in which to live, 2) extend the span of healthy life, 3) assure access to quality health care services, and 4) eliminate health disparities in given demographics. The OAHB serves as a program resource on health promotion for older adults and "baby boomers"; provides technical assistance and training including conferences and workshops on health promotion and aging; identifies, obtains, develops and disseminates relevant information; and serves as liaison with other state agencies and organizations.

The Older Adult Health Branch's goal is to "improve the health and quality of life of older North Carolinians." Two major programs are osteoporosis and arthritis. The Osteoporosis Program is dedicated to increasing public awareness in North Carolina on the prevention, diagnosis, and treatment of the disease, in addition to providing support to those already affected by osteoporosis and their families. The program also strives to carry out the recommendations of the North Carolina Osteoporosis Task Force. Bone Health/Body Health (also known as "train the trainer") was developed by the Osteoporosis Program to provide prevention, diagnosis, and treatment information to health professionals and community leaders. In addition, there are active Osteoporosis Support Groups within North Carolina with future plans for creating more groups. A compilation titled, "Our Personal Stories" was written by Osteoporosis Support Group members.

North Carolina's Arthritis Program began in October 1999 in a cooperative agreement with the CDC. The most noteworthy accomplishment has been the development of the *North Carolina Arthritis Action Plan.* The program initiated a coordinated statewide arthritis program that will improve the capacity of all 100 counties, their health departments and community agencies to reduce the burden of arthritis and other rheumatic conditions in our state. An initiative was implemented to train new Arthritis Foundation self-management program leaders. In addition, the program has continued to increase public awareness in North Carolina by providing more educational programs, exhibits, and arthritis communications. The arthritis program has increased services during the past year. For example, two "People with Arthritis Can Exercise" (PACE) training workshops were held and 29 PACE classes were conducted with 387 participants.

The Healthy Aging Program, which was funded in part by a grant to the NC Department of Public Health and Healthy Aging from the Chronic Disease Director's Association, continues to carry out its objectives with very limited resources. This program includes the collaborative efforts of NC Division on Aging, Institute on Aging, School of Medicine (UNC-CH) and Program on Aging (UNC-CH). Project objectives are to 1) foster and expand the collaboration between the state health and state aging agencies to promote effective disease prevention programs, 2) encourage existing and develop new partnerships with state and local public and private organizations to collaborate on healthy aging initiatives, 3) initiate a healthy aging campaign in the state to increase public awareness of the importance of healthy aging, and 4) provide information and resources to

health and aging service providers to promote healthy aging.

The Division of Public Health works to build healthy communities, promote healthful living, and reduce the risk and consequences of disease. Its primary role is to strengthen local health departments and to improve the health of the people. The division monitors public health achievements and performance and provides incentives and assistance to assure that no community falls below minimum standards. Further, the division is responsible for studying, coordinating, and enhancing health efforts involving or serving multiple communities and/or the state as a whole. Through education and public awareness programs, the division promotes public health, advocates physical fitness, improves the health of minorities, and advances good dental health. Through advocacy, education, and early detection, the division fights chronic diseases such as cancer and diabetes. The division itself is a provider of statewide health services not otherwise available. For migrants and refugees, it provides access to essential preventive and primary health care while they reside in North Carolina.

Division of Services for the Blind
(http://www.dhhs.state.nc.us/dsb/)

The Division of Services for the Blind (DSB) promotes the prevention of blindness through education and vision screenings. Funding for some eye-related treatment is available to assist people with a very low income and no other financial means for obtaining the required treatment. Additionally, the agency provides the specialized services that assist people who are blind and visually impaired to live independently in their homes and communities and obtain or retain employment if desired. Examples of specialized services include Braille instruction, safe travel skills training, and use of adaptive technology such as speech or large print output for computers. Many low tech and high tech devices are available to assist blind and visually impaired people in the home, school, and work environments. Services are available in all counties to people of all ages. However, the Agency has a special Independent Living Rehabilitation Program designed to meet the needs of people 55 and older who lose vision.

The DSB Independent Living Older Blind Program offers an array of services that include: counseling and guidance, information and referral, individual and systems advocacy, instruction in adaptive skills for daily living including personal and home management, safe travel, and adaptive aids and technology.

The Independent Living Rehabilitation Program utilizes the expertise of Independent Living Rehabilitation Counselors, Orientation & Mobility Specialists, Contractual Teachers, and Nurse Eye Care Consultants to provide a variety of services that empower individuals to reach their independent living rehabilitation goals. These services can be provided on an itinerant basis within a consumer's home or in small group settings in their communities called "Mini Centers."

The division also administers Special Assistance payments for blind and visually impaired residents of adult care homes. For SFY 2002-03, these SA payments totaled $29,579 for 58 persons age 60 and older.

Division of Services for the Deaf and the Hard of Hearing

The Division of Services for the Deaf and the Hard of Hearing provides information and assistance to the approximately 705,000 North Carolina residents, 280,000 of whom are 65 years of age or older, who are deaf, hard of hearing, or deaf-blind. The Division provides a broad range of services for people of all ages who have hearing loss, their families, communities and the professionals who serve them. These services include, but are not limited to, advocacy, information and referral, access to and education about technology, Telecommunications Equipment Distribution, Telecommunication Relay Service and community education and outreach.

Division of Social Services
(http://www.dhhs.state.nc.us/dss/)

The Division of Social Services, working with County Departments of Social Services, strives to ensure that every family and individual has sufficient economic resources to obtain the basic necessities of life. Consistent with this objective, the division administers two programs vital to the economic security of low-income seniors. The Food Stamp Program is a federal program

that provides a monthly allotment of Food Stamp benefits issued via Electronic Benefit Transfer cards (ATM cards). The Food Stamp Program is an entitlement program, so all eligible individuals and households can receive assistance. In SFY 2002-03, 69,810 persons age 60 and older received Food Stamps, totaling $43,304,460 in benefits.

The Low-Income Energy Assistance Program (LIEAP) provides for a one-time cash payment to help eligible families pay their heating bills. This payment is usually received in February of each year. In SFY 2002-03, 44,997 persons age 60 and older received Energy Assistance, with payments totaling $2,919,238.

Division of Vocational Rehabilitation

(http://dvr.dhhs.state.nc.us/)

The NC Division of Vocational Rehabilitation Services has responsibility for two major service efforts—Vocational Rehabilitation (VR) and Independent Living (IL), which is now int the Community Services Section—with the goals of promoting employment and independence for persons with disabilities through customer partnerships and community leadership.

In SFY 2002-03, the Division's Vocational Rehabilitation Program assisted 1,341 individuals with disabilities, who were age 60 and older, with services totaling $1,162,430, and its Independent Living Services Program assisted 2,929 such individuals with services totaling $3,009,271.

For persons with physical or mental disabilities, VR focuses on training and work-related services to help overcome obstacles that prevent them from getting or keeping a job. VR services are provided by an outreach effort through 32 VR unit offices statewide, 2 VR facilities and numerous satellite locations to bring services to the people of North Carolina.

Independent Living Services are focused on offering a viable alternative to institutionalization—independent living in the home and community, and, when possible, continuing independence through transition to the VR Services Unit Offices. The outreach of IL is through 16 IL Unit Offices statewide—in strategic collocations to VR service offices. Both service efforts often utilize community partners and resource coordination in jointly developed service plans to assist consumers in achieving their goals—whether primarily work goals through VR, or independent living goals through IL, where a work goal is not required.

Included among services are job training and seeking skills, job placement, supported employment, and job and work-site modifications through VR. Both VR and IL can facilitate such services as vehicle and home modifications, adaptive aides, and rehabilitation engineering for the respective goals of consumers.

One of the most needed and included services in IL plans developed with consumers is housing that is accessible and affordable. Making the transition to or within the community to independence often involves such services as: assistance with securing such housing, including modifications to existing housing if needed; searching for house/apartment rental units; consumer assistance with applications for Section 8 vouchers; utility deposits; purchase of basic consumer needed furniture; and assistive technology such as environmental control systems and communication devices. For participation in community activities, the resource of accessible transportation, and IL therapeutic leisure planning may be important to many consumers. If needed, ongoing IL reimbursed consumer managed personal assistance may be pursued to maintain independence, although increased freedom through other services may diminish assistance needs.

The State Division networks with State and local level partners, and provides overall direction and program practice and oversight, resource support and consultation for offices and clients assisted.

Office of Citizen Services

(http://www.dhhs.state.nc.us/ocs/)

The Office of Citizen Services guides citizens through the human services delivery system. The mission is accomplished through two programs, the Ombudsman Program and the CARE-LINE/Information and Referral Service. The CARE-LINE information and referral specialists provide information and referral on human services in government and nonprofit agencies.Information is taken from a database of over 11,000 agencies. Through the Ombudsman Program, inquiries and complaints regarding the

Department of Health and Human Services are handled. The ombudsman serves as the liaison between citizens and the department. Both programs may also be accessed by calling (919) 733-4261, or toll-free 1-800-662-7030 (voice/Spanish.) The office is equipped with a dedicated TTY phone number, (919) 733-4851, or toll-free 1-877-452-2514. On average, the office handles over 80,000 inquiries a year. The office takes pride in serving as a "one-stop shopping service" for the human services needs of all citizens.

Office of Economic Opportunity

(http://www.dhhs.state.nc.us/oeo/)

The Office of Economic Opportunity (OEO) channels funds primarily to community-based, private nonprofit agencies for activities under the Community Services Block Grant Program, the Emergency Shelter Grants Program and the Weatherization Assistance Program. The federally funded Community Services Block Grant Program enables local communities to address the causes and conditions of poverty. They help people become self-sufficient, gain employment, and find long-term housing. The Emergency Shelter Grants Program helps communities serve homeless individuals and families. Reduction in residential energy consumption and costs is the focus of the Weatherization Assistance Program. The state's 36 Community Action Agencies and the other private, nonprofit agencies that receive grants through OEO, generate, on average, $10 for every $1 provided by the Office of Economic Opportunity.

Office of Long Term Care and Olmstead

Within the Office of the DHHS Secretary is the Office of Long Term Care and Olmstead, headed by the Assistant Secretary for Long Term Care and Family Services. The Secretary established the Office of Long Term Care and Olmstead, as recommended in the 2001 report of the Institute of Medicine Task Force on Long Term Care, to assure that the department's efforts to reform long term care (LTC) are well coordinated. Through reorganization of existing positions and the procurement of federal grants, the Office has developed a core group of professionals to lead inter-divisional activities in such areas as housing, human services transportation, consumer-directed care, and direct care workforce development.

With eight divisions sharing responsibilities for various aspects of the regulation, development, and funding of long term care services for older and younger disabled adults, the Secretary also established a Long-Term Care Cabinet, composed of the directors of these divisions and chaired by the Assistant Secretary for Long Term Care and Family Services. The Cabinet provides a vehicle for inter-divisional LTC planning, leadership, policy and data analysis, research and evaluation, development and coordination of services training, and public communication. In addition, the Office and Cabinet coordinate North Carolina's efforts towards Olmstead planning. In the 1999 case of Olmstead v. LC, the U.S. Supreme Court decided that states must have adequate home and community-based services for patients with mental illnesses and disabilities so that, when considered appropriate by a physician and desired by the patient, the patient can be treated outside of an institution. Many of the issues in the Olmstead decision are closely related to LTC reform.
In spite of the state budget crisis, the Office of Long Term Care and Olmstead has moved forward to implement many of the IOM's recommendations. Key to this progress was the Office's ability to secure a federal Real Choice grant from the Centers for Medicare and Medicaid Services (CMS). With a total of $1.6 million for three years, the Office is using the funds to address direct care workforce issues affecting home and community-based long-term care. Under the grant, CMS authorized the Office to: (1) review state and federal policies governing home and community-based services to identify policies that contribute to an institutional care bias; (2) develop a career ladder to support initial and professional development opportunities for direct care staff in home and community settings; (3) use public education and awareness efforts to promote recruitment and retention of direct care workers; (4) collect and analyze data relevant to workforce issues; and (5) develop a quality improvement system for direct care workers. In addition, the Real Choice grant is helping the Office and Cabinet examine options for consumer-directed care.

The Office and Cabinet have also addressed recommendations in the Institute of Medicine's Long Term Care Plan through the use of inter-

divisional work teams. These teams are addressing the broad issues of service availability and need, financing, entry into the LTC system, workforce, and quality, as well as undertaking specific projects. For example, groups have worked to simplify the financial eligibility process for the Adult Medicaid and Special Assistance for Adults programs and determine the feasibility of sliding scale fees for services. Another team developed a web site to provide individuals, families, providers and other visitors with access to information about the department's work in support of long term care (http://www.dhhs.state.nc.us/ltc/). This site includes progress reports on the work of the Office and Cabinet.

Office of Research, Demonstrations, and Rural Health Development

The Office of Research, Demonstrations, and Rural Health Development administers the Senior Care prescription drug assistance program for persons over the age of 65 who have incomes less than 200% of the federal poverty level. This program, which began in the fall of 2002, pays for 60% of the first $1000 (up to $600 per year) of prescription costs for the treatment of heart disease, diabetes, and chronic lung disease.

As part of Senior Care, the Office also coordinates a medication management program in 24 centers around the state. Each center provides free medication evaluations done by pharmacists for Senior Care eligibles in each of their respective locales. In addition, the centers assist seniors in applying for prescription assistance programs sponsored by drug manufacturers.

Additionally, the Office of Research, Demonstrations, and Rural Health Development provides technical assistance to small hospitals and community health centers in rural and medically underserved communities. The Office recruits health care providers to work in these rural and medically underserved communities and provides grants for community health centers.

The Department of Administration

(http://www.doa.state.nc.us/)

Commission of Indian Affairs

The Commission of Indian Affairs administers the Community Services Program that provides in-home aide services and/or volunteer transportation for older and disabled people in Bladen, Columbus, Halifax, Warren, Cumberland, Sampson, and Harnett counties. The program also provides oversight to a meal program for older and physically challenged Indian senior citizens residing in Sampson County. In FY 1999-2000, the Commission served 6,400 meals and administered over $33,000 in heating and cooling assistance. For the last ten years, the Community Services Program director has coordinated an annual North Carolina Indian Senior Citizens Conference, sponsored by the North Carolina Indian Senior Citizens Coalition.

Council for Women

The North Carolina Council for Women is the official state advocacy agency for women. Its mission is to advise the Governor, the legislature, and the principal state departments on the special needs of women in North Carolina. It also develops and administers programs of special relevance to women. Two such programs of particular value to older women are the Displaced Homemakers Program, which helps women returning to the work force after many years of unpaid employment, and the Domestic Violence Program.

Division of Veterans Affairs

The Division of Veterans Affairs assists veterans and their families in the presentation, processing, proof, and establishment of claims, privileges, rights and benefits as they may be entitled to under federal, state, or local laws. The division also cooperates with the various governmental units and veterans' organizations in seeking to serve veterans. Its work is meant to supplement and augment the efforts of others. As an example of this, the division constructed the state's first nursing facility for veterans with support from the NC General Assembly and the US Department of Veterans Affairs. This 150-bed state veterans home, located in Fayetteville near the VA Medical Center, started admitting residents in 1999.

The Department of Commerce
(http://www.nccommerce.com/)

Employment Security Commission

The Employment Security Commission helps more than 4,500 older workers find jobs each year. Each local office has an older worker specialist who acts as a resource for persons age 55 and older.

The Department of Community Colleges
(http://www.ncccs.cc.nc.us/)

Human Services Technologies Programs

The NC Community College System offers through its Human Services Technologies programs specialized training courses relevant to professional and paraprofessional personnel working with older and disabled adults. The Human Services Technology curriculum prepares students for entry-level positions in institutions and agencies that provide social, community, and educational services. Along with core courses, students take courses to prepare them for such specializations as work with adults with physical, mental, and emotional disabilities; direct service delivery work with older adults and their families; work in the mental health field; direct service delivery work in social services agencies; and work in substance abuse counseling.

North Carolina Literacy Resource Center

The North Carolina Literacy Resource Center (NCLRC) fosters networking among organizations concerned with basic skills and education for adults, assists North Carolina's literacy community in providing quality services to adults in the state, and serves as a link between the National Institute for Literacy and North Carolina's literacy community. Two of the center's initiatives include participation in Equipped for the Future, the National Institute for Literacy's system reform initiative, and the encouragement of local basic skills/literacy programs to access the Internet, establish WWW home pages, and use Internet-based resources in designing lessons. Literacy and basic skills development are both areas of concern for a number of seniors.

The Department of Correction
(http://www.doc.state.nc.us/)

About 43 percent of the state's prison population as of February 2002 were persons of boomer age or older. One result of the aging of the prison population is the increasing demand for health care. An example of the Department of Correction's response is the 54-bed health ward for male inmates with special needs at the Randolph Correctional Center. The Randolph Correctional Center has a unique population. The prison has some inmates who are in wheelchairs, some who have cancer, and others who have multiple heart problems. The prison psychologists started an anger-stress management program for geriatric inmates 65 years and older, many of whom are veterans who were heavy alcohol or substance abusers. A large number of the older inmates are in prison on their first offense. Many have no family, or their children may be aging and unable to visit because of medical problems of their own. Especially because of the needs of its prison population, this center values community volunteers.

The Department of Insurance
(http://www.ncdoi.com/)

Seniors' Health Insurance Information Program
(http://www.ncshiip.com)

The Seniors' Health Insurance Information Program, known as SHIIP, was established in 1986 by North Carolina Insurance Commissioner Jim Long in response to an increased number of calls, letters, and complaints from older North Carolinians confused by their health insurance options. SHIIP's primary objective is to educate the public on seniors' health insurance, concentrating on Medicare, Medicare supplements, and long-term care insurance. SHIIP achieves this by training volunteer counselors in all 100 counties, by operating a toll-free hotline from the state SHIIP office (1-800-443-9354), and by developing educational materials for use by consumers.

Since its creation, SHIIP has trained about 8,000 volunteers who undergo an extensive 24-hour training course to serve as SHIIP counselors. From January 1999 to September 2002, SHIIP staff trained 649 volunteers in the basic curriculum and certified 163 volunteers as long-term care insurance specialists. Currently there are almost 900 active SHIIP volunteer counselors and 119 volunteer county coordinators covering all 100 counties in the state. Between January 1999 to September 2002, the SHIIP toll-free counseling service answered 109,221 calls, averaging 3,100 per month. In addition, SHIIP counselors spent 14,996 hours in 16,590 counseling sessions. To promote SHIIP's services to the public, 298,606 direct mailers were sent to individuals turning 65 years of age.

SHIIP creates a number of consumer publications on a yearly basis, including the Medicare Supplement Comparison Guide and the Guide to Long-Term Care Insurance in North Carolina. It serves as a clearinghouse for many publications of the Centers for Medicare & Medicaid Services. It has served as the state's primary resource for educating Medicare beneficiaries about Medicare+Choice and the other recent Medicare changes. In 2001, SHIIP added to its web site an interactive Medicare Supplement insurance premium database that provides consumers with up-to-date information about Medicare supplement policy choices, premium costs, rate history, and coverage. Also in 2001, SHIIP began development of a statewide partnership with the public library system that resulted in placing the *SHIIP Resource Guide* in a library in each county seat. In 2002, SHIIP produced with the Division of Aging and AARP, a brochure on long-term care, *It's about You, Your Children, and Your Parents: Planning Today for Tomorrow.*

SHIIP is coordinated in each county through an existing human service agency such as a Council on Aging office, a Senior Center, or a Cooperative Extension office. These agencies serve as sponsors that provide important continuity, an available point of access, and model interagency cooperation.

Continuing Care Facilities

Continuing care facilities, also known as CCRCs, provide a living alternative for retirement-aged people. The Continuing Care Facilities Section provides the financial oversight and licensing of continuing care facilities as well as additional safeguards for facility residents and prospective residents. This authority applies only to facilities that furnish lodging or independent living together with health-related services under a contract for the life of the individual or for a period in excess of one year. Current laws provide for facility disclosure of all material facts and financial data; departmental authority to intervene in the event of insolvency or the imminent danger of financial impairment; departmental authority to audit the books and records of facilities; and the establishment of a nine-member advisory committee to advise the Insurance Commissioner.

The Department of Transportation

(http://www.ncdot.org/)
The Department of Transportation administers the Elderly and Disabled Transportation Assistance Program (EDTAP), which amounted to $5.5 million in 2002. It covers all 100 counties.

Public Transportation Division Public transportation in North Carolina operates in many settings, from bus routes in large metropolitan areas to 14-passenger vans in small towns and rural communities. The NCDOT Public Transportation Division administers federal and state funds to support local planning for coordinated transportation systems. In FY 2002-2003, there are 84 coordinated transportation systems (including six regional systems) that serve the general public and/or human service agencies. One transportation program that provide important assistance to older adults without access to a vehicle is the Elderly and Disabled Transportation Assistance Program (EDTAP). In FY 2001, 1,256,387 one-way rides were provided in 99 counties to older adults and younger adults with disabilities through the state EDTAP fund ($5.5 million authorized.)

Unlike urban areas with population density more suitable for mass transit, the state's rural communities face the challenge of transporting fewer people over large geographic areas. Through NCDOT's Rural General Public Program, transportation services in rural areas include demand-response, dial-a-ride programs or deviated fixed route services with designated

stops. Beneficiaries of these services include many older adults living in outlying areas who are transported to stores and other destinations in town. In FY 2001, rural general public services provided 315,031 one-way rides to citizens in rural communities.

Division of Motor Vehicles
In North Carolina, people must demonstrate that they can drive safely in order to get a driver's license or have on renewed. The NCDOT Division of Motor Vehicles has the authority to require written tests, oral tests, road tests, vision tests, or medical examinations to assess a driver's ability and may impose restrictions on a license. A driver may be asked to have their personal physician provide information on their medical condition for review by state medical professionals. DMV's Driver Medical Evaluation Program provides for written appeals of licensure restrictions or denials. According to a study conducted in 2000 by the NC Highway Safety Research Center, only 2.1 percent of licensed drivers age 65 and older in North Carolina had a license restriction other than corrective lenses.

The Office of the Governor

Office of Citizen Affairs: NC Commission on National and Community Service

North Carolina Americorps/Vista (Volunteers in Service to America)
(http://www.volunteernc.org)

This is a full-time, yearlong volunteer program for men and women 17 years of age and older from all backgrounds who commit themselves to increasing the capacity of people with low income to improve the conditions of their own lives. Volunteers are assigned to local sponsors who may be state or local public agencies or private nonprofit organizations. Volunteers may serve in their home, community, or in other parts of the country. Americorps/Vista pays travel expenses and provides some relocation assistance for volunteers who serve outside of their local community.

North Carolina Housing Finance Agency
(http://www.nchfa.com/)

The North Carolina Housing Finance Agency operates a variety of programs to finance home ownership for first-time homebuyers with low or moderate incomes, provide affordable rental housing for low- and moderate-income renters, and rehabilitate substandard owner-occupied and rental housing. Funding for agency programs and operations comes from program fees, earnings from tax-exempt bond sales, federal funds, and the North Carolina Housing Trust Fund.

Corporation for National and Community Service (NC State Program Office)

Retired and Senior Volunteer Program (RSVP)
Every community in North Carolina faces the continuing challenge of providing necessary services with limited resources. Every community also has a growing number of retirees who want to remain active and useful. RSVP, as part of the Corporation for National and Community Service, helps people age 55 years of age and older find service opportunities in their home communities.

RSVP has 17 projects serving 29 counties in North Carolina and could expand to many more if funding were available. The cost of operations is minimal in proportion to the number of persons giving their time and administering care. RSVP has minimal paid staff and provides the following benefits to its volunteers: insurance, meal reimbursement, mileage reimbursement, and recognition. There is no per diem or wage paid to participant volunteers.

Senior Companion Program
The Senior Companion Program is a service initiative through which people age 60 and older provide assistance and friendship to older individuals who are homebound and, generally live alone. Senior Companions receive a modest hourly stipend for their service. They usually serve two to four clients through 20 hours of weekly service. There are six projects in North Carolina.

Foster Grandparent Program
The Foster Grandparent Program (FGP) offers seniors age 60 and older opportunities to serve as mentors, tutors, and caregivers for children and youth with special needs. They provide 20 hours

of weekly service to community organizations such as schools, hospitals, and youth centers.

North Carolina Senior Games

(http://www.ncseniorgames.org/)

North Carolina Senior Games is a statewide, year-round health promotion and education program for individuals age 55 and older. This wellness and prevention program focuses on keeping seniors healthy and independent and involved in personal fitness. There are 52 regional Senior Games that serve the entire state. In 2001, 45,419 older adults participated in local Senior Games events. State Final's competition is held annually. In addition to the games, the organization offers SilverArts-a literary, heritage, visual, and performing arts program; Silver liners-a senior line-dancing association; SilverStriders-a national award-winning walking program; statewide workshops; leadership training for professionals; educational material such as exercise posters; and health information. North Carolina Senior Games is supported by the State, two corporate sponsors, and many coordinating and endorsing agencies such as the Division of Aging, Health Services, Parks and Recreation, AARP, and the medical profession.

Attorney General's Office

(http://www.jus.state.nc.us/)

Consumer Protection Section

The Consumer Protection Section protects the public from fraud, deception, price fixing, price gouging, restraint of trade, and other unfair and deceptive trade practices. This section also represents the using and consuming public in matters before the North Carolina Utilities Commission.

Citizens' Rights Section

The Citizens' Rights Section provides services to state and local agencies on particular legal issues facing the citizens of North Carolina, including victims' rights, child abuse, elder abuse, hate crimes, domestic violence and family matters, open meetings and public records law, as well as certain environmental concerns.

Representatives from the Attorney General's Office, along with representatives from the Division of Aging and AARP, are co-chairing the North Carolina Senior Consumer Fraud Task Force.

North Carolina Higher Education Resources Related to Aging

North Carolina's colleges and universities have distinguished themselves in the field of aging through their research, interdisciplinary professional and postgraduate programs, undergraduate degree programs, community-oriented service and technical assistance activities, and their clinical programs in medicine, dentistry, pharmacy, and nursing. Institutions of higher education in our state are also offering continuing educationprograms for older people and for those who work with persons in this age group. Some of these institutions have opened their doors to provide special programs offering access to resources and lifelong learning opportunities for older adults in our state.

North Carolina Cooperative Extension Service

(http://www.ces.ncsu)

The North Carolina Cooperative Extension Service is an educational organization supported by federal, state, and county funds. It serves 100 North Carolina counties and the Cherokee Reservation. Extension agents, serving as field faculty of land grant universities, deliver research-based informal educational programs addressing the priority concerns selected by each county's advisory system. Extension Specialists at North Carolina State University and North Carolina A & T University develop educational materials as well as train and support the county agents. At present the Extension Service offers a wide range of educational programs and resources on aging issues. One statewide program called *Aging with Gusto!* is designed to give adults research-based information to help them plan for and get the most out of their later years. Specific programs are available on such topics as caregiving, developing positive attitudes, home modification, retirement planning, estate planning, and nutrition and wellness in later life.

Area Health Education Centers Program (AHEC)
(http://www.med.unc.edu/ahec/)

The AHEC program seeks to improve the supply, distribution, and quality of health care professionals in North Carolina through its ten regional centers. AHEC works with the state's four university medical centers to sponsor a wide range of educational activities related to health manpower development, including community training for health science students, medical residency training programs in primary care, continuing education, and information services. AHEC was created in 1972 by the School of Medicine at UNC-CH and funded with a federal grant. In 1974, the General Assembly expanded the AHEC program and took over its funding. Today the program is funded about equally from state and local sources and is administered by the Dean of the UNC-CH School of Medicine. Program activities fall into three broad categories: community-based and medical residents; health professions continuing education; and information services for health care agencies and professionals.

AHEC activities are focused on the supply, distribution, and education of health care professionals. The nine regional centers work within their regions to assess the education and training needs of the health professionals and agencies serving older adults, including long-term care facilities. They then develop educational programming to meet those needs.

UNC Institute on Aging
(http://www.aging.unc.edu/)

The UNC Institute on Aging (IOA) was created by the NC General Assembly in August 1996. The IOA works to enhance the well-being of older North Carolinians through statewide collaboration in research, education, and public service. In addition, the IOA works through its statewide linkages to promote collaborative, applied and basic gerontological research, develop innovative programs of interdisciplinary education and practice, and provide state-of-the-art information to policy makers, program managers, service providers, clinicians, and the general public.

Examples of IOA activities include providing pre- and post-doctoral training on aging issues, conducting research projects on pertinent aging issues (such as workforce development and older workers' retirement), coordinating the annual North Carolina Conference on Aging, hosting a Distinguished Lecture series on aging, administering a central source of aging information, and sponsoring the UNC Senior Leadership Initiative.

Guardianship Reform in the Twenty-First Century

John L. Saxon
Institute of Government
The University of North Carolina at Chapel Hill
February, 2004

1

Guardianship Reform: Where Have We Been?

2

Legal History

- **1837**
  - **Idiots & lunatics**
- **1868**
  - **Clerk of superior court**
- **1879**
  - **Inebriates & asylum inmates**

3

Legal History

- **1933**
  - **Sterilization of mentally retarded**
- **1973**
  - **Adult protective services**

4

Legal History

- **1977**
  - **G.S. Ch. 35, Art. 1A**
    - **Rud Turnbull, Institute of Government**
  - **First *substantive* reform**
    - **Due process**
    - **Modernized definitions & standards**
    - **Introduced limited guardianship**
    - **Human services agencies**
  - ***Partial & incomplete* reform**

5

Legal History

- **1982**
  - **DHR Task Force**
- **1984**
  - **AOC & DSS Study Committee**
- **1987**
  - **G.S. Ch. 35A enacted**
    - **Consolidated & clarified existing laws**
    - **Extended 1977 guardianship reform**
    - **Few substantive changes**

6

Legal History

- 1990-94
  - AOC & DHR Task Force
  - LRC Study Committee
  - H 451
- 2001
  - Proposed legislative study

7

Guardianship Reform: Where Are We Now?

8

Current Law

- G.S. Ch. 35A
  - Minors
    - "Standby" guardians
  - Incompetent adults
    - Legal standard & due process
    - Priorities & qualifications; public agencies
    - Powers & duties; limited guardianship
    - Bond & accounting; estate management

9

Current Issues

- Statutory authority
  - Legal hodge podge
    - Piece-meal revision
    - Some statutes date back to 1800s
- Jurisdiction
  - Interstate
- Incapacity
  - Definition & standard

10

Current Issues

- Due process
  - Role of GAL/attorney
- Guardianship alternatives
  - Least restrictive alternative
- Limited guardianship
  - Partial incapacity
  - Rights retained by ward

11

Current Issues

- Guardian's powers
  - Person vs. property
  - Standard for decisionmaking
  - End of life
- Human services agencies
  - Conflict of interest
  - Funding

12

Guardianship Reform: Where Should We Go?

13

UGPPA

- Uniform Guardianship & Protective Proceedings Act (UGPPA)
  - 1982: NCCUSL
  - 1997 revised
    - Prof. Rhoda Billings (Wake Forest Law)
    - ABA Task Force on Guardianship Reform
    - Enacted by four states (AL, CO, MN, MT)

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UGPPA

- Scope
  - Minors & incapacitated adults
  - Guardians & conservators
- Intent
  - Guardianship is last resort
    - Least restrictive alternative
  - Limited guardianship preferred
    - Tailored to ward's incapacity
  - Input from ward when possible

15

UGPPA

- Incapacitated person
  - Functional definition
    - Unable to receive & evaluate info or make or communicate decisions to extent that lacks ability, even with appropriate assistance, to provide for personal health, safety, or care
    - Unable to manage property & business affairs due to impaired ability to receive & evaluate info or make decisions

16

UGPPA

- Jurisdiction
  - Domicile
    - Interstate
- Authority to appoint
  - Court
  - Spouse or parent
    - Unless objection

17

UGPPA

- Due process
  - Court-appointed visitor
    - Appointment of counsel
  - Professional evaluation
  - Respondent must be present
    - Unless excused by court
  - Clear & convincing evidence
    - No jury

18

UGPPA

- Court-appointed guardian
  - Priorities
    - Existing guardian, nominee, agent, spouse, child, etc.
    - Public or nonprofit agency *if no one else is available and agency is not providing other services to ward*
- Emergency guardian
  - Temporary substitute guardian

19

UGPPA

- Guardian's powers
  - Expend income for ward's care
  - Bring action for ward's support
  - Consent to medical treatment
  - Consent to marriage or divorce
  - Delegate authority (limited time)
  - May not revoke health care directive
  - May not commit to mental institution

20

UGPPA

- Conservator's powers
  - Make or revoke will or gifts
    - With court approval
  - Invest
  - Sell, lease, or exchange property
    - Without court approval

21

UGPPA

- Decisionmaking
  - Ward's expressed wishes
  - Substituted judgment when known
    - What would ward have done?
  - Best interest
  - Prudent investor
- Monitoring
  - Guardians & conservators

22

UGPPA

- Advantages
  - Modern
  - Comprehensive
  - Legally adequate
  - Balanced
  - Proven
  - Can be customized
- Disadvantages
  - Lack of interest
  - No champion
  - Preference for what is known & familiar
  - Preference for incremental reform vs. overhaul
  - Need to pull all players together

23

Guardianship Reform in the Twenty-First Century

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February, 200r

24

Overview of Aging Services & State Aging Plan

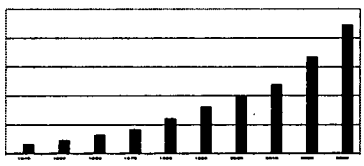
N.C.G.S. 143B-181.1A

prepared by
Division of Aging, N.C. Department of Health and Human Services
for the
Study Commission on Aging

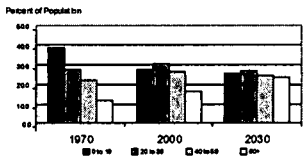
The Aging of North Carolina—General Organization of Plan

- Aging NC
- Healthy Aging
- Long-Term Care and Aging
- Economic Security
- Senior-Friendly Communities
- Priorities of Senior Advocates
- State Agencies—Major Activities and Future Directions

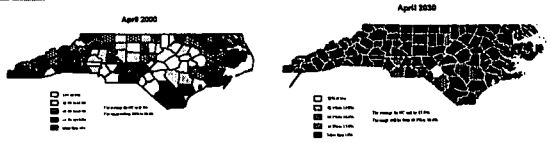
Actual and Projected Population Age 65 and Older, North Carolina, 1940 to 2030



The Aging of North Carolina's Population, 1970 to 2030



Percent of Population Age 65+ in NC



State Plan Themes

- *Draw upon the talents and resources of active seniors*
- *Enhance services for vulnerable seniors*
- *Value diversity while addressing disparity*
- *Be responsible stewards of resources*
- *Help baby boomers prepare for their future.*

Healthy Aging

Healthy aging is the development and maintenance of optimal *physical, mental, and social well-being and function* in older adults. *Individuals, government, and communities* share responsibilities in promoting and maintaining *attitudes and behaviors* known to advance and preserve health and well-being among older adults by providing or using health and other appropriate services effectively to *prevent or minimize the impact of acute and chronic disease on function.*

Economic Security

Economic security is the capacity to sustain a relatively stable economic status given a normal decline of functioning and health over old age. This view was well expressed by a senior advocate: "In my opinion, we seniors are economically secure when we are free from fear or doubt about our ability to pay for necessities such as health and long-term care expenses, housing, and leisure and enrichment activities."

State Resources for Older Adults

DHHS

Divisions
- Aging
- Facility Services
- MH/DD/SAS
- Medical Assistance
- Public Health
- Services for the Blind
- Services for the Deaf & Hard of Hearing
- Social Services
- Vocational Rehabilitation

Offices
- Citizen Services
- Economic Opportunity
- Long-Term Care & Olmstead
- Research, Demonstrations, & Rural Health

Other
- Department of Administration
- Department of Commerce
- Department of Community Colleges
- Department of Correction
- Department of Insurance [SHIIP]
- Department of Transportation [EDTAP]
- Office of the Governor
- Attorney General's Office
- NC Colleges & Universities

Expenditures by Agency

Agency	Total FY 02-03 Expenditures	Percent of Total Expenditures
Medical Assistance	$2,128,691,981	84.0%
Mental Health	$ 170,974,608	6.8%
Social Services	$ 162,341,632	6.4%
Aging	$ 60,279,814	2.4%
Other Agencies	$ 11,619,234	< 1%
TOTAL	$2,533,907,269	100%

Long Term Care

North Carolina's policy for long-term care is to support *older adults and people with disabilities* needing long-term care and *their families,* in making their own *choices* with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the *least restrictive setting.*

State Plan Themes

- *Draw upon the talents and resources of active seniors*
- *Enhance services for vulnerable seniors*
- *Value diversity while addressing disparity*
- *Be responsible stewards of resources*
- *Help baby boomers prepare for their future.*

State Plan Themes

- *Draw upon the talents and resources of active seniors*
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NC Division of Aging 13

Senior Advocate Priorities

- Maintain CAP-DA as a viable service
- Implement national criminal background checks for LTC employees
- Support the Home and Community Care Block Grant
- Make permanent the State Income Tax Credit for LTC insurance premiums
- Support Senior Centers

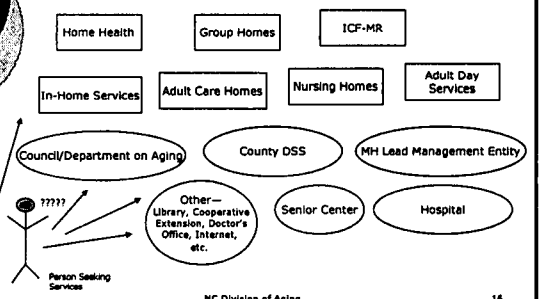
NC Division of Aging 14

State Plan Themes

- *Draw upon the talents and resources of active seniors*
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- *Help baby boomers prepare for their future.*

NC Division of Aging 15

How Citizens Learn about and Locate Services and Supports



NC Division of Aging 16

State Plan Themes

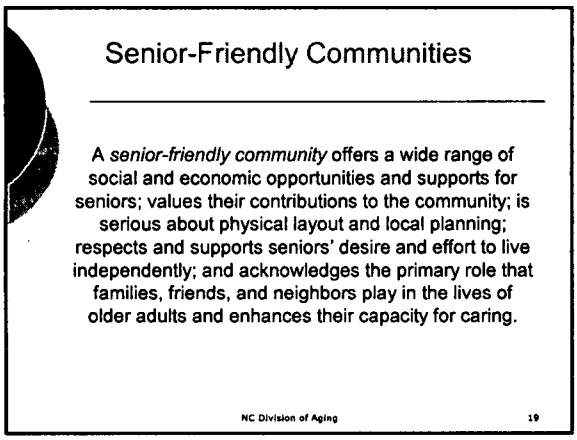
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NC Division of Aging 17

State Plan Themes

- *Draw upon the talents and resources of active seniors*
- *Enhance services for vulnerable seniors*
- *Value diversity while addressing disparity*
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NC Division of Aging 18


Senior-Friendly Communities
A *senior-friendly community* offers a wide range of social and economic opportunities and supports for seniors; values their contributions to the community; is serious about physical layout and local planning; respects and supports seniors' desire and effort to live independently; and acknowledges the primary role that families, friends, and neighbors play in the lives of older adults and enhances their capacity for caring.
NC Division of Aging
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1-800-443-9354

www.ncshiip.com

Facts About Long-Term Care Insurance In North Carolina

Revised February 2004

Shop Carefully and Avoid Pitfalls

Long-term care insurance is designed to pay some or all the costs of nursing home, community, or home health care when you cannot meet the needs of everyday living on your own. While such insurance is costly and might not cover all your expenses it can help to safeguard your assets and protect your financial stability. It is not for everyone. If your only income is Social Security, it is unwise to buy a long-term care policy.

Long term care insurance has two purposes:

- To protect the lifestyle of your spouse and/or family from the high cost of long term care, and
- To protect your assets for your heirs

In general, you should purchase as much coverage as you can reasonably afford. Some policies will provide more coverage than others ..Buyers who fail to ask tough questions may learn too late that their policies don't keep pace with the rising cost of care, don't provide all the benefits promised by an agent or advertisement, or are misleading in the coverage provided.

Keep in mind that insurance companies do underwrite their long-term care policies, which means they look at your health history, and there is no guarantee a policy will be issued to you.

NC Requirements for LTC Policies

- There can be no requirement for a prior hospital or skilled nursing home stay as a trigger for benefits.
- All pre-existing conditions must be covered after 6 months.
- Policies must be issued in a guaranteed renewable basis.
- Portability is required for all group contracts.
- A meaningful inflation protection must be offered.
- Whether expressed or implied no high pressure sales tactics are allowed.
- After age 65, no attained age rating is allowed.
- Policies must provide at least 3 levels of care for at least 12 months.
- Policies must be issued free of exclusionary riders.
- Policies cannot require that home health care be provided by an RN or LPN.
- All policies must have a 30-day "free look" provision.
- Clinical diagnosis must be accepted on all organic brain disorders.
- Annual lapse and financial reports must be filed with the Insurance Commissioner.
- Third party notification is required to prevent loss of coverage.
- Rate revisions must be approved prior to implementation.
- Insurance agents selling long-term care insurance must pass a supplemental exam.
- No new waiting period for pre-existing conditions is required when replacing policies.
- Advertising materials must be accepted by the Insurance Commissioner prior to use.

What is a Federally Tax-Qualified Long-term Care Policy?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (effective January 1, 1997) established that long-term care policies meeting certain standards are referred to as federally "tax-qualified" plans and offer certain federal tax income advantages. The Act requires that the policy and the Outline of Coverage both state that the policy is a qualified long-term care insurance contract.

Benefits

In a tax-qualified policy, out-of-pocket long-term care expenses will be allowed as itemized deductions to the extent that they and other unreimbursed medical expenses exceed 7.5 percent of adjusted gross income.

Benefits paid under a federally qualified plan are not taxable if the amount paid does not exceed the federal per diem of $175. Policies paying benefits based on actual incurred amounts are also exempt from taxation.

Consult with a tax advisor if you have questions about how tax-qualified policies could affect you. Policies approved as long-term care insurance before January 1, 1997 are grandfathered under the Act; therefore, premiums paid for these policies are also subject to favorable tax treatment.

Requirements

To be a federally qualified long-term care plan the contract must meet the following criteria:

- must be guaranteed renewable and cannot have a cash surrender value;
- there must be an offer of a nonforfeiture benefit;
- individuals must be unable to do two activities of daily living (ADL's) without substantial assistance;
- for cognitive impairment to be covered, a person must require substantial supervision; and
- disability must be expected to last for at least 90 days, and verification must be from a certified health care provider.

Consult with a tax advisor if you have questions about how tax-qualified policies could affect you.

Prohibited Practices

Insurance companies and agents may not engage in unfair and deceptive trade practices including:

1. **Twisting** — to knowingly make any misleading representation or comparison causing someone to cancel a policy with one company and buy a replacement from another company,
2. **High Pressure Tactics** — to use force, fright or threat to pressure someone into purchasing a policy, and
3. **Cold Lead Advertising** — develop sales leads for a policy using deceptive advertising techniques.

Insurers also may not advertise a product as long-term care insurance if it provides less than twelve consecutive months of benefits.

Is Long-Term Care Insurance Right For You?

Premium

The premium for the coverage you are considering will be $_____ per month (or $ _____ per year or a one time single premium of $ _____.)

Have you considered whether you could afford to keep this policy if the premiums were raised, for example by 20 percent?

Income

Where will you get the money to pay each year's premium?

__Income __Savings __Family members

What is your annual income?

__Under $10,000 __$10-20,000 __$20-30,000 __$30-50,000 __Over $50,000

How do you expect your income to change over the next 10 years?

__No change __Increase __Decrease

If you will be paying premiums with money received from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than seven percent of your income.

Savings and Investments

Not counting your home, what is the approximate value of all of your assets (savings and investments)?

__Under $20,000 __$20-30,000 __$30-50,000 __Over $50,000

How do you expect your assets to change over the next 10 years?

__No change __Increase __Decrease

If you are buying this policy to protect your assets and your assets (excluding the value of your personal residence) are less than $100,000, you may wish to consider other options for financing your long-term care.

Companies Approved to Sell Long-Term Care Insurance in North Carolina

Please Note:

Following is a list of companies that are currently approved to sell long-term care insurance in North Carolina. Companies that are not currently marketing or that only market to specialized groups are not included on this list. In addition, some companies may have been approved or deleted since this list was printed. For further information, contact the North Carolina Department of Insurance's Seniors' Health Insurance Information Program (SHIIP) at 1-800-443-9354.

AAL Insurance
1-800-225-5225

Aetna Life Insurance Company
1-800-537-8521

Allianz Life Insurance Company of North America
1-800-366-5463

American Family Life Assurance Company of Columbus (AFLAC)
1-800-992-3522

American Fidelity Assurance Company
1-800-437-1011 or
1-405-523-2000

American Heritage Life Insurance Company
1-800-521-3535

American Integrity Insurance Company
1-215-561-1400

American Republic Insurance Company
1-800-247-2190

American Travellers Life Insurance Company
1-800-441-3978

Baltimore Life Insurance Co.
1-410-581-6600

Bankers Fidelity Life Insurance Company
1-800-241-1439

Bankers Life and Casualty Company
1-312-396-6000 - Marketing
1-800-621-3724, ext. 4300 - Claims
1-800-621-3724 - Toll-Free

Bankers Multiple Line Insurance Company
1-214-954-7111

Bankers United Life Assurance Company
1-800-322-1434

Blue Cross Blue Shield of North Carolina
1-800-478-0583

Central States Health & Life Company of Omaha
1-402-397-1111

Cincinnati Life Insurance Company
1-513-870-2000

Colonial Life & Accident Insurance Company
1-803-798-7000

Combined Insurance Company of America
1-312-701-3000

Connecticut General Life Insurance Company
1-860-726-6000

Continental Casualty Company
1-312-822-5000

Continental Life Insurance Company of Brentwood, Tennessee
1-615-377-1300

CUNA Mutual Life Insurance Company
1-319-352-4090

First Penn-Pacific Life Insurance Company
1-708-495-3336

Fortis Insurance Company
1-800-436-7847

General Electric Capital Assurance Company
1-800-456-3399

Globe Life and Accident Insurance Company
1-405-270-1400

Great American Life Insurance Company
1-800-771-2142

Guarantee Trust Life Insurance Company
1-708-699-0600

Harvest Life Insurance Company
1-800-253-0856

IDS Life Insurance Company
1-612-671-7058

Insurance Company of North America
1-215-761-1000

John Hancock Mutual Life Insurance Company
1-800-861-9264

Kanawha Insurance Company
1-803-283-5300

Life Insurance Company of Georgia
1-800-877-7792

Life Investors Insurance Company of America
1-800-325-5823

Lincoln Benefit Life
1-888-503-8110

The Lincoln National Life Insurance Company
1-800-454-6265

Lutheran Brotherhood
1-612-340-7000

Massachusetts Mutual Life Insurance Company
1-888-505-8952

MedAmerica Insurance Co. (State Employees of NC Only)
1-716-238-4277

Medical Life Insurance Co.
1-800-322-3630

Medico Life Insurance Company
1-800-228-9990

Mega Life & Health Insurance Company
1-800-527-5504

Metropolitan Life Insurance Company/AARP
1-800-638-5433

Mid-South Insurance Company
1-910-822-1020

Mid-West National Life Insurance Co. of Tenn.
1-800-767-0700

Monumental Life Insurance Co.
1-800-370-5334

Mutual of Omaha
1-800-775-6000

National Financial Insurance Company
1-817-878-3300

National Foundation Life Insurance Company
1-817-878-3300
1-314-878-0101

National States Insurance Company
1-800-868-6788

New York Life Insurance Co.
1-212-576-7000

Northwestern LTC/Life Insurance Company
1-877-582-6582

Peoples Benefit Life Insurance Company
1-800-523-7900

PFL Life Insurance Company
1-800-338-0257

Physicians Mutual Insurance Company (Physicians Life Insurance Co.)
1-800-228-9100

Pioneer Life Insurance Co.
1-800-736-7311

Provident Life & Accident Insurance Company
1-615-755-1011

Prudential Insurance Co. of America
1-800-732-0416

Pyramid Life Ins. Company
1-913-722-1110

Republic-Vanguard Life Insurance Co.
1-214-559-1222
1-203-677-8621

Shenandoan Life Insurance Company
1-703-985-4400

Southern Farm Bureau Life Insurance Company
1-601-981-7422

State Farm Mutual Automobile Insurance Company
Contact local State Farm Agent

State Life Insurance Company
1-888-505-8101

State Mutual Insurance Company
1-800-241-7598

Stonebridge Life Insurance Company
1-800-527-5433

Teachers Insurance & Annuity
1-212-490-9000

Transamerica Occidental Life Insurance Company
1-800-690-2758

Trustmark Insurance Company (Mutual)
1-800-347-0889
1-708-615-1500

Union Bankers Insurance Company
1-800-792-4368

United American Insurance Company
Contact local agents for materials.

United Teachers Associates Insurance Company
1-800-880-8824

Unum Life Insurance Company of America
1-800-832-0122

Woodmen of the World
1-336-275-9692

Premium Pricing

The initial premium for a long-term care insurance policy is based on:

- your age at policy purchase,
- the elimination period, and
- policy benefits and duration.

AGE - The younger you are when you buy the policy, the less you pay in initial premiums. The premium may increase with age (after age 65 a long-term care insurer cannot use age to increase cost).

ELIMINATION PERIOD - Premiums are lower for longer elimination periods. (The elimination period is the number of days of care you pay for out-of-pocket before the insurance company begins paying benefits for your care.)

BENEFITS - A policy paying $50 per day for three years will cost less than one paying $100 a day for five years.

Ask Before Buying!

- What types of care are covered and in what setting? (A policy is not required to cover every kind of long-term care, nor is it required to cover long-term care in every setting.)
- How much is the daily benefit amount and for how many years will it be paid?
- Does the policy have maximum benefits for each illness or per person, including maximum periods of confinement?
- Does the policy place a lifetime maximum on your benefits? Does collecting benefits for home health care reduce the policy's remaining lifetime benefits amount?
- How long is the elimination period?
- How long is the waiting period before pre-existing conditions are covered?
- What inflation protection is offered?
- How much will the premium increase in the future? Is there a non-forfeiture benefit?

General Shopping Tips

- An agent must give you the long term care policy's "outline of coverage" at the time of application.
- If your income and assets qualify you for Medicaid, you do not need long-term care insurance.
- Talk to several agents and companies, and compare policies.
- Buy locally from an agent you know and trust.
- When buying by mail, see if the company has a local agent or a Toll free number you can call with any questions.
- Never buy a policy on an agent's first visit. Make sure you understand the policy. Have the agent leave a brochure explaining the policy. Ask the agent to return; invite a trusted friend or relative to be present. An ethical agent will not object.
- Never sign a blank application. Be sure to answer all questions truthfully. An insurer can deny a claim or cancel a policy if an answer is incomplete or inaccurate.
- Make checks payable to the insurance company, never to the agent. NEVER PAY CASH. Pay by check or money order and insist on a receipt.
- Don't pay premiums for more than one year at a time. If there is no discount for an annual premium, pay monthly, quarterly or by automatic bank draft.
- Don't wait until retirement to check into long-term care coverage through your company group insurance plan.
- Call the Seniors' Health Insurance Information Program with questions. (1-800-443-9354)

Did You Know?

INFLATION PROTECTION – The NC Department of Insurance requires companies to offer you at least one of three methods of increasing the daily benefit amount to offset the effect of inflation. You may reject or accept the offer. The three methods available are **a)** benefit levels increase annually at a minimum of five percent annually (simple or compounded), **b)** insurer guarantees periodic opportunities to increase benefit level, or **c)** benefit covers a specific percentage of actual reasonable charges. If you reject the inflation protection, it MUST be in writing.

FREE LOOK – All long-term care policies must provide a "free look" period of at least 30 days that will allow you to review your purchase. For a full refund, return the policy before the end of the 30 day period.

DUPLICATE COVERAGE – Do not buy duplicate coverage. Consider increasing current coverage instead. If you replace a policy with another new policy, North Carolina Department of Insurance regulations require agents or insurance companies to **a)** offer to check on all your other policies for possible duplicate coverage, **b)** warn you in writing not to cancel any policy until the "free look" period is over and you are satisfied with the new one and **c)** give credit for time spent under your previous policy toward satisfying pre-existing condition waiting periods.

ELIMINATION PERIODS – An elimination period is the time you must be confined to an eligible facility and must pay for the care you receive before a policy begins to pay benefits. Select the longest elimination period you can afford in order to keep costs down.

HOME HEALTH BENEFITS – Do not confuse at home recovery benefits with more extensive home health care benefits. Recovery benefits often are limited to short periods, usually no longer than your hospital or nursing home stay.

PRE-EXISTING CONDITION – A pre-existing condition is an illness or disability for which you received medical advice or treatment during a period of time before you apply for insurance. Most policies do not pay for these conditions during the waiting period after you become insured. State law limits the long-term care pre-existing policy waiting period to six months.

GUARANTEED RENEWABLE – Long-term care insurance policies sold in North Carolina must be guaranteed renewable. This means you must be allowed to continue in force as long as the premiums are paid. The company may not change policy provisions or refuse to continue your coverage. Premiums, however, may be raised for an entire class of policyholders. Policies issued on or after December 1, 1994 may not increase rates based on attained age after your 65th birthday.

PREMIUM PRICING – Policies with attained age pricing have premiums that start low but increase with the policyholder's age. Policies with issue-age pricing have premiums that do not increase solely due to increasing age.

MENTAL AND NERVOUS DISORDERS – Long- term care policies may limit or exclude coverage of some mental or nervous disorders. However, they must provide coverage of Alzheimer's' disease and related disorders of biologically caused brain diseases and serious mental illness, including progressive dementing illness, organic brain disorders and degenerative brain disorders.

NONFORFEITURE BENEFITS – A non-forfeiture benefit provides that after a policyholder has paid into a policy for a specified period of time, the policyholder continues to have some benefits even if he/she is unable to continue paying premiums. Those benefits take different forms and affect the policy price.

Contacts for General Long-Term Care Information

National Resources

- **National Association of State Units on Aging (NASUA)** 800-677-1116 or www.nasua.org
- **Medicare** 1-800-633-4373 or www.medicare.gov
- **Centers for Medicare and Medicaid Services** www.cms.hhs.gov
- **National Alzheimer's Association** 800-272-3900 or www.alz.org

State Resources

- **Seniors' Health Insurance Information Program (SHIIP)** 800-443-9354 or 919-733-0111 www.ncshiip.com
- **CARELINE** 800-662-7030
- **Duke (Alzheimer's) Family Support Program** 800-522-2451 or 919-660-7510
- **NC Division of Aging** 919-733-0440 or www.dhhs.state.nc.us/aging
- **NC Division of Facility Services** www.facility-services.state.nc.us Health Agency Complaint Hotline 800-624-3004
- **NC Division of Social Services** www.dhhs.state.nc.us/dss
- **NC Division of Vocational Rehabilitation** 800-215-7227 www.dvr.dhhs.state.nc.us
- **North Carolina Housing Finance Agency** 919-877-5700

Regional Resources

- **NC Area Agencies on Aging** www.dhhs.state.nc.us/aging/aaa.htm
- **NC Regional Long Term Care Ombudsman** www.dhhs.state.nc.us/aging/ombud.htm
- **Alzheimer's Association, Eastern NC Chapter** 800-228-8738 or 919-832-3732 (Raleigh) www.alznc.org/home.htm
- **Alzheimer's Association, Western Piedmont Chapter** 800-888-6671 or 704-532-7392 (Main/Piedmont office)
- **Alzheimer's Association, Western Carolina Chapter** 800-888-6671 or 828-254-7363 (Mountain office)

Seniors' Health Insurance Information Program (SHIIP)
111 Seaboard Avenue
Raleigh, NC 27604

1-800-443-9354 – in-state only
(919) 733-0111 – local and out-of-state

www.ncshiip.com

SHIIP is a division of the North Carolina Department of Insurance and offers free, objective information about Medicare, Medicare supplements, Medicare Advantage, Medicare fraud and abuse and long-term care insurance. There is absolutely no selling involved, as the program is a state-operated service.

Tax Treatment of Long-term Care Insurance in Selected States

State	Deduction Or Credit	Covered Payments	Percentage Limitation	Cap	Refundable
North Carolina	**Credit**	**Premiums for taxpayer, spouse, or dependent that were not deducted from Federal income.**	**15%**	**$350 per insurance contract**	**No**
Colorado	Credit	Premiums for taxpayer and spouse. Tapayers must have an income of less than $50,000 if filing for one policy, or $100,000 if filing for two policies.	25%	$150 per policy	No
Kentucky	Deduction	Premiums paid that were not deducted from Federal income.	No	No	---
Maine					
Individual	Deduction	Premiums paid for insurance meeting Federal definition or approved by Bureau of Insurance that were not taken as an itemized deduction.	No	No	---
Employers	Credit	Employer payments on behalf of employees for insurance meeting Federal definition or approved by Bureau of Insurance.	20%	$5000 or $100 per employee	No
Maryland	Credit	Premiums for taxpayer or spouse/parent/child, but insured must be Maryland resident.	No	Age <41 - $240 Age 41-50 -$450 Over 50 - $500	No
Minnesota	Credit	Premiums paid on policies with a lifetime benefit of $100,000 or more for taxpayer or spouse that were not deducted from Federal income.	25%	$100 per beneficiary	No
Missouri	Deduction	Nonreimbursed payments that were not deducted from Federal income	50%	No	---
Oregon					
Individual	Credit	Premiums paid for taxpayer or taxpayer's dependents/parents that were not deducted from Federal income.	15%	$500	No
Employers	Credit	Employer payments on behalf of employees.	15%	$500	No
New York	Credit	Premiums paid for policies approved by Insurance Department	10%	No	No
Utah	Deduction	Premiums paid that were not deducted from Federal income.	No	No	---
Wisconsin	Deduction	Premiums paid for insurance for taxpayers or spouse that were not taken as an itemized deduction. The portion covering the spouse is not allowed if it was taken as part of the federal self-employed health insurance deduction.	No	No	---

LONG-TERM CARE CREDITS CLAIMED FOR TY 2002*

	Single		Married, Joint/Widow		Married, Separate		Head of Household		Total	
NC Taxable Income**	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***
0 or less	521	$122,988	935	$295,118	17	$3,275	127	$16,975	1,600	$438,356
$1 - $2000	417	$91,505	392	$110,394	17	$1,920	109	$16,821	935	$220,640
$2001 - $4000	401	$81,932	450	$123,518	7	$1,486	242	$34,600	1,100	$241,536
$4001 - $6000	335	$64,486	415	$117,418	8	$843	251	$39,057	1,009	$221,804
$6001 - $10000	577	$114,324	773	$201,165	28	$3,568	644	$101,203	2,022	$420,260
$10001 - $10625	113	$22,203	133	$38,802	6	$1,576	91	$13,376	343	$75,957
$10626 - $12750	267	$48,472	412	$113,027	21	$1,908	362	$57,707	1,062	$221,114
$12751 - $15000	277	$53,355	456	$120,152	16	$1,695	319	$46,949	1,068	$222,151
$15001 - $17000	263	$44,718	376	$95,461	10	$1,718	254	$35,211	903	$177,108
$17001 - $20000	354	$61,156	556	$150,371	20	$2,172	273	$39,757	1,203	$253,456
$20001 - $21250	145	$22,816	221	$57,884	10	$795	102	$17,726	478	$99,221
$21251 - $25000	350	$59,508	597	$142,818	25	$3,404	210	$31,092	1,182	$236,822
$25001 - $30000	455	$69,995	867	$208,483	26	$4,588	235	$30,818	1,583	$313,884
$30001 - $40000	645	$97,010	1,611	$344,770	45	$5,437	277	$32,122	2,578	$479,339
$40001 - $50000	442	$69,741	1,528	$307,054	21	$2,656	116	$15,595	2,107	$395,046
$50001 - $60000	295	$45,488	1,330	$259,031	28	$4,697	74	$8,288	1,727	$317,504
$60001 - $75000	263	$35,965	1,525	$290,962	13	$2,355	36	$4,261	1,837	$333,543
$75001 - $100000	218	$36,240	1,688	$322,404	9	1,158	38	$4,492	1,953	$364,294
$100001 or more	194	$34,722	2,590	$582,046	14	1,630	28	$2,215	2,826	$620,613
Total	**6,532**	**$1,176,624**	**16,855**	**$3,880,878**	**341**	**$46,881**	**3,788**	**$548,265**	**27,516**	**$5,652,648**

* As of 6/4/2003

** NC Taxable Income is net of deductions and exemptions, and so generally is lower than Federal Adjusted Growth Income.

*** The total credits figure does not equate to the revenue loss resulting from the credits. For some taxpayers, the loss of revenue is less than the amount claimed because the taxpayers' tax liabilities are less than the amount of credit claimed.

MENTALLY ILL POPULATION IN ADULT CARE HOMES IN N.C.

(Data self-reported and taken from renewal licensure applications for 2003)

Population Data for Adult Care Homes (7 or more beds)								
	18-24	25-34	35-49	50-64	65-74	75-84	85+	ALL
MI	60	219	1143	1500	992	689	315	4918
MR/DD	33	97	314	544	321	153	54	1516
TOTALS	93	316	1457	2044	1313	842	369	6434

Total licensed beds from adult care home data	**33,729**
Total residents in adult care homes	**24,811**
Percentage of residents with an MI diagnosis	**19.82%**
Percentage of Residents with MR/DD diagnosis	6.11%
Combined Percentage for both diagnoses	25.93%
Total number of reporting adult care homes	**606**
Number of adult care homes with MI residents	**428**
Percentage of adult care homes with MI residents	**70.63%**
Number of adult care homes with MR/DD residents	348
Percentage of adult care homes MR/DD residents	57.43%
Number of adult care homes with either diagnosis	538
Percentage of adult care homes with either diagnosis	88.78%

Population Data for Family Care Homes (2-6 beds)								
	18-24	25-34	35-49	50-64	65-74	75-84	85+	ALL
MI	46	103	452	360	161	60	18	1200
MR/DD	27	63	176	198	87	28	5	584
TOTALS	73	166	628	558	248	88	23	1784

Total licensed beds from family care home data	**3503**
Total residents in family care homes	**2797**
Percentage of residents with an MI diagnosis	**42.90%**
Percentage of Residents with MR/DD diagnosis	20.88%
Combined Percentage for both diagnoses	63.78%
Total number of reporting family care homes	**624**
Number of family care homes with MI residents	**392**
Percentage of family care homes with MI residents	**62.82%**
Number of family care homes with MR/DD residents	261
Percentage of family care homes MR/DD residents	41.83%
Number of family care homes with either diagnosis	479
Percentage of family care homes with either diagnosis	76.76%

Total licensed beds from all care home data	**37,232**
Total residents in all care homes	**27,608**
Percentage of residents with an MI diagnosis	**22.16%**
Percentage of Residents with MR/DD diagnosis	7.61%
Combined Percentage for both diagnoses	29.77%
Total number of reporting all care homes	**1230**
Number of all care homes with MI residents	**820**
Percentage of all care homes with MI residents	**66.67%**
Number of all care homes with MR/DD residents	609
Percentage of all care homes MR/DD residents	49.51%
Number of all care homes with either diagnosis	1017
Percentage of all care homes with either diagnosis	82.68%

Adult Care Rules Related to Mentally Ill Residents

Admission of Residents (10A NCAC 13G .0701)

- Prohibits admission of persons for treatment of mental illness
- Prohibits admission of persons who pose direct threat to the health or safety of others

Medical Examination (10A NCAC 13G .0702)

- Have to arrange for examination by physician of any new resident who was an inpatient of a psychiatric facility within the 12 months prior to admission

Personal Care Training and Competence (10A NCAC 13G .0502)

- 80 hour training
- 25 hour training (Family Care Homes only)

Training includes 5 hours training on interventions to reduce behavioral problems

Special Care Units* for Mental Health Disorders (10A NCAC 13F .1401)

- Provides for a closed unit for up to 12 beds for persons with a mental health disability
- Requires additional training for staff
- Requires assessment and care planning review and case management by area mental health program

*Currently none licensed in N.C.

NORTH CAROLINA STUDY COMMISSION ON AGING
FEBRUARY 10, 2004

TOPIC: ADULT CARE HOME RULES & CARING FOR THE MENTALLY ILL

Good Afternoon Honorable Representatives and Senators, Ladies and Gentlemen.

I am the parent of an 43 year old adult child diagnosed with paranoid schizophrenia, residing in an 80 bed assisted living facility. Approximately 20 of the residents are young adults with a severe and persistent mental illness [SPMI].

Adult Care Homes [Assisted Living Facilities] are neither an age nor disability appropriate setting for young adults. They are there because there is no other housing "choice."

NEUROBIOLOGICAL BRAIN DISORDERS: [a.k.a. - severe mental illnesses.]

Schizophrenia and other SPMIs are classified as "brain disorders". They are in the same family as Multiple Sclerosis, Alzheimer's Disease and Epilepsy. They are chemical and neurological malfunctions within the brain. They are no-fault brain disorders and are genetic in origin.

Research now indicates that there may be a viral assault to the fetus during pregnancy causing the "bad gene" to activate.

I would also note here that these individuals are no more violent than any other segment of society. They are more likely to be victims of violence than the perpetrators. [My son has been mugged three times. Once at gun point.

The communications media has done much to insult, demean and perpetuate the stigma associated with severe mental illness.

The 1990's are referred to as the "Decade of the Brain" because more knowledge about the brain was discovered in that time frame than all others before it.

Evidenced based best practices for persons with SPMI have evolved from years of research and better medications that are now available.

We know that Recovery from these disorders is possible. Recovery is not to be confused with curing these disabilities. The Recovery Model of Care, when adhered to, means we can improve the optimal level of functioning of these, our citizens, and with appropriate support systems they can and do become productive members of their communities.

A vital component of the Recovery Model is appropriate housing, with necessary supports, based upon the individuals' level of functioning and needs. This has long been the model followed for persons with Developmental Disabilities. This array of housing covers a broad

spectrum based on where the individual is on the road to recovery. It can range from group
homes consisting of six individuals, to transitional housing, supervised
apartments and independent living with appropriate supports.

THE CONSEQUENCES OF THE LACK OF APPROPRIATE SERVICES OF WHICH HOUSING IS
A BASIC NEED ARE:

Of the estimated 3/4 of a million people who are on the streets and homeless, 40 to 50 % of them have a diagnosable mental illness.

*10.2 of the NC Prison and jail population are diagnosed with a mental illness
* 971 patients were discharged from our state psychiatric hospitals to homeless shelters.
. [Hospital discharge summary - Calendar Year 2002 5.23% of discharges]
* 32 were discharged to hotels
*1193 were discharged to correctional facilities.
* 54 patients were discharged: "Destination unknown."
* 21 patients were discharged to "supervised apartment living."
* 4 individuals were discharged to "supported living" situations."

This statistics point to the obvious need for appropriate housing.

I would also ask you if our society would tolerate these statistics if we applied them to persons diagnosed with Alzheimer's Disease?

Are assisted living or adult care home the answer? The answer is an emphatic NO!

Why not?

* This is called "transinstitutionalization." [Moving a person from one
institution to another.]
*The environment promotes dependence...Everything is done for you
* Stifles individuality and personal growth
* Promotes conformity
* Reduces individuals to the lowest common denominator.
* Activities, when there are any, are usually geared to the geriatric population.
* The majority of these young adults spend their day watching TV, pacing the halls, walking around the grounds or sitting and smoking. There is nothing else for them to do.
* The death of an older individual is extremely distressing to them.

Staffing and Training:

* It is rare to find a facility with either an RN or an LPN as full time staff. *At minimum , an RN or LPN should be dispensing medications.

1.At this time, a "Med Tech" receives 10 hours of training on how to

dispense medications but has no knowledge of what the medication is for
or the effect the medication should produce.

2. Medications administered to the elderly and psychiatric patients have potentially toxic effects and require skilled observation as to the
patient's reactions to them.

* The one hour before and after rule on dispensing medications.

1. The rules state that a medication may be given one hour before or one hour after the designated time. If the patient is not available during the time frame the medication is not administered.

2. Missed dosages of psychiatric medications leads to relapse and psychosis helping to perpetuate the "revolving door" of multiple unnecessary hospitalizations.
[I have had personnel experiences related to this rule.]

* In too many instances if the psychiatric patient refuses a medication, the Mental Health provider is not notified. [This has happened to many of our family members.]

* Patients can leave the facility at will. They must sign out first noting their destination.
This is as it should be but, does anyone check on them if they do not return. [Note enclosed newspaper article.]

1. Policies and Procedures need to be established and enforced regarding leaving the premises in order to avoid "lost or forgotten" patients.

* Staff need training in the various mental illness and how to interact
with the patients.
This is sorely lacking. [Personal Experiences]

* Reduce staff turnover.

*The Division of Facility Services clearly defines the numbers of staff
necessary to meet the needs of specific populations. If an adult care home has over a certain percentage of adults diagnosed with a severe mental illness, the staffing ratio is to be increased proportionately.

1. This rule can be skirted by placing a physical diagnosis as the primary diagnosis and the psychiatric diagnosis as secondary.

NORTH CAROLINA AND MENTAL HEALTH REFORM:

* This law clearly states that evidenced based best practices will be followed and that the patients will be served in their communities. This includes appropriate housing according to the

person's level of capability. In the vast majority of instances, adult
care home are not appropriate as noted for the reasons listed above.

The State of North Carolina and persons diagnosed with Brain Disorders would be much better served if the monies appropriated for these facilities were put into a funding pot for housing that is more conducive to Recovery and Community Integration.

This money would do much to make North Carolina Mental Health Reform Plan a reality.
This would be a "win....win" for all concerned.

Severe Mental Illnesses are not an obstacle to full participation within
the community. The lack of appropriate systems of care, of which housing
is a vital component is.

If I may be of any further assistance to you, please do not hesitate to call me. I am at your disposal.

Thank You for the opportunity to speak to you today on behalf of the National Alliance for the Mentally Ill [NAMI] of North Carolina.

Mrs. Dorothea M. Harrison, RN
VP, NAMI [National Alliance for the Mentally Ill] of North Carolina
117 Shadow Lane
Mooresville, NC 28117

Tel: 704 664 1097
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The Mentally Ill

In

Adult Care Homes

- Lou B. Wilson,
Executive Director
North Carolina Association, Long Term Care Facilities

February 10, 2004

Presentation: North Carolina Study Commission on Aging

Good Evening,

Madam Chair (Rep. Clary), Representative Nye, Senator Swindell and Committee Members, Thank you for allowing me to speak to you today on the important topic of care for the mentally ill in Adult Care Homes.

Most of you know me: I am Executive Director of the North Carolina Association, Long Term Care Facilities. I grew up in the old county-home in Randolph County where I played with the mentally ill as a child. Over the last 46 years, my family and I have been administrators of Adult Care Homes. But most of all, I am a Care Giver and feel that for the past 25 years, I have been "a voice in the wilderness" for people who need mental health services living in Adult Care Homes.

I would like to take a few minutes today to tell you what I have observed over these many years.

In the early 70's, de-institutionalization came about. People were discharged from state hospitals, in a few instances receiving adequate mental health care in the community, but in most instances receiving very little. In North Carolina, a great number of these people were sent to Adult Care Homes.

Through-out the years, there have been no state guidelines or Rules specific to the state's expectations for how services for the mentally ill should be delivered in an Adult Care Home. In other words, the state has no expectations. Because of this and inadequate funding, no additional facility-provided mental health resources are available for people with mental illness.

The Division of Mental Health failed to develop programs or services for people with mental illness that lived in Adult Care Homes until ... 2003. Last year, Geriatric Specialty Teams were developed, which is supposed to serve people 60 and older. The state has provided very little guidance for area mental health programs as to how the teams should be operated, thus the program has floundered in many areas of the state.

Problems have been compounded while area mental health programs have tried to develop these teams, while at the same time dealing with reform issues.

The Division of Mental Health has also historically failed to set forth consistent policies for area programs to follow. Area programs all over the state have developed criteria, protocol, policies and procedures that are unique to their area program. As a result, consumers and providers of services are expected to muddle through a system of inconsistency. This is a barrier for Adult Care Homes, providers and for people who live in Adult Care Homes. There have never been standardized policies from the state indicating how area mental health programs are expected to serve people in Adult Care Homes. Some area programs have worked tirelessly with Adult Care Home providers to develop services for residents, while other area programs have provided practically no support for people in Adult Care Homes.

The state is not entirely at fault for people receiving inadequate services. Even though funding is inadequate, there are Adult Care Home owners who work diligently to ensure all residents receive the services and support they need and deserve. On the other hand, there are some bad apples in the Adult Care Home industry. However, most providers have been left with little support and residents have been left with few opportunities for the level of services provided for the mentally ill who live in other settings.

The vast majority of Adult Care Home owners wants to and tries to provide services that are quality in nature, but the regulatory monster that has been created makes it more important to complete endless amounts of documentation. Given the lack of direction and support by the state, Adult Care Home providers simply do not know how to muddle through the complex mental health systems, develop good rapports with mental health providers, provide mental health training for staff and recognize issues when specific residents are having difficulty.

At the beginning of this speech, I shared some personal information with you about my family and my background because I wanted you to know that I have been around for

a long time. I have seen trends come and go. I've seen a time when people could receive quality care because we were concerned more about the resident than we were about a piece of paper. I have also seen a continual reluctance on the part of the Division of Mental Health to develop standardized protocol for area mental health programs to follow. I have seen people with mental illness ignored and denied mental health services because they lived in an Adult Care Home. I've seen advocates demand people with mental illness be moved out of Adult Care Homes, yet do nothing to support those same people while they remain in Adult Care Homes. We can no longer pretend they do not exist because they do not live in the type of setting WE would prefer.

It is time for change. It is time to provide training for Adult Care Home staff that will enable them to recognize symptoms of mental illness. It is time to go beyond the surveys to determine if people with mental illness live in Adult Care Homes, and provide actual services for them. Finally, it's time that the state, advocates and the Adult Care Home industry put aside their differences, and work together to ensure people with mental illness receive the services they are entitled to regardless of whether they live in their own home, a supervised apartment, a group home or ... an Adult Care Home.

I have attached a copy of a recent recommendation for you that I presented to Secretary Hooker-Odom. I would like to discuss that briefly with you.

Thank you for your time and attention.

Lou B. Wilson

Lou B. Wilson
Executive Director
North Carolina Association, Long Term Care Facilities
4010 Barrett Drive, Suite 102
Raleigh, NC 27609
Phone: (919) 787-3560

Recommendation for Legislation

Geriatric Specialty Teams are a program established by the Division of MH/DD/SAS (2002-2003) to provide treatment and support services to individuals who are geriatric, have a mental illness and reside in an Adult Care Home or Nursing Home, or in a state psychiatric facility. The program consists of transitioning people from the hospitals into the community, direct services to residents in the facilities, and training/consultation to the staff serving the identified individuals. The teams are prohibited from serving persons in the facilities that are less than 60 years old unless they have "geriatric-like needs".

During the past two weeks, two separate incidents have occurred in North Carolina Adult Care Homes where residents who have a history of mental illness have murdered other residents. One murder occurred in Guilford County, and the other occurred in Halifax County.

In response, North Carolina Association, Long Term Care Facilities is requesting DHHS to propose legislation in the 2004 General Assembly as follows:

1. Rename the Geriatric Specialty Teams as *LTC Facility Specialty Teams.*
2. Make it mandatory for all licensed Adult Care Homes and Nursing Homes that serve people with a mental illness to participate in the program.
3. Delete the age requirements and the restrictions for residents to be at risk of psychiatric hospitalization, and make services available for all persons with a mental illness who reside in Adult Care Homes and Nursing Homes.
4. Increase the number of professionals on each team and/or decrease the geographic areas that each team is responsible for covering. The current requirements specify that each team shall have a Licensed Clinical Social Worker and a Psychiatric RN. Fiscal savings could be realized if additional team members were Qualified Mental Health Professionals who would still provide mental health expertise, but at a reduced cost.
5. Develop standardized criteria for:
    a. Purpose of the Teams
    b. Eligibility for Service
    c. Referral Process
    d. Screening Process
    e. Training Manuals
    f. Service Orders/Authorizations from area mental health programs
    g. Medical record requirements
    h. Relationship with Psychiatric Hospitals
    i. Billing/Invoicing
    j. Consent forms and all other forms
6. Estimate the number of persons and facilities that will be eligible for the services, develop a fiscal note, and recommend to Governor Easley that the program be fully funded and be a priority item in the budget.
7. Repeal the current Adult Care Home Special unit rule for persons with mental illness, create a new licensure law and develop rules that are more realistic.

The Mentally Ill

In

Adult Care Homes

- Lou B. Wilson,
Executive Director
North Carolina Association, Long Term Care Facilities

February 10, 2004

Presentation: North Carolina Study Commission on Aging

Good Evening,

Madam Chair (Rep. Clary), Representative Nye, Senator Swindell and Committee Members, Thank you for allowing me to speak to you today on the important topic of care for the mentally ill in Adult Care Homes.

Most of you know me: I am Executive Director of the North Carolina Association, Long Term Care Facilities. I grew up in the old county-home in Randolph County where I played with the mentally ill as a child. Over the last 46 years, my family and I have been administrators of Adult Care Homes. But most of all, I am a Care Giver and feel that for the past 25 years, I have been "a voice in the wilderness" for people who need mental health services living in Adult Care Homes.

I would like to take a few minutes today to tell you what I have observed over these many years.

In the early 70's, de-institutionalization came about. People were discharged from state hospitals, in a few instances receiving adequate mental health care in the community, but in most instances receiving very little. In North Carolina, a great number of these people were sent to Adult Care Homes.

Through-out the years, there have been no state guidelines or Rules specific to the state's expectations for how services for the mentally ill should be delivered in an Adult Care Home. In other words, the state has no expectations. Because of this and inadequate funding, no additional facility-provided mental health resources are available for people with mental illness.

The Division of Mental Health failed to develop programs or services for people with mental illness that lived in Adult Care Homes until ... 2003. Last year, Geriatric Specialty Teams were developed, which is supposed to serve people 60 and older. The state has provided very little guidance for area mental health programs as to how the teams should be operated, thus the program has floundered in many areas of the state.

Problems have been compounded while area mental health programs have tried to develop these teams, while at the same time dealing with reform issues.

The Division of Mental Health has also historically failed to set forth consistent policies for area programs to follow. Area programs all over the state have developed criteria, protocol, policies and procedures that are unique to their area program. As a result, consumers and providers of services are expected to muddle through a system of inconsistency. This is a barrier for Adult Care Homes, providers and for people who live in Adult Care Homes. There have never been standardized policies from the state indicating how area mental health programs are expected to serve people in Adult Care Homes. Some area programs have worked tirelessly with Adult Care Home providers to develop services for residents, while other area programs have provided practically no support for people in Adult Care Homes.

The state is not entirely at fault for people receiving inadequate services. Even though funding is inadequate, there are Adult Care Home owners who work diligently to ensure all residents receive the services and support they need and deserve. On the other hand, there are some bad apples in the Adult Care Home industry. However, most providers have been left with little support and residents have been left with few opportunities for the level of services provided for the mentally ill who live in other settings.

The vast majority of Adult Care Home owners wants to and tries to provide services that are quality in nature, but the regulatory monster that has been created makes it more important to complete endless amounts of documentation. Given the lack of direction and support by the state, Adult Care Home providers simply do not know how to muddle through the complex mental health systems, develop good rapports with mental health providers, provide mental health training for staff and recognize issues when specific residents are having difficulty.

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March 31, 2004

MEMORANDUM

TO: Members, NORTH CAROLINA STUDY COMMISSION ON AGING

FROM: Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, C-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NORTH CAROLINA STUDY COMMISSION ON AGING:

DAY: Tuesday TIME: 10:00 A. M.

DATE: March 9, 2004

LOCATION: Room 643, LOB

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives (see attached map). The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Jo Bobbitt, Committee Assistant, at (919) .733.5477, or e-mail nyela@ncleg.net if you will be unable to attend.
For planning purposes, the following meeting dates have been scheduled for future meetings: April 13, 2004, and April 27, 2004. These meetings will be in Room 643 at 10:00 A.M.

Posted:

cc: Committee Record _____
Interested Parties _____

Draft Copy
For Review Only

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Tuesday, March 9, 2004
10:00 A. M.
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, March 9, 2004 in Room 643 of the Legislative Office Building. Senator A. B. Swindell, Co-Chair, presided. Members also in attendance were Co-Chairs Representative Debbie Clary and Representative Edd Nye; Senators Allran, Dannelly, and Moore; Representatives Weiss, and Earle; public members Allen, Elliott, Price, Marsh, Soltys, Howard, and Sheppard.

Theresa Matula, Dianna Jessup, and Susan Morgan provided staff support to the meeting. Attached is the visitor registration sheet that is made a part of the minutes (See Attachment 1).

Senator Swindell convened the meeting at 10 a.m. and welcomed members, staff and visitors. He recognized the two new members appointed to the Commission, Ms. Linda Howard and Ms. Frances Soltys. Senator Swindell next reviewed the agenda schedule with the members. He stated they had asked for different associations and organizations that represent the aging of North Carolina to come before the Commission to make a brief presentation, and to give written comments as to what they would be saying. Each presenter was given three minutes to address the Commission. Their handouts are grouped together (See Attachment 2).

PRESENTATIONS

June Brotherton, Friends of Residents in Long Term Care
Ms. Brotherton stated there are several key issues on their agenda. They are very concerned about mixed populations in facilities, national criminal background checks, maintaining Medicare/Medicaid funding, discharge rules, staffing, and maintaining funding for the people who oversee and protect the health and safety of long-term care residents.

Jerry Cooper, NC Assisted Living Association
Mr. Cooper began by saying there are 14,000 licensed assisted living beds in their facilities. Thirty percent are reserved for Medicaid recipients. Their association does not feel it is appropriate to blend the young mentally ill, developmentally disabled with the frail elders. They do not provide the intense medical skill provided in a nursing home. One of the primary issues is SB 10, which relates to Alzheimer disease. There is much more required for these residents.

Jean Reaves, NC Coalition on Aging
Ms. Reaves stated that in North Carolina two-thirds of the male population over the age 60 are veterans. Federal funding of the VA health care system is at least an indirect impact on our state availability of resources. The coalition urges the Commission to look to the federal delegation for any and all potential direct and indirect funding to be appropriately allocated to the citizens of North Carolina. Ms. Reaves told members they would receive an official printed copy of the NC Coalition on Aging Legislative Agenda for 2004. Other topics mentioned include; CAP/DA, HCCBG funding, Medicaid for Adult Day Services, Long Term Care insurance tax credit, support for federal criminal records background checks.

Theresa Johnson, NC Adult Day Services Association
Ms. Johnson presented the members a letter from a caregiver relating how her family has benefited from adult day services and the value it adds to their lives. She asked they consider budgets and bills that could make adult day services more accessible and available to other North Carolinians who need and want these services.

Stacy Flannery, NC Health Care Facilities Association
State and federal licensure regulations for skilled nursing facilities include more than 900 individual requirements. North Carolina facilities achieve over 96% compliance with those regulations. Twenty thousand nursing assistants are used and a medical director is required for their facilities. The Institute of Medicine has commended NC nursing home facilities for providing excellent quality care as measured by the new quality indicators. She asked the members to fund items needed.

Cindy Trumboer, NC Senior Games
In her remarks, Ms. Trumboer thanked the Commission for their investment in Senior Games and gave a brief update.

Tom Southern, NC Senior Citizens Association
Their agenda is to establish a Governor's commission on efficiency and effectiveness, enact a taxpayer's bill of rights patterned after Colorado, and malpractice and tax reform.

Ann Johnson, Governors Advisory Council on Aging
Ms. Johnson reviewed the recommendations of the Governor's Council for the year 2004.

Vernon Dull, Senior Tar Heel Legislature
Mr. Dull reviewed the five priorities they have for this year.

Kathy Lowe, National Association of Social Workers, North Carolina Chapter
Ms. Lowe briefly described the Association and then reviewed their recommendations that are based upon what their experienced and professional social workers have learned in working with this population of persons.

Bill Milner, NC Dental Society-Commission on Aging/Access Dental Care
North Carolina is a national leader in providing community based oral health services to residents of nursing facilities, and persons with mental disabilities living in group homes as well as those residing within the community having mental and physical disabilities.

Joe Connolly, Alzheimer's Association
Mr. Connolly represents the western area of the State for the Association. He reviewed his handout and stated it is important to make respite programs for families caring for a loved one with Alzheimer's disease available as a service across North Carolina.

Von Valletta, AARP
Ms. Valletta reviewed his handout with the members, which listed the legislative priorities they are interested in for the year 2004.

Jim Edgerton, Association for Home and Hospice Care of North Carolina
Mr. Edgerton briefly described home care and he also reviewed their recommendations listed their handout.

Alice Watkins, Alzheimer's Association
Ms. Watkins represents the eastern area of the State for the Association. She stated they have designed programs and services to educate the public. They advocate for the aging population and offer training to families and caregivers.

Senator Swindell thanked the speakers representing the associations. He asked Alan Dobson to come forward for his presentation on disease management.

DISEASE MANAGEMENT
Alan Dobson, Chairman of Cabarrus Community Cares; Chairman of Physician Advisory Group; and President/CEO of Cabarrus Family Medicine, presented the members a handout (See Attachment 3) and used a PowerPoint presentation. Senior Care is working to bring together quality and cost. To develop their Medicaid program, they went into the communities and partnered with hospitals, physicians, health departments and the Access Program is built upon that. They started out looking at quality measures, but due to Medicaid budget, they have had to mostly look at cost containment over the last year or so. He said they have done a good job of engaging their physicians apd providers at the local level in helping control State budget. They have a major pharmacy initiative that will hopefully save $40 to $50 million this year. What has really captured the physicians' attention and all the providers is their disease management efforts. It is getting people at the grassroots level around the table to discuss how care is delivered. Asthma was their first initiative for the pediatric population, but they have now moved into diabetes and some of the other chronic diseases. Last year they did a pilot looking at the dually eligible population in nursing homes to see if they could improve care. He stressed it is important to develop systems at the local level to improve care for all the patients. They are on track to get the majority of the other counties in the State covered in the next year. The members had questions and there was discussion.

NC SENIOR CARE AND MEDICATION MANAGEMENT CENTER UPDATE

Senator Swindell next introduced Michael Keough, NC Senior Care, (See Attachment 4). He gave a brief review of the program as to its benefits of the last 15 months since Senior Care became effective. He reviewed their enrollment outreach efforts and the Medication Assistance Program. He told the members that Senior Care was established by the NC Health and Wellness Trust Fund Commission. It was established to focus on health and wellness. The prescription assistance program was their first initiative. The Department of Health and Human Services administers the program for the Health and Wellness Trust Fund Commission. It covers drugs for three diseases; cardiovascular disease, diabetes, and chronic lung disease. The enrollee pays 40% plus a $6.00 administration fee for dispensing and claims processing. About 150,000 North Carolina seniors are estimated to be eligible. Eligibility qualifications are; 65 years of age or older, resident of NC, Household income at or below 200% of federal poverty level, no other prescription drug coverage, and the drug coverage is needed for one of nine illnesses. This effort is unique nationally because it is rooted in the community. The big issue is the ramifications of the Medicare drug bill that was recently passed. Senator Swindell called for questions, and after some discussion and questions by the members; he thanked Mr. Keough for his presentation.

MEDICARE PRESCRIPTION DRUG PROGRAM

Carla Obiol, Seniors' Health Insurance Information Program (SHIIP), Department of Insurance (See Attachment 5). Ms. Obiol presented to the members a brief summary of the Medicare Prescription Drug Improvement and Modernization Act of 2003, an act that will provide the option to purchase prescription drug coverage for many people with Medicare. This is not an automatic benefit. The Prescription Discount Card is a voluntary program slated to begin in June 2004. It is a temporary program to provide immediate assistance. Annual premiums will be up to $30.00 and access to discounts estimated from 10 to 25%, is through enrollment in official card programs. All Medicare beneficiaries are eligible except persons with outpatient Medicaid drug coverage. Other topics for discussion covered timetable of benefits, Medicare prescription Drug Discount Card and the Transitional Assistance Program. At the conclusion of Ms. Obiol's presentation, the members had questions and expressed interest in this program.

GERIATRIC MENTAL HEALTH SPECIALTY TEAMS

Bonnie Morell, Community Policy Section, Division MH/DD/SAS, DHHS. (See Attachment 6). Dr. Morell used a PowerPoint presentation and discussed the handout. In her opening remarks, Dr. Morell stated the mental health system in North Carolina is focusing on appropriate community alternative programs and downsizing the mental health hospitals. They are working to get services in place. Many older people in NC have been in these hospitals. There are twenty Geriatric Mental Health Specialty Teams and their purpose is to assist with transition to the community. These teams provide consultation and technical assistance to nursing facilities and adult care homes regarding the needs of older person with mental illness. They also help link individuals with ongoing treatment or case management needs with local mental health services. These 20 teams are located in 20 local programs, but have the responsibility of covering the entire geography of the state. They will have information available on their website concerning

Agenda

North Carolina Study Commission on Aging

March 9, 2004
10:00 AM
Legislative Office Building
Room 643

I. Welcome

Representative Debbie Clary,
Representative Edd Nye,
Senator AB Swindell,
Cochairs

II. Brief Remarks from Aging Associations and Organizations

Speakers	Associations
Joan Black	NC Self Help for the Hard of Hearing
June Brotherton	Friends of Residents in Long Term Care
Von Valletta	AARP
Jerry Cooper	NC Assisted Living Association
Jean Reaves	NC Coalition on Aging
Teresa Johnson	NC Adult Day Services Association
Stacy Flannery	NC Health Care Facilities Association
Cindy Trumboer	NC Senior Games
Tom Southern	NC Senior Citizens Association
Ann Johnson	Governors Advisory Council on Aging
Vernon Dull	Senior Tar Heel Legislature
Kathy Lowe	National Association of Social Workers – NC Chapter, Aging Unit
Bill Milner	NC Dental Society – Committee on Aging/ Access Dental Care
Joe Connolly	Alzheimer's Association
Jim Edgerton	Association for Home and Hospice Care of NC

III. Disease Management

Alan Dobson, Chairman of Cabarrus Community Cares; Chairman of Physician Advisory Group; and President/CEO of Cabarrus Family Medicine

IV. NC Senior Care and Medication Management Center Update

Michael Keough, NC Senior Care

V. Medicare Prescription Drug Program

Carla Obiol, Seniors' Health Insurance Information Program (SHIIP), Department of Insurance

VI. Geriatric Mental Health Specialty Teams

Bonnie Morell, Community Policy Section, Division MH/DD/SAS, Department of Health and Human Services

VII. Next Meeting: April 13, 2004

Comments by
Friends of Residents in Long Term Care
June Brotherton, Executive Director
Before House Study Commission on Aging
Tuesday, March 9, 2004, 10 a.m., 643 LOB

Mr./Madam Chairman and Members of the Study Commission on Aging,

My name is June Brotherton, and I serve as Executive Director of Friends of Residents in Long Term Care, a non-profit education and advocacy organization serving the almost 80,000 residents of North Carolina's nursing homes, adult care homes and assisted living facilities and their families. Our mission is to improve quality of care and quality of life for our frail elders and disabled people residing in and paying for care in these facilities, whether by private-pay or through Medicaid. We receive no appropriated state dollars and are supported by memberships and grants.

There are several key issues related to long term care and our members' interests that we would like to outline here for this session and future sessions. All of these issues are not resolvable during a short session legislature or within this 3-minute time limit, but we want to serve notice that these will be key issues on our agenda and for those aging organizations with whom we collaborate.

Our issues include:

Mixed Populations. We are increasingly receiving calls from residents and their families and hearing comments from ombudsmen and others who work with residents about the mixed population issue. Our frail elders living in adult care homes are scared and worried about the increasing numbers of mental health patients in these facilities, with good reason. Think about these very real scenarios – a bedridden or wheelchair-bound elderly person being approached by a younger, able-bodied person who has a mental condition that manifests itself by nonsensical conversations and sometimes hallucinations or screaming, demonstrations of anger, or aggressive actions toward other residents. The elderly resident has no real protection from other mentally ill residents as staff cannot be with every individual resident every moment of every day. As stated at the last meeting, adult care homes have already experienced two severe incidents since December involving mentally ill residents.

Friends of Residents supports a review of the current classification system for facilities, looking toward creating a special adult care home classification for mental health patients. However, we also feel that adult care homes, both in staffing, training and activities programming, are not adequately equipped to handle these special needs patients. We would favor a special classification only if the adequate staffing, training and activities programming requirements are put in place, and the adult care homes are able to provide the level of care these patients need.

National Criminal Background Check. The original legislation for national criminal background checks was introduced in 1999 and passed in 2000. There was an effort

to get the bill repealed, citing cost and lack of process for the background checks to be done, which led to a compromise moratorium in 2001 with provision for study committee to resolve the remaining issues. Today, almost four years later, the moratorium remains in place and the study commission has never been appointed. Friends of Residents is resolved in its commitment to see the moratorium lifted and a centralized process put in place to handle the checks. Mississippi has done it, why can't we? If it is important for everyone who comes into contact with a child in a daycare setting to have a national criminal background check, why is it not important for an equally vulnerable population, our frail elders?

Maintaining Medicare/Medicaid funding, including expanding funding for consumer-directed care initiatives, aimed at helping the elderly and disabled stay at home as long as possible. We favor doing away with quotas for CAP and in-home SA funding and allowing funding streams to follow the eligible individual for the provision of services in a setting of their choosing. Without such a change, North Carolina can only pay lip service to consumer-directed services.

Discharge rules. Rules for adult care home residents are currently moving through the Medical Care Commission to the Rules Review Commission. We feel these new rules remove due process for adult care home residents that are as protective as those afforded to nursing home residents, which was the intent of Senate Bill 10.

Staffing. Research has shown again and again that adequate staffing is the key determiner of quality of care. Most long term care workers don't want to do a bad job...they don't want to neglect patients. However, right now, patient care standards for adult care facilities is 1 to 20 on day and evening shifts and 1 to 30 for night shifts. Most of these standards are over 10 years old. Given the acuity level of residents going into adult care homes today, there is absolutely no way these residents can be adequately served, even when enhanced care staff time is factored in.

Maintaining funding for the people who oversee and protect the health and safety of our long term care residents. There has never been a time in the history of long term care when the state and regional ombudsmen, and the case managers and adult care specialists mattered more. They are on the front line in ensuring that our residents get adequate care, and are not neglected and abused without recourse. The system is about to collapse from budget cuts and benign neglect. For example, case statistics for the ombudsmen appear as if they have leveled off and caseloads are not increasing. This is misleading. The ombudsmen have simply maxed out their capacity – they cannot take on any more cases. The cases they do take on are triaged so that the most egregious are addressed first, which often leaves no time to work with early problems. In North Carolina, we are supposed to have 1ombudsman for every 2,000 long term care beds to adequately serve needs. Our ratio is1ombudsman for every 3,900 beds, double the appropriate workload. If we are truly expecting the local level to manage care for our long term residents, we must give them adequate resources to do it well.

Thank you.

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Discharge rules. Rules for adult care home residents are currently moving through the Medical Care Commission to the Rules Review Commission. We feel these new rules remove due process for adult care home residents that are as protective as those afforded to nursing home residents, which was the intent of Senate Bill 10.

Staffing. Research has shown again and again that adequate staffing is the key determiner of quality of care. Most long term care workers don't want to do a bad job...they don't want to neglect patients. However, right now, patient care standards for adult care facilities is 1 to 20 on day and evening shifts and 1 to 30 for night shifts. Most of these standards are over 10 years old. Given the acuity level of residents going into adult care homes today, there is absolutely no way these residents can be adequately served, even when enhanced care staff time is factored in.

Maintaining funding for the people who oversee and protect the health and safety of our long term care residents. There has never been a time in the history of long term care when the state and regional ombudsmen, and the case managers and adult care specialists mattered more. They are on the front line in ensuring that our residents get adequate care, and are not neglected and abused without recourse. The system is about to collapse from budget cuts and benign neglect. For example, case statistics for the ombudsmen appear as if they have leveled off and caseloads are not increasing. This is misleading. The ombudsmen have simply maxed out their capacity – they cannot take on any more cases. The cases they do take on are triaged so that the most egregious are addressed first, which often leaves no time to work with early problems. In North Carolina, we are supposed to have 1ombudsman for every 2,000 long term care beds to adequately serve needs. Our ratio is1ombudsman for every 3,900 beds, double the appropriate workload. If we are truly expecting the local level to manage care for our long term residents, we must give them adequate resources to do it well.

Thank you.

Comments by
Friends of Residents in Long Term Care
June Brotherton, Executive Director
Before House Study Commission on Aging
Tuesday, March 9, 2004, 10 a.m., 643 LOB

Mr./Madam Chairman and Members of the Study Commission on Aging,

My name is June Brotherton, and I serve as Executive Director of Friends of Residents in Long Term Care, a non-profit education and advocacy organization serving the almost 80,000 residents of North Carolina's nursing homes, adult care homes and assisted living facilities and their families. Our mission is to improve quality of care and quality of life for our frail elders and disabled people residing in and paying for care in these facilities, whether by private-pay or through Medicaid. We receive no appropriated state dollars and are supported by memberships and grants.

There are several key issues related to long term care and our members' interests that we would like to outline here for this session and future sessions. All of these issues are not resolvable during a short session legislature or within this 3-minute time limit, but we want to serve notice that these will be key issues on our agenda and for those aging organizations with whom we collaborate.

Our issues include:

Mixed Populations. We are increasingly receiving calls from residents and their families and hearing comments from ombudsmen and others who work with residents about the mixed population issue. Our frail elders living in adult care homes are scared and worried about the increasing numbers of mental health patients in these facilities, with good reason. Think about these very real scenarios – a bedridden or wheelchair-bound elderly person being approached by a younger, able-bodied person who has a mental condition that manifests itself by nonsensical conversations and sometimes hallucinations or screaming, demonstrations of anger, or aggressive actions toward other residents. The elderly resident has no real protection from other mentally ill residents as staff cannot be with every individual resident every moment of every day. As stated at the last meeting, adult care homes have already experienced two severe incidents since December involving mentally ill residents.

Friends of Residents supports a review of the current classification system for facilities, looking toward creating a special adult care home classification for mental health patients. However, we also feel that adult care homes, both in staffing, training and activities programming, are not adequately equipped to handle these special needs patients. We would favor a special classification only if the adequate staffing, training and activities programming requirements are put in place, and the adult care homes are able to provide the level of care these patients need.

National Criminal Background Check. The original legislation for national criminal background checks was introduced in 1999 and passed in 2000. There was an effort

to get the bill repealed, citing cost and lack of process for the background checks to be done, which led to a compromise moratorium in 2001 with provision for study committee to resolve the remaining issues. Today, almost four years later, the moratorium remains in place and the study commission has never been appointed. Friends of Residents is resolved in its commitment to see the moratorium lifted and a centralized process put in place to handle the checks. Mississippi has done it, why can't we? If it is important for everyone who comes into contact with a child in a daycare setting to have a national criminal background check, why is it not important for an equally vulnerable population, our frail elders?

Maintaining Medicare/Medicaid funding, including expanding funding for consumer-directed care initiatives, aimed at helping the elderly and disabled stay at home as long as possible. We favor doing away with quotas for CAP and in-home SA funding and allowing funding streams to follow the eligible individual for the provision of services in a setting of their choosing. Without such a change, North Carolina can only pay lip service to consumer-directed services.

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Thank you.

GOOD MORNING My name is Jean Reaves and I stand before you today as the President of the North Carolina Coalition on Aging. We are a statewide coalition of organizations committed to improving the quality of life for older adults. I am the one standing before you but please realize that I represent 40 member organizations whose combined membership represents millions of voting North Carolinians.

I feel it important to further express to you that like others in this room I wear many hats. I am the wife and caregiver of a 100% disabled Veteran who served in Vietnam and Beirut, I am a Veteran myself; and I am a professional caregiver as the Director of Roanoke Valley Adult Day Center in rural Halifax County located in northeastern North Carolina. It is the fact that as I wear these many hats they shape who I am, they shape my attitudes and they shape the fact that much of the past 15 years I have spent right here in this building and in this room advocating for the frail elderly, the vulnerable who so often can not speak for themselves.

We are all very much aware of the fact that our over 60 population is increasing and that our over 85 population is increasing at even greater proportions. But are you also aware that the average WWII Veterans is 80 years old, the average Korean War Veteran is 74 years old and that the average Vietnam Veteran is a grandparent and 55 years old. I hope you also know that in North Carolina of the ***male*** population over the age of 60 2/3 are Veterans. With this brief symposis of demographics I hope you also see that Federal Funding of the VA Health Care system is at least an indirect impact on our state availability of resources. Presently approx 1/7 of the population over age 60 is receiving some treatment and medications from the four VA hospitals in NC. I wish I could tell you in specific dollars how this equates. But at a mimium I hope I spark your attention to the fact that this and other Federal Funding is an impact on our state resources. The NC Coalition on Aging urges you in the face of our state budget issues to look to our Federal Delegation for any and all potential direct and indirect funding to be appropriately allocated to the citizens of North Carolina. We further ask that you serious look at various new state revenue streams that could be used to provide services for elderly and disabled.

You will each receive an official printed copy of the North Carolina Coalition on Aging Legislative Agenda for 2004. As you review these initiatives I hope it will be very apparent to you that the delegates very thoughtfully and responsibly are asking you to support proven cost effective programs such as continuation of the Community Alternative Program often referred to as CAP-DA. They are asking you to support restoration of funding to the Home and Community

Care Block grant that has proven to reduce waiting lists when funding is appropriated. The delegates are also asking you to support bold initiatives such as expanding the use of Medicaid Funds for Adult Day Services. As mental health reform continues to evolve we must allow dollars to follow the individuals as they move into safe, cost effective comprehensive community based programs such as adult day centers. Additionally the delegates of the North Carolina Coalition on Aging are asking you to take the information presented to you at your February meeting and make the tax credit for Long Term Care Insurance premiums permanent. We also ask you to consider the safety of perhaps some of our most vulnerable frail citizens by making it possible for all long term care facilities to receive federal criminal records background checks. We the members of the North Carolina Coalition on Aging have truly deliberated and are responsibly asking you to support these initiatives. We are doing so recognizing the budget challenges faced by the General Assembly and also realizing at the same time the projected growth of the older population and the potential for continued increases in waiting lists for services. In closing we ask you to not only review the long term benefits of these of these requests but to also ask you to use your wisdom, knowledge and power as members of the General Assembly and of this Study Commission to recommend increases in state revenues that will provide for services for the elderly and disabled of North Carolina for years to come.

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North Carolina Adult Day Services Association

www.NCADSA.org

5220 Beckwyck Drive * Fuquay-Varina, NC 27526-9293
(919) 552-0254 FAX (919) 552-0155 ncadsa@springmail.com

March 9, 2004

Presenter: Teresa Johnson, NCADSA Executive Director

The attached letter is from a caregiver in Davidson County who could not be here today. She has asked that I share her story with you so that others can understand how her family has benefited from adult day services and the value it adds to their lives. Please remember Diana and her mother when you consider budgets and bills that could make adult day services more accessible and available to other North Carolinians who need and want them.

The delegates also ask you to support bold initiatives such as expanding the use of Medicaid Funds for Adult Day Services. As mental health reform continues to evolve we must allow dollars to follow the individuals as they move into safe, cost effective, comprehensive community based programs such as adult day centers.

For Your Information

In response to the Special Provision passed last summer for a rate increase for adult day services, NCADSA hopes to present to the Social Services Commission soon about what the rates should be. NCADSA is working closely with the NC Division of Aging and Adult Services to assess unit costs among adult day service providers across North Carolina.

Representatives from NCADSA and Partners in Caregiving, the national program formerly funded by the Robert Wood Johnson Foundation, recently collected data from 30 files of centers that have closed in North Carolina since January 2000. We will be working closely with the NC Division of Aging and Adult Services to compile and analyze the data as we work toward trying to establish a more secure future for this very valuable community-based service.

From a Thankful Caregiver

My name is Diana, and I am a "Recovering Horrible Daughter", addicted to: wanting time for myself, my children, my husband, for my home responsibilities, and for pursuing personal interests, friends, reading, hobbies and a career.

My "problem" is a 100 pound, 5'2" gray haired, 78 year old lady-my mother is making my life impossible. Mother is an otherwise healthy woman, diagnosed with Alzheimer's Disease.

Ten years ago she was the primary caregiver to my father as he was dying from cancer. Before that she raised me and my 3 siblings in a normal, nurturing home. She was Always there for us-ALWAYS!

How can I now feel such anger when she needs me?

Well, she is NOT my mother. Certainly she is not the same person who raised me. Her disease has stolen her short-term memory, her loving maternal spirit and the disease has made her suspicious and untrusting and she accuses me of stealing her jewelry and her money.

I have to retrieve her clothing after she goes to sleep and replace with clean clothing, or she will wear the same thing everyday. She does not remember what she wore yesterday, does not remember to wash her hands or brush her teeth. She refuses to shower or shampoo. She remembers well she "just did that yesterday." She will go with me to the grocery store, then refuse to get out of the car. Unable to leave her alone, we return home; a wasted trip.

My siblings' lives to date have been too busy to assist with caregiving responsibilities. After all, I made the decision to move into my mother's home when my father was dying...Isn't Mother also my responsibility?

My sanity depleted, I needed to take action. My overwhelming guilt was still there, but I have a degree in sociology, for goodness sake. I knew where this road was leading.

Long term placement was not an option. Mother didn't need the help-I did!

Through much trial and error, I found an adult day health program. "You mean a place where my mother can go during the day-socialize with others her age-receive breakfast, lunch and an afternoon snack, receive the services of a hairdresser, participate in exercise, music, and fun activities, AND have a trained health care team in event of an emergency-A fun place that Mother actually looks forward to attending?

Mother enjoys her days at the center and I now have my days back to focus on my parenting and household activities and to explore other opportunities.

I now am able to assist my mother in remaining in her home and her community and to avoid premature placement in a care facility; an option I cannot deal with at the present time.

I am blessed that Mother is physically very healthy. But the adult day health facility also is able to meet the needs of individuals in wheelchairs, with walkers and canes, visually impaired, incontinent, and with greater needs than Mother.

Mother's disease has stolen the person she was from all of us. But I can now enjoy her remaining years to an extent I once thought impossible. Thanks for the services available through adult day health care.

Diana,
A Thankful Caregiver

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N O R T H
CAROLINA
Senior Games

PRESENTATION TO STUDY COMMISSION ON AGING
March 9, 2004
Cindy Trumbower, Vice President, North Carolina Senior Games, Inc.

What a pleasure it is to be here today to thank you and update you on *Your* wise investment in Senior Games. Senior Games is affordable and enjoyable health care… what more could we want?

"Senior Games" may sound like a simple topic compared to others you may hear today. It is not! Our most important issues are health promotion, prevention and wellness.

Since we last met with you, North Carolina State University faculty conducted professional research on our local Games participants statewide and they confirmed that our mission is being accomplished and your investment is powerful. Participants said Senior Games definitely motivates them to be physically active and once they get involved they stay involved! The "F-words", twenty years later, are still relevant: Fitness, family, fellowship, friendship and financial management.

Participants save money and so do all of us, by staying healthy. The best way to save money and reduce expenditures is to continue funding programs like *Senior Games* that promote physical activity, good health and independent living!

We are very lucky in N.C.....
We have a tradition and reputation of an Aging Network that is small, yet very effective. Our Division of Aging and our 17 Area Agencies on Aging manage and coordinate our resources well. Our Senior Centers and Councils on Aging serve us well on the front lines everyday. Our Coalition on Aging, AARP, and Senior Tarheel Legislators represent our needs and interests well.

We can be proud that our Senior Games program is the best in the country! It is the largest and most effective with 53 Local Games serving all 100 counties and over 50,000 participants from long-term care facilities, adult day care and retirement centers to your neighborhoods and communities.

The spirit of Senior Games impacts people of all ages and is contagious to children, grandchildren, friends, spectators and volunteers. We hear from so many participants each year on the importance of Senior Games. One participant recently wrote to Senator Basnight and stated, "North Carolina Senior Games and its local games provide opportunities for feelings of pride and self worth at a time in life when we may begin to doubt our abilities." Another Ambassador wrote "We, who are senior citizens find a sense of community in Senior Games, thus easing loneliness, which can lead to depression and other health issues. We are among the most vital, active and alert folks I have ever met and we need to stay that way!"

Senior Games is a very small item in the budget...but it has a huge impact! For the costs of keeping 3 people in a nursing home for one year – we can keep 50,000 people active through Senior Games!!!

Thank you for letting us continue to do it...we will not let you down. And, we will help the State save money with this intelligent long-term investment in healthy aging.

Presentation to the North Carolina Study Commission on Aging Tuesday, March 9, 10:00 AM

Address the: Honorable Senator Swindell
Honorable Representative Debbie Clary
Honorable Representative Edd Nye
Chairman of the North Carolina Study Commission on Aging and members of the Study Commission

My name is Tom Southern, Legislative Chairman of the North Carolina Senior Citizens Association. It is an honor to appear before this esteemed commission today. Thank you for inviting our Association.

I represent an association, organized in June 1977 that is a non-profit, non-partisan organization dedicated to benefit senior citizens throughout North Carolina. Our members are volunteers.

The Board of Directors of the Association has created a legislative agenda, state and federal that we feel reflects the philosophy of our Association's members. We are a non-partisan association and our membership is open to all persons age 55 and older in North Carolina.

The North Carolina Senior Citizens Association Agenda

State Agenda

Establish a Governor's Commission on Efficiency and Effectiveness (Sunset Commission) to study every state funded entity/program and either make it more efficient/streamlined or eliminate it.

- Government Efficiency - Eliminate programs that are redundant, inefficient, outdated or failures. The Commission should also identify public functions/jobs for which there is a private counterpart. These functions should be evaluated yearly to ascertain whether private or public operation would be more fiscally sound.

Enact a TABOR (Taxpayer's Bill of Rights), patterned after Colorado, which will protect the taxpayer from irresponsible state expenditures. Rebates or unused taxes should be sent to the taxpayers.

- TABOR - During the decade of the nineties taxes in North Carolina grew approximately 2% more yearly than did income, while in Colorado billions of

unspent monies were returned to taxpayers. In Colorado, in order to increase taxes, passage of a referendum is necessary and taxes are indexed.

To help contain health care costs and to assure provision of medical services the state should enact tort reform similar to California with a $250,000 cap on non-economic damages.

- Malpractice Reform - California has had these laws since the seventies and their malpractice rates have increased approximately 1/3 of states that do not have these laws. Malpractice rates rise, not as a result of medical errors, but because of unregulated and unwarranted awards.

Study and reform tax code to make it simpler to understand, more efficient to administer, and more equitable to individuals and businesses.

- Tax Reform - A consumption sales tax to replace the income tax would save hundreds of millions in compliance costs, bureaucracies, and by eliminating withholding, according to a Federal Reserve Study, would increase worker productivity. A flat tax has a number of these same advantages.

As you can tell we are not requesting special privileges for seniors nor are we requesting to raise taxes to pay for senior programs and services. We are requesting equitable thought and action for ALL citizens.

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Recommendations of the Governor's Advisory Council on Aging for 2004

- Increase state revenues (including but not limited to taxing cigarettes, liquor and soft drinks; closing corporate loopholes; and extending sales tax on some services) to provide services for the elderly and disabled.

- Make the state income tax credit for long-term care insurance premiums permanent.

- Restore the $1 million in funding cut in 2003 from the Home and Community Care Block Grant.

- Make it possible for all long-term care facilities to receive federal criminal records background checks on prospective employees.

- Restore funding for the development and operation of senior centers to the 2001-2002 level.

- Take steps to strengthen the direct care workforce, including support of increased nurse aide salaries and benefits.

- Support a guardianship mediation initiative to provide families with an additional option to further protect the rights of older and disabled adults.

- Continue to increase the capability of the Medicaid Community Alternatives Program for Disabled Adults (CAP/DA) to enable individuals to remain in their homes as long as possible and to comply with the U.S. Supreme Court's Olmstead decision.

- Strengthen the Long-Term Care Ombudsman Program by securing Medicaid administrative funds to expand the number of regional Ombudsmen.

- Take steps to assure that implementation of the Department of Health and Human Services' Plan for Information and Assistance is supportive of older and disabled adults and the local aging and adult services system.

- In an effort to better address the housing needs of vulnerable citizens, including at-risk older and disabled adults, have the Department of Health and Human Services create either an Office or a Division of Housing within the Department.

Presentation to the Study Commission on Aging
Vernon Dull, Speaker
N.C. Senior Tar Heel Legislature
March 9, 2004

Thank you for giving the Senior Tar Heel Legislature the opportunity to share with you our 2004 legislative priorities. I am Vernon Dull, Speaker of the Senior Legislature.

During the course of the last ten years, the Senior Tar Heel Legislature, which was created by the General Assembly in 1993, has sought to be a visible and effective non-partisan advocate for older North Carolinians. With representation from all 100 counties in our state, we believe that we are a direct link to the 1.4 million persons 60 years of age and over in our state.

The Senior Tar Heel Legislature has five priorities this year. You have received a copy of our fact sheet which is goldenrod in color. This lists our priorities as well as provides background information about each issue. I will not read this sheet to you, but do want to make a few key points regarding each of the priority recommendations. Please note that our priorities are not rank ordered.

First Recommendation

Restore the $1 million in funding cut from the Home and Community Care Block Grant in 2003. The Block Grant funds in-home and community-based services which help impaired older adults stay in their homes. Key Block Grant services include home delivered meals, adult day care/day health care, in-home aide services, respite care for family caregivers, and transportation services. Although the state's older adult population is increasing each year, state funding for home and community based services has not increased since 1998-99 – in fact, funding for these programs was reduced by $1 million in 2003. The Division of Aging estimates that this $1 million cut will result in a projected loss of 178,153 units of service this year – there will be **over 61,000 less home delivered meals** and **over 50,000 less congregate meals** served, **over 33,000 less hours of in-home aid services** provided, a **reduction of 2,500 days of adult day care/day health care services** available, and **more than 30,000 fewer units (a one way trip) of transportation** provided.

(over)

Second Recommendation

Pass legislation to make the tax credit for long-term care insurance permanent. This tax credit is an important incentive to encourage more people to purchase long-term care insurance policies. We encourage the General Assembly to adopt legislation which will restore this credit which expired with the 2003 tax year and make it permanent.

Third Recommendation

Take steps to ensure that the Medicaid Community Alternatives Program for Disabled Adults (CAP/DA) remains a viable service for older and disabled adults in our state. I have been told that the Commission will be receiving a report this month from the Division of Medical Assistance which details some of the efforts underway to improve the overall management and cost effectiveness of the CAP/DA program. We ask that the General Assembly continue to support this important program and the efforts of the Division of Medical Assistance to make the program better. CAP/DA is a cornerstone of our state's long term care efforts and it needs to remain a viable option for more older and disabled adults.

Recommendation Four

Restore funding for the development and operation of senior centers to the 2001-2002 level. The 158 senior centers in our state are key focal points for the delivery of programs and services to older adults in our state. The state appropriation for senior centers was cut by $381,000 in 2002-2003. The General Assembly took action in the 2003 legislative session to restore $100,000 of this cut, but increased the match on the state funds from 10% to 25%. Currently, there is only $1,062,316 appropriated to support senior centers in the state. This funding does not go far and many senior centers have had to reduce their operations due to the cut.

Recommendation Five

Take steps to ensure that national criminal background checks for employees of long term care facilities are completed. This issue has been before the General Assembly the last several years, but no action has been taken. Residents in long-term care facilities are some of North Carolina's most vulnerable citizens and it is past time that our state figure out what needs to be done so that FBI background check data can be obtained for employees in long term care facilities.

Thank you again for allowing me this opportunity to share the Senior Tar Heel Legislature's priorities for the 2004 short legislative session.

FACT SHEET

North Carolina Senior Tar Heel Legislature

The North Carolina Senior Tar Heel Legislature was created by the North Carolina General Assembly with the passage of Senate Bill 479 in July of 1993.

The Senior Tar Heel Legislature was created to:

- Provide information to senior citizens on the legislative process and matters being considered by the North Carolina General Assembly.
- Promote citizen involvement and advocacy concerning aging issues before the North Carolina General Assembly.
- Assess the legislative needs of older citizens by convening a forum modeled after the North Carolina General Assembly.

There is one delegate to the Senior Tar Heel Legislature from each of the 100 counties in the state. Most counties also have an alternate delegate. Delegates and alternates must be age 60 or older. The North Carolina Division of Aging provides staff support for the Senior Legislature in cooperation with the 17 Area Agencies on Aging who are responsible for conducting the selection of delegates and alternates. Current officers of the Senior Tar Heel Legislature are: Vernon Dull, Speaker (Davie); Lamar Moore, Speaker Pro Tempore (Davidson); Pat Capehart, Deputy Speaker Pro Tempore (Beaufort); and Wanda Hinshaw, Secretary (Guilford).

2004 Legislative Priorities

Restore the $1 million in funding cut in 2003 from the Home and Community Care Block Grant.

Home and community-based services help impaired older adults stay in their homes. Key services include home-delivered meals, adult day care/day health care, in-home aide, and respite care for family caregivers. As the older population continues to grow, so does the demand for services. Those in particular need of services are the over 117,000 older adults in the state who are 85 and older and those who are disabled. More than a quarter of the persons age 65 and older living in the community have two or more physical or mental conditions that make it difficult for them to do such activities as walking, dressing, and bathing. Although there is an increased need for services, the state is losing ground in its effort to help frail older people in the community. State funding for home and community based services has not increased since 1998-99 – in fact, funding for these programs was also reduced by $1 million in 2003. During the last three years, there has been a decline in the number of persons served and the number of services provided through the Home and Community Care Block Grant. Currently, some counties in the state are reporting waiting lists for these services in excess of 400.

(over)

Pass legislation to make the tax credit for long-term care insurance permanent. The General Assembly passed legislation in 1998 to allow individuals who purchase a long-term care insurance policy to claim a state income tax credit. The purpose of the credit was to encourage more people to purchase long-term care insurance policies which assist with the cost of in-home and nursing home care. This credit is 15% of the premium paid, not to exceed $350 for each qualified long-term care insurance contract. The credit was effective for the tax year which began on January 1, 1999. The legislation had a sunset provision which stipulated that the credit expired for taxable years beginning on or after January 1, 2004. Therefore, unless action is taken by the General Assembly in the short session, this credit can no longer be taken after 2003.

Take steps to ensure that the Medicaid Community Alternatives Program for Disabled Adults (CAP/DA) remains a viable service for older and disabled adults in our state. CAP/DA is one of four programs under Medicaid which provides home and community care as a cost-effective alternative to institutionalization. The program provides a package of services to allow disabled adults age 18 and older who qualify for nursing home care to remain in their private residences. Because of the budget shortfall in the Medicaid program, a freeze was placed on the CAP/DA program October 1, 2001, and efforts were initiated to closely examine the program and its operation. The freeze has been partially lifted and as of February 2004, there were over 9200 persons being served through the program. Prior to the freeze, 10,131 persons were receiving CAP/DA services. Because of the critical role that CAP/DA plays in addressing the long-term care needs of our state's older and disabled adults, the General Assembly is urged to maintain support for CAP/DA and to look at ways to enhance the operation of the program.

Restore funding for the development and operation of senior centers to the 2001-2002 level. There are 158 senior centers in North Carolina currently operational or under development in 95 counties in the state. These centers provide a variety of programs and services to enhance the health and wellness of older adults and to support their efforts to remain independent in their communities. For 2002-2003, the state appropriation for senior centers was cut by $381,000. The General Assembly took action in the 2003 legislative session to restore $100,000 of this cut for the 2003-2004 SFY, but increased the match on the state funds from 10% to 25%. Currently, there is only $1,062,316 appropriated to support senior centers. Many senior centers have had to reduce the variety of activities and services they offer, reduce operating hours or days, close satellite locations, reduce outreach to older adults in remote areas, and delay needed maintenance and repairs to facilities and equipment because of the cuts in funding.

Take steps to ensure that national criminal background checks for employees of long term care facilities are completed. State legislation was first passed in 1996, and expanded in 2000, to require criminal background checks of applicants for employment in long term care facilities. In meeting the requirements for background checks, a problem has been identified in obtaining national criminal background check information. Current federal law does not permit the FBI to release background check data to adult care homes or to nursing homes for staff other than those involved in direct patient care. For this reason, legislation was passed in 2001 and again in 2002 and 2003 which imposed a moratorium on the criminal records check law until a system for receiving the checks from the FBI can be worked out. The moratorium is currently extended to January 1, 2005. Action needs to be taken to ensure that any problems in obtaining national criminal background checks are addressed and steps are taken so that this data can be received by all long-term care facilities in North Carolina and for all employees of those facilities. Residents in long-term care facilities are some of our state's most vulnerable citizens, and this action is needed to help protect them.

NASW NORTH CAROLINA CHAPTER
National Association of Social Workers

RECOMMENDATIONS TO STUDY COMMISSION ON AGING

Thank you for the opportunity to address our concerns to the Committee. The North Carolina Chapter of the National Association of Social Workers has over 3,700 members statewide and over 150,000 nationwide. Our social workers work with the elderly in all capacities: in homes, nursing facilities, with their families, in medical facilities, and in providing necessary services so that they may live a full life in their later years. All professional social workers have either a bachelors, masters or PhD, from an accredited school of social work and adhere to the NASW Code of Ethics and standards of practice for the aging population.

The below recommendations are based upon what our experienced and professional social workers have learned in working with this population of persons.

1) Expansion of Senior Care Centers and Day Programs
Senior Centers provide the elderly with the resources to permit them to stay at home longer. They provide meals, bathing services and respite for caregivers. Last year, the North Carolina General Assembly took over two million for funding for these services. The loss of funding has forced many persons into residential placements rather than being able to stay at home. Forcing persons into residential treatment facilities is significantly more expensive than allowing them to stay at home and this cost is generally paid through long term care Medicaid.

2) Transportation
Comprehensive transportation services are needed for the elderly. Transportation is a tremendous barrier for the elderly. Access to doctor's appointments, the pharmacy to fill medications, the grocery store, and other necessary needs is extremely limited. If a person has Medicaid, then transportation is usually available to only see a doctor. Medicare does not have transportation programs. Often patients will have to rely upon family and friends

3) Professional Care Coordination
More professional caregivers are needed for care coordination for the array of complex services that the population receives. This population is a fragile one and they require guidance and advocacy in an often confusing and bureaucratic system. Professional social workers have the knowledge and skill base to facilitate their movement through the different agencies that they often come into contact with. Therefore, those positions designated as social work positions should only be filled by social workers.

4) Access to Medications
The elderly need assistance with greater access to medications. The cost is prohibitive because most of the population is on a fixed income. Many elderly persons are on as many ten medications and with high multiple co-pays they struggle trying to live each month on their income.

For more information, please contact Jennifer M. Sullivan, MSW, JD at 919-828-9650

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North Carolina Study Commission on Aging
Tuesday, March 9, 2004
Special Care Dentistry Presentation

North Carolina is a national leader in providing community based oral health services to residents of nursing facilities, persons with mental disabilities living in group homes and those residing within the community having mental and physical disabilities. This growing network of non-profit programs combines private foundation support and fee-for-service care to arguably the most difficult to serve population in dentistry. People with disabilities deserve the same quality of care that is provided the community at large. The Study Commission on Aging can be an advocate for improving the care provided to this often-neglected group by appointing the following work groups to improve the oral health status of special care populations.

- Ask that the Division of Medical Assistance, Division of Aging and Office of Rural Health meet with directors of North Carolina's four current special care dentistry programs[1] to review creative funding options for direct care services.
- Establish a task force to review oral health standard of care issues for North Carolina's special care populations.
- Request that these two groups report back to the Study Commission on Aging with their findings.

[1] Access Dental Care, Greensboro and Concord/Kannapolis; Carolina's Mobile Dentistry, Carolina's Health Care System, Charlotte; Special Needs Dentistry, North Carolina Baptist Hospital, Winston-Salem.

Totals from August, 2000-August, 2003 (716 Treatment Days)

- 2305 Total Patients
- 450 MR/DD patients out of this total are seen at day centers
- 10,229 Total Patient Visits
- 18,239 Patient Services
  1. 65% Diagnostic/Preventive
  2. 13% Restorative
  3. <1% Endodontic
  4. 2% Periodontic
  5. 5% Removable Prosthetic (dentures)
  6. <1% Fixed Prosthetic (crown/bridges)
  7. 15% Oral Surgery
- $1,625,000 Billed, $1,202,000 Net, $1,122,704 Paid (93% of net paid)
- Over $502,300 in uncompensated care provided. This amounts to almost one year of production. (80% of our patients are Medicaid)
- 108 Operating Room Patients (All are MR/DD patients whose behaviors could not be controlled during on-site care.

access
DENTAL CARE

Special Care Dentistry for a Special State

TAKING DENTISTRY TO NURSING HOMES, GROUP HOMES, DAY CENTERS AND HOSPITALS

Easy Set-up:

- *Dental team uses small truck to transport state-of-the-art portable dental equipment to each care or residential facility.*
- *With 2 electrical outlets, a nearby sink and a minimum of a 12' x 15' room, the team can set-up a 2-chair dental office inside a facility in 20 minutes.*

Professional Team of Specially Trained Dentist, Hygienist and Assistant:

- *Provides full range of dental services and regular follow-up care to all patients.*
- *Works with patients' families and secures approval of treatment plans prior to care.*
- *Provides care 5 days per week and treats an average of 15 patients per day.*
- *Examines each patient seen at least twice per year.*
- *Visits each contracted facility monthly.*
- *Offers emergency service on 24/7 basis.*
- *Offers treatment in hospital operating room for hard-to-manage patients.*

Dental care provided by community non-profit which funds itself through Medicaid, grants and donations.*

**Private care provided by private practitioner at standard rates.*



Access Dental Care | 2275 Vanstory Street | Suite 102
Greensboro | North Carolina | 27403
Telephone 336.292.5029 | Facsimile 336.292.4206
www.accessdentalcare.org

North Carolina
Study Commission on Aging

March 9, 2004

My name is Joe Connolly and I am the Director of Programs and Public Policy for the Western Carolina Chapter of the Alzheimer's Association.

Thank you for the opportunity to speak today.

The 2000 census figures tell us that over 12% of our population in North Carolina, or about 970,000 people are over the age of65, and 21% are over 55. More importantly, in just over 15 years, the number of adults over the age of 65 is expected to increase by more than 75%. It is projected that more than 1,600,000 of our states residents, or 17.5%, will be over 65 years of age by the year 2020.

However, in the western half of the state, these numbers are even more significant. The population of adults over the age of 65 in counties such as Haywood, Macon, Ashe, Allegheny, Henderson, and Transylvania is projected to be over 30 % by 2020. In many other western counties the population base of older adults is expected to be in excess of 25%. (Of course, the same types of statistics are true in the eastern part of our state.)

This growth in the population of older adults is having, and will continue to have, widespread implications, some extremely positive and others more challenging, for local economic, government, and social service sectors.

We also know that the single biggest risk factor for Alzheimer's Disease is age. As our population of older adults increases, we will also see an increase in the number of people with Alzheimer's Disease.

In 2000, it was estimated that 132,325 adults in North Carolina have Alzheimer's disease. Due to the expected population increased that I just mentioned, this number is projected to increase to 253,176 by 2025. We believe that is essential to build the necessary program knowledge and operational infrastructure to be prepared for this coming crisis in care for those with Alzheimer's disease and their caregivers.

We need to collectively build on our current program knowledge and experience base. In addition to continuing to improve existing services, we also need to further develop appropriate, innovative program responses in order to be prepared to deal with this very significant pending change in our county's demographics.

The Western Carolina Chapter of the Alzheimer's Association has been in operation for twenty years and serves forty-nine western counties in North Carolina. The chapter serves as an advocate for individuals with dementia, and provides information, education and training to family and professional caregivers. In the last fiscal year, the Western Carolina Chapter responded to over 5,600 HelpLine calls, worked with over 100 Support Groups, reached over 1100 members of our communities with general information about this disease and provided training and education to approximately 4,400 family caregivers and paid care providers.
Our colleagues in the eastern
To a large extent, this work is made possible by the support that the Chapter receives from funds received through the North Carolina General Assembly and I want to take this opportunity to thank the members of the Study Commission on Aging for their support over the years and for their continuing support of these programs in the future. This funding enables the Chapters to provide outreach, education and training to families and health care providers throughout the state.

The hardships associated with the physical, emotional and financial demands of caring for a family member with dementia are well documented. Finding respite from the relentless demands of providing supervision and assistance is essential to the health and well being of the caregiver and ultimately for the quality of life of both the caregiver and the person receiving care.

In response, the Western Carolina Chapter of the Alzheimer's Association provides crucial education, training and supportive counseling, as well as programs that directly assist the home caregiver.

I would like to discuss with you briefly some information on an innovative program that the Chapter is delivering in cooperation with the North Carolina Division of Aging, the Duke Family Support Program, the Mecklenburg County Department of Social Services, the Family Caregiver Support Program and four separate Area Agencies on Aging. Project C.A.R.E. (or Caregiver Alternatives to Running on Empty) is actually funded through the Alzheimer's Disease Demonstration Program of the Administration On Aging. As a Demonstration program, Project C.A.R.E. is now only available in 6 counties in the state.

In the last year, Project C.A.R.E. has provided support and respite funding to over 251 families in the counties of Mecklenburg, Forsyth, Henderson, Polk, Rutherford and Transylvania. An additional 237 families in these counties received valuable consultation and information about other community resources. Unfortunately, there are always families on a waiting list for the respite funding. Families are often forced to seek placement for the person with Alzheimer's while waiting for respite services. The number of families using Project C.A.R.E. has exceeded all expectations, even in rural and minority communities and among groups identified as "reluctant", "distrustful" or "hard to reach". Both non-profit and for-profit agencies are now eager to train staff and to provide dementia-specific flexible respite services. Project C.A.R.E., and other respite programs delivered through the Western Carolina Chapter of the Alzheimer's Association, have helped to create a more responsive service system in the targeted communities.

The success of the respite programs is primarily attributable to the collaboration among the sponsoring agencies, hospice organizations, private and nonprofit home care providers, adult day services and faith-based communities in the targeted regions. As a demonstration program, Project C.A.R.E.'s goals are to improve the access, choice, use, and quality of respite services. Uniquely, the program provides immediate financial assistance for respite care, as well as professional consultation in flexibly customizing use of available funds for each family. The Family Consultant meets with the family caregiver to assess needs and to help determine the most appropriate type of respite care. There is additional assistance in locating an appropriate and acceptable local provider.

We need to make respite programs for families caring with a loved one with Alzheimer's Disease available as a service across North Carolina.

According to research information provided through the National Alzheimer's Association, the increased use of respite services not only delays nursing home placement but, more significantly, the combination of counseling and support programs such as Project C.A.R.E. can delay nursing home placement of a person with Alzheimer's by an average of over 10 months. It is important to note that the type of respite program delivered through the Alzheimer's Association has the potential to have a direct and immediate fiscal impact by reducing state spending on long-term care.

Again, thank you for your support,

Respectfully submitted,

Joe Connolly, Director, Program and Public Policy,
Alzheimer's Association, Western Carolina Chapter

DRAFT
1/22/04

ALZHEIMER'S ASSOCIATION
NORTH CAROLINA COALITION
2004-2005 PLATFORM

1. We support increasing respite care by designating funds exclusively for support to caregivers of people with Alzheimer's disease, or a related dementia, which shall include adult day services, in-home and institutional respite options. *There is a serious lack of respite care options for family caregivers who sacrifice their own rest and health needs to provide round the clock care.*

2. We support immediate improvements to salaries, benefits, training and working conditions for Certified Nursing Assistants in Long-Term Care. *Statewide and nationally there are critical deficits in the number of qualified direct care workers as exhibited by excessive turnover and shortages of certified nursing assistants.*

3. We support efforts to remove the funding bias (e.g., expand funding for CAP and other home and community based services) that favors institutional care over in-home care. *This action supports the NC Institute of Medicine's Report on Long-Term Care, which recommends that the state's long-term care policy should result in "appropriate, high quality, cost-effective care provided in the least restrictive setting."*

4. We support the continuation of $200,000 in funding from the North Carolina Legislature that enables the Alzheimer's Association Chapters and the Duke Family Support Program to provide outreach, support and education services to families and health care providers throughout the state. *As our aging population continues to grow, the numbers suffering from Alzheimer's disease and related dementias is also on the increase, further stressing our medical and support systems.*

5. We support strong statutory clarification of the regulations established through the Long Term Care Safety Initiative (Senate Bill 10/ House Bill 60) for reforms in long-term care. *Examples: Residents of Adult Care Homes deserve protection from discharge equal to federally mandated protections due nursing home residents. Locked units in Adult Care Homes must meet specific standards as defined under special care criteria.*

AARP North Carolina

AARP North Carolina 2004 State Legislative Priorities

NC State Budget

Use revenue enhancements (e.g., increasing the tax on cigarettes, changing certain corporate taxes, and adding a sales tax on certain services) to prevent additional cuts in health and human services programs that are essential to frail and disabled individuals and restore the cuts made in recent legislative sessions.

Long Term Care

Permanently authorize the tax credit for long term care insurance policy premiums. (This tax credit expired on Jan. 1, 2004. If reauthorized this year, it will be applicable to tax returns for 2004.)

Repeal the moratorium on national criminal background checks required for workers in nursing homes, adult care homes, and home care agencies.

Advocate for increased wages for direct care workers in nursing homes and adult care homes.

Prescription Drugs

The enactment of the new prescription drug benefit for Medicare has altered the landscape of this issue on both the national and state level. While the details and rules of this enormously complicated legislation are being worked out, AARP in North Carolina will monitor how the new benefits will impact state programs and state consumers. AARP will continue to advocate improvement and expansion of the state's prescription drug benefit, the Senior Care Program. We will also continue efforts to develop an evidence-based drug formulary within the Medicaid program.

Consumer Protection

AARP opposes a specific cap on non-economic damages for victims of medical malpractice. We support improved state regulations regarding physician discipline, medical malpractice insurance reform, and a shift in emphasis from the physician-attorney controversy to consumer protection. In the context of this issue, AARP strongly opposes the proposal to shield nursing home inspection reports from use as evidence in malpractice lawsuits.

Establish terms and conditions for payday loans that permit longer repayment period, lower effective interest charges, and allow installment payments.

Advocate for adoption of a "Transfer on Death" provision to facilitate transfer by individuals of securities without having to resort to probate or estate administration to make a transfer.

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James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org/nc

Jim Edgerton

Association for
Home & Hospice Care
of North Carolina

Presentation

To the

NC Study Commission on Aging

March 9, 2004

WHAT IS HOME CARE?

- Home care is a broad term that describes a wide variety of health and health-related services provided in the home or community. Home care is available to people of all ages with either acute or chronic conditions, as well as the disabled and terminally ill. The home care staff work with the patients and their families to teach them about their conditions and how to assist in the care so that the patients can be as independent as possible.

- The demand for home care has grown for many reasons. As our elderly population increases and needs assistance, more patients and their families prefer to stay at home. Improvements in medical science and technology allow many treatments to be done in the home that once could only be done in a hospital.

- Home care allows patients to live at home, be mobile, and remain productive members of society. These patients continue to contribute to the economy in their communities and to the county and state tax base. Concerned patients, their families and home care employees are active constituents in the political process and strong advocates of in-home and community-based services.

- Home Care services includes Home Health, Home Infusion Therapy, Home Medical Equipment, Hospice, Personal Care Services, Private Duty Nursing, and Community alternative Programs for Disabled Adults, Disabled Children and the Developmentally Disabled.

HOME CARE IN NORTH CAROLINA

- In SFY 2003-2004, home care providers will serve approximately 400,000 patients and families and employ more than 200,000 North Carolina citizens. Home Health services are largely provided by registered nurses and skilled therapists. In-home aide services are provided under the supervision of registered nurses. The Division of Facility Services licenses home care services and in addition home health services are further certified. Furthermore, some providers seek additional accreditation.

- Overall, Home Care Services represent only 12% of the Medicaid Budget while institutional services represent 37% of the Medicaid Budget. Historically in North Carolina, Institutional Services has received a higher priority for funding than Home Care Services.

- In SFY 2002-03 the Medicaid Budget increased by 7% over SFY 2001-2002. Home Care Services only increased by 2.9% for the same period.

- For the first 7 months of SFY 2003-2004 the total Medicaid Expenditures have increased by 10.37% over the same period in SFY 2002-2003. Home and Hospice Care expenditures only increased by 3 % during this same period and represented only 11% of total Medicaid expenditures.

- Home Care Services have not received a rate increase since January 1, 2002 and inflation rates have not been allowed for the last two years. During the 2001 and 2002 Legislative Sessions, Home Care was cut $42.4 million ($13.8 in State Funds). In the 2003 session inflation increases were not funded for the next two years, which totals $12.6 million for 2003-2004 and $24.2 million for 2004-05. This is a total reduction of $79.2 million dollars over a three-year period.

Recommendations

- The Legislature should place a higher priority on funding Home Care Services in the Medicaid Program. Home Care is the lowest cost service and it ensures that families are still able to contribute to the patient's care and that the patient remains an economically contributing member of the community.

- The Legislature should provide funds for inflation increases in SFY 2004-2005.

- The Legislature should explore ways to allow the Department the flexibility to transfer funds from institutional services to home care services when the patient chooses home care and home care can be an effective setting. Continued support should be given to the Special Assistance In-home projects and State funding made available for the Special Assistance case management. Currently DSS must provide this case management under their current limited resources.

- The Association for Home & Hospice Care is very committed and highly involved in a project with DMA to restructure the in-home PCS program. The goal is to ensure that the program serves only those in need of the program's services by strengthening its eligibility criteria, streamlining its policies, and putting in place utilization review. The Quality Initiative under taken by the Association will likely require some administrative rule changes and possibly some legislative changes in next year's session. AHHC will be seeking support from the Study Commission on Aging as this unfolds.

- Home Care Services should be the last priority for budget reductions. In their report to the General Assembly, the N.C. Institute of Medicine recommended removing the institutional bias in Medicaid eligibility rules. Their report pointed out that:

  - *Institutional services account for the largest share of publicly funded expenditures.*
  - *Institutional care is usually more expensive than home and community- based care, which explains part of the reason why the State spends so much of its resources on institutional care...*
  - *Another reason that public funding is weighted toward institutional care is that Medicaid and other program rules make it easier for people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community.*
  - *Under existing laws, individuals can qualify for either nursing home care or State County/Special Assistance (SC/SA) for adult care homes with higher monthly incomes than they can if they want to obtain Medicaid coverage for health services provided in their own home...*

Established in 1972, the Association for Home & Hospice Care of North Carolina (AHHC) is a nonprofit trade association made up of professionals from a wide variety of disciplines, all with an active interest or involvement in North Carolina's in-home health, hospice, and community based care industry. Today, the Association represents nearly 570 agencies, including the largest licensed home care providers in the State.

For more information, please contact: Timothy Rogers, Executive Vice-President, Jim Edgerton, Director, Government Relations, Jack Cozort, Legislative Consultant Association for Home & Hospice Care of North Carolina
226 West Millbrook Rd
Raleigh, NC 27609 (919) 848-3450

NORTH CAROLINA

SENIOR CARE



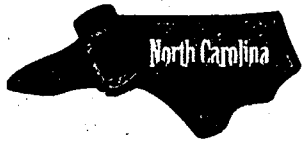


Update to NC Study Commission on Aging

Tuesday, March 9, 2004

Health & Wellness Trust Fund Commission

- NC devoted 25% to establish Health & Wellness Trust Fund Commission
- Focused on Health and Wellness
- Senior Pharmacy first project
- $30M/year for drugs
- $2M for administration



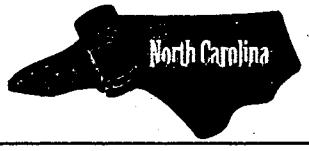
North Carolina Senior Care Program.

Designed specifically to provide assistance to North Carolina seniors diagnosed with one of three diseases who are coping with the rising costs of prescription medicine.



Benefit Design

- 60% of first $1000 or $600 per year
- Covers drugs for treatment of heart disease, diabetes and chronic lung
- Enrollee pays 40% plus $6 administration fee for dispensing and claims processing
- About 150,000 NC Seniors are estimated to be eligible
- 70% of all NC seniors have one of these diagnoses



ELIGIBILITY QUALIFICATIONS

- 65 years of age or older
- Resident of North Carolina
- Annual Household Income at or below 200% of Federal Poverty Level
- No other prescription drug coverage
- You need drug coverage for one of the following illnesses:
  - Angina
  - Arrhythmia
  - Asthma
  - bronchitis
  - diabetes mellitus
  - emphysema
  - heart failure
  - high cholesterol
  - hypertension



REQUIRED DIAGNOSES:

"*Diabetes*" means *diabetes mellitus* (sugar diabetes)

"*Cardiovascular disease*" means *hypertension* (high blood pressure), *angina* (chest pain), *arrhythmia* (irregular heartbeat), hyperlipidemia (high cholesterol) and/or *heart failure*

"*Chronic obstructive pulmonary disease*" means *emphysema*, *chronic bronchitis* and *asthma*.



COVERED DRUGS:

- Drugs that require a prescription (including all insulins)
- Drugs that are for outpatient use
- Drugs that are specific treatments for the following disease states:

- Diabetes Mellitus
- Heart Failure
- Emphysema
- Bronchitis
- Asthma

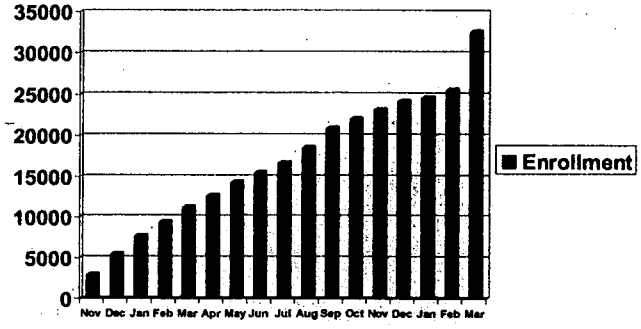


- Hypertension
- Hyperlipidemia
- Angina
- Arrhythmia

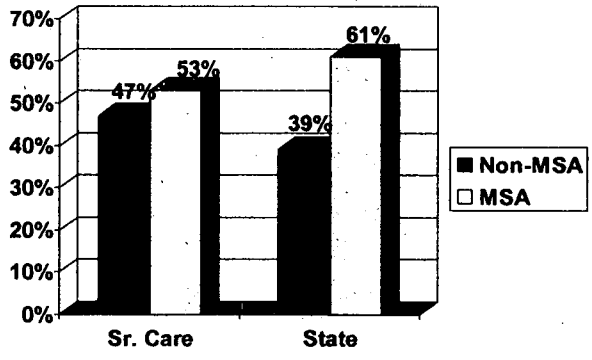
Enrollment To Date

- 32,600 enrollees
- Enrollees in all 100 counties
- 13.6 prescriptions per member per year

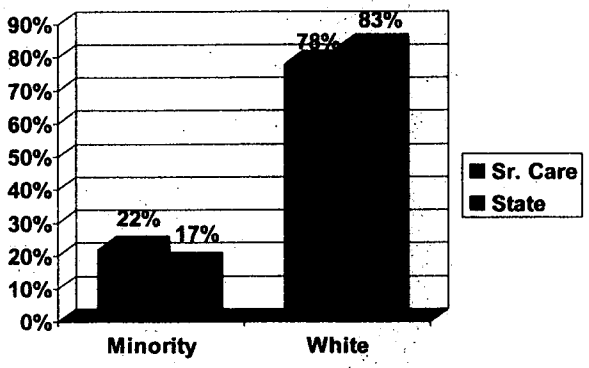
Senior Care Enrollment Thru 3/1/04



Comparison of Percentage Enrollment to Statewide Population by MSA/Non-MSA



Comparison of Percentage Minority/White Enrollment to Statewide 65+ Population



Enrollment Outreach Efforts

- 400,000 enrollment applications distributed to:
  - 1600 local pharmacies
  - 100 local health department locations
  - 17 Area Aging Agencies
  - Over 300 Senior Service Agencies
  - 100 Local Departments of Social Service
  - 100,000 individual callers to Senior Care Hotline

General Baptist State Convention Outreach Grant

- GBSC includes 2,000 traditionally African-American churches
- Outreach grant to Center for Health & Healing funded by Health & Wellness Trust Fund Commission
- Plans to reach out to entire African American community to encourage and facilitate enrollment in Senior Care

Medication Assistance Program

- Developed and funded by the Health & Wellness Trust Fund Commission
- $2M/Year Currently
- 23 Grantees covering 60 sites in 60 counties

Medication Assistance Program Services

- Prescription Assistance (facilitating use of pharmaceutical manufacturers' free and low cost drug programs)
- Medication Management including pharmacist evaluation of individual senior's drug regimens

Medication Assistance Program Services

- Over 4,000 seniors screened and referred to centers as "high risk" based on responses to health questionnaire on Senior Care application
- Over 1,000 seen on site at Medication Assistance Program centers
- Another 500 contacted by telephone for phone consult and assistance

Medicare Drug Bill

- Drug Discount Cards available in June
- Free cards plus $600/year credit for persons at or below 135% of FPL
- Reviewing options to coordinate Senior Care coverage with Drug Discount Card especially for those under 135% of FPL

Seniors' Health Insurance Information Program

The Medicare Reform Bill

Just the Facts

1-800-443-9354 • www.ncshiip.com

March 2004

The Medicare Reform Bill is one of the most sweeping reforms in the program's history. On December 8, 2003, the President signed the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), a bill that will provide the option to purchase prescription drug coverage for many people with Medicare across America. **Remember, this is not an automatic benefit.**

Interim Drug Card (The Medicare Prescription Drug Discount Card and Transitional Assistance Program)

In 2004 and 2005, Medicare beneficiaries are eligible to purchase a prescription drug discount card (which will cost no more than $30/year) estimated to yield drug-cost savings of 10 to 25 percent or higher. People who have outpatient prescription drug coverage through Medicaid will not qualify for the prescription drug discount cards.

People with low incomes ($12,569-single and $16,862-married couple) may qualify for a $600 credit each year to help pay for their prescription drugs. Those who qualify will not have to pay the annual enrollment fee. People who have outpatient prescription drug coverage from Medicaid, TRICARE for Life or an employer group health plan will not qualify for the $600 credit.

Main Drug Benefit

In 2006, Medicare beneficiaries can enroll in a stand-alone drug plan or join a private health plan. Plans may vary and will be offered by private companies. In general, they will work as follows:

- Medicare beneficiaries will pay a premium of about $35 per month.
- After Medicare beneficiaries meet a $250 deductible, Medicare will pay 75 percent of prescription drug costs up to $2,250. Medicare beneficiaries will be responsible for 25 percent of the costs.
- There will be no Medicare coverage for prescription drug costs between $2,250 and $3,600 out-of-pocket. Medicare beneficiaries will pay 100 percent of the drug costs between $2,250 and $3,600.
- After Medicare beneficiaries have spent $3,600 out-of-pocket for prescription drugs, Medicare will pay about 95 percent of the costs for prescription drugs.

Some prescription drug plans may have additional options to help pay for out-of-pocket costs.

People with low incomes and limited assets may qualify to receive extra help to pay for prescription drugs through the Medicare prescription drug benefit. Medicare beneficiaries who qualify will only pay a small copayment for each prescription drug they need. Depending on income and asset levels, the premiums and deductibles may be covered or lowered. There will be a limited amount paid for each prescription drug.

New Preventive Benefits

In 2005, there will be several new preventive benefits added to Medicare including:

- One-time wellness physical exam within six months of the day you first enroll in Medicare Part B.
- Screening blood tests for early detection of cardiovascular (heart) diseases.
- Diabetes screening tests for people with Medicare at risk of getting diabetes.

Other Features of the Bill Include:

- An additional $25 billion for rural hospitals and health care providers.
- A requirement for higher-income seniors to pay more for Medicare Part B coverage.
- Billions of dollars to discourage corporations from eliminating existing coverage for their own retirees.

Medicare Prescription Drug Improvement and Modernization Act of 2003

Carla Obiol, Deputy Commissioner
Seniors' Health Insurance Information Program
(SHIIP)



President Bush signing the legislation on December 8, 2003

Medicare Prescription Drug Improvement and Modernization Act of 2003

2004-2005	Medicare-Approved Prescription Drug Discount Card and Transitional Assistance Program and Medicare Advantage
2006	Medicare Part D: Prescription Drug Plan

Topics for Discussion Today

- Timetable of benefits
- Medicare Prescription Drug Discount Card and the Transitional Assistance Program
- Discount card sponsor qualifications
- Medicare Part D: Prescription Drug Plan (PDP)
- CMS and SHIIP education & outreach efforts

Calendar for Implementation of Medicare Modernization Act (MMA)

May 2004

Marketing for the Medicare Prescription Drug Discount Card Program and the Transitional Assistance Program begins



June 2004

Drug discount cards become effective through early 2006 or enrollment in Medicare Part D/PDP

January 1, 2005

- Medicare Part B deductible increases to $110
- New preventive care benefits

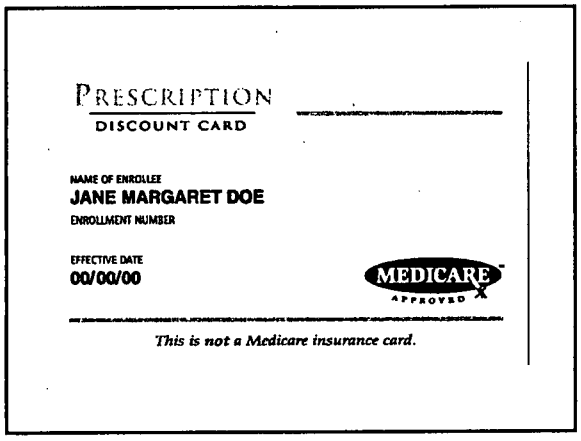


January 1, 2006

- Medicare Part D available
- Low-income beneficiaries may qualify to receive extra help in meeting prescription costs. Premium & deductibles may be waived with a small copayment for prescriptions
- $70 billion in tax-free subsides to employers for maintaining drug coverage in employee group health programs for retirees

Prescription Drug Discount Card

- Voluntary program slated to begin in June 2004
- Intended as a temporary program to provide immediate assistance
- Annual premium up to $30
- Access to discounts estimated from 10-25% are through enrollment in official card program
- All beneficiaries are eligible—except persons with outpatient Medicaid drug coverage.
- This program is only one of many available to assist beneficiaries.
- Discount cards will display a Medicare-approved mark on the card.



Eligibility and Enrollment Requirements for Medicare Prescription Drug Discount Card

Medicare Prescription Drug Discount Card

Eligibility and Enrollment Requirements:

- ✓ Eligible for Medicare Part A or enrolled in Medicare Part B
- ✓ Not a Medicaid recipient
- ✓ Remains eligible for duration of benefit period (June 1, 2004 – December 31, 2005)
- ✓ Card sponsor will process applications (At least two cards available in each state)
- ✓ Must have information verified through matches prior to approval
- ✓ Enrollment is limited to one Medicare prescription drug discount card program

Changing Approved Discount Card Programs

- In 2005 beneficiaries will have to option to change card programs
- General Election Period for changes: November 15 – December 31, 2004
- Special Election periods
  - move outside service area
  - election to disenroll from a Medicare managed care plan

Transitional Assistance Program

- Individuals who have income that is 135 percent of the Federal Poverty Level can receive a $600 credit for prescription drugs.
  - Qualified beneficiaries with income limits between $12,569 (individuals) -$16,862 (married couples)
- In 2005 the benefit can be renewed and will be pro-rated depending on time of enrollment
- Benefit will end on January 1, 2006 when beneficiaries formally enroll in Medicare Part D

Transitional Assistance Program

Enrollment Requirements:

- ✓Applicant can not have drug coverage from other sources—Medicaid, TRICARE, (group) health insurance or FEHBP
- ✓Applicant uses the standard drug application
- ✓Applicant "self-certifies" income but card sponsor can verify (Medicaid, SSA, IRS)
- ✓If application is rejected, then applicant must re-apply for the discount card

Sponsor Qualifications

A non-governmental organization with relevant organizational experience in these areas:

- Adjudicating and processing pharmacy claims at the point of sale + negotiating with manufacturers
- Financially stable and reputable
- Meets service area and pharmacy network standards
- Ability to administer transitional benefit

Sponsor Qualifications

- Ability to manage the eligibility and enrollment process
- Able to provide customer service
- Can provide a grievance process
- Complies with HIPAA privacy provision
- Agrees to provide date to CMS

Service Area Requirements

- A state is the smallest service area permitted
- Convenient access to retail pharmacies
- Medicare-approved programs may offer a mail-order option in addition to pharmacy network
- Prohibited from providing a mail-order only program
- May not require enrollees to use mail-order pharmacies

Minimum Formulary Requirements

- Purpose is to establish a floor to ensure that formularies include the types of drugs commonly needed by Medicare beneficiaries
- Formulary must include:
  - At least one drug in each of 209 therapeutic categories as published in regulation and solicitation
  - At least 55% of the 209 categories must include a generic offered for a discount

Pricing

- Programs must obtain rebates, discounts and pass throughs from manufacturers to lower costs of drugs purchased by enrollees
- Discount programs may offer savings on over-the-counter drugs — $600 credit cannot be used for over the counter medications

Medicare & You

Pricing

- Approved discount card programs may update their prices and list of drugs on a weekly basis
- CMS will monitor drug price changes
- CMS will identify if programs deviate from expected changes (average wholesale price)
- Each approved program will have a toll-free customer call center

2005 Preventive Care Benefits

In 2005 new preventive care benefits

- One-time wellness physical exam upon enrollment in Medicare Part B (subject to deductible and coinsurance)
- Screening blood tests for detection of cardiovascular diseases
- Diabetes screening tests for people at risk

Medicare & You

In November of 2005, enrollment begins for the

Medicare Part D: Prescription Drug Program (PDP)

- Monthly premium of $35 with a $250 deductible
- Medicare will cover 75% of costs of prescription drugs between $250 and $2,250
- Beneficiary will pay 100% of costs between $2,250 and $3,600
- After beneficiary pays $3,600 Medicare will pay 95 percent of costs of prescription drugs



Medicare Part D: The Prescription Drug Plan (PDP)

Initial Enrollment Period

November 15, 2005	Start of initial enrollment under Medicare Part D
May 15, 2006	Initial enrollment period for Medicare Part D ends
January 1, 2006	Effective date of Medicare Part D

Eligibility and Enrollment Requirements for Medicare Part D Prescription Drug Plans (PDP)

Medicare & You

Prescription Drug Plans Enrollment

Enrollment for PDPs is open to all Medicare beneficiaries (entitled to Part A and enrolled in Part B)

The premium is expected to be $35/month (1st year average)
(Estimated to be $58 by 2013-based on choice of plan)

The deductible will be $250 in 2006 and expected to grow annually by the growth in per capita Part D drug spending by beneficiaries
(Estimated to be $445 by 2013)

Medicare & You

PDPs Enrollment

Most beneficiaries are eligible and may enroll in Medicare Part D during the open enrollment period (11/15/05 – 5/15/06)

Premium amount is increased by one percent each month the beneficiary did not have creditable coverage at the end of the open enrollment period

PDPs Enrollment

Premium can be

- ✓ deducted form Social Security check
- ✓ paid directly to the PDP or to the Medicare Advantage plan
- ✓ paid through an electronic funds transfer

Government Subsidies for Low Income Beneficiaries

- All Medicaid full-benefit eligibles (regardless of income and assets) are eligible for full premium subsidy
- Incomes below 135% of FPL and meet asset test receive full premium subsidy
- Incomes below 150% of FPL and meet asset test receive premium subsidies on a sliding scale

Formularies

A formulary must be developed that meets Medicare's standards and meet Medicare's basic requirements:

- ✓ Will be reviewed by physicians and pharmacists with expertise in care of elderly and disabled
- ✓ Must include drugs within each therapeutic category and class
- ✓ Plans may change categories and classes at the beginning of the plan year
- ✓ The United State Pharmacopia would develop model classes for use by plans
- ✓ Appropriate notice by plans to providers when a drug is removed from formulary

Drug Pricing

- Plans would negotiate prices with manufacturers
- Enrollees must have access to pricing
- Plan sponsors must provide that each pharmacy provide information of differentials—generic vs. therapeutically equivalent

Medicare Supplement Insurance

- Plans H, I or J will not be sold after 1/1/06
- Policyholders can change plans under Guarantee Issue provisions:
  - Standardized Plans A,B,C,F with no pre-existing conditions
- Policyholders must be notified 60 days before initial Part D open enrollment
  - Offer to continue current plan without drug coverage
  - Switch to a substitute guaranteed issue policy
  - If they do not enroll during open enrollment in Part D a guaranteed issue may not be available

CMS & SHIIP Outreach Efforts

Price comparison website at www.medicare.gov

- Compare negotiated prices, fees, features
- Negotiated prices displayed will be drug's maximum price for service area
- Actual prices may vary but not higher than the posted prices

CMS & SHIIP Outreach Efforts

1-800-MEDICARE

- Source for answering questions
- Walk-through price comparison website
- Log calls
- Make referrals to appropriate sponsor or other resources—
  e.g. -- State Pharmacy Assistance Programs

CMS and SHIIP Outreach Efforts

Contact SHIIP

- at www.ncshiip.com for latest developments
- Staff members are available for presentations and interviews
- SHIIP Fact Sheet and other educational materials
- County coordinating sites for SHIIP counseling

Resources for Understanding the Medicare Modernization Act

Medicare & You

Resources

The Medicare Program
www.medicare.gov
www.cms.gov
1-800-MEDICARE

Medicare & You

The Seniors' Health Insurance Information Program (SHIIP)
www.ncshiip.com
1-800-443-9354

SHIIP — N.C. Department of Insurance

Seniors' Health Insurance Information Program

Thank You for your attention and interest!

Geriatric Mental Health Specialty Teams

North Carolina Study Commission on Aging
March 9, 2004

Bonnie Morell, Dr.PH, Community Policy Section, Division MH/DD/SAS, Dept of Health and Human Services

Background

- 20 programs were given start-up MH Trust Funds in FY 02-03 as part of the preparation to increase community capacity to serve older adults prior to reducing the number of geriatric beds in State Psychiatric hospitals.

Purpose of the teams

- Assist with transition to the community
- Provide consultation and technical assistance to nursing facilities and adult care homes regarding the needs of older persons with mental illness
- Link individuals with ongoing treatment or case management needs with local mental health services

Services are provided to

- Older adults who are returning to the community from State hospital geriatric units that are to be closed
- Older adults who are currently in the community who have mental health treatment needs who may be at risk of hospitalization

Location of teams

- Teams provide services in more than one local program in order to make services available throughout the State.

Background and training

- Each team is to have a nurse and a masters level mental health clinician with geriatric experience
- Two meetings have been held this year to identify training needs
- Resource information about training and networking opportunities will be put on the web

Effectiveness and Feedback

- Division of Mental Health is collecting data about the types of services being provided
- Feedback indicates that the teams have linked with the Aging Ombudsman staff, contributed to successful returns to the community, and provided help to facilities regarding residents' needs and behaviors.

Next Steps

- This is a fairly new program that is being implemented during a time of change in the public mental health system.
- Focus will be on identifying ways in which to support the work that is being done by the teams that have been put in place.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **March 9, 2004**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Connolly	Alzheimer's Association, Western Carolina
Teresa Johnson	NC Adult Day Services Association
Alicia Watkins	Alzheimer's Assoc. Eastern NC Chapter
Jean Reaves	NCCOA PO Box 127 Weldon, NC
Lonnie Hedgepeth	Council on Aging P.O. Box 159 Hulfax, NC 27844
June Ballas	NC Senior Citizens Assoc.
Curtis Wilkerson	" " "
Donald Lein	" " "
Tom Southern	NCSCA
Veonan Dull	STHL
Doris Dick	Senior Tar Heel Legislature
Phil Brown	North Carolina Senior Citizens Association
Cindy Trumbower	North Carolina Senior Games, Inc.
Antoinette Mayer	" "
June Brotherton	Friends of Residents in Long Term Care
Karen Gottovi	Division of Aging - Adult Services
Michelle Frazier	NC Bar Ass'n
F. Ben Douglas	NC STHL
Jeremy Coppas	NCALA
Mary Bu...	Div. of Aging - Ad. Services
Ann Johnson	Gov's Ad. Council on Aging
Roxanne Bragg-Cook	NCAOA
Polly W. Richmond	NC Justice Center
Elizabeth Dalton	Bonen Assoc.
Jim Eden	AHFC
Abby Emmanuelson	NMSS

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **March 9, 2004**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sharon Mosley	NCCASA
Suzanne Merrill	NCDAAS
Betsy Lee	Access Dental Care
Bill Milner	Access Dental Care
Bob Lawing	NCPHIPS
Stacy McKenney	NC DHHS
Ed Regan	N.C. R G E A.
KATHY LOWE	NASW
Jennifer Sullivan	NASW. Aging Intern
Patricia A. Young	FRLTC
Ken Melton	Allen Assoc.
Jim Royer	Assoc for Home & Hospice Care
Grant	"
Barbara Hemingway	NCSCA
DAVID BARNES, JR	Poyner + Spruill LLP
Van Vollmer	RRRP
Michael Keough	ORDRHD - SC Care

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **March 9, 2004**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jackie Franklin	Div. of Aging & Adult Svcs
Carla Obiol	Dept of Insurance (SHIIP)
Bonnie Morell	Div MH/DD/SAS
John Goodman	Alley Assoc.
Ken Melton	Alley Assoc.
Steve Mitchell	Novartis
Joshua Bowditch	AstraZeneca

THIS MEETING HAS BEEN MOVED TO ROOM 544

March 31, 2004

MEMORANDUM

TO: Members, NORTH CAROLINA STUDY COMMISSION ON AGING

FROM: Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NORTH CAROLINA STUDY COMMISSION ON AGING:

DAY:	Tuesday	TIME:	10:00 A.M.
DATE:	March 23, 2004		
LOCATION:	**Room 544, LOB**		

Please advise Jo Bobbitt, Committee Assistant, at (919) 733-5477, or e-mail nyela@ncleg.net if you will be unable to attend.
For planning purposes, the following meeting dates have been scheduled for future meetings: April 13, 2004, and April 27, 2004. These meetings will be in Room 643 at 10:00 A. M.

Posted: March 10, 2004

cc: Committee Record _____
Interested Parties _____

Agenda North Carolina Study Commission on Aging

March 23, 2004
10:00 AM
Legislative Office Building
Room 643

I. Welcome
Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair
Senator AB Swindell, Cochair

II. Elder Housing Update
Bob Kucab, NC Housing Finance Agency

III. LTC Workforce Update
Susan Harmuth, Office of Long Term Care and Family Services, DHHS

IV. Adult Day Services
Nancy Cox, Partners in Caregiving/Wake Forest University School of Medicine
Suzi Kennedy, Life Enrichment Center of Cleveland County, Inc.
Steve Freedman, Service Operations Section, Division of Aging, DHHS

V. Home and Community Care Block Grant (HCCBG)
Dennis Streets, Planning, Budget & Systems Support, Division of Aging, DHHS
~~*Gary Cyrus, Planning, Budget & Systems Support, Division of Aging, DHHS.*~~

VI. Report on CAP/DA (Required by S.L. 2003-284, Section 10.29B)
Gary Fuquay, Division of Medical Assistance, DHHS

VII. Criminal Record Checks
John Aldridge, Office of the Attorney General
Jackie Sheppard, Office of Long Term Care and Family Services, DHHS
Roger Manus, Friends of Residents in Long Term Care
Stacy Flannery, NC Health Care Facilities Association

VIII. Summary of Association Presentations
Theresa Matula and Dianna Jessup, Commission Staff

IX. Next Meeting: April 13, 2004

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Tuesday, March 23, 2004
10:00 A. M.
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, March 23, 2004 in Room 643 of the Legislative Office Building. Representative Debbie Clary, Co-Chair, presided. Members also in attendance were Co-Chairs Senator A. B. Swindell and Representative Edd Nye; Senators Allran and Dannelly; Representatives Weiss, Wilson and Earle; public members Allen, Elliott, Price, Marsh, Soltlys, Howard and Sheppard.

Theresa Matula, Dianna Jessup, and Susan Morgan provided staff support to the meeting. Attached is the visitor registration sheet that is made a part of the minutes (See Attachment 1).

Representative Clary convened the meeting at 10 a. m. and welcomed members, staff and visitors. She remarked that it was good to see Rep. Wilson in attendance since his absence due to surgery. Rep. Wilson responded that he was doing well and thanked everyone for the phone calls, cards flowers and prayers. Representative Clary also told the members that Ms. Price was expecting her grandson home from Iraq. The news was received with a round of applause.

PRESENTATIONS

ELDER HOUSING UPDATE

Representative Clary recognized Bob Kucab, NC Housing Finance Agency, to give an update on Elder Housing (See Attachment 2). The NC Housing Finance Agency helps seniors "age in place" by improving their existing housing, and also by working to develop new apartments where seniors can have affordable rents, good living environments, and connections to community services. He stated that support to increase the $3 million state appropriation for the Housing Trust fund in the next legislative session can make a real difference. All state funds that they administer are invested in bricks and mortar; they pay the staff costs from their revenue. In addition, State funds help bring in other investment. As an example, since the creation of the State Housing Credit, they have increased funds for housing development from the Federal Home Loan Bank 275%. He concluded his presentation by stating that with support from the General Assembly, they can continue to create these success stories.

LONG TERM CARE WORKFORCE UPDATE

Susan. Harmuth reviewed initiatives of the Department. She stated that they are working on a variety of projects in collaboration with many partners. Major areas are public

education, awareness and recognition, training and new job categories (see Attachment 3).

ADULT DAY SERVICES

Nancy Cox, Partners in Caregiving/Wake Forest University School of Medicine, made a presentation concerning the predictors of success from marketing, financing and programming perspective for Adult Day Services Centers (see Attachment 4). She reviewed *Lessons Learned & Benchmarks from a National Initiative* in her handout that summarizes the predictors of success. A minimum population base of 20,000 can support an adult day center, with approximately 1% of this population, or 200 people, as potential candidates for a center seeking to serve 20-30 people per day. Average adult day center start-up time is 2 to 3 years, with a price tag of $200,000 to $250,000 per year. This is an average annual operating budget for non-profit programs serving up to 35 people per day. Centers in rural areas and small towns find it necessary to serve everyone, since the absolute market size is usually too small to focus on a smaller market niche; however, centers in larger urban areas can serve a specific market niche (such as dementia-specific, multiple scleroses, or HIV/AIDS) and penetrate that particular market. Centers must respond to the needs and wants of their consumers and program hours must be long enough to serve working caregivers. The handout Ms. Cox made available provides a summary of the national study, which was funded by The Robert Wood Johnson Foundation in Princeton, New Jersey.

Suzi Kennedy, Life Enrichment Center of Cleveland County, Inc., was recognized by Representative Clary to discuss the Life Enrichment Center that she operates in Cleveland County (see attachment 5). They help families keep loved ones at home and in the community. Life Enrichment provides quality day services for adults with physical and mental disabilities, including Alzheimer's, mental retardation and frailties associated with aging. This is a model center and they have had less than 10% turnover rate in direct care staff for the twenty-three years they have been in operation. She suggested looking at day care centers when looking at how to retain direct care workers. Their philosophy is that if a family chooses or is able to keep their loved one at home, then the center will do whatever it takes to help them accomplish that goal. They are open 12 ½ hours a day. The main reason clients leave their center to enter a residential setting is because of "burn out" of the caregiving family members. Ms. Kennedy's presentation was accompanied by a visual PowerPoint presentation that showed their facilities for baths, showers and hair care. Providing baths and personal grooming at the center is very important to the families. They have five levels of care. They have three full-time nurses on staff, which increases their overhead costs. People want medical care. Ms. Kennedy stressed that without financial stability; there can be no social good. She stated finances really have to be in place to run a center.

Representative Clary announced a break for lunch and asked the members to return at 12:30 p.m.

The afternoon meeting began with Representative Clary bringing the meeting back to order and introducing Steve Freedman, the last person on the agenda to discuss Adult Day Services.

Steve Freeman, Service Operations Section, Division of Aging, DHHS presented the members a handout *Adult Day Services in Brief* (see Attachment 5). He reviewed the funding information, cost information and current initiatives in the handout. When Representative Clary called for questions, Senator Allran stated he would like for them to look into the issue of "delay of certification" issue.

HOME AND COMMUNITY CARE BLOCK GRANT (HCCBG)

Dennis Streets, Planning, Budget & Systems Support, Division of Aging, DHHS was next recognized by Representative Clary to give an overview of Home and Community Care Block Grant (HCCBG) (see Attachment 6). He reviewed the handout and discussed the population being served by the Block Grant. North Carolina has the fourth largest population of older adults The HCCBG gives counties the flexibility to choose among the 18 possible services. The purpose of these services is to help older adults to stay at home. By offering a broad range of services designed to improve the quality of life of older adults, the HCCBG has explicitly focused on supporting frail elderly in their preference to be cared for at home; improving and maintaining the physical and mental health of older adults; assisting older adults and their caregivers with accessing services and information; providing relief to family caregivers so that they can continue their caregiving; and allowing older adults to remain actively engaged with their communities.

REPORT ON CAP/DA

Gary Fuquay, Division of Medical Assistance, DHHS provided a report to the members on the Community Alternatives Program for Disabled Adults (CAP/DA) (See Attachment 7). He began by saying the 2003 Session of the General Assembly passed a special provision that focused on community care programs for disabled adults. The provision was to have the state auditor and DHHS examine the program from an operation perspective, a programmatic perspective, and an expenditure perspective. The special prevision required them to examine the total program funds used to care for CAP/DA recipients and to compare that cost with Medicaid recipients in adult care homes and nursing home facilities. Also, there was a request for cost information for clients needing special assistance, interim programs and recipients of Medicaid in-home personal care services. Proper comparisons of cost of care among CAP/DA, nursing facilities, adult care homes, and PCS are not easily achieved because client acuity cannot be accurately compared across these settings. Cost comparisons are most accurate when comparing care for individuals with the same medical acuity level. While medical need and acuity level data are available at the State level for nursing facility patients, at present this information is not readily available for CAP/DA recipients and other long-term care program recipients. Until the acuity data for clients in each population is available for analysis, it is not possible to complete a true cost comparison across the CAP/DA, nursing facility, adult care home, and PCS populations.

CRIMINAL RECORD CHECKS

Representative Clary recognized John Aldridge, Office of the Attorney General, to address the issue of criminal record checks (See Attachment 9). In North Carolina records maintained by the individual clerks of Superior Court are public records. They can be

accessed in doing any type of criminal record check of a particular applicant or employee. These are very comprehensive and contain all felonies, misdemeanors and traffic offenses. These are checked using the persons name and date of birth. They are not fingerprint based. The SBI maintains criminal history record information on those individuals in North Carolina who have been fingerprinted. It isn't as complete a repository as with the clerks. They contain felonies, but not misdemeanors or traffic offences. The FBI uses an indexing system. States send fingerprint files and they are indexed and given an identifying number. The FBI will notify upon request whether they have an individual in their system. They will provide the name of the state from which they received the fingerprints, but the state or department requesting the information must contact the other state directly.

Jackie Sheppard, Office of Long Term Care and Family Services, DHHS spoke to the members and reviewed the State of Mississippi's criminal record checks law (See Attachment 10). Mississippi does their criminal record check both mechanically and electronically. The facilities are outfitted by purchasing their own software at $250.00. This is for a license fee. They purchase a desktop scanner. Information is electronically sent to the Mississippi Department of Health, which in turn, sends it to a criminal information center state agency. If this does not show any disqualifying offense, then it is sent to the FBI for a national check. There are 178 facilities out of 800 that participate, including hospitals, home health agencies, and nursing homes. Staff is trained to take fingerprints and they are scanned and sent to Mississippi Department of Health. The turnaround time is four to six hours if no offenses are found. If there are offenses, turn around time is no more than 72 hours.

Staff asked that a handout, Mississippi Law and Procedure for Conducting Criminal Records Checks of Employees of Long Term Care Facilities, be passed out for the members review (See Attachment 11).

Roger Manus, Friends of Residents in Long Term Care, was introduced and provided the members with a copy of his remarks. He also provided a summary of some information from the State of Florida, which he stated presents an additional model that North Carolina could use concerning criminal record checks (See Attachment 12). He said there are two agencies where the responsibility for national criminal background checks could reside, DHHS or Crime Control and Public Safety. A last option would be to build upon the privatization initiative in State government and contract with a private entity to provide background checks. However, there is some question as to whether they are able to conduct fingerprint based national background checks. He called for an end to the moratorium stating that technology exists to do what is needed to be done and at a cost that is not overwhelming. They want the State to provide a more secure and safe environment for vulnerable elderly and disabled.

Stacy Flannery, North Carolina Health Care Facilities Association was the last presenter to address the members on the topic of criminal record checks (See Attachment 13). She began by stating she would like to give the members some background information concerning this issue. She informed the members that in 1996 the provider association

went to the General Assembly and asked for the mandatory State background check for their employees. This legislation was adopted in 1996 and they began doing background checks for unlicensed personnel. At the beginning of the 2000 session, they were asked by then Attorney General, Mike Easley, and Senator Tony Rand to support SB 1182. This bill would implement the national background check for those unlicensed applicants who had not lived in North Carolina for at least five years. They actively supported that legislation based upon the assurance by the Attorney General's office that they could obtain these checks themselves. They were told that the language in the bill had been approved by the FBI. After the legislation was adopted, the Attorney General's office learned there was a conflict between State and federal law. She told the members they believe they have several options. The first would be to conform State law to Public Law 105-277. This would allow nursing homes and home care agencies to continue obtaining the national checks on the direct care employees. They could establish a process similar to that in the Department of Child Development, or continue the moratorium until they could work through all of the issues surrounding establishing that system. She concluded by saying that their primary concern is always for their patients and their safety and quality of care by their caregivers.

Theresa Matula and Dianna Jessup, Commission Staff, presented a handout to the members *Summary of Presentations by Organizations Representing Older Adults* (See Attachment 14). This provides members with an overview of the presentations made by organizations during the March9, 2004 meeting. The staff indicated that they hope this information would be helpful to the Commission as they formulate recommendations. She again encouraged members to contact Commission staff if they had preferences for recommendations.

Representative Clary announced that at the April 13, 2004 meeting, they would be presented with a group of different pieces of legislation in draft form for their consideration and they would be able to cast a final vote on April 27, 2004 as to whether the legislation should move forward for consideration in the short session of the General Assembly.

There being no further business, Chairman Clary adjourned the meeting.

Jo Bobbitt

Representative Debbie Clary, Co-Chair

Jo Bobbitt, Committee Assistant

Representative Edd Nye, Co-Chair
Senator A. B. Swindell, Co-Chair

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **March 23, 2004**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Teresa Johnson	NC Adult Day Services Association
Jan Rogers	Assoc for Home & Hospice Care of NC
Sherry Thomas	
Jim Edgerton	
Steven Freedman	NC Div. Aging / Adult Services
Will Rush	NC DOT
DAVID BARNES	Poyner Spruill LLP
Mary Cyrus	Aging
Abby Emanuelson	NMSS
Shadoh Mosley	NCCASA
Karen Bottori	Div of Aging + Adult Services
Dennis Streets	Div. of Aging + Adult Services
My Bates	" "
Jane Brotherton	Friends of Residents in Long Term Care
Doctrine Glenn	FRLTC
Mary H. Odom	AARP
Richard C Hatch	AARP + NCCOA
Jean Reaves	NCCOA NCADSA
Beverly Wheeler	Friends of Residents in LTC
Shannon Crane	NC Div. of Aging
Nancy Evans	NC Division of Aging + Adult Services
Glenda C. Autry	Division of Aging + Adult Services
Anna Vann	NCDHHS
Debbie Brantley	Div of Aging + Adult Serv.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **March 23, 2004**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Shepherd	DHHS/DCC 319 Chapanoke Rd, Raleigh 27603
Nancy Cole	WFU School of Medicine
Suzi Kennedy	Life Enrichment Center of Cleveland County 103 TR HARRIS DRIVE, SHELBY, NC 28150
Jackie Franklin	DAAS (Aging and Adult Services) 325 N. Salisbury st Raleigh 27603
Suzanne Merrill	" " "
Bonnie Briggs-Cook	NCAOA
Jerry Cooper	NCALA
Kenneth Dalton	Dunn & Associates
John Bowdish	AstraZeneca
Stacey Flannery	NCHCFA
ANN LORE	OUHS
Daphne Lyon	OSBM
Polly Williams	NC Justice Center/Triangle GWL
Jack Cozort	PARKER POE
Jim Edgerton	AHHC
Brenda Jackson	Greene County Dept. of Social Services
Stana McKenney	NC DHHS
WILLIAM GUILLET	Speaker Black's Office
CASANDRA SKINNER	NC CCPS
Ashby T. Ray	NC DOJ
Tammy Tyson	SBI
[illegible]	AGO
John Aldridge	AGO
[illegible]	DFS
[illegible]	

NORTH CAROLINA
HOUSING
FINANCE
AGENCY

MEMORANDUM

TO: N.C. Study Commission on Aging

FROM: A. Robert Kucab
Executive Director

DATE: March 23, 2004

SUBJECT: Elderly Housing Issues

A self-supporting
public agency

A. Robert Kucab
Executive Director

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My name is Bob Kucab and I represent the North Carolina Housing Finance Agency. Thank you for this opportunity.

We are a self-supporting public agency that was created by the General Assembly 30 years ago to finance housing for persons who are not served by the private market.

We have successfully been a part of over $8 billion of housing production that has improved the lives of over 500,000 persons in every county of North Carolina.

The financing tools that we use are tax-exempt bonds, federal and state tax credits, the state Housing Trust Fund, the federal HOME Program and general revenues that we earn. We blend these financing sources to produce the greatest benefit for North Carolina citizens.

Our agency both helps seniors age in place by improving their existing housing and also by working to develop new apartments where seniors can have affordable rents, good living environments, and connections to community services.

To promote aging in place, we have two initiatives. First, the Urgent Repair Program provides grants of up to $3,500 to correct a serious housing problem that threatens to displace a homeowner. Second, the Single-Family Rehabilitation Program provides deferred-payment loans of up to $40,000 to comprehensively upgrade a single family home and eliminate hazards such as lead-based paint.

In both programs, we have worked through over 250 partners to help almost 9,000 elderly households, all with incomes below 50% of median income. We also started a partnership with the 16 offices of the Independent Living Program in DHHS to provide financing for disabled clients on their long waiting lists who have special need of home modifications.

On the production side, we have financed 238 developments that provide over 10,300 affordable apartments for persons aged 55 or older. Last fiscal year, we added 19 new developments in 16 counties. We also manage HUD rent subsidies for another 8,440 existing apartments that are available for seniors with incomes below 30% of median.

Numerous adaptive reuse projects have converted historic schools, mills and hotels into new apartments for seniors. Some, but not all, historic buildings can provide attractive living environments. The Dallas High School in Dallas and the Golden Leaf Apartments in Wilson are recent examples of successful projects.

New developments have been built in a variety of styles to blend into the neighborhood. In the rural east and west, most properties are one story, duplex and quadplex configurations with separate community buildings similar to these new properties in Tabor City and in Rockingham. In the bigger cities, most properties are one and two story, single building configurations with their own interior community space. Huntington Senior Apartments, which is near the regional hospital in Goldsboro, and Parkview Manor, which is a part of a public housing revitalization effort here in Raleigh, are good examples.

There are also some unique properties, like the shared living developments that have been built in a few small towns such as Farmville. They offer small scale, home-like environments and communal living, but the financing for these is very difficult to replicate and management and supportive services are costly.

To test a new approach, we worked with the developer of this traditional apartment community in Raleigh to fully incorporate universal design features as a further way to help tenants age in place. Here are a few examples of inexpensive but helpful changes.

Also, last year we were privileged to be a part of financing the first housing development that is specifically designed for seniors who have developmental disabilities. This $1.9 million property was sponsored by Residential Services, Inc. and is located in Durham County.

In summary, there is a lot of exciting work being done, but a lot more yet to do. Applications for funding exceed available capital by 3 to 1.

Consequently, your support to increase the $3 million state appropriation for the Housing Trust Fund in the next legislative session, can make a real difference. All state funds that we administer are invested in bricks and mortar, we pay the staff costs from our revenue. In addition, state funds help us bring in other investment. As an example, since the creation of the state Housing Credit, we have increased funds for housing development from the Federal Home Loan Bank by 275%. With your support in the General Assembly, we can continue to create these success stories.

As always, I appreciate the Aging Study Commission's interest in, and long time support for, our work. Thank you for this opportunity.

NORTH CAROLINA
HOUSING
FINANCE
AGENCY

MEMORANDUM

TO: N.C. Study Commission on Aging

FROM: A. Robert Kucab
Executive Director

DATE: March 23, 2004

SUBJECT: Elderly Housing Issues

A self-supporting
public agency

A. Robert Kucab
Executive Director

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As always, I appreciate the Aging Study Commission's interest in, and long time support for, our work. Thank you for this opportunity.

North Carolina Study Commission on Aging
March 23, 2004

Nancy J. Cox, M.S.W., Director
Partners in Caregiving: The Adult Day Services Program
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Partners in Caregiving is a national adult day services program, created in 1987 by The Robert Wood Johnson Foundation. Located in the Department of Psychiatry at the Wake Forest University School of Medicine, the focus of the program revolves around teaching non-profit adult day centers the principles of business and marketing to be financially self-sufficient and not rely on grants. Through our research, we have determined the predictors of success from a marketing, financing, and programming perspective – the basics for survival.

Lessons Learned & Benchmarks from a National Initiative (attached) summarizes the predictors of success, such as:

- A minimum population base of 20,000 can support one adult day center.

- Average start-up time is 2-3 years (like a small business) with a price tag of $200,000 to $250,000 per year to serve 35 people per day. In the non-profit arena today, serving 40-50/day equates to financial viability and 60-70/day in the for-profit arena.

- If an adult day center is in a rural area (or small town), they need to serve everyone (beyond just the frail elderly and people with dementia) or probably will not make it financially.

- To be financially viable, program hours must be long enough to serve working caregivers. Being open Monday through Friday from 7:00 or 7:30 a.m. to 6:00 p.m. is a predictor of success.

- Know your unit cost and set your fee equal to or greater than unit cost, with individual discounts available for those who cannot afford to pay the full amount.

- Provide or arrange for transportation. Daily census increases when transportation is offered.

- Pursue a variety of revenue streams to avoid reliance on any one revenue source.

- Another logical predictor of success is to keep the center full. One in three who inquire will enroll, and you need to enroll two people for every slot (since everyone does not attend every day).

- And, successful centers do target marketing, targeting the formal referral source network (health care professionals, social service agencies, employers, etc.). 75% of all referrals and two-thirds of all enrollments come from formal referral sources.

National Trends (attached), as observed by Partners in Caregiving, also connect to predictors of success, such as:

- New centers being opened today are adult day health centers (the medial model), and existing social models are converting to adult day health, because it opens the door to additional revenue streams (e.g., Medicaid home and community-based waiver dollars, and funds through the Department of Veterans Affairs and managed care companies).

- To help eliminate barriers caregivers face, centers are providing personal care services, particularly bathing and hair care, and charging extra.

- Populations served are being expanded to include people with mental retardation/ developmental disabilities, and the chronically mentally ill – additional revenue streams.

- Home health agencies, hospitals, assisted living facilities, and long-term care facilities are getting in the business, with adult day centers as their new product line.

- And, more for-profit adult day centers are being opened, targeting the private pay market (middle and upper income) and targeting states with higher Medicaid waiver reimbursement rates. Due to low reimbursement rates, the for-profit chains are avoiding North Carolina.

The latest venture of Partners in Caregiving was to conduct a ***National Study of Adult Day Services*** funded by The Robert Wood Johnson Foundation (summary attached). This 2-year study, with results released in 2003, revolved around 3 major activities: (1) conduct a census of adult day service providers to determine how many adult day centers exist and where they are located; (2) survey all providers to create a profile of the field; and, (3) identify gaps in the current service delivery system.

The study confirmed 3,407 adult day centers in the United States (of which 107 were in North Carolina). Growth in the industry was evident, but it lags behind the need for the service, with 56% of the counties in the United States under served. In North Carolina, 75 out of 100 counties (75%) are under served (map attached). With current need not being met, 5,415 new adult day centers are needed nationwide, of which 138 new centers are needed in North Carolina (ranging from 1 new center needed in 43 counties to 7 new centers needed in 3 counties).

The study also provides a profile of existing adult day centers. Ironically, although we need more adult day centers in every state, those that exist are not full! The average center has a maximum capacity of 38 people, with an average daily attendance of 25 (i.e., a 66% utilization rate). For North Carolina, the average utilization rate is worse – only 55%, which is based on an average maximum capacity of 29 and an average daily attendance of 16.

50% of adult day centers nationwide do not know their unit cost! Of the 50% who do know, it is (on average) $56 per day. However, the top private pay fee is $46 per day – a $10/day differential! And you wonder why 44% of centers had a deficit at the end of their fiscal year! But, for North Carolina, it is worse! Average unit cost is $44/day, with the average top private pay fee at $32/day (i.e., charging $12/day less than cost), with 61% of centers in North Carolina reporting a deficit!

Nationally, the #1 revenue stream coming into adult day centers is from 3rd party public reimbursements (38%), of which Medicaid waiver dollars tops the list. This is a problem since these funding streams usually reimburse at less than cost. The #2 revenue stream is the private pay market at 35%. For North Carolina, 23% of revenue is from 3rd party public reimbursements and 25% private pay. But, there is a larger private pay market out there.

Overall, the ***National Study of Adult Day Services*** shows a level of sophistication in service delivery of which many people are not aware (in regard to populations served and services offered), dispelling the myth of being just a babysitting service, going beyond a meal and bingo.

The study shows adult day centers as a viable, cost-effective, community-based service option in the long-term care continuum that helps keep individuals (in need of chronic care) at home, in the community, with family and friends for as long as possible – delaying or preventing institutionalization. The average length of stay in an adult day center is 2 years, with the #1 reason for discharge being placement in a long-term care facility. The #2 reason for discharge is death.

The study also shows the need for capacity building at the state level in 3 areas:

- increased public awareness in underutilized areas;

- increased availability in areas where the service is not currently an option for caregivers; and,

- increased knowledge at the provider level regarding predictors of success (from a marketing, financing, and programming perspective).

To address the need for increased public awareness, the field needs a national public awareness campaign, flowing from the top down. This could also be the role of state government or the state adult day services association.

To increase availability, given the current economic climate, how can the need be funded? By giving people a choice (with existing funds). Make the service a benefit (from which to choose) under Medicaid and Medicare. Right now the funding chooses for us, with an institutional bias. In many states, Medicaid long-term care spending is breaking the bank. Long-term care reform is needed. Adult day centers can be part of the reform as a service option.

And, since states do not want Medicaid-only systems to pay for long-term care, we need to promote long-term care insurance. 75% of policies sold last year cover adult day services.

Funding start-up ventures (to open new adult day centers) needs to be a partnership between local/state/federal government, the private sector, and philanthropy.

The mission of Partners in Caregiving is to increase knowledge at the provider level regarding predictors of success to keep the doors open. The worst thing that can happen is for an adult day center to open and then close – devastating for caregivers. The field, however, is in a state of flux, with centers opening and closing on a daily basis. During the census portion of the national study, a 20% closure rate was recorded over the 2-year period. What is the answer? Ongoing technical assistance.

The challenge Partners in Caregiving now faces is how can we do this? How can we integrate the predictors of success in the field on a state-by-state basis? How, and through whom, can we replicate our mentoring program (another key to success)? The most logical avenue seems to be through the state adult day services associations, using a train-the-trainer approach.

In 1998 , the North Carolina Department of Health & Human Services contracted with Partners in Caregiving to provide technical assistance for one year to 23 start-up centers that each received a $35,000 state grant. Six (26%) of these centers have now closed. Why? The bottom line is you can teach the predictors of success, but it is only those centers that apply the information that are the successful ones. Also, Partners in Caregiving research has shown that it is a 3-year (versus 1-year) technical assistance program that works best – that has the most significant impact on financial self-sufficiency.

Several weeks ago I had the opportunity to go to the Division of Aging Services and review records of 30 adult day centers in North Carolina that have closed since the Year 2000. Still a work-in-progress, some of what I saw that was not conducive to financial viability was: centers were too small, designed to serve less than 40 people/day; centers were not full/under utilized; hours of operation were not conducive to working caregivers; centers were overstaffed; and, some had restrictive eligibility criteria.

The majority of centers that closed did not make it past the 3-year start-up phase. Why? In addition to the predictors of success not being applied, prior to the technical assistance project with the 23 start-up centers, it was obvious that some were doomed to fail from the beginning. Many were going into the service blindly, not knowing what it was going to take, with many misconceptions, such as: caregivers would be beating down the door when the center opened because there was a need; $35,000 was adequate start-up funds (when in fact it really was seed money); and, in 6 months to 1 year they would be full and making a profit! Wrong! It was rare to see a start-up center with a business plan, marketing plan, or strategic plan as part of their grant proposal. If start-up funds do become available again through the generosity of the state legislature, a pre-grant workshop is recommended to dispel myths and bust bubbles! If that prevents someone from opening a center, that would be a good thing.

As Partners in Caregiving continues to formulate its next steps as to what is in the best interest of the field, and as the Commission does the same, I am available at your convenience to assist in anyway I can. Thank you for the opportunity to speak to you today.

ADULT DAY SERVICES

Lessons Learned & Benchmarks from a National Initiative

Dementia Care & Respite Services Program

Partners in Caregiving: The Dementia Services Program

Population Base

- a minimum population base of 20,000 can support an adult day center, with approximately 1% of this population, or 200 people, as potential candidates for a center seeking to serve 20-30 people per day.

Financial Considerations

- average adult day center start-up time is 2 to 3 years, with a price tag of $200,000 to $250,000 per year (excluding renovations); this is an average annual operating budget for non-profit programs serving up to 35 people per day.

Target Populations

- adult day centers can serve a variety of populations – the frail elderly, persons with Alzheimer's disease or other dementing illnesses, and those who are cognitively intact but physically challenged (such as multiple sclerosis).

- adult day centers in rural areas and small towns find it necessary to serve everyone, since the absolute market size is usually too small to focus on a smaller market niche; however, centers in larger urban areas can serve a specific market niche (such as dementia-specific, multiple sclerosis, or HIV/AIDS) and penetrate that particular market.

Service Decisions

- adult day centers must respond to the needs and wants of their consumers.

- to help ensure that the needs and wants of both participants and caregivers are being met, centers should provide either a continuum of care – using a one-stop shopping approach – or create partnerships with other community service providers.

- program hours must be long enough to serve working caregivers.

- a full day of engaging activities must be provided that offers choices, focusing on the interests and abilities of the participants.

Predictors of Success – from a Financial Perspective

- a center being open from 7:00 or 7:30 a.m. to 6:00 p.m., Monday through Friday, has been shown to be a predictor of success.
- unit cost must be calculated and fees must be set to equal or exceed costs, with individualized discounts available.
- centers must provide or arrange for participant transportation; centers note an increase in daily census when transportation is offered.
- many day centers achieve financial viability by pursuing a variety of revenue streams (self-pay/out-of-pocket payments, government funds, private insurance, etc.); by using this diversified strategy, reliance on any one revenue source is avoided.
- a noteworthy accomplishment is to become fully self-sufficient through operating revenue, which is revenue from direct participant care on a fee-for-service basis; on average, Partners in Caregiving sites met 83% of their cash expenses through net operating revenue.
- to obtain financial self-sufficiency, a major objective is to keep the day center full: one in three people who inquire will enroll, and a center with a capacity of 25 per day needs an overall enrollment of 50 (double the average daily attendance); the best practice is to enroll at least one new person every week.

Predictors of Success – from a Marketing Perspective

- adult day centers must be able to meet the wants and needs of a variety of caregivers: care seekers (potential heavy users of service) who want or need full-day, center-based services, including extended hours and ancillary services such as transportation and bathing; and, respite seekers (potential moderate users of service) who need occasional time-out from caregiving but do not want full-time daily care; a "care" center can meet the needs of caregivers who want "respite" but a "respite" center will not be able to meet the needs of those who want "care."
- adult day centers need to know how to apply the principles of marketing: marketing is defined as solving someone else's problem by developing, delivering and communicating services that will attract, satisfy and keep customers.
- since 75% of all referrals and two-thirds of all enrollments come from formal referral sources (health care professionals, social service agencies, employers, etc.), targeting these sources is one of the most effective ways to promote adult day centers.
- in order to implement an effective marketing effort, one must have a working knowledge of the process of converting inquiries to enrollments, which involves five steps: the first call, following-up the first call, the first visit, converting the first visit into an enrollment, and customer satisfaction.

ADULT DAY SERVICES

National Trends

As observed by Partners in Caregiving

- new adult day centers being opened are adult day health centers – more appealing to managed care companies
- existing social model day centers are converting to adult day health centers
- ancillary services provided by day centers are on the increase:
  - personal care services (bathing & hair care)
  - up & tuck services
  - weekend & overnight respite
  - 1-week & 2-week stays
  - rehabilitation therapy (speech, physical, occupational)
  - subacute care
- more centers are striving to be a one-stop shop
- there is an increase in the frailty of participants
- the % of dementia clients is increasing
- target populations served are being expanded to incorporate persons with mental retardation/developmental disabilities & the chronically mentally ill
- there is an increase in the number of for-profit adult day centers being opened, targeting the private pay market (middle & upper income)
- home health agencies, hospitals, assisted living facilities, and long term care facilities (non-profit & for-profit) are getting into the business – looking for a new "product line"
- but existing adult day centers are also adding new product lines as well, such as assisted living!!

National Study of Adult Day Services
2001-2002

Funded by: The Robert Wood Johnson Foundation
Princeton, NJ

Partners in Caregiving: The Adult Day Services Program
Wake Forest University School of Medicine
Winston-Salem, NC

Executive Summary

A **National Study of Adult Day Services**, conducted by Partners in Caregiving: The Adult Day Services Program (with PMD Advisory Services, LLC and the Seniors Research Group of Market Strategies, Inc.), revolved around three major activities: (1) conducting a census of adult day service providers to determine how many adult day centers exist and where they are located; (2) surveying these providers to determine populations served and services offered; and, (3) identifying gaps in the current service delivery system. The assessment of gaps included analysis of utilization gaps (i.e., where centers exist but are underutilized) and availability gaps (i.e., where no centers exist despite a probable need), illustrating counties that are under served, in equilibrium, or have excess capacity.

The study confirmed 3,407 adult day centers in the United States, of which 53% are well established, having been open for 11-20 or more years. Individuals being served range in age from 18 to 109, with an average age of 72. The two most prevalent conditions are dementia (52%) and 41% frail elderly (age 60+ in need of supervision and/or at-risk of social isolation; no dementia). Twenty-four percent (24%) are diagnosed with mental retardation/developmental disabilities, 23% are physically disabled but cognitively intact, and 14% have a chronic mental illness. Forty-three percent (43%) of individuals enrolled in an adult day center need assistance with toileting, 37% with walking, and 24% with eating.

Twenty-one percent (21%) of adult day centers are based on the medical model of care, 37% are based on the social model of care (with no medical component), and 42% are a combination of the two. Adult day centers provide a vast array of services such as: therapeutic activities, health monitoring, social services, personal care services, meals, transportation, nursing services, medication management, caregiver support services, rehabilitation therapy, medical services, overnight care and emergency respite.

Most people attending an adult day center live with an adult child (35%) or a spouse (20%). The average length of stay at the center is two years, with the number one reason for discharge from the center being placement in a residential setting (such as a long-term care facility). The number two reason for discharge is death.

The study notes that the majority of adult day centers are not-for-profit (78%), operate under the umbrella of a large parent organization (70%), and are open Monday through Friday, eight or more hours a day. On average, adult day centers serve 25 people per day (with an overall enrollment of 42) at an average cost of $56/day. The average daily fee, however, is $46/day (less than cost). Annual revenue (on average) is $365,208, of which 38% comes from third-party public reimbursements (mainly Medicaid Home- and Community-Based Waiver dollars), 35% from private pay/out-of-pocket payments, 14% from non-operating revenue (such as grants and donations), and 13% from other operating revenue (such as private insurance and ancillary services like transportation).

Growth in the adult day services industry is evident, with 26% of all adult day centers opening in the last five years. However, growth lags behind the need for the service, with 56% of the counties in the United States under served (1,770 counties out of a total of 3,141). The study concludes that the current population base of the United States can support a total of 8,520 adult day centers. With current need not being met, 5,415 new adult day centers are needed nationwide (1,424 in rural areas and 3,991 in urban areas).

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National Study of Adult Day Services
2001-2002

Conclusions

The **National Study of Adult Day Services**, conducted by Partners in Caregiving: The Adult Day Services Program (with PMD Advisory Services, LLC and the Seniors Research Group of Market Strategies, Inc.), provides a wealth of information – a portrait of the field, resulting in valuable planning information for individual adult day centers, and local/state/federal officials, legislators, and policymakers. The information can be used to benchmark centers within their own state, do state-by-state comparisons, and state/national comparisons.

The **National Study of Adult Day Services** shows a level of sophistication in service delivery of which many people are not aware (in regard to populations served and services offered), dispelling the myth of being just a babysitting service. It shows adult day centers as a viable, cost-effective community-based service option in the long-term care continuum, that helps keep individuals (in need of chronic care) at home, in the community, with family and friends for as long as possible.

The **National Study of Adult Day Services** shows the need for capacity building at the state level. Based on current service gaps (i.e., availability gaps and utilization gaps), and based on an increase in demand that will occur (due to a projected increase in the disabled elderly population and because centers are now serving a younger population with chronic conditions), capacity building needs to occur at the state level in three areas:

1 – increased public awareness in underutilized areas;

2 – increased availability in areas where the service is not currently an option; and,

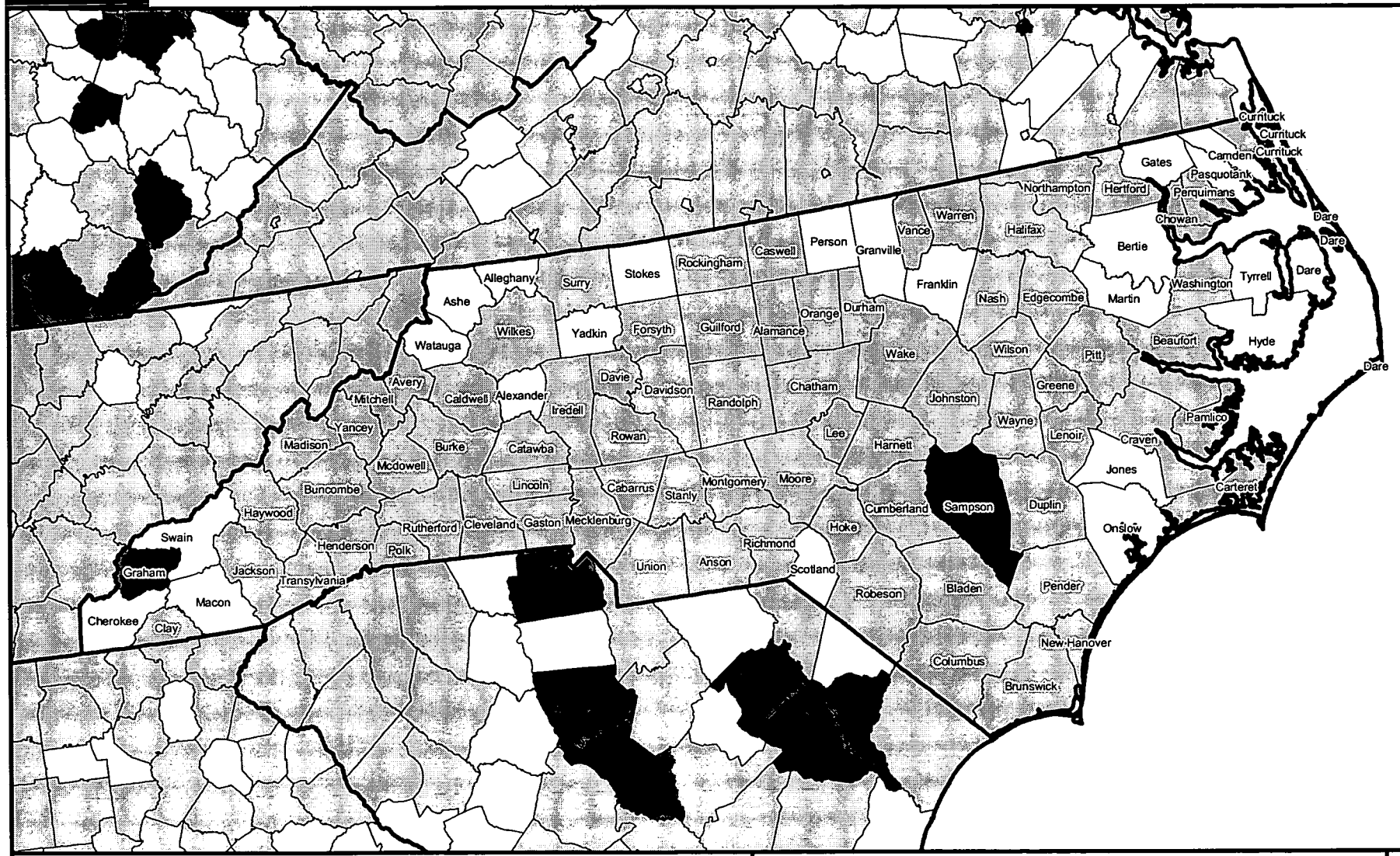
3 – increased knowledge at the provider level regarding predictors of success (from a marketing and financial management perspective), in order to increase utilization at existing centers and even expand existing centers (when appropriate) to be able to serve more people with chronic care needs.

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PARTNERS IN CAREGIVING

A National Study of Adult Day Services

North Carolina
Adult Day Center Service Gaps



Source: A National Study of Adult Day Services by Partners in Caregiving: The Adult Day Services Program (with PMD Advisory Services, LLC & Seniors Research Group of Market Strategies, Inc.)

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Legend

- Under Served Counties: 84 Confirmed Centers; 138 New Centers Needed
- Counties in Equilibrium: 19 Confirmed Centers
- Counties with Excess Capacity: 4 Confirmed Centers

Adult Day Services in Brief

Adult day care and adult day health services are part of the continuum of long-term care for older and disabled adults in North Carolina. They offer a means for an impaired adult to get out of the house during the day into a safe and supervised environment, an opportunity for group involvement and individually planned services, and activities directed toward stabilization or improvement of self-care. The programs also provide a critical period of respite for family caregivers, enabling them to continue their responsibilities more effectively.

Definition

- Day care services for adults is the provision of an organized program of services during the day in a community group setting for the purpose of supporting adults' personal independence, and promoting their social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, a nutritious meal and snacks as appropriate to the program, and referral to and assistance in using other community resources.

- The health care component of adult day health services distinguishes it from adult day care, which also provides a structured program of activities and services during the day for aging, disabled and handicapped adults. As part of the structured program of activities and services, participants enrolled in adult day health also require daily nursing supervision. Participation in adult day health can enable such persons to achieve and maintain their optimum level of independence and can support family members and other caregivers who are providing full-time care to frail adults living at home.

- Adult day health care programs and combination adult day care/adult day health programs include an on-site RN or LPN for a minimum of 4 hours daily.

- Providers of adult day services must meet North Carolina state Standards for Certification, which are administrative rules (10A NCAC 06R and 10A NCAC 06S) set by the Social Services Commission and enforced by the Division of Aging and Adult Services.

Program Information

- There are currently 113 certified programs in the state (3/17/04).
  - 57 are adult day care programs
  - 54 are combination adult day care and adult day health programs
  - 2 are adult day health programs
- Certified adult day services are located in 60 counties.
- On any given week day approximately 3272 slots for participants are available at adult day services in North Carolina.

History/Development

- Adult day service has grown in North Carolina from two programs in 1973 to its peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. Although some programs would close, others would open. In many cases, the program that closed reopened under a new organization. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. As a result, we now have 113 programs in 60 counties. The majority of growth in adult day care at this time is in the larger metropolitan areas such as Mecklenburg and Guilford counties.
- In 1999 the Division of Aging considered approaching the social services commission about a rate increase, however were advised by DHHS budget and analysis that there was little chance of a rate increase without an overall increase in the State Adult Day Care fund since a rate increase without a budget increase would result in a cut to services.

Funding Information

Adult Day Care Expenditures **SFY 02-03**
Proration of In-Home Services for agreement with BD-701, dated 6/29/03 03/17/2004

Home and Community Care Block Grant
 # Funded Providers as of 3/17/04: 59

	Federal	State	Local	Total	Exp. %	Clients Over 60
Adult Day Care	857,023	536,744	154,863	1,548,630	52.44%	652
Adult Day Health	777,269	486,795	140,452	1,404,516	47.56%	516
	1,634,292	1,023,539	295,315	2,953,146	100.00%	1,168
	55.34%	34.66%	10.00%	100.00%		

State Adult Day Care Fund
 # Funded Counties as of 3/17/04: 65

	Federal	State	Local	Total	Exp. %	Clients Under 60	Clients Over 60	Clients Total
Adult Day Care	1,534,080	521,540	293,660	2,349,280	74.15%	242	811	1,053
Adult Day Health	534,808	181,818	102,375	819,001	25.85%	72	295	367
	2,068,888	703,358	396,035	3,168,281	100.00%	314	1,106	1,420
	65.30%	22.20%	12.50%	100.00%				

Adult Day Services Total

	Federal	State	Local	Total	Exp. %	Clients Under 60	Clients Over 60	Clients Total
Adult Day Care	2,391,103	1,058,284	448,523	3,897,910	63.68%	242	1,463	1,705
Adult Day Health	1,312,077	668,613	242,827	2,223,517	36.32%	72	811	883
	3,703,180	1,726,897	691,350	6,121,427	100.00%	314	2,274	2,588
	60.50%	28.21%	11.29%	100.00%				

Funding Information *(continued)*

- The maximum reimbursement rate for the purchase of adult day services is $565 per month ($26.07 per day). Of this amount, $500 per month ($23.07) is for daily care and $65 per month ($3.00 per day) is for round trip transportation.
- The maximum reimbursement rate for the purchase of adult day health services is $715 per month ($33 per day). Of this amount, $650 per month is for daily care ($30.00 per day) and $65 per month ($3.00 per day) is for round trip transportation.
- These rates were established by the Social Services Commission effective December 8, 1997.

Cost Information

According to the North Carolina Adult Day Services Association, the average cost to operate an adult day program in North Carolina was $31.00 per day for social programs and $44.00 per day for health models.[1] Public reimbursements fall short of that amount, leaving a deficit for non-private pay participants of sometimes 50% or more. Businesses such as adult day care programs must charge fees equal to or greater than their cost to at least break even.

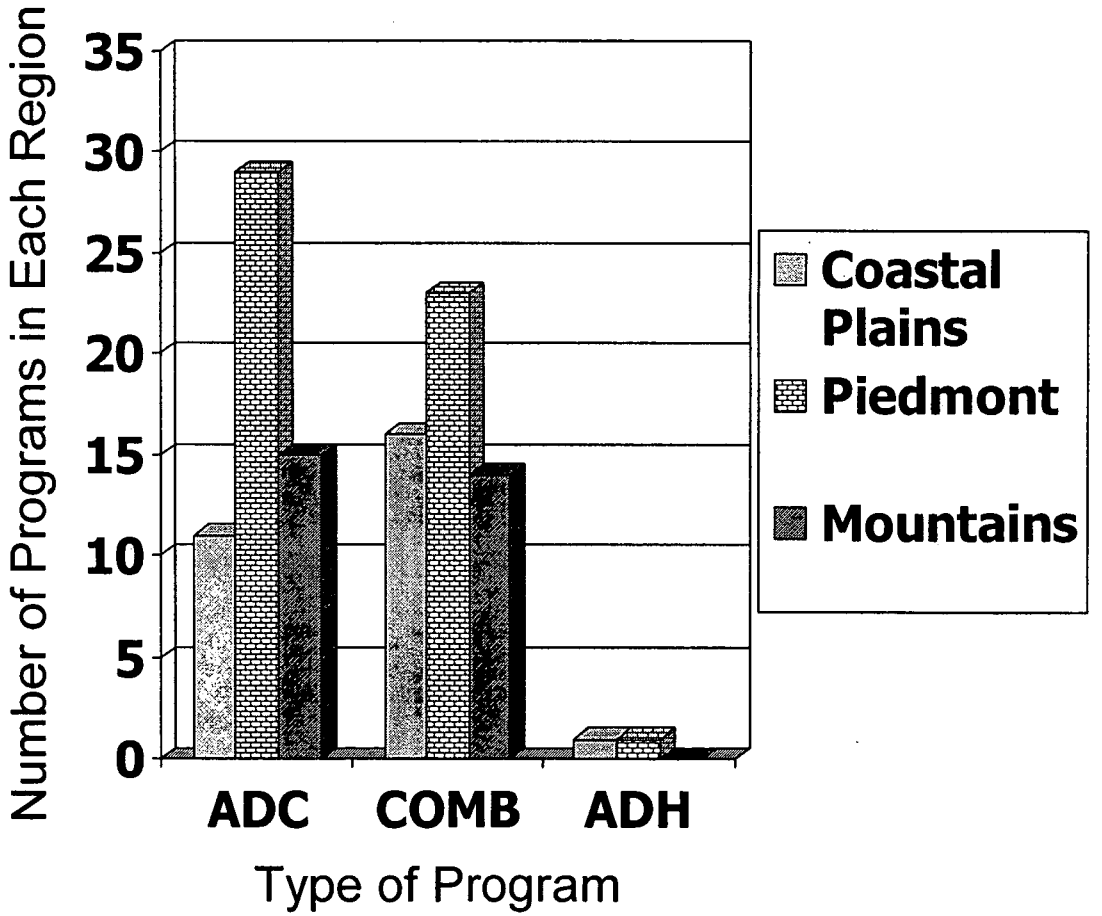
Current Initiatives

- In 2003 a special provision was introduced to the North Carolina General Assembly (House Bill 397) as follows: "The Social Services Commission shall consider adopting rules increasing the rates for adult day centers and adult day health centers. Any rate increase adopted by the Social Services Commission for adult day centers and adult day health centers shall be implemented within existing funds."
- The Division of Aging has been working closely with the North Carolina Adult Day Services Association to develop fiscal training for adult day programs. The aim of this project is to assist adult day programs with budgeting and help increase their understanding of service costs. Adult day care programs who have participated in the training will mentor other programs to understand the revenue stream and develop a business plan to balance their budget.

[1] Information based on a 2001 survey conducted by the North Carolina Adult Day Services Association in conjunction with the Division of Aging.

The Types of Programs and Geographic Location in North Carolina

- Adult Day Care Programs (57)
- Combination Adult Day Care and Adult Day Health Programs(54)
- Adult Day Health Programs (2)



Regulation of Adult Day Services in North Carolina

North Carolina General Statute (G.S.) 131D-6

The General Assembly enacted General Statute 131D-6 in 1986 that required certification of adult day programs.. Adult day care means the provision of group care and supervision in a place other than their usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled. The following programs are exempted from the provisions of G.S. 131D-6:

- Those that care for three people or less;
- Those that care for two or more persons, all of whom are related by blood or marriage to the operator of the facility;
- Those that are required by other statutes to be licensed by the Department of Health and Human Services.

*Adult day health services is the provision of an organized program of services during the day in a community group setting for the purpose of supporting an adult's personal independence, and promoting his social, physical and emotional well-being.(10A NCAC 06S.0102)

↓

Department of Health & Human Services

G.S. 131D-6 mandates the NC Department of Health and Human Services (DHHS) to "annually inspect and certify all adult day programs under rules adopted by the Social Services Commission."

↓

Social Services Commission

The Social Services Commission is given the authority to adopt rules to protect the health, safety and welfare of persons in adult day care programs. The rules are to include minimum standards in the areas of management, staffing, building requirements, etc.

↓

Division of Aging

DHHS delegates authority to the Division of Aging to regulate adult day services in NC and to administer the State Adult Day Care Fund.(G.S.143B-153)

↓

Area Agency on Aging

The Area Agency on Aging (AAA) and Adult Program Representatives (APRs) monitor adult day programs and counties that receive Home and Community Care Block Grant Funds (Older Americans Act).

↓

County Health Dept.

Local County Health Departments have the responsibility of certification of Adult Day Health Programs (10ANCAC 6S.0101)

↓

County DSS

Local County Departments of Social Services have the responsibility for all aspects of local regulation of adult day programs and managements of State Adult Day Care Fund (10A06R.0101)

Staffing Ratios

The 2001 session of the General Assembly Senate Bill 1115 requested a report on staffing requirements in long-term care facilities, including adult day service programs. In response, the Division of Aging and Adult Services prepared a report, the highlights of which are below.

Number of staff required per resident [participant]

Adult Day Care Homes 1:6
Adult Day Care Centers 1:8
Adult Day Health Centers and Adult Day Health Homes 1:5
Adult Day Care/Day Health Combination Programs 1:6

A national study of Adult Day Services conducted by the Robert Wood Johnson Foundation found the following national staffing averages:

Social model 1:7.3
Medical model 1:7.8
Combination 1:7.4

History, Rationale and Justification for Existing Ratios

The North Carolina Adult Day Care Services Standards for Certification, which dictate the existing staff ratios, were adapted from child day care regulations and originally in place in 1974, prior to mandatory certification. In 1986, legislation passed requiring the certification of all adult day care programs. The social services commission was responsible for establishing the initial rules and regulations. During this time, the Division of Social Services served as the certifying agency and responded to any concerns with regard to program certification and/or operation. This responsibility transferred to the Division of Aging in July of 1998.

The current rationale and justification is based on the Standards and Guidelines for Adult Day Services determined by the National Adult Day Services Association. In the revised 1997 recommendations, this guideline suggests a MINIMUM of 1:6 for programs offering "core services" (comparable to adult day care services) and suggests a staff--participant ratio of 1:4 when providing "enhanced and/or intensive services" (comparable to adult day health and adult day care/day health combination services.) Furthermore, the North Carolina ratios are in keeping with the national average as evidenced by the Robert Wood Johnson Foundation study previously cited.

Staff Requirements

The Standards for certification do not detail specific staff requirements except for the program director and the health care coordinator. The health care coordinator, a RN or LPN, is only required to be present 4 hours per day in programs that have the health care component. Other staff positions are not mandated by the Standards and will vary from program to program.

Adult Day Services
Program Closings 2001 - 2003

Adult Day Services	County	Closing Date	Reason Provided for Closing
*DayBreak Adult Day Services (ADC/ADH)	Lenoir	1/31/2001	Not cost effective.
Quality Life Center (ADC)	Harnett	2/28/2001	Not financially feasible to stay open.
Abundant Life Community Outreach (ADC)	Onslow	3/29/2001	Decided not to recertify. No participants. Budget would not allow program to operate.
Sumtymers Adult Day Health Center (ADC/ADH)	Haywood	5/31/2001	Closed for personal and financial reasons.
The Day Center at Stanly Manor (ADC/ADH)	Stanly	5/11/2001	Continued financial losses and lack of adequate funding sources.
Mabel's Hope (ADC)	Montgomery	8/17/2001	Program could not comply with standards and decided to discontinue the service.
Covington House (ADC)	New Hanover	11/1/2001	Program closed because they did not submit recertification documents.
Loving Years ADHC, Inc. (ADC)	Cabarrus	11/30/2001	Not financial feasible.
Emma's Loving Care (ADC)	Randolph	11/30/2001	Program was not operating according to standards. The operator had to close the business.
Adult Development Center (ADC)	Warren	12/31/2001	Financial reasons.
Day Star ADHC (ADC/ADH)	Forsyth	2/1/2002	Closed because continued violation of standards (rules).
Richmond Adult Day Health Center (ADC/ADH)	Richmond	3/4/2002	Financial reasons.
Creative Choices (ADC/ADH)	Wayne	3/31/2002	Financial reasons. Low participant enrollment.
Adult Life Program-Newton (ADC/ADH)	Catawba	6/30/2002	Had to relocate.
*Jackson County Adult Day Care (ADC)	Jackson	7/31/2002	The parent organization indicated that it was not financially feasible to continue program.
Bethel PALS (ADC/ADH)	Mecklenburg	8/31/2002	Low enrollment, freeze on CAP-DA program.
*Blue Ridge Adult Day Care (ADC/ADH)	Yancey	10/31/2002	The owner stated that the operation could not support itself.
Gem Recreation (ADC)	Dare	11/1/2002	Financial reasons -- decided to open as a respite program instead.
[illegible]nick-Elder Kare [illegible]DC/ADH)	Moore	11/15/2002	It is no longer financial feasible to support the program

Adult Day Services
Program Closings 2001 - 2003
(Continued)

Adult Day Services	County	Closing Date	Reason Provided for Closing
Southern Wake Adult Day Care (ADC)	Wake	12/31/2002	The director stated that he could not financially maintain the program any longer
Tender Care Adult Day Health (ADC/ADH)	Craven	1/31/2003	Financial reasons. Program losing money
Helping Hands (ADC/ADH)	Cherokee	6/30/2003	Financial reasons (The parent organization was struggling financially)
Rex Adult Day Center (ADC/ADH)	Wake	6/30/2003	Financial reasons
Grace Unity Adult Day Care (ADC)	Robeson	9/30/2003	Decided not to recertify
Adult Quality of Life Center (ADC)	Stokes	10/02/2003	Financial reasons

* Indicates that the program has reopened under new ownership or organization

ADULT DAY SERVICES FUNDING FACT SHEET

The following is a list of possible funding sources for certified programs. This is a general list and all sources may not apply or be available in your area. **Automatic funding is not guaranteed.**

NORTH CAROLINA HOME AND COMMUNITY CARE BLOCK GRANT

- Older Americans Act funding and other state and local funds are combined into this block grant to support home and community-based services.
- Available for participants age 60 and older.
- Administered through Area Agencies on Aging.
- Contact the lead agency in your county or your regional Area Agency on Aging.

NORTH CAROLINA STATE ADULT DAY CARE FUND

- Funds allocated to counties by the North Carolina Division of Aging.
- Administered through county Departments of Social Services to purchase Adult Day Services for eligible participants.
- Contact your local Department of Social Services for more information.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

- This program reimburses non-residential adult day programs designed to meet the needs of the frail elderly and functionally impaired adults for nutritious meals and snacks. Facilities can be public or private non-profit organizations. The nutritional plan must follow USDA standards.
- Program payments are based on individual enrollee income eligibility as determined by USDA guidelines.
- Administered by the North Carolina Division of Women's and Children's Health.
- Contact the Special Nutrition Programs Unit at the NC Division of Public Health at 919-715-1926 for more information.

PRIVATE PAY / OUT OF POCKET PAYMENTS

- Set the top fee equal to or greater than the cost of services.
- Give everyone the opportunity to pay what the service actually costs, allowing for discounts on a case by case basis.

MEDICAID – COMMUNITY ALTERNATIVES PROGRAM (CAP)

- Certified Adult Day Programs with the Day Health component are possibly eligible for reimbursement under CAP for Disabled Adults (CAP/DA), Mental Retardation/Developmental Disabilities (CAP/MR-DD), or AIDS (CAP/AIDS).
- Administered by the North Carolina Division of Medical Assistance (DMA). Contact DMA at 919-733-6775 for more information.

VETERANS ADMINISTRATION

- For Adult Day Health only.
- Administered through area Veterans Administration Hospitals and/or outpatient clinics.
- Contracted reimbursement for qualifying veterans.
- Contact your area VA for more information.

MEDICARE PART B

- This covers only the services listed below. It does not cover the daily cost of Adult Day Care/Day Health services.
- Covers out-patient or partial hospitalization mental health services by licensed clinical social workers or psychologists for assessment and psychotherapeutic treatment.
- Covers out-patient restorative and functional maintenance rehabilitation by licensed physical therapists, occupational therapists, and/or speech therapists or approved personnel.
- Covers psychiatrist and physician visits.

UNITED WAY

- Contact the local agency for specific requirement for obtaining funds and/or becoming a member agency.

TITLE V (SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM, SCSEP)

- This program is designed to address the income and employment needs of economically disadvantaged individuals age 55 and older.
- Title V workers can be employed in an adult day service center as long as the adult center is not-for-profit.
- This program is administered by various agencies. Contact your regional Area Agency on Aging for more information.

GRANTS AND FOUNDATION FUNDING

- Start up, operating, capital and special projects funding.
- For more information, contact The Foundation Center, 79 Fifth Avenue, Dept. MF, New York, NY 10003-3076, (800) 424-9836. This organization publishes the National Guide to Funding in Aging.
- Check for a local foundation center or library which carry many publications on funding opportunities.

COMMUNITY DEVELOPMENT BLOCK GRANTS

- Administered through city governments.
- The Housing and Community Development Act of 1974 authorizes some funding for the construction and improvement of facilities.
- Contact the area field office of the US Department of Housing and Urban Development for more information.

AREA MENTAL HEALTH/ DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE PROGRAMS (MH/DD/SA)

- Adult day centers can possibly contract with Area MH/DD/SA Programs who reimburse for adult day services for the older and younger MR/DD population.
- Some Area Programs are especially interested in the health services provided in adult day centers.

CITY/ COUNTY GENERAL FUNDS

- Many localities use discretionary money to fund human services agencies. Call your local government office for more information.

CHURCHES / CIVIC ORGAINZATIONS

- These organizations may offer sponsorship, space or scholarships for clients.

Lessons Learned & Benchmarks from a National Initiative

Dementia Care & Respite Services Program

Partners in Caregiving: The Dementia Services Program

Population Base

- a minimum population base of 20,000 can support an adult day center, with approximately 1% of this population, or 200 people, as potential candidates for a center seeking to serve 20-30 people per day.

Financial Considerations

- average adult day center start-up time is 2 to 3 years, with a price tag of $200,000 to $250,000 per year (excluding renovations); this is an average annual operating budget for non-profit programs serving up to 35 people per day.

Target Populations

- adult day centers can serve a variety of populations – the frail elderly, persons with Alzheimer's disease or other dementing illnesses, and those who are cognitively intact but physically challenged (such as multiple sclerosis).

- adult day centers in rural areas and small towns find it necessary to serve everyone, since the absolute market size is usually too small to focus on a smaller market niche; however, centers in larger urban areas can serve a specific market niche (such as dementia-specific, multiple sclerosis, or HIV/AIDS) and penetrate that particular market.

Service Decisions

- adult day centers must respond to the needs and wants of their consumers.

- to help ensure that the needs and wants of both participants and caregivers are being met, centers should provide either a continuum of care – using a one-stop shopping approach – or create partnerships with other community service providers.

- program hours must be long enough to serve working caregivers.

- a full day of engaging activities must be provided that offers choices, focusing on the interests and abilities of the participants.

Predictors of Success – from a Financial Perspective

- a center being open from 7:00 or 7:30 a.m. to 6:00 p.m., Monday through Friday, has been shown to be a predictor of success.
- unit cost must be calculated and fees must be set to equal or exceed costs, with individualized discounts available.
- centers must provide or arrange for participant transportation; centers note an increase in daily census when transportation is offered.
- many day centers achieve financial viability by pursuing a variety of revenue streams (self-pay/out-of-pocket payments, government funds, private insurance, etc.); by using this diversified strategy, reliance on any one revenue source is avoided.
- a noteworthy accomplishment is to become fully self-sufficient through operating revenue, which is revenue from direct participant care on a fee-for-service basis; on average, Partners in Caregiving sites met 83% of their cash expenses through net operating revenue.
- to obtain financial self-sufficiency, a major objective is to keep the day center full: one in three people who inquire will enroll, and a center with a capacity of 25 per day needs an overall enrollment of 50 (double the average daily attendance); the best practice is to enroll at least one new person every week.

Predictors of Success – from a Marketing Perspective

- adult day centers must be able to meet the wants and needs of a variety of caregivers: care seekers (potential heavy users of service) who want or need full-day, center-based services, including extended hours and ancillary services such as transportation and bathing; and, respite seekers (potential moderate users of service) who need occasional time-out from caregiving but do not want full-time daily care; a "care" center can meet the needs of caregivers who want "respite" but a "respite" center will not be able to meet the needs of those who want "care."
- adult day centers need to know how to apply the principles of marketing: marketing is defined as solving someone else's problem by developing, delivering and communicating services that will attract, satisfy and keep customers.
- since 75% of all referrals and two-thirds of all enrollments come from formal referral sources (health care professionals, social service agencies, employers, etc.), targeting these sources is one of the most effective ways to promote adult day centers.
- in order to implement an effective marketing effort, one must have a working knowledge of the process of converting inquiries to enrollments, which involves five steps: the first call, following-up the first call, the first visit, converting the first visit into an enrollment, and customer satisfaction.

Presentation to NC Study Commission on Aging

March 23, 2004

Overview of Home and Community Care Block Grant (HCCBG)

- General Assembly established HCCBG in July 1992
- Combined federal Older Americans Act, SSBG in support of respite, and relevant State Appropriations
- Gave counties greater discretion and authority in determining services, service levels, and providers
- Counties choose from among 18 eligible services
- Focus is on supporting frail elderly at home, improving physical & mental health, assisting with access to services & information, providing family caregiver relief, and helping seniors remain active

Making a Difference—Who Is Served?

- 71% are women
- 33% are minority
- 68% are age 75+
- 46% live alone
- 66% are at risk of malnutrition
- 67% are unable to manage on their own
- 26% have 2+ ADL limits; 13% are very frail
- 50% reportedly low income

Making a Difference—Are the funds used wisely?

- Of the 18 services, 13 are clearly 'core' long-term care services
- 92% of the funds over which counties have discretion go to 'core' LTC services
- The relationship between need and service is strong—the services profile is logical
- Providers are efficient and accountable
- Performance outcome measures are positive

Status of Funding, Utilization, Service Availability, and Need

- Some Federal increase since 2000 while State support has decreased; $343,000 decrease in Federal Funds for FFY 04-05
- Statewide utilization/expenditure rate is very high
- Service unit costs have generally increased
- Decline in clients served and service units; some decrease in counties offering services
- More than 6,500 unmet service needs, especially for home-delivered meals and in-home aide services

Forces Affecting Future of HCCBG

- Demographics—growth in # of seniors—changing family structure
- Movement toward supporting people in least restrictive setting
- Federal budget deficit and effect on domestic programs

What It Will Take to Respond—What Happens If We Don't

- $9.3 million needed to address current wait list
- Efforts to assure effective screening and targeting of resources and cost-sharing

- Could affect other services and funding sources
- Could undermine existing provider infrastructure in face of growing need

Advocates' View

"Restore the $1 million in funding cut in 2003 from the Home and Community Care Block Grant."—

Governor's Advisory Council on Aging and NC Senior Tar Heel Legislature

Facts about the Home and Community Care Block Grant (HCCBG)

History and Purpose of HCCBG

In effect since July 1, 1992, the Home and Community Care Block Grant (HCCBG) was established by the General Assembly (G.S. 143B-181.1(a)(11), on the recommendation of the DHHS Advisory Committee on Home and Community Care and with the support of the N.C. Association of County Commissioners. By consolidating several funding sources (i.e., the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations)—some of which traditionally went to separate organizations—the HCCBG represented an important step toward establishing a well coordinated service delivery system to meet the needs of a rapidly growing older population. By offering a broad range of services designed to improve the quality of life of older adults, the HCCBG has explicitly focused on:

(1) supporting frail elderly in their preference to be cared for at home;
(2) improving and maintaining the physical and mental health of older adults;
(3) assisting older adults and their caregivers with accessing services and information;
(4) providing relief to family caregivers so that they can continue their caregiving; and
(5) allowing older adults to remain actively engaged with their communities.

The two principal purposes of the HCCBG are to:

- *Give counties greater discretion, flexibility, and authority* in determining services, service levels, and service providers. With direct input from older adults in the planning and decision-making process, County Commissioners approve an annual funding plan that defines services to be provided, the funding levels for these services, and the community agencies to provide these services. Counties can select from among the following 18 eligible services under the HCCBG (see pages 8-11 for a description of these services):

Adult Day Care	Health Screening	Mental Health Counseling
Adult Day Health Care	Home Delivered Meals	Senior Center Operations
Care Management	Housing and Home Improvement	Senior Companion
Congregate Nutrition	Information and Assistance	Skilled Home (Health) Care
Group Respite	In-Home Aide (levels I-IV)	Transportation (General and Medical)
Health Promotion and Disease Prevention	Institutional Respite Care	Volunteer Program Development

In advocating for the HCCBG, Patrice Roesler of the N.C. Association of County Commissioners stated that it "accomplishes a long-range goal of the Association in that it gives counties decision-making authority in regards to funding and services for the elderly, and allows county commissioners direct participation in determining the needs and priorities for their areas." She adds that "it gives Commissioners the opportunity to coordinate this money with other resources to maximize the effect."

- *Streamline and simplify the administration of services*, seen as especially important as aging budgets are reduced or become static while demand for services grows. This includes establishing a *single set of policies and procedures* for in-home and community-based services funded under the HCCBG (e.g., *uniform definitions and standards for services, consolidated reporting on services and units, and consistent eligibility requirements*). It is also a process intended to ease re-budgeting locally and statewide to assure maximum use of available resources. In SFY 02-03, 97.9% of allocated funds were expended.

In establishing the HCCBG, the General Assembly also amended G.S. 143B-181.1(a)(10) in 1992 to require the Division of Aging to use *a sliding fee scale, based on the client's ability to pay for home and community-based services.* Effective July 1, 1992, the Division of Aging instituted a voluntary cost-sharing policy for the HCCBG that includes use of a sliding fee scale to guide participant contributions that support the publicized cost of the service. As stipulated by State statute, these contributions are used to extend the availability of in-home and community-based services. This policy is still in effect, and in SFY 02-03 resulted in contributions of nearly $2.4 million.

HCCBG's Track Record

Emphasis on Core LTC Services

While the HCCBG funds support a wide range of activities designed to develop and maintain optimal physical, mental, and social well-being and function in older adults—ranging from senior centers and health screening to in-home aide and home-delivered meals—counties are continuing to emphasize services to those who are most in need of home and community care to remain living independently. *As of fiscal year 2002-03, counties elected to use 80% of the HCCBG funds to support "core LTC services." If you exclude the funds for congregate nutrition, which are required by the Older Americans Act, the percent targeted to "core LTC services" increases to 92%.*

Of the 18 fundable HCCBG services, 13 are clearly among the "Core Services" as identified in Recommendation #11 of the 2001 Institute of Medicine Long-Term Care Plan for North Carolina (see page 12). The other services (i.e., Congregate Nutrition, Senior Centers, Health Promotion and Disease Prevention, Health Screening, and Volunteer Program Development) are arguably supportive of persons needing long-term care as well as their family caregivers. For

example, results from a 2001 survey of senior centers in North Carolina show that nearly a quarter (23%) of senior center participants are 80 and older; about 1 in 12 participants (8%) need help to get around (i.e., use a walker, wheelchair, or help from another person); and about 5% reportedly have some dementia. More than half of the state's senior centers report an increase in frail participants.

The following findings from the Division's 2002 Performance Outcome Measurements Project also illustrate the importance of nutrition services, including 'non-core' congregate meals, for the physical health and emotional well-being of vulnerable seniors:

- 87% of congregate site participants were at risk of malnutrition, including 33% at high risk; 100% of those receiving home-delivered meals were found to be at risk, including 77% at high risk.
- 66% of congregate participants report that the meal they receive represents at least half of their daily consumption.
- 83% of congregate participants say visiting with friends is a major reason for their participation, and 72% of home-delivered clients cite interacting with the person who delivers the meal as important to them.

These additional findings from the Performance Outcome Measurements Project show the vulnerability of many HCCBG clients:

- 21% of congregate and 78% of home-delivered meal clients have difficulty going outside the house for shopping or doctors' offices. 21% of congregate participants cannot drive a car.
- 36% of congregate and 72% of home-delivered meal clients have problems walking.
- 30% of congregate and 72% of home-delivered meal clients cannot do their own housework.

Emphasis on Serving the Most Needy

While any person age 60 and older is eligible for services under the HCCBG, the program places an emphasis on reaching those most in need of services. This begins with the requirement of the Older Americans Act (OAA) to give priority to serving the "socially and economically needy" (with particular attention to low-income minority elderly and older individuals residing in rural areas). Additionally, the OAA calls for reaching out to older individuals with severe disabilities, limited English-speaking ability, and Alzheimer's disease or related disorders (and caregivers of such individuals). In fact, the HCCBG funding formula, approved by the U.S. Administration on Aging, is based on the following criteria: # of persons age 60 and older (50%), # of 60+ who live at or below poverty (30%), # of non-white persons 60+ (10%), and # of 60+ persons who live in rural areas (10%). Additionally, the HCCBG provides $42,930 annually to each county as its equal base allocation. The formula's rural factor and its base allocation are generally considered helpful in directing funds to the sparsely populated rural counties and in reducing abrupt fluctuations in funds allocation.

State service standards for the HCCBG also give priority to serving Adult Protective Services (APS) clients, those at risk of APS, and those who otherwise are most impaired. Providers use these various screening and targeting criteria

in determining whom to serve with available resources. Finally, in allocating additional funds for the HCCBG, the General Assembly has indicated its support of serving older persons who are not eligible for Medicaid and who are on the waiting list for these services.

Nearly half (49.5%) of the 60,621 different clients receiving at least one HCCBG service in SFY 02-03 were reportedly low income. At the time of registering for HCCBG services, clients are informed of the federal poverty figure. Those who self-report their income as less than this amount are considered 'low income.' Those receiving congregate meals are the least likely to report living at or below poverty (41%). Significantly, congregate participants contribute the most to the cost of service through voluntary cost-sharing under the HCCBG (providing more than $1 million, or about 14% of the total expenditure for this service in SFY 02-03).

It is believed that many of the other recipients of HCCBG services are among the so-called "near poor"—those with income just above the poverty level, making them ineligible for Medicaid but having to struggle with paying for such necessities as prescription drugs and utilities. This is the group that the General Assembly has especially wanted to reach through their additional appropriations to the HCCBG. According to the 2000 Census, 13.2% of North Carolinians age 65 and older (and 11.13% of 60+) had incomes below the poverty level in 1999 ($7,990 for an individual; $10,075 for a couple). An additional 36% were at "near poverty" with incomes between 100 and 200% of poverty. Even though HCCBG providers do not substantiate income information, service statistics suggest that HCCBG services are reaching a high percentage of poor and near-poor elderly. A higher percentage of women, minorities, older-old, rural residents, those living alone, and the frail have low income. The following HCCBG service profile from SFY 2002-03 suggests the success of this targeting:

- 71% of HCCBG participants are women;
- 33% are minority;
- 68% are age 75 or older;
- 46% live alone;
- 50% are low income;
- Nearly two-thirds (64%) are at risk of malnutrition; and
- Two-thirds (67%) are unable to manage on their own because of inability to perform basic self-care tasks (e.g., dressing, bathing, eating), limitations in instrumental activities of daily living (e.g., shopping, housekeeping, preparing meals), and/or cognitive impairment. 26% have 2 or more ADL limitations while 13% have 3 or more ADL limitations that suggests they are very frail [much higher for such services as in-home aide and home-delivered meals].

Access Services and Information

A major frustration for many people is not knowing whom to call when there is a question or problem. Their frustration is made worse when they are referred from one organization to another and still are not helped. Thus, it is not

surprising to find from the Division's 2002 survey of family caregivers (cited below) that more than two-thirds (69%) want a central place to call for information, and more than half (57%) want help dealing with agencies/bureaucracies to get services. For seniors themselves, such experiences can create personally devastating consequences. This is why the state's Long-Term Care Plan, Olmstead Plan, and Aging Services Plan have made development of a more effective system for information and assistance (I&A) a priority. Support of I&A in the HCCBG, though, has been minimal because of other pressing demands. In fact, the HCCBG funds for I&A declined by 4% between SFY 2001-02 ($1.7 million in expenditures) and SFY 2002-03 ($1.6 million, budgeted). The number of counties using HCCBG funds for I&A dropped from 44 in SFY 2001-02 to 36 currently. A similar decline of 3% in funding is evident in Care Management, another important access service. On the other hand, transportation, another, albeit different form of access service, increased by 4% from $6 million in SFY 2001-02 to $6.25 million in SFY 2002-03.

Relieve Family Caregivers

Families are the key providers of care, but there are many stresses associated with this caregiving. Results from a Division-sponsored question in the 2003 NC Behavioral Risk-Factor Surveillance System (BRFSS) Survey show that more than 1 in 4 adults report providing regular care or assistance to an older family member or friend. Nearly 1 in 5 HCCBG clients (19.5%) report that the services they receive provide some relief to their caregivers. While some clients do not have a caregiver, this is believed to be a very conservative figure for those who do.

The following findings from the Division's 2002 Performance Outcome Measurements Project illustrate the importance of HCCBG services for caregivers as well as seniors:

- *'Not enough time for self' or 'family' and 'stress' are major burdens for at least 30% of the caregivers helped by HCCBG services.*
- Various forms of in-home aide services (including respite), care management, and information about services are the principal HCCBG services provided to caregivers. 94% are satisfied with the services they receive, including 66% who are 'very satisfied.'
- *97% of caregivers report that the services help them to be a better caregiver, with 84% saying 'they help a lot.'*
- *88% of caregivers report that the services enable them to provide care for a longer time*, which is important to avoiding more costly and restrictive interventions.
- More than one-third of caregivers want additional help with housekeeping (49%), respite or adult day services (39%), help with ADLs/personal care (38%), and transportation (35%).

Active Engagement

The primary means of supporting active engagement through the HCCBG are through general transportation, congregate meal site, senior centers, and volunteer development. The importance of this support is evident in the aforementioned statistics on congregate meal participants. More than one in five

congregate participants cannot drive and have difficulty navigating outside the house, and 83% of congregate participants say visiting with friends at the site is very important to them.

While support of activities to allow older adults to remain actively engaged is an important goal and can be accomplished through a number of means, it certainly appears that counties make the difficult choice to put priority on HCCBG services that help the most at risk.

Profile of HCCBG Services

Below is a list of the services funded under the HCCBG for which clients are reported to the Division of Aging through its Aging Resources Management System (ARMS). The information that describes the "average client" is based on at least 50% of the older adults receiving the HCCBG service. Under the HCCBG, 'economically needy' is self-reported by clients based on whether their income is at or below the federal poverty level ($8,980 for 2003). Clients are also assessed using several functional criteria that include: activities of daily living (ADLs), which describe basic self-care tasks (e.g., bathing, dressing, grooming, moving around the house, and eating; and instrumental activities of daily living (IADLs), which describe basic tasks essential to living independently (e.g., cooking meals, housekeeping, laundry, paying bills, shopping, and using the telephone.)

Adult day care (ADC) provides an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. *The average client is 81 years old, female, economically needy, has limitations with 1+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 37% are cognitively impaired. Among ADC clients, 65% report that the services they receive relieve their caregiver. 46 counties currently fund ADC under the HCCBG.

Adult day health (ADH) services are similar to adult day care in providing an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. In addition, ADH providers offer health care services to meet the needs of individual participants. *The average client is 85 years old, female, economically needy, has limitations with 2+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 45% are cognitively impaired. Among ADH clients, 73% report that the services they receive relieve their caregiver. 31 counties currently fund ADH under the HCCBG.

Care management incorporates case finding, assessment, care planning, negotiation, care plan implementation, monitoring, and advocacy to assist clients and their families with complex needs in obtaining appropriate services. *The average client is 81 years old, female, has limitations with 3+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 10 counties currently fund care management under the HCCBG.

Congregate nutrition is a service where a meal (typically lunch), offering one-third of the recommended daily dietary allowance, is provided in a group setting. *The average client is 76 years old, female, and does not have limitations in ADLs or IADLs.* Nearly half (46%) live alone and 44% are at risk of malnutrition. 99 counties currently fund congregate meals under the HCCBG.

Group respite is a service that trains volunteers to offer temporary, part-time relief to unpaid, primary caregivers of cognitively or physically impaired older adults and to provide meaningful social and recreational activities for those receiving care. *The average client is 82 years old, female, has limitations with 1+ ADLs and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* Nearly half are economically needy (48%). 8 counties currently fund group respite.

Home-delivered meals is a service that provides a meal (typically lunch), offering one-third of the recommended daily dietary allowance, to a home-bound older adult. *The average client is 81 years old, female, has limitations with 1+ ADLs and 3+ IADLs, and is at risk of malnutrition.* Nearly half (49%) live alone, and 57% are economically needy. 97 counties currently fund home-delivered meals under the HCCBG.

Home health is skilled health care prescribed by a physician that is provided in the home of an older adult in need of skilled nursing; physical, occupational, and/or speech therapy; medical social services; and/or nutrition care. *The average client is 81 years old, female, economically needy, has limitations with 2+ ADLs and 3+ IADLs, and is at risk of malnutrition.* One county currently funds home health under the HCCBG.

Housing and home improvement is a service that assists older adults with obtaining or retaining adequate housing and basic furnishings, by providing information about available options for housing and housing with services and how to finance them; assisting with finding and relocating to alternative housing; and providing labor and/or materials for minor renovations and/or repair of dwellings to remedy conditions that create a risk to personal health and safety. *The average client is 77 years old, female, economically needy, has limitations with 2+ ADLs and 2+ IADLs, and is at risk of malnutrition.* 38% live alone. 36 counties currently fund this service.

In-home aide (level 1) is a service that provides assistance with basic home management tasks, such as housekeeping, cooking, shopping, and bill paying to enable the older adult to remain at home as long as possible. *The average client is 82 years old, female, lives alone, has limitations with 3+ IADLs, and is at risk of malnutrition.* 29% are cognitively impaired, and 48% are economically needy. 76 counties currently fund level 1 under the HCCBG.

In-home aide (level 2) is a service that provides support to persons/families who predominately require assistance with basic personal care (bathing, shaving, toileting, and personal hygiene) and associated home management tasks. *The average client is 82 years old, female, has limitations with 2+ ADLS and 3+*

IADLs, and is at risk of malnutrition. 37% are cognitively impaired, 39% live alone, and 45% are economically needy. 88 counties currently fund level 2.

In-home aide (level 3) is a service that provides intensive education and support to persons/families in carrying out home management tasks and improving family functioning skills, or provides substantial ADL support to individuals/families who require assistance with health and personal care tasks. *The average client is 81 years old, female, has limitations with 3+ ADLs and 3+ IADLs, and is at high risk of malnutrition.* 34% are cognitively impaired, 26% live alone, and 43% are economically needy. 49 counties currently fund level 3 under the HCCBG.

In-home aide (level 4) is a service that provides a wide range of educational and supportive services to persons/families who are in crisis or who require long-term assistance with complex home management tasks and family functioning skills. *The average client is 75 years old, female, economically needy, has limitations in 1+ ADLs and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* One county currently funds level 4 under the HCCBG.

Institutional respite is a service that temporarily places older adults, who require constant care and/or supervision, out of their homes to provide their unpaid, primary caregiver with relief from caregiving responsibilities. *The average client is 82 years old, female, has limitations in 1+ ADLS and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* 49% are economically needy. One county currently funds this service under the HCCBG.

The Senior Companion program offers a part-time stipended volunteer opportunity for low-income persons 60 years of age or older who provide support, task assistance, and/or companionship to other adults with exceptional needs (developmental disabilities, functional impairments, or persons who have other special needs for companionship). *The average senior companion is 78 years old, female, economically needy, lives alone, and is at risk of malnutrition.* 7 counties currently fund this program under the HCCBG.

General transportation is a service that provides travel to and/or from community resources, nutrition sites, and other places where older adults need access to services and activities necessary for daily living. *The average client is 78 years old, female, economically needy, lives alone, has limitations in 1+ IADLs, and is at risk of malnutrition.* 97 counties currently fund this program under the HCCBG.

Medical transportation is a service that provides travel to medical appointments. *The average client is 78 years old, female, economically needy, lives alone, has limitations in 1+ ADLs and 1+ IADLs, and is at risk of malnutrition.* 50 counties currently fund this service under the HCCBG.

Other HCCBG Services [non-unit]

Health Screening is a service that provides general medical testing, screening, and referral to promote the early detection and prevention of health problems in older adults. Two counties currently fund this service under the HCCBG. This service is also supported in some counties under Title III-D of the Older Americans Act.

Health Promotion and Disease Prevention is a service category that promotes the health and wellness of eligible older adults. One county currently funds this under the HCCBG; however, many counties receive funds under Title III-D of the Older Americans Act for this purpose.

Information and Assistance is a service that assists older adults, their families, and others acting on their behalf in their efforts to acquire information about programs and services and to assist older persons with obtaining appropriate services to meet their needs. 36 counties currently fund this service under the HCCBG.

Mental Health Counseling is a service that incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems. No counties currently fund this service under the HCCBG.

Senior Center Operation supports provision of a broad spectrum of services and activities for older adults. The primary objectives of a multipurpose senior center are: the centralized provision of services that address the special needs of older adults; opportunities for older adults to become more involved in the community; and the prevention of loneliness and premature institutionalization by promoting personal independence and wellness. 51 counties currently fund the operation of senior centers under the HCCBG.

Volunteer Program Development supports the development and operation of a systematic program for volunteer participation. The service involves volunteers of all ages in providing services to older adults while also providing community service opportunities for older adults. 9 counties currently fund this service under the HCCBG.

HCCBG Services and LTC 'Core Services'

HCCBG Services	LTC Core Services[1]
Adult Day Care	Adult Day Care
Adult Day Health	Adult Day Health
Care Management	Care Management for High-Risk or Complex Conditions
Congregate Nutrition	
Group Respite	Respite Care
Home Promotion and Disease Prevention	
Health Screening	
Home-Delivered Meals	Home-Delivered Meals
Home Health	Home Health
Housing & Home Improvement	Housing & Home Repair and Modification
Information & Assistance	LTC Information & Assistance
In-Home Aide {Levels 1, 2, 3 and 4}	In-Home Aide Services
Institutional Respite	Respite Care
Senior Centers	
Senior Companion	Respite/Attendant Care
Transportation, General	Transportation
Transportation, Medical	Transportation
Volunteer Program Development	
	Adult Care Homes
	Durable Medical Equipment and Supplies
	Medical Alert or Related Services
	Nursing Homes
	Adult Protective Services
	Guardianship

[1] The Institute of Medicine Long-Term Care Task Force recommended that every North Carolinian should have access, either in the county of residence or within reasonable distance from the county, to the services identified in the right-hand column of the table. In addition, the Task Force said that "older adults and people with disabilities need other medical, mental health, dental, vision, and hearing services to meet specific health and functional needs. Individuals who have functional, medical, or cognitive impairments may also need guardianship services or protective services to ensure that their long-term care needs are being met." [Recommendation #11 in the Task Force's Final Report]

Summary of Home and Community Care Block Grant Bugeted Funding SFY 99-00 through SFY 04-05
Federal, State, Local Funding & Client Cost Sharing
Division of Aging and Adult Services
March, 2004

	99-00		00-01		01-02		02-03		03-04		04-05		00-05 % Variance
Fed. Older Americans Act	14,774,992	30.01%	15,684,346	31.24%	17,660,615 *	34.64%	18,333,029	34.80%	19,081,277	36.45%	18,738,003	36.06%	126.82%
Fed. Social Services Block Grant	1,909,077	3.88%	1,909,077	3.80%	1,834,077	3.60%	1,834,077	3.48%	1,834,077	3.50%	1,834,077	3.53%	96.07%
State Appropriations	25,533,005	51.87%	25,418,695	50.62%	24,191,821 **	47.45%	25,128,469	47.69%	24,072,779 ***	45.99%	24,026,079	46.24%	94.10%
Required Local Match	4,690,786	9.53%	4,779,124	9.52%	4,854,057	9.52%	5,032,842	9.55%	4,998,681	9.55%	4,998,681	9.62%	106.56%
Client Cost Sharing	2,321,695	4.72%	2,421,185	4.82%	2,446,052	4.80%	2,360,150	4.48%	2,360,150 ****	4.51%	2,360,150	4.54%	101.66%
Total	49,229,555	100.00%	50,212,427	100.00%	50,986,622	100.00%	52,688,567	100.00%	52,346,964	100.00%	51,956,990	100.00%	105.54%
Unduplicated Clients Served	66,253		63,809		61,790		60,601		58,921 ****				
Total Units Provided	8,333,217		8,132,622		7,952,080		7,804,632		7,281,380 ****				

* $1,000,000 in FFY 03 OAA funds awarded to offset loss of $1,008,273 in state appropriations

** SFY 01-02 state appropriations reduced by $1,008,273 in 3/02 reduction was non-recurring

*** Includes recurring reduction of $1,000,000 in state appropriations effective July 1, 2003

**** Projections of 03-04 client cost sharing, clients served, and units to be provided reflect annualized estimates based on December 03 activity

CAP/DA Report

Below is the provision from the 2003 Appropriations Act, S.L. 2003-284, Section 10.29B(b), requiring the Department of Health and Human Services to examine and report on the Community Alternatives Program for Disabled Adults (CAP/DA).

SECTION 10.29B.(b) The Department of Health and Human Services shall continue to examine CAP/DA and shall make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004. The report shall include the following information:

(1) A review of the current assessment process for CAP/DA clients, including an explanation of how assessments are conducted and a comparison of the assessment process for CAP/DA clients with the assessment process for nursing home and adult care home clients.

(2) A description of total program costs to the State and counties for clients receiving CAP/DA payments and an analysis of per-client costs in CAP/DA to per-client costs in nursing homes and adult care homes. This analysis shall include the costs of all forms of assistance received by CAP/DA clients, such as food stamps and housing assistance.

(3) A description of total program costs and an analysis of per-participant costs for individuals in the State-County In-Home Program. The analysis shall include a comparison of per-client costs for participants in the In-Home Program to per-client costs in adult care homes.

(4) A description of total program costs and an analysis of per-person costs for persons receiving personal care services through the Medicaid program. The analysis shall include a comparison of per-person costs in nursing homes and adult care homes.

(5) A description of the monitoring of quality of care for CAP/DA clients.

(6) An evaluation of the current waiting list procedures.

SECTION 10.29B.(c) The Department of Health and Human Services shall review, on a pilot basis, a selected number of CAP/DA programs to determine compliance with eligibility requirements for the program. The Department shall include the results of the review in its report to the Study Commission on Aging required under subsection (b) of this section.

Report to the North Carolina Study Commission on Aging

House Bill 397
Section 10.29B. (b-c)

Findings on the Community Alternatives Program for Disabled Adults (CAP/DA)

March 1, 2004

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I. Executive Summary

This report was prepared in response to a special provision in House Bill 397, Section 10.29B.(b) and Section 10.29B.(c). The report describes program methodologies and presents public expenditure data from State Fiscal Year 2002 for the Community Alternatives Program for Disabled Adults (CAP/DA) and other long-term care services[1]. CAP/DA is recognized as an important program that supports older adults and physically disabled adults in their own homes in order to delay or prevent nursing facility placement.

The North Carolina General Assembly is seeking to ensure that the CAP/DA program remains a cost effective alternative to institutional care. It is essential that data is available to the legislature and to the administration for on-going analysis of the costs and quality of all state-funded long-term care programs. Based on the available information, the data used to compare the cost of CAP/DA (Intermediate Level) clients, adult care home clients, and nursing facility (Intermediate Level) patients indicate that the average monthly public expenditure (federal, state, county program costs) for CAP/DA (Intermediate Level) clients is slightly less than nursing facility (Intermediate Level) patients and significantly higher than adult care home residents. In addition, the report indicates that the average monthly public expenditure for clients in the Special Assistance In-Home Program is slightly less than adult care home clients. The report also reflects the Medicaid payment data for recipients of In-Home Personal Care Services (PCS). Although total PCS expenditure data is reflected in the report, detailed comparison of the per-person costs for PCS recipients with the per-person costs in nursing facilities and adult care homes was not possible due to the lack of information on functional and medical needs of the recipients.

Proper comparisons of cost of care among CAP/DA, nursing facilities, adult care homes, and PCS are not easily achieved because client acuity cannot be accurately compared across these settings. Obviously, cost comparisons are most accurate when comparing care for individuals with the same medical acuity level. While medical need and acuity level data are available at the State level for nursing facility patients, at present, such information is not readily available for CAP/DA recipients and other long-term care program recipients.

While there are many barriers in obtaining comparative data on long-term care populations in North Carolina, **the Division of Medical Assistance (DMA) took the best approach available in performing the requested analyses.** The data included in this report on CAP/DA, nursing facility, and adult care home populations reflect a random sample of each population. DMA recognizes that these may not be statistically valid samples nor representative samples of the populations. Another random sample of these populations could yield costs that differ from those included in this report. However, it should be noted that the data used for this report were thoroughly reviewed to ensure accuracy and to verify that no costs were duplicated or inadvertently excluded. **Until the acuity data for clients in each population are available for analysis, it is not possible to complete a true cost comparison across the CAP/DA, nursing facility, adult care home, and PCS populations.**

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[1] The data in this report represents the method of reimbursement during State Fiscal Year 2002 for each respective program (CAP/DA, nursing facilities, and adult care homes) and does not address any subsequent rate increases or pending reimbursement initiatives. The data used for PCS represents the method of reimbursement and expenditures from State Fiscal Year 2003.

DHHS Initiatives To Address Data Needs for Long-Term Care

The Department of Health and Human Services (DHHS) has several important initiatives underway to address the problem of obtaining comparative data on long-term care populations. The initiatives will provide a foundation for improved targeting of long-term care services and strengthen the management of the CAP/DA program. Many of these initiatives follow the recommendations made by the North Carolina Institute of Medicine in its 2003 Report to the General Assembly on CAP/DA. These initiatives include the following:

Study of Long-Term Care Populations

- DHHS has issued a Request for Proposals for a study on the acuity levels of adult care home residents, adult day care clients, adult day health care clients, and nursing facility patients. This study will be initiated during 2004.

New Assessment Instrument for CAP/DA

- DMA and Medical Review of North Carolina (MRNC) are developing a new automated assessment instrument for the CAP/DA program that will rate the acuity level of all CAP/DA clients. The new instrument was piloted in several counties during February 2004 and will be implemented statewide beginning in March 2004.

New Quality Improvement Program for CAP/DA

- DMA and MRNC are developing and implementing a new quality improvement program for CAP/DA by March 2004 and a pilot review of four CAP/DA programs by September 2004.

Restructuring of the Personal Care Assistance Program

- DMA has organized work groups to improve the medical criteria, create a new assessment instrument, and develop a quality assurance program for the Medicaid Personal Care Services (PCS) program.

Assessment Instrument for Adult Care Home Residents

- DHHS has plans to improve the assessment instrument for adult care home residents.

Standards for CAP/DA Lead Agencies

- DMA is working on new statewide standards for CAP/DA lead agencies including standards for maintaining waiting lists.

Additional resources are needed to ensure the successful implementation of these initiatives. Over the next several months, DHHS will identify the resources necessary to improve the targeting of long-term care services and strengthening the CAP/DA program.

II. Background and Future Plans for CAP/DA

The Community Alternatives Program for Disabled Adults (CAP/DA) is offered to Medicaid recipients who would otherwise need nursing facility placement. The state operates the program under a Federal Home and Community-Based Services Waiver (42 U.S.C. § 1915(c)), which permits the state to offer a broad range of home and community-based services as long as the program remains cost neutral to Medicaid. CAP/DA clients on the average cannot have higher Medicaid costs than nursing facility patients. The program meets the Federal cost neutrality requirements.

To qualify for CAP/DA, individuals must meet the medical, functional, and financial eligibility requirements. While individuals must require nursing facility level of care, they must also have some possibility of being safely cared for in the community. The CAP/DA program, available in all 100 counties of North Carolina, is administered by the Department of Health and Human Services, Division of Medical Assistance (DMA) working through 96 local CAP/DA lead agencies.

This report provides current information on CAP/DA as requested by the 2003 session of the North Carolina General Assembly. The report details assessment methodologies and various program data derived from Medicaid paid claims data. While medical need and acuity level data are available at the State level for nursing facility patients, such information is not readily available for CAP/DA recipients and other long-term care program recipients. **Therefore, care must be taken when drawing conclusions from the data because one cannot compare level of care indicators.**

DHHS recognizes the need to improve the medical and functional assessment processes and data collection systems for its long-term care populations and is proceeding with plans to make significant progress in these areas over the next two years. In the following months, DHHS will conduct assessments on a sample of adult care home residents, adult day care recipients, adult day health care recipients, and CAP/DA clients and compare these program recipients to nursing facility patients. Once this study is completed, DHHS will be able to compare, for the first time, the medical and health care needs of CAP/DA recipients to adult care home residents, adult day health recipients, adult day care recipients, and nursing facility patients.

III. Report

A. Review of the CAP/DA, Nursing Facility, and Adult Care Home Assessment Processes

Initial Recommendation from an Attending Physician

Before a Medicaid recipient can be considered "medically eligible" for CAP/DA, nursing facility admission or for placement in an adult care home, the recipient's attending physician must complete and sign a one-page FL-2 that includes information such as current level of care; recommended level of care; primary and secondary diagnosis; and other information about the patient including whether the person is disoriented, demonstrates inappropriate behaviors (such as wandering, verbally or physically abusive), whether the person needs help with bathing, feeding, dressing or total care, the last physician visit, whether the person can walk, functional limitations (including contractures or limited sight, hearing, and/or speech), whether the person can participate in social activities, any neurological problems, problems with bladder or bowel control, ability to communicate, skin problems, respiration problems, nutrition status, and use of medications.

If the physician recommends that the individual needs placement in a nursing facility or CAP/DA, the FL-2 is routed to the Medicaid fiscal agent (EDS) for review and a final determination is made using specific Medicaid criteria for nursing facility level of care. When the physician recommends placement in an adult care home, the physician routes the FL-2 to the local county department of social services for placement services. A more detailed assessment is performed once the recipient gets to the appropriate service level or facility placement. These more detailed assessments are described below:

CAP/DA Assessment Process

The local CAP/DA lead agency is responsible for completing a comprehensive assessment when an individual is first determined medically eligible for CAP/DA by the Medicaid fiscal agent. The assessment must be completed by the local lead agency within 60 days of the FL-2 approval. The local CAP/DA lead agency is responsible for ensuring that the individual is assessed using the DMA 3011 (CAP/DA Assessment Form) in accordance with Medicaid guidelines. The assessment is conducted by both a Registered Nurse (RN) and a social worker at the individual's home. If the individual is awaiting discharge from a hospital or nursing facility, the RN and social worker may conduct the assessment at the hospital or nursing facility. The CAP/DA assessment evaluates the individual's

- Current physical health, mental health, and medical history
- Ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Informal and formal social supports
- Home environment
- Economic status

The CAP/DA assessment provides the local CAP/DA lead agency with information needed to develop an individual Plan of Care. The CAP/DA assessment must be completed on an annual basis.

Nursing Facility Assessment Process

Federal regulations require nursing facilities to assess individuals within 14 days after they have been admitted to the nursing facility. All clients must be assessed using the Minimum Data Set (MDS), version 2.0. The MDS must be completed by the facility RN with input from the individual's social worker or other related health professionals. The MDS is a standardized, federally mandated instrument that assesses a nursing facility patient's clinical and functional status. On a quarterly basis, the facility RN assesses the patient using an abbreviated version of the MDS. The full MDS must be completed annually and whenever there is a significant change in the patient's condition. All assessments are transmitted to a national data warehouse supported by the Centers for Medicare and Medicaid Services (CMS). The MDS is used nationwide by all Medicare certified nursing facilities.

Adult Care Home Assessment Process

Adult care homes (ACH) are required by the State to assess individuals within 72 hours of admission to the adult care home. All Medicaid residents must be assessed using the DMA 3050-R (ACH Assessment Form). The DMA 3050-R is completed by the adult care home staff and signed and approved by the individual's attending physician. On an annual basis, the adult care home staff must reassess their residents using the DMA 3050-R. In addition, a reassessment using the DMA 3050-R is required when there is a significant change in the resident's condition. The DMA 3050-R assesses an individual's overall physical and functional health including his/her ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). For those residents who may need enhanced personal care services, a referral from the adult care home to the local county department of social services will trigger a comprehensive assessment by the case worker at social services.

Table 1: Comparison of the Assessment Processes

	CAP/DA	Nursing Facility (NF)	Adult Care Home (ACH)
Responsible Agency	Local CAP/DA lead agency	Nursing Facility	Adult Care Home
Who Completes the Assessment	RN and Social Worker *Signed by RN and Social Worker*	RN and Social Worker *Signed by RN*	Adult Care Home staff *Signed by attending physician*
Assessment Tool	DMA 3011: CAP/DA Assessment Form	Minimum Data Set (MDS), Version 2.0	DMA 3050-R: ACH Assessment Form
When Assessment is Initiated	After approval of FL-2	After approval of FL-2	After recommendation of ACH placement by physician
Timing of the Assessment	Must be completed within 60 days of the FL-2 approval	Must be completed within 14 days after the NF admission	Must be completed within 72 hours of the ACH admission
Location of Assessment	• Client's home • Hospital/NF, if the client is awaiting discharge	• Nursing facility	• Adult Care Home
Reassessments	• Annually	• Quarterly *(brief assessment)* • Annually • At time of significant change in client's condition	• Annually • At time of significant change in client's condition

Evaluation and Revision of the Current CAP/DA Assessment Process

The current assessment tool for CAP/DA (DMA 3011 Form) does collect important data related to an individual's functional status, but it does not provide information on the client's level of acuity. This limitation prevents DMA from making accurate comparisons among the CAP/DA, nursing

facility, and adult care home populations. DMA is actively working with a contractor, Medical Review of North Carolina (MRNC) and the local CAP/DA lead agencies to design a new automated assessment tool for CAP/DA based on the MDS, a federally mandated instrument which is used to assess clients residing in nursing facilities. The new tool will be used to calculate a Resource Utilization Group (RUG) score for each assessed client to correspond with the MDS scoring system used for nursing facility patients. This new tool and scoring system will enable DMA to make comparisons between the medical and functional needs of nursing facility patients and CAP/DA clients. The tool will also enable DMA to determine each CAP/DA client's level of acuity and form the foundation for a new CAP/DA quality improvement program (described in detail on page 13).

DMA and MRNC are in the process of piloting the new CAP/DA assessment tool in five counties. DMA will require local CAP/DA lead agencies to transition from using the DMA 3011 to the new CAP/DA assessment tool beginning March 15, 2004. It will take approximately 12 months for all CAP/DA lead agencies to complete this transition. Once the transition is underway, DMA will have access to more accurate data on acuity and will begin conducting in-depth comparative studies of the CAP/DA and nursing facility populations.

B. Total Program Costs *(Actual Public Expenditures)* for CAP/DA, Nursing Facility, and Adult Care Home Clients

This section addresses the total federal, state, and county program costs for Medicaid recipients in CAP/DA, nursing facilities, and adult care homes. **For the purposes of this report, total federal, state, and county program costs are interpreted to be the total actual public expenditures (excluding Medicare) related to each specific program.** A comparison of per-recipient costs in CAP/DA to per-recipient costs in nursing facilities and adult care homes is provided in this section.

The analysis does not include the costs related to all forms of housing assistance. Housing costs outside of licensed facilities are not available for comparison. DMA does not currently track the residential status of Medicaid recipients. Participants may be living in any number of housing arrangements, with or without family members, in homes they own, or in rental units. There are small state funded programs that provide various forms of one time housing assistance to various populations, security deposits, emergency utility payments, funding for urgent repair needs or making accessibility modifications. However, there is no cross agency data capacity to document if CAP/DA participants have accessed this assistance. There is also no ongoing source of state funded housing assistance outside licensed facilities. CAP/DA participants may be living in the community with Section 8 rental assistance, or in another type of subsidized unit, but these are 100% federally funded programs. Again, there is no cross agency data capacity to document if CAP/DA participants have accessed this assistance.

Limitations in Drawing Comparisons and Plans for Improvement

It is difficult to make comparisons among CAP/DA, nursing facilities, and adult care homes because client acuity cannot be accurately compared across these three settings. This is due to the limitations of the current CAP/DA assessment tool and the assessment tool used by the adult care homes. These assessment tools are not collecting the same comprehensive data that are gathered on nursing facility clients using the MDS. Until a new MDS-based tool is created for CAP/DA and for adult care home residents, all comparisons among the three groups will be problematic. DMA is addressing this issue by creating a new MDS-based assessment tool for CAP/DA that will be implemented across the state in 2004. By September 2004, some acuity data will become available

which may be used to draw more accurate comparisons across these populations. DMA will also develop a new assessment tool for the adult care home population.

Random Sampling Methodology

Given the limitations noted above, the following analysis is based on data from a random sample of 75 CAP/DA clients, 75 nursing facility clients, and 75 adult care home clients. While these are random samples, it should be noted that they are not statistically valid samples of each population. Each sample of 75 was selected using the following methodology. All clients that were on CAP/DA for at least part of each month during the entire 2002 State Fiscal Year were identified. Every 10th client from this sample was selected and used to comprise the sample of 75 CAP/DA clients. This random sampling methodology was replicated for the nursing facility and adult care home populations. DMA recognizes that while this is a random sample of each population, it may not be a representative sample of the populations. However, due to the data limitations noted above, it was the best approach available to perform the requested analysis. Until the acuity data for clients in each population are available for analysis, DMA cannot complete a true cost comparison across the CAP/DA, nursing facility, and adult care home populations.

Use of Income in Long-Term Care Settings

The primary sources of income for Medicaid recipients in long-term care settings include Social Security (retirement and disability), Supplemental Security Income, Veteran's Administration benefits and a variety of pension/retirement funds. Supplemental Security Income (SSI) is for those persons who either do not receive a Social Security check, receive only a small Social Security check or do not have sufficient sources of other income to provide a basic level of financial support.

CAP/DA Recipients: In general, CAP/DA recipients retain their personal income to support their basic needs of housing, food and personal items. CAP/DA recipients with monthly income over $749 are required to meet a monthly deductible by incurring expenses for medical care/treatment.

Nursing Facility Residents: Nursing facility residents on Medicaid are required to give all of their personal income (except for $30 as a personal needs allowance) to the nursing facility provider. There may be additional income disregards if a person has a spouse and/or dependents who are not in a nursing facility, has medical expenses not covered by Medicaid, or has mandatory deductions from his income.

Adult Care Home Residents: Adult care home residents may qualify for a State-County Special Assistance payment. The adult care home residents are required to give all of their State-County Special Assistance payment (except for $46 as a personal needs allowance) to the adult care home provider. The State-County Special Assistance payment is calculated by subtracting all the resident's countable income from the adult care home rate after the personal needs allowance is deducted.

Cost Comparison of CAP/DA, Nursing Facility, and Adult Care Home Clients

DMA has attempted to address the North Carolina General Assembly's request to analyze the CAP/DA total program costs and make comparisons to the nursing facility and adult care home costs. **For the purposes of this report, total program costs are interpreted to be the total actual public expenditures (excluding Medicare) related to each specific program.**

Paid claims data for a total of 225 clients was pulled from DMA's decision support information system called DRIVE. There were 75 CAP/DA clients, 75 nursing facility clients, and 75 adult care home clients who were randomly selected for the analysis (see preceding section for a detailed description of the sampling methodology). Each of these clients had been on his/her respective service (CAP/DA, nursing facility, or adult care home) for at least part of each month during State Fiscal Year 2002[2]. This analysis shows that the total monthly federal, state, and county program cost for CAP/DA-Intermediate Level clients falls in between the total monthly federal, state, and county program costs for nursing facility (Intermediate Level) and adult care home clients. The Intermediate Level was selected because 86% of the CAP/DA clients are at the Intermediate Level (not Skilled Level).

Table 2: SFY 02 Average Total Costs *(Public Expenditures)* for CAP/DA, Nursing Facility, and Adult Care Home Clients Based on Three Random Samples*

	CAP/DA Intermediate Level Client	Nursing Facility-Intermediate Level Client	Adult Care Home Client
Average Total Annual Cost Per Client	$ 31,077	$ 32,644	$ 18,770
Average Total Monthly Cost Per Client	$ 2,590	$ 2,720	$ 1,564

*DHHS acknowledges that Medicaid recipients in all care settings receive mental health and mental retardation-developmentally disabled services (MH/MR-DD). Since specific medical and functional information for these recipients is not available, the costs for these services were not reflected in the tables and calculations in this report.

Table 3: SFY 02 Average Annual and Monthly Costs *(Public Expenditures)* for CAP/DA, Nursing Facility, and Adult Care Home Clients by Payer Source*

Payer Source	CAP/DA Intermediate Level Client	Nursing Facility Intermediate Level Client	Adult Care Home Client
Average *Annual* Costs by Payer Source			
Annual Federal Share	$ 19,668	$ 20,572	$ 8,478
Annual State Share	$ 9,697	$ 10,260	$ 6,809
Annual County Share	$ 1,712	$ 1,812	$ 3,483
Average *Monthly* Costs by Payer Source			
Monthly Federal Share	$ 1,639	$ 1,714	$ 707
Monthly State Share	$ 808	$ 855	$ 567
Monthly County Share	$ 143	$ 151	$ 290

*DHHS acknowledges that Medicaid recipients in all care settings receive mental health and mental retardation-developmentally disabled services (MH/MR-DD). Since specific medical and functional information for these recipients is not available, the costs for these services were not reflected in the tables and calculations in this report.

[2] DMA recognizes that another random sample of these population groups could yield costs that differ from those listed in Tables 2-4 due to the data limitations mentioned earlier. However, it should be noted that the data used for this report were thoroughly reviewed to ensure accuracy and to verify that no costs were duplicated or inadvertently excluded.

Table 4: Total Annual Costs *(Public Expenditures)* for the Random Samples of CAP/DA, Nursing Facility, and Adult Care Home Clients during SFY 02

Service Category[1]	Total Annual Costs for CAP/DA-ICF Sample (n=75)	Total Annual Costs for Nursing Facility-ICF Sample (n=75)	Total Annual Costs for Adult Care Home Sample (n=75)
Pharmacy	$ 295,181	$ 232,931	$ 361,781
MH/MR-DD Services[2]	-	-	-
NF/Hospital Payments	$ 288,062	$ 2,187,415	$ 167,712
CAP Case Management	$ 94,972	-	-
Case Management (DAAS, HIV)	-	-	$ 3,336
Adult Day Health	$ 20,117	-	-
Home Health Nursing[3]	$ 63,910	-	$ 60,628
In Home/Personal Care Aide[4]	$ 1,276,419	-	$ 257,814
Home Health Supplies	$ 42,868	-	$ 9,545
Medical Procedures & Testing	$ 40,221	$ 3,661	$ 2,094
Physician Visits	$ 30,432	$ 10,041	$ 68,663
Dental	$ 3,186	$ 6,838	$ 13,496
All Other Claims	$ 158,543	$ 7,429	$ 18,938
Total Medicaid Paid Claims	$ 2,313,911	$ 2,448,315	$ 964,007
Case Mgmt (Adult Care Home)[5]	-	-	$ 56,775
Special Assistance	-	-	$ 386,992
Supplemental Security Income[6]	Not Available	Not Available	Not Available
Food Stamps[7]	$ 16,836	-	-
Total Paid	**$ 2,330,747**	**$ 2,448,315**	**$ 1,407,774**

[1] Refer to Appendix A for a listing of the DRIVE Categories of Services included under the Service Categories in Table 4.
[2]DHHS acknowledges that Medicaid recipients in all care settings receive mental health and mental retardation-developmentally disabled services (MH/MR-DD). Since specific medical and functional information for these recipients is not available, the costs for these services were not reflected in the tables and calculations in this report. However, the MH/MR-DD costs for the samples used in this report are as follows: $2,720 for the CAP/DA-ICF sample (n=75); $1,563 for the Nursing Facility-ICF sample (n=75); and $652,052 for the Adult Care Home sample (n=75).
[3]8.7 average home health visits per year per individual paid by Medicaid.
[4]1,223 average hours per year per individual.
[5]The total budget for ACH Case Management Services (CMS) for SFY 2002 was $5,616,624. A total of 7,419 recipients received ACH CMS during the same period. This amounts to an annual average of $757 in ACH CMS per recipient.
[6] Medicaid recipients receive Supplemental Security Income (SSI) in all care settings. However, DHHS does not have access to historical SSI payment data for Medicaid recipients. This data is maintained by the Social Security Administration.
[7] Food stamp costs are based on data from September 2003. The amount included above was an estimated amount for SFY02 CAP/DA clients. The average food stamp payment for CAP/DA clients during September 2003 was $87.69. This amount was multiplied by the number of food stamp recipients from the CAP/DA sample and further multiplied by 12 to obtain an annual total for SFY02. More complete food stamp data were unavailable due to database limitations.

C. Total Program Costs *(Actual Public Expenditures)* for State-County In-Home Clients

Background

The Special Assistance (SA) In-Home Program provides an alternative payment to individuals who are at risk of placement in an adult care home but who could, with appropriate services, remain safely at home in the community. The SA In-Home Program is administered by the Department of Health and Human Services, Division of Aging and Adult Services (DAAS), working with county departments of social services. The SA In-Home payments are funded using existing state and county SA funds.

This section of the CAP/DA report presents information on total program costs for the SA In-Home Program as requested by the 2003 session of the NC General Assembly. The costs for SA In-Home (SA/IH) recipients are compared to the costs for SA recipients living in adult care homes (SA/ACH). The data used in this analysis was compiled for SFY 2002 to be consistent with data used in the analysis of costs for CAP/DA, nursing facilities, and adult care homes.

Average SA Payments

Prior to December 1, 2001, the SA payment level was equal to the difference between a recipient's income and the income limit, which is set at 100% of the federal poverty level. However, the General Assembly authorized a change in the methodology for calculating the SA/IH payment that became effective December 1, 2001. The new methodology raised the average SA/IH payment from SFY 2002 to SFY 2003. This current SA/IH methodology requires that the maximum in-home payment be up to, but no more than, one-half the payment the same recipient would receive if living in an adult care home. The payment may actually be less, depending on the needs assessment and the service plan developed by the case manager.

Table 5: Comparison of Average Monthly Payments for SA/ACH and SA/IH Recipients

	Average Monthly Payment for SFY02	Average Monthly Payment for SFY03
SA/In-Home Recipients	$185.66	$221.96
SA/Adult Care Home Recipients	$427.52	$455.20

Medicaid Expenditures

The following chart provides a comparison of Medicaid expenditures for SA/IH and SA/ACH recipients during SFY 2002. Since there is a limit on the number of SA/IH recipients, Medicaid paid claims data was obtained for all 131 recipients who were eligible for SA/IH during SFY 2002. Individuals who became eligible, but left the program during the year, were excluded to ensure complete and accurate claims data for the entire fiscal year.

The number of recipients in CAP/DA, nursing facilities and adult care homes is much larger than the SA/IH population, and DMA chose to use a random sample of those populations to analyze their expenditures. The Medicaid claims data for the 131 SA/IH recipients has been compared to the same random sample of 75 adult care home residents used in the comparison of CAP/DA and nursing facility clients described earlier in this report (see Table 4). Annual Medicaid expenditures have been calculated on a "per recipient" basis by dividing the annual expenditures by the total sample.

Table 6: Annual Medicaid Costs *(Public Expenditures)* for SA/ACH and SA/IH Recipients during SFY 02

Service Category	Annual Costs for the SA/ACH Sample (n=75)	Average Annual Per SA/ACH Recipient Cost	Annual Costs for the SA/IH Program (n=131)	Average Annual Per SA/IH Recipient Cost
Pharmacy	$361,781	$4,824	$388,965	$2,969
MH/MR-DD Services[1]	-	-	-	-
NF/Hospital Payment	$167,712	$2,236	$171,636	$1,310
Case Management (HIV)	$1,671	$22	$154	$1
Adult Day Health	$0	$0	$0	$0
Home Health Nursing	$60,628	$808	$81,985	$626
In Home/Personal Care Aide	$257,814	$3,438	$474,291	$3,621
Home Health Supplies	$9,545	$127	$52,975	$404
Medical Procedures	$2,094	$28	$1,294	$10
Physician Visits	$68,663	$916	$92,402	$705
Dental	$13,496	$180	$9,003	$69
All Other Claims	$18,938	$253	$14,349	$110
Total Medicaid Costs	$962,342	**$12,832**	$1,287,054	**$9,825**

[1]DHHS acknowledges that Medicaid recipients in all care settings receive mental health and mental retardation-developmentally disabled services (MH/MR-DD). Since specific medical and functional information for these recipients is not available, the costs for these services were not reflected in the tables and calculations in this report.

NOTE: DAAS Case Management Services are excluded from Table 6 but included in Tables 4 and 7.

Summary of Total Costs

As requested by the General Assembly, Table 7 summarizes and compares the total program costs for SA recipients in adult care homes and those receiving the SA In-Home payment. The average monthly payment is converted to an annual amount and added to other program costs for the purposes of comparison. In addition to benefits received in the three primary areas of SA payment amount, case management services and Medicaid expenditures, the summary includes information on Food Stamp benefits.

Table 7: Average Annual Total Costs for SA/ACH and SA/IH Recipients during SFY 02

	Average Annual SA Payment (SFY03)	Average Annual Medicaid Costs Per Recipient (SFY02)	Average Annual DAAS Case Management Costs Per Recipient (SFY02)	Average Annual Food Stamps Per Recipient (9/00-8/02)	**Total Average Annual Cost**	**Total Average Monthly Cost**
SA/ACH	$5,130	$12,832	*$757	-	**$18,719**	***$1,560**
SA/IH	$2,228	$9,825	**$572	$456	**$13,081**	****$1,090**

*Less than 25% of SA recipients in adult care homes receive Adult Care Home Case Management Services. For the remaining SA recipients in adult care homes, the average monthly cost would equal $1,497 ($18,719 - $757 = $17,962 ÷ 12 = $1,497).

**All SA/IH recipients receive ongoing case management services.

D. An Analysis of In-Home Personal Care Services Costs *(Actual Public Expenditures)*

The total program and per-recipient costs (actual public expenditures) for In-Home Personal Care Services (PCS) were also requested for this report. (*Note: Medicaid Personal Care Services (PCS) are available to persons living in the home and to residents of adult care homes. The data presented in this section only reflects the In-Home PCS program and not the adult care home Personal Care Services program or CAP/DA In-Home Aide program.)* This PCS data covers SFY 2003 and is provided below in Table 8. The PCS data used for this analysis is based on paid claims from the DRIVE system. It should be noted that the data used in Table 8 reflects all public expenditures for PCS services for every Medicaid recipient that received PCS during State Fiscal Year 2003 regardless of how long they received PCS. Thus the data reflects PCS expenditures for recipients that may have used PCS only one day, one week, or throughout all 12 months of State Fiscal Year 2003.

Table 8: Medicaid Cost *(Actual Public Expenditures)* for In-Home Personal Care Services during SFY 03

SFY	Total Medicaid Expenditure for PCS	Total # of PCS Recipients	Average Annual Per Recipient Expenditure for PCS	Average Monthly Per Recipient Expenditure for PCS
2003	$190,036,701	33,834	$5617	$468

NOTE: The General Assembly implemented a 60-hour monthly limit on PCS for each PCS recipient on December 1, 2002. The previous monthly limit was 80 hours of PCS per recipient.

In-Home PCS Comparisons

Section 10.29B.(b)(4) of House Bill 397 requested "an analysis of per-person costs for persons receiving personal care services through the Medicaid program. The analysis shall include a comparison of per-person costs in nursing homes and adult care homes." This analysis was not completed for several reasons: (1) PCS recipients are not required to meet the same functional criteria as recipients in nursing facilities or adult care homes. (2) Nursing facility and adult care home recipients must have FL-2 approval and meet level of care criteria before accessing those services while PCS recipients are assessed by an RN and require a physician's approval to obtain PCS. (3) PCS recipients do not need to have FL-2 approval nor meet nursing facility level of care to begin receiving PCS. Since PCS recipients are not required to meet the same level of care as nursing facility and adult care home recipients, it is not possible to make any proper comparisons among these populations. In addition, while per-person costs for PCS in adult care homes are identifiable, the per-person costs of personal care services in nursing facilities cannot be separated.

Restructuring PCS

DMA is currently working on plans to improve the medical policy criteria and the overall management of the PCS program to assure that Medicaid resources are targeted appropriately. Plans include the establishment of new oversight processes and a new utilization management program for PCS. Utilization management will provide assurances that the services are: 1) provided to persons meeting the Medicaid criteria based on medical need; and, 2) provided in the right amount and duration to meet the client's needs. In addition, new assessment tools will be designed to collect acuity data on PCS recipients.

E. Monitoring Quality of Care for CAP/DA Clients

Current Quality of Care Program

CAP/DA has three ways to monitor quality: 1) the local CAP/DA lead agency; 2) the DMA CAP/DA State consultants; and 3) Medical Review of North Carolina (MRNC). At the local level, the case manager is responsible for monitoring whether the services are provided as specified in the client's care plan and whether the care plan must be modified due to a change in the client's condition. At the State level, there are five DMA CAP/DA consultants who conduct annual on-site reviews of each local program. DMA also contracts with MRNC for a monthly review of a random sample of active CAP/DA cases. MRNC reviews assessments, care plans, case activities, and services provided to clients. The objectives of these reviews are to ensure that:

1. Clients meet the medical policy criteria for Intermediate or Skilled level of care
2. Clients have been given an option to choose between CAP/DA and institutional care
3. Plans of care are relevant to client assessments
4. Services provided to clients assure their health, safety, and well-being
5. Services are provided in accordance with plans of care
6. Services are provided within cost limits for the level of care

The current CAP/DA quality monitoring activities are not an outcomes-based quality improvement program but rather a paper-based chart review. The MRNC monthly reviews were designed to evaluate a handful of CAP/DA clients and identify deficiencies related to the above-mentioned objectives. DMA is in the process of redesigning the quality assurance program for CAP/DA.

Developing a New Quality Improvement Program for CAP/DA

DMA is working with MRNC and local CAP/DA lead agencies to develop a new outcomes-based Quality Improvement Program for CAP/DA that follows the National Home and Community-Based Services Quality Framework. The Framework defines quality through the delineation of desired outcomes for waiver participants across seven broad domains and 35 sub-domains. The National Home and Community-Based Services (HCBS) Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports for people with disabilities. The Framework focuses attention on the desired outcomes of HCBS quality management and improvement efforts.

The new quality improvement program for CAP/DA is called the Automated Quality and Utilization Improvement Program (AQUIP). It has been designed in conjunction with the new CAP/DA assessment tool. The assessment tool, used serially, will provide the critical data that will drive quality improvement in AQUIP.

AQUIP has been designed to provide the local CAP/DA lead agencies with more useful information and to allow DMA to determine statewide patterns for cost, quality, and level of care. AQUIP addresses the following domains: participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, rights and responsibilities, outcomes and satisfaction, and system performance. AQUIP is scheduled for implementation in Spring 2004.

Table 9: Comparisons Between the Current and Proposed Quality of Care Program

Current CAP/DA Quality Assurance Program	Proposed Quality and Utilization Improvement Program *(AQUIP)*
• Monthly review of a small CAP/DA sample	• Monthly review of all CAP/DA clients
• Manual Review	• Automated Review
• Paper-based System	• Web-based System
• Identifies individual errors	• System measures and individual results
• Provides limited data	• Provides comparative data

F. CAP/DA Waiting List Procedures

The waiting list procedures vary for each local CAP/DA lead agency. Currently there are 96 CAP/DA lead agencies and each one maintains its own waiting list. In general, individuals interested in CAP/DA are placed on a waiting list immediately after they have contacted the lead agency. Some lead agencies screen these individuals to determine if they would qualify for CAP/DA services before placing them on their waiting lists. The extent of the screening also varies by county. There are several lead agencies that conduct a home visit and collect extensive data on interested individuals before adding them to the waiting list, while other lead agencies only complete a brief screening over the phone. However, there are many lead agencies that do not complete any screenings and place all referrals on their waiting lists, regardless of whether or not they may qualify.

There is wide variation in the way individuals on the waiting lists are selected for CAP/DA services. Many agencies maintain a first-come, first-serve policy. Once an individual reaches the top of the list, these lead agencies complete a screening to determine if the individual still qualifies for CAP/DA before taking them off the list and initiating CAP/DA services. However, other lead agencies assign priority to certain individuals on the wait list such as referrals from Adult Protective Services or hospice. The priority preference allows these referrals to bypass other individuals who have been waiting for a longer period of time.

Standardizing Waiting List Procedures

The absence of standardized waiting list procedures creates problems in CAP/DA access. To address this issue, DMA met with several local CAP/DA lead agencies from across the State to discuss how to standardize the CAP/DA waiting list procedures. DMA intends to work with the lead agencies to gather data on the size of each waiting list, how each lead agency handles their waiting list, and which referrals are given priority. Once these data have been analyzed, DMA will develop new standardized guidelines on waiting lists and assist the lead agencies in implementing them to assure that there is no variation in how the guidelines are interpreted across the State. The target date for these standards is July 2004.

G. Plan for Pilot Review of CAP/DA Programs

Following the implementation of the new CAP/DA quality and utilization improvement program being developed by DMA and MRNC, DMA plans to conduct a pilot review of four CAP/DA programs. This pilot review will determine whether the four selected programs are operating in compliance with CAP/DA waiver requirements. Depending on the findings from the review, DMA may choose to conduct additional reviews across the State.

DMA anticipates that by September 2004, the selected CAP/DA programs will be ready to undergo an extensive review. This timeframe will provide adequate time to test the new CAP/DA assessment tool and new quality assurance and utilization improvement program. This will allow time for DMA to adequately prepare the local CAP/DA lead agencies on the new tool and quality improvement program and enable the lead agencies to begin their transition to the new system.

H. Conclusion

The information and data presented in this report should be viewed as part of a continuing effort to examine North Carolina's long-term care system. The report represents another step in understanding the multi-dimensional and complex nature of the current system of long-term care in North Carolina. Just as there is a critical need to capture important information on the utilization of public expenditures for long-term care populations across settings of care, it is equally important to understand the relationship between utilization of services and the medical needs of the recipients. Existing systems of collecting, storing and accessing data are in need of improvement and DHHS is aggressively working towards building the necessary program tools and data systems that will lead to strengthening public policy, developing an improved long-term care service delivery system and evaluating the impact of the improvements over time.

IV. Appendix A

Listing of DRIVE Categories of Service Included in the Table 4 Service Categories

Service Categories Listed in Table 4	DRIVE Categories of Service
Pharmacy	32: Prescribed Drugs
MH/MR-DD	4: Clinics-Mental Health
	56: CAP-Mentally Retarded
NF/Hospital Payments	15: Inpatient Hospital-General
	16: Outpatient Hospital-General
	19: Inpatient Specialty
	20: ICF-State owned and not state owned
	35: SNF-State owned and not state owned
	36: SNF Swing Bed
	42: Outpatient
	45: Outpatient Specialty
	48: Ambulatory Surgery
	50: Emergency Room
	51: Hospital Inpatient General-Crossovers
	52: Hospital Outpatient General-Crossovers
CAP Case Management	55: CAP-Disabled
Case Management DAAS, HIV	62: Case Management DAAS
	81: HIV Case Management
ADH	Not Applicable
Home Health Nursing	14: Home Health
In-Home/Personal Care Aide	53: Personal Care Services
	75: ACH-PCS Basic
	83: ACH-PCS Enhanced
Home Health Supplies	54: Durable Medical Equipment
Medical Procedures and Testing	23: Lab and X-ray
Physician Visits	2: Clinics-Free Standing
	3: Clinics-Health
	6: Clinics-Rural
	27: Physician
	65: FQHC-Core and ambulatory
Dental	7: Dental
All Other Claims	1: Ambulance
	13: Hearing Aids
	28: Chiropractic
	29: Optical Supplies
	30: Optical
	33: Health Check-Health Dept.
	38: Family Planning-Health Dept.
	46: Podiatry
	59: Home Infusion Therapy
	60: Hospice
	70: Physical Medicine, Non-Physician
	74: ACH-Transportation
	78: Health Maintenance

Appendix B:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

SESSION LAW 2003-284

HOUSE BILL 397

AUDIT OF CAP/DA PROGRAMS BY STATE AUDITOR SECTION 10.29B.(a) If State funds are appropriated to the Office of State Auditor for this purpose, then the State Auditor shall perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA). The audit shall build upon the results of the study conducted in accordance with Section 10.16(c) of S.L. 2002-126, by the North Carolina Institute of Medicine and shall provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor shall report the results of the audit to the North Carolina Study Commission on Aging by
January 1, 2004.

SECTION 10.29B.(b) The Department of Health and Human Services shall continue to examine CAP/DA and shall make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004. The report shall include the following information:

(1) A review of the current assessment process for CAP/DA clients, including an explanation of how assessments are conducted and a comparison of the assessment process for CAP/DA clients with the assessment process for nursing home and adult care home clients.

(2) A description of total program costs to the State and counties for clients receiving CAP/DA payments and an analysis of per-client costs in CAP/DA to per-client costs in nursing homes and adult care homes. This analysis shall include the costs of all forms of assistance received by CAP/DA clients, such as food stamps and housing assistance.

(3) A description of total program costs and an analysis of per-participant costs for individuals in the State-County In-Home Program. The analysis shall include a comparison of per-client costs for participants in the In-Home Program to per-client costs in adult care homes.

(4) A description of total program costs and an analysis of per-person costs for persons receiving personal care services through the Medicaid program. The analysis shall include a comparison of per-person costs in nursing homes and adult care homes.

(5) A description of the monitoring of quality of care for CAP/DA clients.

(6) An evaluation of the current waiting list procedures.

SECTION 10.29B.(c) The Department of Health and Human Services shall review, on a pilot basis, a selected number of CAP/DA programs to determine compliance with eligibility requirements for the program. The Department shall include the results of the review in its report to the Study Commission on Aging required under subsection (b) of this section.

Findings on the Community Alternatives Program for Disabled Adults (CAP/DA)

N.C. Legislative Study Commission on Aging
March 23, 2004
Presented by Gary Fuquay, Director
Division of Medical Assistance
Department of Health and Human Services

Presentation Overview

- Overview of programs described in the report
- Highlights from the Report
- Program Improvements
- Concluding Remarks

CAP/DA Program

- A federally approved home and community-based waiver program for elderly and disabled Medicaid recipients who are eligible for nursing facility placement.
- CAP/DA is available in all 100 counties.
- CAP/DA currently serves over 9400 clients.
- CAP/DA now has the capacity to serve over 10,700 clients statewide.
- The CAP/DA budget for SFY 03-04 is $217,791,639.

Improvements in CAP/DA

- Implementation of a new automated assessment instrument
- Development of standards for local lead agencies and service providers
- Evaluation of the CAP/DA slot distribution methodology
- Standardization of CAP/DA waiting lists

Special Assistance In-Home Program (SA/IH)

- SA/IH provides an alternative payment to individuals who are at-risk of adult care home placement but who could, with appropriate services, remain safely at home in the community.
- SA/IH is available in 61 counties.
- There are currently 363 SA/IH clients.

In-Home Personal Care Services (PCS) Program

- In-Home PCS provides assistance in the home to help elderly and disabled adults perform activities of daily living and home management tasks.
- PCS is a physician authorized service.
- PCS is provided by licensed home care agencies.

Restructuring In-Home PCS

- Revision of the PCS functional eligibility criteria.
- Development of new PCS screening and assessment tools.
- Implementation of a PCS utilization review and quality assurance program.

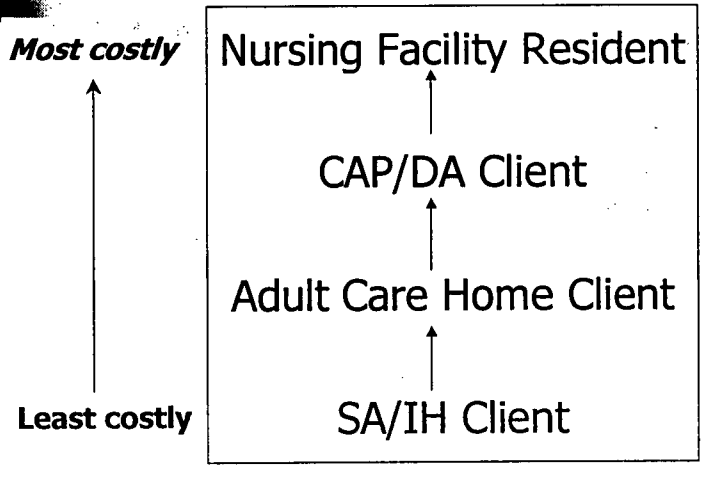
Comparison of Total Program Costs

- It was difficult to make proper program comparisons without medical and functional data on clients.
- Mental health costs were excluded from the data tables.
- The average CAP/DA client cost slightly less than the average nursing home resident.

Comparison of Total Program Costs (continued)

- The average adult care home client cost less than both the average CAP/DA client and the average nursing facility resident.
- The average SA/IH client was the least costly when compared to the average CAP/DA client, adult care home client, and nursing facility resident.

Comparison of Total Program Costs (continued)



Other Planned Improvements

- Our existing systems of collecting, storing, and accessing long-term care program data are in need of improvement.
- A new Medicaid Management Information System.
- Long-Term Care Populations' Study.
- DMA Organizational Changes to Improve Long-Term Care Policy.

Handouts for March 23, 2004

Included:

1. **Letter reference SB 1192 on March 15, 2001, from the FBI.**
2. **Public Law 92-544**
3. **NCGS 114-19.3**
4. **NCGS 114-19.6**
5. **Public Law 105-277**
6. **NCGS 131D-40**
7. **NCGS 131E-265**

U.S. Department of Justice

Federal Bureau of Investigation

Clarksburg, WV 26306

March 15, 2001

Ms. Dee Loran-Parker
Supervisor
Identification Section
North Carolina State Bureau
of Investigation
Post Office Box 29500
Raleigh, NC 27626-0500

Dear Ms. Loran-Parker:

Reference is made to your facsimile dated February 21, 2001, requesting a review of proposed Senate Bill (SB) 1192 to determine if it would meet the requirements of Public Law (Pub. L.) 92-544 for access to FBI criminal history record information (CHRI).

As background, the FBI Criminal Justice Information Services Division serves as the central repository for criminal justice information services in the FBI and incorporates the National Crime Information Center (NCIC) and the Fingerprint Identification Records System (FIRS). These systems are established and maintained under the authority of Title 28, United States Code (U.S.C.), Section 534, which provides that the exchange of these records shall be "with, and for the official use of authorized officials of the Federal Government, the state, cities and penal and other institutions." "Other institutions" has been interpreted by the United States Department of Justice (DOJ) to mean government or, in very limited situations, quasi-government entities. The DOJ and federal courts have further interpreted this language to restrict access to such criminal history records to criminal justice agencies for criminal justice purposes and to federal agencies authorized to receive it pursuant to a federal statute or executive order.

Ms. Dee Loran-Parker

As background to the issue of criminal history checks for noncriminal justice purposes, the decision of the United States District Court in Menard v. Mitchell, 328 F. Supp. 718 (D.D.C. 1971), placed strict limitations on dissemination of CHRI maintained by the FBI. The court held that the FBI had no statutory authority to disseminate CHRI outside of the federal government for licensing or employment purposes. The restricted dissemination afforded to FBI CHRI was reaffirmed in United States Department of Justice v. The Reporters Committee for Freedom of the Press, 489 U.S. 749 (1989). The Supreme Court held that the unauthorized disclosure of the contents of an FBI "rap sheet" to a third party could reasonably be expected to constitute an unwarranted invasion of personal privacy and was, therefore, prohibited.

In response to the Menard decision, Congress enacted Pub. L. 92-544, 86 Stat. 1115, which permits the FBI to exchange CHRI with officials of federally chartered or insured banking institutions and, if authorized by a state statute which has been approved by the Attorney General of the United States, with officials of state and local governments for purposes of licensing and employment. The Attorney General's approval authority is delegated to the FBI by 28 C.F.R. § 0.85(j).

One of the primary purposes for enacting Pub. L. 92-544 was to establish a national policy with adequate sanctions and administrative safeguards regarding the dissemination of FBI CHRI to state and local governments for noncriminal justice licensing and employment purposes.

The FBI's authority to provide CHRI for the noncriminal justice purpose of licensing and employment, including volunteers, is predicated upon federal or state law approved by the United States Department of Justice. The National Child Protection Act (NCPA) of 1993 encourages states to adopt legislation requiring national background checks of child care providers through the FBI's criminal history record system. As amended by the Violent Crime Control and Law Enforcement Act of 1994, the NCPA also applies to the elderly and individuals with disabilities. The NCPA established procedures for background checks, including the requirement that the background checks be conducted in accordance with Pub. L. 92-544.

In order to comply with Pub. L. 92-544, the state statute establishing guidelines for a category of employment, the issuance of a license, or for any other noncriminal justice suitability purpose must: (1) exist as the result of legislative

enactment; (2) require the applicants to be fingerprinted; (3) authorize the submission of the fingerprints through the state identification bureau to the FBI for a national criminal history record check; (4) identify the specific category of applicants/licensees; and **(5) provide that an authorized governmental agency is designated to be the recipient of the results of the record check, as such information cannot be disseminated to a private entity without authorizing federal legislation.** However, FBI CHRI obtained as a result of positive fingerprint identification can be introduced as evidence in administrative hearings for employment or licensing screening purposes. The record should be used only for the purpose of the administrative hearing and must not be made part of any record or file available to the public. Further, the FBI has no objection to the authorized governmental agency releasing a copy of such record to the subject of the record.

Congress amended the NCPA, on October 9, 1998, by enacting the Volunteers for Children Act (VCA), Pub. L. 105-251, which specifically authorizes a "qualified entity" which has been "designated by the State" to "contact an authorized agency of the State to request national criminal fingerprint background checks for the purpose of determining whether a provider has been convicted of a crime that bears upon the provider's fitness to have responsibility for the safety and well being of children, the elderly, or individuals with disabilities." 42 U.S.C. § 5119a(a)(1). This removed the NCPA's requirement that a state enact a statute acceptable under Pub. L. 92-544 [42 U.S.C.§ 5119a(b)(5)]. **All other requirements, e.g., that fingerprints be utilized, that the fingerprint cards be forwarded to the appropriate State Identification Bureau for transmittal to the FBI, and that CHRI not be released to a private entity, are retained.**

Also, effective October 19, 1998, Congress enacted Pub. L. 105-277, of which Section 124 provided that a nursing facility or home health care agency may request a fingerprint-based national criminal history background check by the FBI for an applicant for employment if the position is involved in direct patient care. However, in this instance, Congress authorized the dissemination of FBI CHRI to a private nursing facility or home health care agency for a "first hand" suitability determination by such employing entity. To ensure that such information is not misused by the private employer, information obtained as a result

of the background investigation "may be used only by the facility or agency requesting the information and only for the purpose of determining the suitability of the applicant for employment by the facility or agency in a position involved in direct patient care."

The Access Integrity Unit's (AIU) legal staff has completed a review of SB 1192, which would amend Article 4 of Chapter 114 of the North Carolina General Statutes, by adding new section 114-19.10. This new section pertains to "criminal record checks for adult care homes, nursing homes, home care agencies, and area mental health, developmental disabilities, and substance abuse services authorities." Section 114-19.10 states that the Department of Justice may provide to the following entities the criminal history from the State and National Repositories of Criminal Histories: (1) Nursing homes or combination homes, adult care home, home care agencies, area mental health, developmental disabilities, and substance abuse services authorities including a contract agency of an area authority. Some of these homes and agencies are clearly "private entities" and as such are not entitled to receive FBI CHRI as stated above. Therefore, the AIU has determined that § 114-19.10, as currently written, would not qualify for access to FBI CHRI under the standards of Pub. L. 92-544.

In order for § 114-19.10 to qualify under the standards of Pub. L. 92-544, it would have to be amended to ensure that, dissemination of FBI CHRI would only be provided to private agencies covered under Pub. L. 105-277, as explained above. For all other agencies listed, a governmental agency must be made the recipient of FBI CHRI, and they would not be authorized to further disseminate this CHRI to a private entity. Should SB 1192 be amended as suggested, it should be resubmitted to the AIU when enacted, for final review and approval.

Ms. Dee Loran-Parker

Should you have further questions concerning this matter, please do not hesitate to contact Ms. Marilyn Walton of the AIU at (304) 625-3616.

Sincerely yours,

William C. Temple
Chief
Programs Support Section
Criminal Justice Information
Services Division

1 - Special Agent Donald K. Roberts
Supervisor
Division of Criminal Information
North Carolina State Bureau
of Investigation
Post Office Box 29500
Raleigh, NC 27626-0500

SALARIES AND EXPENSES, ANTITRUST DIVISION

For expenses necessary for the enforcement of antitrust, consumer protection and kindred laws, $12,830,000: *Provided*, That none of this appropriation shall be expended for the establishment and maintenance of permanent regional offices of the Antitrust Division.

SALARIES AND EXPENSES, UNITED STATES ATTORNEYS AND MARSHALS

For necessary expenses of the offices of the United States attorneys and marshals, including purchase of firearms and ammunition; $91,000,000: *Provided*, That of the amount herein appropriated not to exceed $200,000 shall be available for payment of compensation and expenses of Commissioners appointed in condemnation cases under Rule 71A(h) of the Federal Rules of Civil Procedure.

FEES AND EXPENSES OF WITNESSES

For expenses, mileage, and per diems of witnesses and for per diems in lieu of subsistence, as authorized by law, and not to exceed $900,000 for such compensation and expenses of expert witnesses pursuant to section 524 of title 28, United States Code, and sections 4244-48 of title 18, United States Code; $10,500,000: *Provided*, That no part of the sum herein appropriated shall be used to pay any witness more than one attendance fee for any one calendar day.

SALARIES AND EXPENSES, COMMUNITY RELATIONS SERVICE

For necessary expenses of the Community Relations Service established by title X of the Civil Rights Act of 1964 (42 U.S.C. 2000g-2000g-2), $8,800,000.

FEDERAL BUREAU OF INVESTIGATION

SALARIES AND EXPENSES

For expenses necessary for the detection and prosecution of crimes against the United States; protection of the person of the President of the United States; acquisition, collection, classification and preservation of identification and other records and their exchange with, and for the official use of, the duly authorized officials of the Federal Government, of States, cities, and other institutions, such exchange to be subject to cancellation if dissemination is made outside the receiving departments or related agencies; and such other investigations regarding official matters under the control of the Department of Justice and the Department of State as may be directed by the Attorney General, including purchase for police-type use without regard to the general purchase price limitation for the current fiscal year not to exceed nine hundred eighty, including one armored vehicle (for replacement only) and hire of passenger motor vehicles; firearms and ammunition; not to exceed $10,000 for taxicab hire to be used exclusively for the purposes set forth in this paragraph; payment of rewards; and not to exceed $70,000 to meet unforeseen emergencies of a confidential character, to be expended under the direction of the Attorney General, and to be accounted for solely on his certificate; $351,075,000.

The funds provided for Salaries and Expenses, Federal Bureau of Investigation, may be used hereafter, in addition to those uses authorized thereunder, for the exchange of identification records with officials of federally chartered or insured banking institutions to promote or maintain the security of those institutions, and, if authorized by State statute and approved by the Attorney General, to officials of State and local governments for purposes of employment and licensing, any such exchange to be made only for the official use of any such official and subject to the same restriction with respect to dissemination as that provided for under the aforementioned appropriation.

None of the funds appropriated for the Federal Bureau of Investigation shall be used to pay the compensation of any civil-service employee.

§ 114-19.3. Criminal record checks of providers of treatment for or services to children, the elderly, mental health patients, the sick, and the disabled.

(a) Authority. - The Department of Justice may provide to any of the following entities a criminal record check of an individual who is employed by that entity, has applied for employment with that entity, or has volunteered to provide direct care on behalf of that entity:

(1) Hospitals licensed under Chapter 131E of the General Statutes.

(2), (3) Repealed by Session Laws 2000-154, s. 5, effective January 1, 2001.

(4) Hospices licensed under Chapter 131E of the General Statutes.

(5) Child placing agencies licensed under Chapter 131D of the General Statutes.

(6) Residential child care facilities licensed under Chapter 131D of the General Statutes.

(7) Hospitals licensed under Chapter 122C of the General Statutes.

(8) Repealed by Session Laws 2000-154, s. 5, effective January 1, 2001.

(9) Licensed child care facilities and nonlicensed child care homes regulated by the State.

(10) Any other organization or corporation, whether for profit or nonprofit, that provides direct care or services to children, the sick, the disabled, or the elderly.

(b) Procedure. - A criminal record check may be conducted by using an individual's fingerprint or any information required by the Department of Justice to identify that individual. A criminal record check shall be provided only if the individual whose record is checked consents to the record check. The information shall be kept confidential by the entity that receives the information. Upon the disclosure of confidential information under this section by the entity, the Department may refuse to provide further criminal record checks to that entity.

(c) Repealed by Session Laws 1995 (Regular Session, 1996), c. 606, s. 1.

(d) Foster or Adoptive Parent. - The Department of Justice, at the request of a child placing agency licensed under Chapter 131D of the General Statutes or a local department of social services, may provide a criminal record check of a prospective foster care or adoptive parent if the prospective parent consents to the record check. The information shall be kept confidential and upon the disclosure of confidential information under this section by the agency or department, the Department may refuse to provide further criminal record checks to that agency or department.

(e) Fee. - The Department may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee may not exceed fourteen dollars ($14.00).

(1993, c. 403, s. 1; 1995, c. 453, s. 1; 1995 (Reg. Sess., 1996), c. 606, s. 1; 1997-506, s. 38; 2000-154, s. 5; 2003-214, s. 1(2).)

§ 114-19.6. Criminal history record checks of employees of and applicants for employment with the Department of Health and Human Services, and the Department of Juvenile Justice and Delinquency Prevention.

(a) Definitions. - As used in this section, the term:

(1) "Covered person" means:

a. An applicant for employment or a current employee in a position in the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention who provides direct care for a client, patient, student, resident or ward of the Department; or

b. Supervises positions providing direct care as outlined in sub-subdivision a. of this subdivision.

(2) "Criminal history" means a State or federal history of conviction of a crime, whether a misdemeanor or felony, that bears upon a covered person's fitness for employment in the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention. The crimes include, but are not limited to, criminal offenses as set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(b) When requested by the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention, the North Carolina Department of Justice may provide

to the requesting department a covered person's criminal history from the State Repository of Criminal Histories. Such requests shall not be due to a person's age, sex, race, color, national origin, religion, creed, political affiliation, or handicapping condition as defined by G.S. 168A-3. For requests for a State criminal history record check only, the requesting department shall provide to the Department of Justice a form consenting to the check signed by the covered person to be checked and any additional information required by the Department of Justice. National criminal record checks are authorized for covered applicants who have not resided in the State of North Carolina during the past five years. For national checks the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention shall provide to the North Carolina Department of Justice the fingerprints of the covered person to be checked, any additional information required by the Department of Justice, and a form signed by the covered person to be checked consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the State or National Repositories. The fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State criminal history record file and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention shall keep all information pursuant to this section confidential. The Department of Justice shall charge a reasonable fee for conducting the checks of the criminal history records authorized by this section.

(c) All releases of criminal history information to the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention shall be subject to, and in compliance with, rules governing the dissemination of criminal history record checks as adopted by the North Carolina Division of Criminal Information. All of the information either department receives through the checking of the criminal history is privileged information and for the exclusive use of that department.

(d) If the covered person's verified criminal history record check reveals one or more convictions covered under subsection (a) of this section, then the conviction shall constitute just cause for not selecting the person for employment, or for dismissing the person from current employment with the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention. The conviction shall not automatically prohibit employment; however, the following factors shall be considered by the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention in determining whether employment shall be denied:

(1) The level and seriousness of the crime;
(2) The date of the crime;
(3) The age of the person at the time of the conviction;
(4) The circumstances surrounding the commission of the crime, if known;
(5) The nexus between the criminal conduct of the person and job duties of the person;
(6) The prison, jail, probation, parole,

rehabilitation, and employment records of the person since the date the crime was committed; and

(7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

(e) The Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention may deny employment to or dismiss a covered person who refuses to consent to a criminal history record check or use of fingerprints or other identifying information required by the State or National Repositories of Criminal Histories. Any such refusal shall constitute just cause for the employment denial or the dismissal from employment.

(f) The Department of Health and Human Services and the Department of Juvenile Justice and Delinquency Prevention may extend a conditional offer of employment pending the results of a criminal history record check authorized by this section. (1997-260, s. 1; 1997-443, s. 11A.118(b); 1998-202, s. 4(f); 2000-137, s. 4(h); 2003-214, s. 1(2).)

1ST DOCUMENT of Focus printed in FULL format.

UNITED STATES PUBLIC LAWS
105TH CONGRESS-SECOND SESSION
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PUBLIC LAW 105-277 [H.R. 4328]
OCTOBER 19, 1998
CONFERENCE REPORT ON H.R. 4328, MAKING OMNIBUS CONSOLIDATED AND EMERGENCY
SUPPLEMENTAL APPROPRIATIONS FOR FISCAL YEAR 1999

105 P.L. 277; 1998 Enacted H.R. 4328; 105 Enacted H.R. 4328

THE TEXT OF THIS DOCUMENT HAS BEEN SPLIT INTO 3 DOCUMENTS.
THIS IS PART 1.
USE THE LEXSEE FEATURE TO REVIEW ALL PARTS.

[*124x1] Sec. 124. (a). (1) A nursing facility or home health care agency may submit a request to the Attorney General to conduct a search and exchange of records described in subsection (b) regarding an applicant for employment if the employment position is involved in direct patient care.

(2) A nursing facility or home health care agency requesting a search and exchange of records under this section shall submit to the Attorney General through the appropriate State agency or agency designated by the Attorney General a copy of an employment applicant's fingerprints, a statement signed by the applicant authorizing the nursing facility or home health care agency to request the search and exchange of records, and any other identification information not more than 7 days (excluding Saturdays, Sundays, and legal public holidays under section 6103(a) of title 5, United States Code) after acquiring the fingerprints, signed statement, and information.

(b) Pursuant to any submission that complies with the requirements of subsection (a), the Attorney General shall search the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the appropriate State agency or agency designated by the Attorney General to receive such information.

(c) Information regarding an applicant for employment in a nursing facility or home health care agency obtained pursuant to this section may be used only by the facility or agency requesting the information and only for the purpose of determining the suitability of the applicant for employment by the facility or agency in a position involved in direct patient care.

(d) The Attorney General may charge a reasonable fee, not to exceed $50 per request, to any nursing facility or home health care agency requesting a search and exchange of records pursuant to this section. [Page H11064]

(e) Not later than 2 years after the date of enactment of this Act, the Attorney General shall submit a report to Congress on the number of requests for

searches and exchanges of records made under this section by nursing facilities and home health care agencies and the disposition of such requests.

(f) Whoever knowingly uses any information obtained pursuant to this section for a purpose other than as authorized under subsection (c) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

(g) A nursing facility or home health care agency that, in denying employment for an applicant, reasonably relies upon information provided by the Attorney General pursuant to this section shall not be liable in any action brought by the applicant based on the employment determination resulting from the incompleteness or inaccuracy of the information.

(h) The Attorney General may promulgate such regulations as are necessary to carry out this section, including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, the imposition of fees, and any necessary modifications to the definitions contained in subsection (i).

(i) In this section:

(1) The term home health care agency'' means an agency that provides home health care or personal care services on a visiting basis in a place of residence.

(2) The term nursing facility'' means a facility or institution (or a distinct part of an institution) that is primarily engaged in providing to residents of the facility or institution nursing care, including skilled nursing care, and related services for individuals who require medical or nursing care.

(j) This section shall apply without fiscal year limitation.

Article 5.
Miscellaneous Provisions.

§ 131D-40. (See Editor's Note) Criminal history record checks required for certain applicants for employment.

(a) Requirement; Adult Care Home. - An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Adult Care Home. - An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the adult care home or a contract agency of the adult care home shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.

(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the adult care home or the contract agency of the adult care home. If the adult care home or a contract agency of the adult care home disqualifies an applicant after consideration of the relevant factors, then the adult care home or the contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. - An adult care home and an officer or employee of an adult care home that, in good faith, complies with this section is not liable for the failure of the home to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. - As used in this section, "relevant offense" means a State crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of aged or disabled persons. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(e) Penalty for Furnishing False Information. - Any applicant

for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. - An adult care home may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The adult care home shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The adult care home shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment.

(g) Immunity From Liability. - An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (1995 (Reg. Sess., 1996), c. 606, s. 2; 1997-125, s. 1; 2000-154, s. 2.(a), (b).)

Article 16.
Miscellaneous Provisions.

§ 131E-265. (See Editor's Note) Criminal history record checks required for certain applicants for employment.

(a) Requirement; Nursing Home or Home Care Agency. - An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. If the applicant for employment or if the current employee who is changing employment status has been a resident of this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status. A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) **(See Editor's Note)** Requirement; Contract Agency of Nursing Home or Home Care Agency. - An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is

conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the nursing home or home care agency, or the contract agency of a nursing home or home care agency, shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the nursing home or home care agency, or the contract agency of the nursing home or home care agency. If a nursing home, home care agency, or contract agency of a nursing home or home care agency disqualifies an applicant after consideration of the relevant factors, then the nursing home, home care agency, or contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. - An entity and an officer or employee of an entity that, in good faith, complies with this section is not liable for the failure of the entity to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. - As used in this section, the term "relevant offense" has the same meaning as in G.S. 131D-40.

(e) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise

gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. - A nursing home or home care agency may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The nursing home or home care agency shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The nursing home or home care agency shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment.

(g) Immunity From Liability. - An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (1995 (Reg. Sess., 1996), c. 606, s. 3; 1997-125, s. 2; 1997-140, s. 4; 2000-154, ss. 3(a),(b).)

MISSISSIPPI LEGISLATURE REGULAR SESSION 2003

By: Representatives Smith (59th), Moody

To: Public Health and Welfare

HOUSE BILL NO. 1077
(As Sent to Governor)

AN ACT TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO CLARIFY PROCEDURES FOR REQUIRED EMPLOYEE CRIMINAL BACKGROUND CHECKS AND AFFIDAVITS AT LICENSED HEALTH CARE FACILITIES; TO PROVIDE THAT CERTAIN CONTRACT EMPLOYEES ARE SUBJECT TO BACKGROUND CHECK REQUIREMENTS; TO PROVIDE FOR TEMPORARY EMPLOYMENT OF THOSE EMPLOYEES AND WAIVERS FOR MITIGATING CIRCUMSTANCES; TO EXTEND THE AUTOMATIC REPEALER ON CERTAIN LICENSURE STANDARDS FOR PERSONAL CARE HOMES; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Section 43-11-13, Mississippi Code of 1972, is amended as follows:

43-11-13. (1) The licensing agency shall adopt, amend, promulgate and enforce such rules, regulations and standards, including classifications, with respect to all institutions for the aged or infirm to be licensed under this chapter as may be designed to further the accomplishment of the purpose of this chapter in promoting adequate care of individuals in those institutions in the interest of public health, safety and welfare. Those rules, regulations and standards shall be adopted and promulgated by the licensing agency and shall be recorded and indexed in a book to be maintained by the licensing agency in its main office in the State of Mississippi, entitled "Rules, Regulations and Minimum Standards for Institutions for the Aged or Infirm" and the book shall be open and available to all institutions for the aged or infirm and the public generally at all reasonable times. Upon the adoption of those rules, regulations and standards, the licensing agency shall mail copies thereof to all those institutions in the state that have filed with the agency their names and addresses for this purpose, but the failure to mail the same or the failure of the institutions to

receive the same shall in no way affect the validity thereof. The rules, regulations and standards may be amended by the licensing agency, from time to time, as necessary to promote the health, safety and welfare of persons living in those institutions.

(2) The licensee shall keep posted in a conspicuous place on the licensed premises all current rules, regulations and minimum standards applicable to fire protection measures as adopted by the licensing agency. The licensee shall furnish to the licensing agency at least once each six (6) months a certificate of approval and inspection by state or local fire authorities. Failure to comply with state laws and/or municipal ordinances and current rules, regulations and minimum standards as adopted by the licensing agency, relative to fire prevention measures, shall be prima facie evidence for revocation of license.

(3) The State Board of Health shall promulgate rules and regulations restricting the storage, quantity and classes of drugs allowed in personal care homes. Residents requiring administration of Schedule II Narcotics as defined in the Uniform Controlled Substances Law may be admitted to a personal care home. Schedule drugs may only be allowed in a personal care home if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.

(4) (a) Notwithstanding any determination by the licensing agency that skilled nursing services would be appropriate for a resident of a personal care home, that resident, the resident's guardian or the legally recognized responsible party for the resident may consent in writing for the resident to continue to reside in the personal care home, if approved in writing by a licensed physician. However, no personal care home shall allow more than two (2) residents, or ten percent (10%) of the total number of residents in the facility, whichever is greater, to remain in the personal care home under the provisions of this subsection (4). This consent shall be deemed to be appropriately

informed consent as described in the regulations promulgated by the licensing agency. After that written consent has been obtained, the resident shall have the right to continue to reside in the personal care home for as long as the resident meets the other conditions for residing in the personal care home. A copy of the written consent and the physician's approval shall be forwarded by the personal care home to the licensing agency.

(b) The State Board of Health shall promulgate rules and regulations restricting the handling of a resident's personal deposits by the director of a personal care home. Any funds given or provided for the purpose of supplying extra comforts, conveniences or services to any resident in any personal care home, and any funds otherwise received and held from, for or on behalf of any such resident, shall be deposited by the director or other proper officer of the personal care home to the credit of that resident in an account that shall be known as the Resident's Personal Deposit Fund. No more than one (1) month's charge for the care, support, maintenance and medical attention of the resident shall be applied from the account at any one time. After the death, discharge or transfer of any resident for whose benefit any such fund has been provided, any unexpended balance remaining in his personal deposit fund shall be applied for the payment of care, cost of support, maintenance and medical attention that is accrued. If any unexpended balance remains in that resident's personal deposit fund after complete reimbursement has been made for payment of care, support, maintenance and medical attention, and the director or other proper officer of the personal care home has been or shall be unable to locate the person or persons entitled to the unexpended balance, the director or other proper officer may, after the lapse of one (1) year from the date of that death, discharge or transfer, deposit the unexpended balance to the credit of the personal care home's operating fund.

(c) The State Board of Health shall promulgate rules and regulations requiring personal care homes to maintain records relating to health condition, medicine dispensed and administered, and any reaction to that medicine. The director of the personal care home shall be responsible for explaining the availability of those records to the family of the resident at any time upon reasonable request.

(d) The State Board of Health shall evaluate the effects of this section as it promotes adequate care of individuals in personal care homes in the interest of public health, safety and welfare. It shall report its findings to the Chairmen of the Public Health and Welfare Committees of the House and Senate by January 1, 2003. This subsection (4) shall stand repealed June 30, 2004.

(5) (a) For the purposes of this subsection, the term "licensed entity" means a hospital, nursing home, personal care home, home health agency or hospice. For the purposes of this subsection, the term "employee" means any individual employed by a licensed entity. The term "employee" also includes any individual who by contract provides to the patients, residents or clients being served by the licensed entity direct, hands-on, medical patient care in a patient's, resident's or client's room or in treatment or recovery rooms.

(b) Under regulations promulgated by the State Board of Health, the licensing agency shall require to be performed a criminal history record check on (i) every new employee of a licensed entity who provides direct patient care or services and who is employed on or after July 1, 2003, and (ii) every employee of a licensed entity employed before July 1, 2003, who has a documented disciplinary action by his or her present employer.

Except as otherwise provided in paragraph (c) of this subsection, no such employee hired after or on July 1, 2003, shall be permitted to provide direct patient care until the results of

the criminal history record check have revealed no disqualifying record or the employee has been granted a waiver. In order to determine the employee applicant's suitability for employment, the applicant shall be fingerprinted. Fingerprints shall be submitted to the licensing agency from scanning, with the results processed through the Department of Public Safety's Criminal Information Center. If no disqualifying record is identified at the state level, the fingerprints shall be forwarded by the Department of Public Safety to the Federal Bureau of Investigation for a national criminal history record check. The licensing agency shall notify the licensed entity of the results of an employee applicant's criminal history record check. If the criminal history record check discloses a felony conviction, guilty plea or plea of nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, sex offense listed in Section 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust or aggravated assault, or felonious abuse and/or battery of a vulnerable adult that has not been reversed on appeal or for which a pardon has not been granted, the * * * employee applicant shall not be eligible to be employed at the licensed entity.

(c) Any such new employee applicant may, however, be employed on a temporary basis pending the results of the criminal history record check, but any employment contract with the new employee shall be voidable if the new employee receives a disqualifying criminal record check and no waiver is granted as provided in this subsection.

(d) Under regulations promulgated by the State Board of Health, the licensing agency shall require every employee of a licensed entity employed before July 1, 2003, to sign an affidavit stating that he or she has not been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex

offense listed in Section 45-33-23(f), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea. No such employee of a licensed entity hired before July 1, 2003, shall be permitted to provide direct patient care until the employee has signed the affidavit required by this paragraph (d). All such existing employees of licensed entities must sign the affidavit required by this paragraph (d) within six (6) months of the final adoption of the regulations promulgated by the State Board of Health. If a person signs the affidavit required by this paragraph (d), and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed in this paragraph (d) and the conviction or plea has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury. If the offense that the person was convicted of or pleaded guilty or nolo contendre to was a violent offense, the person, upon a conviction of perjury under this paragraph, shall be punished as provided in Section 97-9-61. If the offense that the person was convicted of or pleaded guilty or nolo contendre to was a nonviolent offense, the person, upon a conviction of perjury under this paragraph, shall be punished by a fine of not more than Five Hundred Dollars ($500.00), or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment.

(e) The licensed entity may, in its discretion, allow any employee who is unable to sign the affidavit required by paragraph (d) of this subsection or any employee applicant aggrieved by the employment decision under this subsection (5) to appear before the licensed entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the

licensed entity. The licensed entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (i) age at which the crime was committed; (ii) circumstances surrounding the crime; (iii) length of time since the conviction and criminal history since the conviction; (iv) work history; (v) current employment and character references; and (vi) other evidence demonstrating the ability of the individual to perform the employment responsibilities competently and that the individual does not pose a threat to the health or safety of the patients in the licensed entity.

(f) The licensing agency may charge the licensed entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00), which licensed entity may, in its discretion, charge the same fee, or a portion thereof, to the employee applicant. Any costs incurred by a licensed entity implementing this subsection (5) shall be reimbursed as an allowable cost under Section 43-13-116.

(g) If the results of an employee applicant's criminal history record check reveals no disqualifying event, then the licensed entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the licensed entity, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any licensed entity with the necessity of an additional criminal record check. Any licensed entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the letter

to conduct or have conducted a criminal history record check as required in this subsection (5).

(h) The licensing agency, the licensed entity, and their agents, officers, employees, attorneys and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this subsection (5). The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, licensed entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment * * * decision or action based in whole or in part on compliance with or attempts to comply with the requirements of this subsection (5).

(i) The licensing agency shall promulgate regulations to implement this subsection (5).

SECTION 2. This act shall take effect and be in force from and after its passage.

North Carolina General Assembly
Legislative Services Office

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March 23, 2004

MEMORANDUM

TO: North Carolina Study Commission on Aging

FROM: Dianna Jessup, Staff Attorney
Research Division

RE: Mississippi Law and Procedure for Conducting Criminal Records Checks of Employees of Long Term Care Facilities

During the meeting of the Commission on March 9, members requested information concerning Mississippi's approach to requiring and conducting criminal records checks of employees of long term care facilities. I have reviewed Mississippi law, specifically, Mississippi Code Sec. 43-11-13.

Which entities are required to have their employees' criminal history checked?
All licensed entities, defined as hospitals, nursing homes, personal care homes, home health agencies, and hospices.

Which employees are required to be checked?
Every new employee of a licensed entity who provides direct patient care or services and who is employed on or after July 1, 2003, and every employee of a licensed entity employed before July 1, 2003 who has a documented disciplinary action by the employee's present employer.

Who determines whether a prospective employee should be disqualified from employment and how does that occur?
Fingerprints are scanned and submitted to the licensing state agency, which in turn submits the fingerprints to the state's criminal information center. If no disqualifying record is identified at the state level, the state's criminal justice center forwards the fingerprints to the FBI for a national criminal records check. The licensing agency notifies the licensed entity of the results of the criminal records check. If the check reveals a conviction, guilty plea, or plea of nolo contendere to certain specified crimes, the applicant is not eligible for employment.

If the results of an employee's criminal history check reveals no disqualifying event, the employee receives a notarized letter confirming the employee's suitability for employment that may be used by the employee for two years to seek employment at another licensed entity.

What are the disqualifying crimes?
An employee applicant is disqualified if the employee is convicted of or has pleaded guilty or nolo contendere to a felony of possession or sale of drugs murder, manslaughter, armed robbery, rape, sexual battery, other sex offenses specified, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult.

What about employees that were employed before July 1, 2003?
These employees are required to sign an affidavit affirming that they have not been convicted, or have pleaded guilty or nolo contendere to certain specified crimes. If an employee signs the affidavit and it is later found that it is false, the person is guilty of perjury. If a person can't sign an affidavit, the licensed entity can waive the requirement to sign the affidavit if the employee can show mitigating circumstances such as the age of the employee when the crime was committed, the employee's work history, the circumstances surrounding the crime, the length of time since the conviction and criminal history since the conviction, and other evidence demonstrating the ability of the employee to perform the employment responsibilities competently and that the employee does not pose a threat to the health or safety of the patients.

Who pays for the criminal records check?
The licensing agency can charge the licensed entity a fee not to exceed $50, and the licensed entity can charge the same fee to the employee applicant.

Does the statute provide for immunity from liability?
Yes. The licensing agency, the licensed entity, and their agents officers, employees, attorneys and representatives are presumed to be acting in good faith for any employment decision made or action taken under the statute and cannot be held liable in any employment decision or action based in whole or in part on compliance with the statute.

Charles Schaeffer (*person interviewed*)
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FACTSHEET: Civil Workflow Control System (CWCS) – pronounced "Quicks"

Background
The CWCS system was put in place in response to a Governor's Executive Order for the Florida Department of Law Enforcement (FDLE) to take over security of Florida's ports in response to 9/11 and heightened drug smuggling activity. The old manual system of national criminal records checks, using fingerprint cards mailed to the FBI with a 4-6 week turnaround, was insufficient due to the rapidity of turnover among personnel in the ports.

The Florida State Legislature appropriated $2.1 million to develop the programming necessary, purchase database software, and purchase hardware. It took them six months to build and deploy the system after the executive order. Over 3 years, the state has invested about $5 million in the system, mainly through federal grants and anti-terrorism money that were given to them. He said, "Before we even deployed the system, other state agencies had heard about it and were chomping at the bit to use it. How we did business before changed night and day as to how we do it now."

Charles Schaeffer stated that he was "maybe stepping out on a limb, but thought that Florida would be willing to give North Carolina the programming code they developed for the CWCS system if we wanted it, saving the state the development costs." He indicated that it has the flexibility built in to be tailored to our particular state's IT architecture and systems. He also indicated they would be willing to talk with legislative staff, IT staff, or legislators about their experience with the system.

Equipment Required
There are two components to Florida's CWCS system: state and local level infrastructure.

State level architecture requires 5 servers at a cost of about $50,000 total. Local level, or edge equipment, costs about $20,000 per workstation and fingerprint scanner. Florida deployed one workstation in each of its 67 counties, generally in the sheriff's department or in a large police department in a county. To do so, they partnered with other state agencies, such as the Department of State, and school boards (Florida now how a CWCS station in every school board district), who either helped pay for the initial workstation deployment or bought additional workstations to tap into the system for their own needs.

Schaeffer stated that, "$20,000 per workstation sounds like a lot, but next to the risk you're taking by hiring someone who potentially has a criminal record to work with children and the elderly, the liability issues make the cost look small."

He indicated that five vendors produce the easy-scan equipment: **Lockheed-Martin, Cogent, Cross Match, Visionics, and Motorola/Print Track**. He said that competition for business was very competitive and that competition had already driven prices down for them from the almost $30,000 per station when they started to $20,000 per station for the last ones they bought. He predicts the cost of the technology will probably drop even further this year.

How the Record Check Information is Handled

FDLE never sends or shares information with the individual whose background is being checked. They send it to the agency of licensure or agency of record making the determination of licensure, certification, or employability, where final determination is made, based on criteria set by the legislature and the agency. Where necessary, they bifurcate information, as some entities are not authorized to receive federal information. For example, in foster care situations, the national background check is initiated to determine if potential foster parents are eligible. When FDLE receives it, they send the public information to the local foster care agency, and the federal information to their Department of Health and Human Services. "Wants" and warrants information go directly to local sheriff's departments. For gun permits, the sheriff's department takes the prints, but the information goes directly to the Department of State, which makes decisions concerning eligibility for gun permits and licensed agents. They do not have statutory authority to make determinations of any kind concerning employability, licensure or certification; in fact, he said the Florida state legislature passed a law prohibiting it.

Success in Utilization of the System

Schaeffer indicated that now that the basic infrastructure is in place, many other state agencies (besides Ports, Insurance, Department of State, Education, and Children's and Family Services) and private entities are signing on for national criminal records checks. Universal Studios and Disney are two major corporations that use their services daily, and have purchased their own workstations to do so. Their Highway Safety (Highway Patrol) recently bought a number of workstations and scanners for homeland security purposes, as they want to know who has HAZMAT and Commercial Drivers' License (CDL) certification in hopes of preventing another Oklahoma City incident.

Schaeffer also indicated that several bills were currently before their legislature that would expand background checks even further, but that the CWCS system is flexible and robust enough to handle the additional volume of checks.

Interview conducted by:
June Brotherton, Executive Director
Friends of Residents in Long Term Care

Testimony to Study Commission on Aging
By Roger Manus, President
Friends of Residents in Long Term Care
Tuesday, March 23, 10 a.m., 544 LOB

Mr. Chairman, Co-Chairs and Members of the Study Commission on Aging, my name is Roger Manus, and I am President of Friends of Residents in Long Term Care, a non-profit education and advocacy organization that advocates for the almost 80,000 long term care residents residing in nursing homes, adult care homes and assisted living facilities and their families. Our mission is to improve quality of care for those residents.

The issue of national criminal background checks has been on the Friends of Residents in Long Term Care legislative agenda ever since I have been on the board. We need to resolve this issue this year. It is time to remove the moratorium on this process.

I would like to state categorically that a majority of long term care workers provide humane, compassionate and very competent care for our frail elders and the disabled, under trying circumstances. These are not the people I want to discuss today.

Situation

One only has to read the national media to know that incidences of assault, rape, murder and other serious crimes against people are increasing across society. In response to national incidences of child abuse in daycare facilities, the state mandated national and state criminal background checks for anyone working in a daycare facility, because children are considered highly vulnerable populations that need this protection.

A long-term care facility is a similar microcosm of society in general – it can be likened to a small town, with many of the same crime problems. The difference is that people living in long-term care facilities are the vulnerable frail elderly and disabled, and they cannot defend themselves. Many cannot communicate when they perceive a threat. Worst of all, unlike children, they cannot go home at night and tell a parent about inappropriate behaviors – they spend the night in these facilities when staffing levels decrease even further with greater potential and opportunity for abuse.

As you know, facilities across this state have for some time conducted state criminal background checks on long term care workers who provide direct services and treatment to vulnerable frail elders. However, with the mobility of our population, long term care workers are no longer our neighbors next door, or people we went to school or church with. In some instances, they are people from other states who have committed crimes that render them unemployable in long term care facilities, so they simply cross over into other states to work, states that do not conduct national criminal background checks. As a result, states have had people working in long term care facilities who had convictions for serious crimes against people, serial killers and serial rapists.

History

In 1999, a bill was introduced in the General Assembly to make national criminal background checks a reality. It passed in 2000, but 10 months after the effective date of the law, a moratorium was imposed due to concerns about cost and how the checks would be

handled and communicated. In the 2001 legislation that imposed the moratorium, a study committee was promised to resolve the remaining issues. In the ensuing years to date, the moratorium has continued to be put in place annually, with the same promise of a study commission to resolve the issues, but this has never happened. So, here we are almost five years later, and our vulnerable frail elders and the disabled are no closer to the same level of protections offered our small children. One has to ask why.

The Fiscal Research Division researched the cost of doing the national criminal background checks, so a fiscal note exists on the original cost of the system as proposed at that time. However, given the hundreds of millions spent annually on Medicaid services for the elderly, I fully believe that the people of this state would find national criminal background checks a worthwhile expenditure to ensure the safety of the elderly and disabled in long term care.

Options for National Criminal Background Checks

The real question is how to conduct the national criminal background checks in an expeditious manner – who should do them, who should receive the information from the check, and what criteria should be used to disqualify someone from employment and for how long.

Designated Agencies

There are two agencies where the responsibility for national criminal background checks could reside. The first is the Department of Health and Human Services, which already has responsibility for conducting those same checks for childcare workers. However, after the law authorizing national criminal background checks was passed in 2000, this department has had almost 4-1/2 years to resolve the questions about how the process should be conducted, and they have not done so.

The other option for getting the national checks underway is to place responsibility for conducting the national checks, as well as the budget and personnel to do them in Crime Control and Public Safety where there are current responsibilities for homeland security. This agency is well-versed in records checks and would only need procedural direction. Placing the records checks in this agency could be accompanied by general centralization of records checks that are currently done by various state agencies.

A last option for national criminal records checks is to build upon the privatization initiative promoted in state government, and contract with a private entity to provide background checks. However, there is some question as to whether they are able to conduct fingerprint-based national background checks.

Designated Receivers of National Criminal Background Check Information

Once you determine the agency that will have responsibility for overseeing the checks and communicating the information expeditiously to long term care facilities, the question then becomes who will receive the information from the background check. From our research, we find three key methods are being used, with one qualification. One state has what we consider to be the premier program for national background checks, and this state's program is discussed separately in a handout you have received.

In some states, the potential employee is asked to complete forms authorizing a national criminal background check. The potential employee pays zero, some or all of the records check fees, depending on the state's policy. Some states view the cost issue as a way to weed out people who know they have criminal backgrounds or those who tend to job-hop. Once the criminal background check is completed, the potential employee receives the results of his or her background check. In order to complete the employment process, the employee must be willing to provide the employer with a copy of the results of the criminal background check. Those who do not supply it are not employed. The employer, based on the information provided, makes the final employment decision.

In the second method, the potential employee authorizes a national criminal background check. If the potential employee has a court case pending for a crime that might disallow employment, any further processing of his application is suspended until the case is tried. If there is no pending court case, the state check is conducted first, and if the record is clear of disqualifying convictions, then the federal check is conducted. The results come back to the state-designated agency, which compares any convictions against a pre-determined list of crimes that are deemed to render any applicant unapproved for employment. An "approved" or "unapproved" for employment message is transmitted back to the potential employer. If the disapproved potential employee feels that the record is inaccurate or his or her identity has been used by another person to commit a crime, he or she can appeal and provide additional information to the agency designated as responsible for the background checks in an effort to make a final determination on employability.

In the third method, the employee fills out an authorization for the national background check and designates to which agency it will go for the private entity, which conducts the check. The results of the check can be sent to the agency, or based on a list of criteria, the private entity can determine if the person is eligible for employment and communicate that to the agency.

Criteria for Employment

Then comes the question of which criteria are used to determine employability. There are two options used here, also. Pennsylvania's legislature developed a list of convictions that render potential employees of long-term care facilities unapproved for employment. Other states allow the potential employer, once they have seen the results of the national criminal background check and talked with the potential employee for clarification, to make the final determination as to employability.

Background Check Systems

In looking at potential systems for national criminal background checks, one can go two major ways: 1) manual fingerprinting and mailing fingerprint cards to state and federal agencies, with a turnaround time of 6-8 weeks by a governmental or private entity; or 2) use of electronic scanning technology, with a 48-hour maximum turnaround time. While more upfront cost would be involved with option 2, it would be preferable because of accuracy of fingerprinting, timeliness of response, and scalability for a large variety of uses and high volume of use.

A Background Check System That Works - Florida

Of the systems we have examined, the Florida system appears to be most flexible and expandable, although not least-cost. It was originally used in Florida's ports to guard against

drug smuggling, theft, terrorism, and sabotage, but has since been extended to their Departments of State, Education, and Children and Families, Insurance, and Sheriff's Offices, as well as non-governmental agencies. A copy of an interview was distributed with my remarks that Executive Director June Brotherton conducted with one of the developers of the system, FDLE Data Center Director Charles Schaeffer, that provides fuller information on the Florida system.

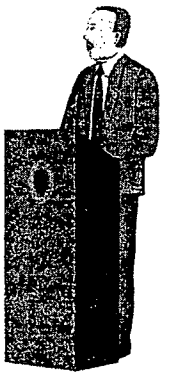
Florida uses electronic scanning of fingerprints and secure, encrypted Internet access to request and receive national records check information. By using e-technology instead of the old manual fingerprint cards, they are able to provide criminal records check information within a maximum of 48 hours (the real timeframe is often 5 hours), compared to the 4-6 weeks required by the FBI for hard-copy fingerprint cards. To use this system, the sheriff's office or private entity must have a computer and fingerprint scanner with Internet access. The Florida Department of Law Enforcement, the designated agency for these checks, has five Windows 2000 servers, with Internet access and a specialized software interface they developed for this program. During the January-March 2003 quarter alone, over 45,000 checks were performed.

Florida changed to this method because of the turnover rate and mobility of its population, and because state agencies and employers were being required to make critical employment, licensing and certification decisions in the absence of criminal records information. In addition, Florida applies an e-commerce component that allows the state to automatically charge the appropriate criminal record check fee electronically to the appropriate agency or entity. In Florida, this system is used for national criminal background checks by the Department of Insurance before it issues agent licenses and certifications; Department of Children and Families for daycare workers, foster care providers and long term care workers; Department of State for concealed weapons permits; private security companies; and organizations using volunteers to work with vulnerable populations.

This is but one example of a system that works. The technology exists to do what we need to do at a cost that is not overwhelming. We can provide a more secure and safe environment for our vulnerable elderly and disabled if we stop making excuses and start looking for solutions. Let's end the moratorium, and protect our frail and disabled citizens who reside in long term care facilities throughout the state.

Thank you.

Summary of Presentations
by
Organizations Representing Older Adults



Prepared for the
North Carolina Study Commission on Aging

March 23, 2004

The following organizations made brief presentations on March 9, 2004, to the North Carolina Study Commission on Aging

Friends of Residents
June Brotherton

NC Assisted Living Association
Jerry Cooper

NC Adult Day Services Association
Teresa Johnson

NC Senior Games
Cindy Trumbower

Governor's Advisory Council on Aging
Ann Johnson

National Association of Social Workers – NC Chapter, Aging Unit
Kathy Lowe

Alzheimer's Association, Mountain Region
Joe Connolly

Alzheimer's Association, Eastern Region
Alice Watkins

AARP
Von Valletta

NC Coalition on Aging
Jean Reaves

NC Health Care Facilities Association
Stacy Flannery

NC Senior Citizens Association
Tom Southern

NC Senior Tar Heel Legislature
Vernon Dull

NC Dental Society – Committee on Aging/Access Dental Care
Bill Milner

Association for Home and Hospice Care of North Carolina
Jim Edgerton

ISSUE FREQUENCY

Each organization's legislative priorities/issues of concern are summarized and presented in a table format on the following pages.

The number of organizations that mentioned the issue is in parentheses ( ) next to the issue.

The individual issues presented were grouped in the following broad categories: Community-Based Issues, Facilities Issues, Workforce Issues, and Other.

For Summary Purposes, the issues with the highest frequency were:

- **Access to National Criminal Record Checks** *(6)*
- **Restoration of the LTC Insurance Tax Credit** *(4)*
- **Support for and/or Restoration of Funding for the Home and Community Care Block Grant (HCCBG)** *(3)*
- **Support for and/or Restoration of Funding for Senior Centers** *(3)*
- **Maintaining the Viability of the Community Alternatives Program for Disabled Adults (CAP/DA)** *(3)*

Issues

	Friends of Residents	AARP	NC Assisted Living Assoc.	NC Coalition on Aging	NC Adult Day Services Assoc.	NC Health Care Facilities Assoc.	NC Senior Games	NC Senior Citizens Assoc.	Governors Advisory Council on Aging	NC Senior Tar Heel Legislature	National Assoc. of Social Workers – NC Chapter, Aging Unit	NC Dental Society – Com on Aging/Access Dental Care	Alzheimer's Association, Mountain Region	Assoc. for Home and Hospice Care of NC	Alzheimer's Association, Eastern Region
COMMUNITY-BASED ISSUES															
Support for/Restoration of Funding HCCBG *(3)*				x					x	x					
Support for/Restoration of Funding for Senior Centers *(3)*									x	x	x				
Maintain the Viability of CAP/DA *(3)*				x					x	x					
Funding Support for Home Care Services in the Medicaid Program *(1)*														x	
Support SA In-home *(1)*														x	
Remove Institutional Bias *(1)*														x	
Expand Use of Medicaid Funds for Adult Day Services *(2)*				x	x										
Funding Support for NC Senior Games *(1)*							x								
Support for Respite Care Programs *(2)*													x		x
Support for Community-Based Assistance Programs *(1)*															x
FACILITIES ISSUES															
Expressed Concern Over Mixed Populations in LTC Facilities *(1)*	x														
Discharge Rules-Maintain Due Process for Adult Care Home Residents *(1)*	x														
Maintain Licensure Rule Enforcement Consistency From County to County *(1)*			x												
Concern Over Professional Liability Insurance Increases for Providers *(1)*			x												
Increased Funding for Individuals in Alzheimer's/Dementia Units *(1)*			x												
WORKFORCE ISSUES															
Access to National Criminal Record Checks *(6)*	x	x		x		x			x	x					
Increase Salaries and Benefits for Direct Care Workers *(2)*		x							x						
Examine the Shortage of Nursing Workforce (Nursing Asst. to RN) *(1)*						x									
Support for Nurse Aide Training *(1)*						x									
Insure Adequate LTC Staffing Levels *(1)*	x														

	Friends of Residents	AARP	NC Assisted Living Assoc.	NC Coalition on Aging	NC Adult Day Services Assoc.	NC Health Care Facilities Assoc.	NC Senior Games	NC Senior Citizens Assoc.	Governors Advisory Council on Aging	NC Senior Tar Heel Legislature	National Assoc. of Social Workers – NC Chapter, Aging Unit	NC Dental Society – Com on Aging/Access Dental Care	Alzheimer's Association, Mountain Region	Assoc. for Home and Hospice Care of NC	Alzheimer's Association, Eastern Region
OTHER ISSUES															
Restore LTC Insurance Tax Credit *(4)*		x		x					x	x					
Guardianship Mediation Initiative *(1)*									x						
Establish Creative Funding Options for Direct Care Dental Services*(1)*												x			
Establish Task Force to Review Oral Health Standard of Care for Special Care Populations *(1)*												x			
Increase State Revenues to Provide Services for the Elderly and Disabled *(2)*		x							x						
Establish Governor's Commission on Efficiency and Effectiveness *(1)*								x							
Enact a Taxpayer's Bill of Rights *(1)*								x							
Malpractice Reform (1)								x							
Tax Reform – Consumption Sales Tax to Replace Income Tax *(1)*								x							
Ensure execution of DHHS Plan for Information and Assistance is Supportive of Older and Disabled Adults *(1)*									x						
Establish DHHS Office to Address Housing Needs of Vulnerable Citizens *(1)*									x						
Transportation Services for the Elderly *(1)*											x				
Professional Care Coordination - Emphasis on Social Workers*(1)*											x				
Prescription Drug Assistance *(1)*											x				
Strengthen LTC Ombudsman Program *(1)*									x						
Maintain funding for State & Regional Ombudsmen, Case Managers, & Adult Care Specialists *(1)*	x														
Maintain Medicare/Medicaid Funding *(1)*	x														
Oppose Cap on non-economic damages for victims of medical malpractice & to shielding nursing home inspection reports from use as evidence*(1)*		x													
Payday loans – longer repayment, lower interest, allow installment payments *(1)*		x													
Support "Transfer on Death" to Facilitate Securities Transfer *(1)*		x													

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH 27603

March 30, 2004

MEMORANDUM

TO: Members, NORTH CAROLINA STUDY COMMISSION ON AGING

FROM: Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NORTH CAROLINA STUDY COMMISSION ON AGING:

DAY:	**Tuesday**	TIME:	**10:00 A.M.**
DATE:	**April 13, 2004**		
LOCATION:	**Room 643, LOB**		

Please advise Jo Bobbitt, Committee Assistant, at (919) 733-5477, or e-mail nyela@ncleg.net if you will be unable to attend.
For planning purposes, the following meeting date has been scheduled for future meeting: April 27, 2004. This meeting will be in Room 643 at 10:00 A. M.

Posted: March 30, 2004

cc: Committee Record _____
Interested Parties _____

DRAFT COPY
FOR REVIEW ONLY

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Tuesday, April 13, 2004
10:00 A.M.
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, April 13, 2004 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator A. B. Swindell, Representative Debbie Clary, and Representative Edd Nye, Co-Chairs; Senators Austin Allran, Charlie Dannelly, Tony Moore, Joe Sam Queen; Representatives Jennifer Weiss, Gene Wilson; public members Brad Allen, Jan Elliott, Katherine Fox Price, Sam Marsh, and Jackie Sheppard.

Theresa Matula, Dianna Jessup, Susan Morgan, and Gann Watson provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Swindell presided at the meeting. He called the meeting to order and welcomed members and guests. He then asked Jackie Franklin, Division of Aging and Adult Services, DHHS, to present to the Committee the Report on State/County Special Assistance-In Home Report. (See Attachment No. 2)

PRESENTATION- SPECIAL ASSISTANCE IN-HOME PROGRAM

Ms. Franklin gave an update on the status of the Special Assistance In- Home Program. In 1999, the General Assembly approved a special provision authorizing the Department to carry out a demonstration project. This pilot project began with 22 counties. This project would provide Special Assistance payments to up to 400 eligible individuals living at home for a two-year period beginning July 1, 1999 and ending June 30, 2001. In 2000, the General Assembly amended the special provision to provide these Special Assistance payments through June 2002. In 2001, the General Assembly amended the special provision to extend the project through June 30, 2003 and required the Department to submit a final report by January 1, 2003.

In the 2003 session, the General Assembly approved a special provision to expand the Program to 800 slots and made it statewide, with counties participating on a voluntary basis at the option of their DSS office. The provision specified that no eligible individuals would receive a payment less than they would have received in 2003 and continued the maximum payment at one half the amount the individuals would receive if living in an adult care home. The actual amount of the payment is based on a service needs assessment conducted by a case manager in the Department to submit a final report by January 1, 2005.

Sixty-one counties, which included the original 22, submitted proposals. All 61 were approved. The counties are providing this service with existing staff and funding resources. In 2000 several training events were presented for the original 22 project counties prior to implementation. When the General Assembly authorized expansion of the program in 2003, a comprehensive updated training curriculum was developed and conducted for all participating counties, including the original project counties.

In summary, the Program has received continuing support from county DSS agencies. This program is an essential component in the continuum of care for aging and disabled adults in North Carolina. It provides an option that is cost effective when compared to institutional care, incorporates the principles of consumer directed care, and supports the Department's Olmstead Plan to provide options for aging and disabled individuals to live in the least restrictive setting possible.

The Department recommends the continuation of the Program at is present level through the biennium to allow time for a complete analysis of costs and benefits of the expanded program.

There was a lot of enthusiasm and support for the program by the members. They questioned Ms. Franklin concerning why more of the slots were not filled and why the other 49 counties were not participating. They would like to see all 800 slots filled and more counties involved in the Program. There was discussion concerning the number of staff allocated for this program. Ms. Franklin stated that she is the Program manager for both portions of the SA Program and there is one other staff position that is now vacant. There are two field monitors who go out to monitor county activity. The same staff that does SA Adult Home also does SA In-Home. The members expressed encouragement in utilizing the Program and want a report back to see when the slots have been utilized. Senator Dannelly asked for the number of slots being utilized by each county. Ms. Franklin stated she would get that information for him. She then concluded her presentation.

Theresa Matula, legislative research staff, was recognized by Senator Swindell to review the draft proposals for the Commission. (See Attachments # 3 & 4) There were 12 recommendations on nine topics.

DRAFT PROPOSALS

A. The Commission recommends the General Assembly repeal the sunset on the Long Term Care Insurance Tax Credit.

B. The Commission recommends the General Assembly require DHHS to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

C. The Commission recommends the General Assembly require DHHS to work with long-term care providers and advocates for the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Recommendation was made to include wording to add ***the elderly*** as well as the mentally ill in this recommendation.

Senator Allran asked for a copy of the law that defines mentally ill. Staff would get that for him.

E. The Commission recommends the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

F. The Commission recommends the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

G. The Commission recommends the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

H. The Commission recommends the General Assembly require DHHS to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

The members recommended that the study be done by an outside source rather than the Department, that $150, 000 be allocated for the study, and to include all other in-home services, specifically including CAP/DA, PCS, and Home Health.

J. The Commission recommends the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

K. The Commission recommends the General Assembly require DHHS to develop and deliver business basics training for adult day services providers with a goal of fostering successful and financially viable centers.

Senator Dannelly asked if the business basics training for adult day services providers was necessary. He wanted to know how many of the Adult Day Care Centers there are in the State. Ms. Matula responded there are 113 programs in 60 counties. Previously there was a peak of 125 in 68 counties. Over a two-year time period, 30 centers have closed. Ms. Jean Reaves, Director Adult Daycare Center in Halifax County, was recognized and suggested a combination of several things are needed to prevent centers from failing.

Senator Dannelly commented that one of the serious problems is how much is being paid for the services in the centers. Reimbursement rates need to be enough to provide for overhead. Ms. Reaves commented they have to provide for a registered nurse to be on staff and funds have to be available for this salary. Senator Dannelly expressed concern that they were moving into requiring a course in business management. He requested this recommendation be pulled at the time of the vote.

L. The Commission recommends the General Assembly direct the Social Services Commission to consider adopting stronger rules related to the financial management of adult day services programs.

SenatorSwindell then recognized Dianna Jessup, Research Staff, to review the two remaining draft proposals.

I. The Commission recommends the General Assembly establish a Legislative Study Commission to study State guardianship laws.

Mr. Allen stated he thought someone from the Area Agency on Aging should be a member of the Commission. Ms. Jessup stated they could add wording to include a representative of the Area Agency on Aging as an ex officio member.

Senator Swindell announced the meeting would break for lunch.

The meeting continued after lunch with Ms. Jessup returning to review the remaining draft recommendation.

D. The Commission recommends the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

There were many questions and much discussion concerning this recommendation. Rep.Weiss expressed concern that this was a very narrowly drawn pilot. Rep. Nye stated he thought there were too many problems with this recommendation and it should not be included in the report. He said a member of the legislature could introduce a bill during session to address criminal records check. After more discussion, Senator Swindell stated they would return to vote on recommendations and come back to criminal record checks.

Ms. Matula was again recognized and asked that copies of the recommended changes be given to the members. (See Attachment #5) After discussion, Senator Swindell stated they would vote on all the recommendations except criminal record checks. Senator Allran made a motion to accept the recommendations of the Commission. Senator Moore seconded the motion. A voice vote was taken and the motion carried.

The members again discussed the recommendation concerning criminal record checks. Senator Dannelly made a motion that the Commission send the bill forward. Senator

Swindell asked the members to vote by a show of hands. The motion carried with seven members voting in favor and three against the motion.

Rep. Clary asked that they reconsider the previous vote on the full package. She asked that the business basics for Adult Day Services on page 18 be pulled. Staff had prepared a handout with the proposed changes to 2003-SHz-10[v.8]-Study Mentally Ill LTC Resident Issues for Senator Allran and members were given a copy. Senator Allran moved for a favorable report on this amendment. The amendment was approved by voice vote.

Senator Swindell announced that the report would be mailed to the members and the next meeting would be April 27, 2004.

The meeting adjourned at 2:30 P.M.

Jo Bobbitt

Senator A. B. Swindell, Co-Chair

Jo Bobbitt, Committee Assistant

Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

VISITOR REGISTRATION SHEET

NC Study commission on Aging — **April 13, 2004**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Karen Gottovi	NC Div. of Aging & Adult Svcs.
Stacy Flannery	NCHCFA
Polly Williams	Coalition on Aging / Triangle OA
[illegible]	NCAOA
Abby Emmanuelson	Nat'l MS Society
Mary Bethea	Div. of Aging
[illegible]	Allen Associates
[illegible]	CAPS
Richard C Hatch	AARP / NC Coalition on Aging
[illegible]	NCACDS
CHARLES TREFZGER	NCALTCF
[illegible]	NCALTCF
Belinda Wilson	NCALTCF
Cathy B. Danner	RUAL
Hugh B Hammett	NCALTCF
Joyce G. CherryEN	NCALTCF
Susan Lane Morris	NCALTCF
John Goodman	Alley Assoc.
[illegible]	Bove + Assoc.
Jenny Cooper	NCALA
Evelyn Hawthorne	EH&R
Jim Edgett	AHHC
[illegible]	NCLHSA
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Agenda North Carolina Study Commission on Aging

April 13, 2004
10:00 AM
Legislative Office Building
Room 643

I. Welcome
Senator AB Swindell, Cochair
Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair

II. Report on State/County Special Assistance – In Home
Jackie Franklin, Division of Aging and Adult Services, DHHS

III. Draft Commission Recommendations

IV. Vote on Recommendations
Direct Staff to Prepare Report

V. Next Meeting: April 27, 2004

Special Assistance In-Home Program

Pursuant to S.L. 2003-284 (HB 397), Section 10.51(b)

Report
To
House of Representatives Appropriations Committee
and
House of Representatives Appropriations Subcommittee
on Health and Human Services
and
Senate Appropriations Committee
and
Senate Appropriations Committee
on Health and Human Services

January 2004

North Carolina
Department of Health and Human Services

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I. Background

In 1999, the General Assembly approved a special provision in S.L. 1999-237, Section 11.21 authorizing the Department of Health and Human Services (Department) to carry out a demonstration project. This project would provide Special Assistance payments to up to 400 eligible individuals living at home for a two-year period beginning July 1, 1999 and ending June 30, 2001. In 2000, the General Assembly amended the special provision in S.L. 2000-67, Section 11.13 to provide these Special Assistance payments through June 2002. In 2001, the General Assembly amended the special provision in S.L. 2001-424 to extend the project through June 30, 2003 and required the Department to submit a final report by January 1, 2003.

The Department completed the study and submitted the report in January 2003 for the period of the project from September 2000 through August 2002. The study indicated that providing Special Assistance (SA) payments to individuals at risk of adult care home placement to enable them to continue to live at home is an effective alternative to placement. The report included a recommendation that the General Assembly authorize the Department to expand the scope of the project from 400 slots to 800 slots and to allow the option in all counties.

In the 2003 session, the General Assembly approved a special provision in S.L. 2003-284, Section 10.51(b) authorizing the Department to expand the Special Assistance In-Home Program (formerly referred to as the SA Demonstration Project) to 800 slots statewide, with counties participating on a voluntary basis. The provision specified that no eligible individuals would receive a payment less than they would have received in SFY 2003 and continued the maximum payment at one half the amount the individuals would receive if living in an adult care home. The actual amount of the payment is based on a service needs assessment conducted by a case manager in the county department of social services (DSS). The provision also required the Department to submit a report to the General Assembly by January 1, 2004 and a final report by January 1, 2005.

Within the Department, responsibility for administration of the Special Assistance Program and the Special Assistance In-Home Program shifted from the Division of Social Services to the Division of Aging, effective September 1, 2003. This occurred with the merger of the Adult Services Section, formerly a part of the Division of Social Services, into the Division of Aging.

II. Expansion of the SA In-Home Program

A. Expansion of the Number of Participating Counties

The original special provision authorizing the SA In-Home Program limited the number of SA In-Home recipients to 400 people. Since it was not feasible for all 100 county departments of social services (DSS) to participate in a project for such a small number of people, a Request for Proposals was sent to all county DSS agencies in April 2000 notifying them about the project, the conditions of participation, and requesting that all interested agencies submit their proposals. Twenty-two (22) county DSSs responded with proposals, and all were approved to participate.

When the 2003 General Assembly authorized expansion of the program, Requests for Proposals were sent to all county DSSs in July 2003. County DSSs that had not previously participated were invited to submit proposals, and county DSSs already participating were invited to request additional slots if appropriate to their local needs. The deadline for proposals was August 15, 2003.

The response from the county DSS agencies was very positive, especially considering that the counties, and not the state, assume the matching requirement for the Medicaid-funded case management necessary for the service. Sixty-one (61) county DSSs submitted proposals indicating a desire to provide this service and the commitment of local resources to participate. After taking into account the need for statewide geographical distribution; the need for participation by small, medium, and large county DSS agencies; and the ability of the county DSS agencies to provide case management to these clients with existing funding sources, the decision was made to approve all requests to participate. The newly participating county DSSs were notified of their approval, with an effective date of October 1, 2003, and arrangements were made to train their staff.

A list of the county DSS agencies participating in the project is shown below. The asterisks indicate the original 22 counties.

Appendix A is a map of North Carolina that highlights the participating counties and indicates the widespread coverage of the program throughout the state.

SA In-Home Program Counties – October 2003		
Alamance	Franklin	Pamlico*
Ashe	Gaston	Pasquotank*
Avery	Graham*	Pender
Bertie	Guilford*	Pitt*
Bladen	Harnett*	Randolph
Buncombe	Haywood	Robeson*
Cabarrus*	Henderson	Rockingham
Caldwell	Hertford	Rowan*
Camden	Iredell*	Rutherford
Caswell	Johnston*	Sampson
Catawba	Lee	Scotland
Chatham*	Lenoir	Surry
Cleveland*	Lincoln*	Swain
Columbus*	Martin	Transylvania
Craven*	Mecklenburg*	Union
Cumberland*	Moore	Wake
Currituck*	New Hanover	Warren
Dare*	Northampton*	Watauga
Davidson	Onslow*	Wayne
Durham	Orange	Wilson
Forsyth		

B. Training and Technical Assistance for Participating Counties

In calendar year 2000 several training events were presented for the original 22 project counties prior to implementation. When the General Assembly authorized expansion of the program in 2003, a comprehensive updated training curriculum was developed and conducted for all participating counties, including the original project counties.

The training sessions were two-day events, held during late September and early October 2003 in Fayetteville and Hickory. A third training session was held in Williamston to accommodate those counties unable to attend their originally scheduled training due to Hurricane Isabel. The seven member training team comprised of Division of Aging and county DSS staff covered all aspects of the SA In-Home Program. Approximately 250 county DSS staff attended these training sessions, expressing enthusiasm about implementation of the expanded program. The contribution by county DSS staff with experience in the SA In-Home Program provided important depth to the training.

The first day of the training session was directed to all county DSS staff involved with the SA In-Home Program. Collaboration and communication are essential between the SA eligibility caseworker who determines financial eligibility and the Adult Services case manager who completes the assessment of needs. The first day of training focused on the importance of the flow of information between services and income maintenance and provided the tools for enabling that collaboration. All aspects of eligibility for the program were reviewed, both financial eligibility and the need for services that enable the individual to live at home safely as an alternative to adult care home placement. The updated SA In-Home Program Manual was distributed at the training. This manual was revised and updated, bringing all policies and procedures for the SA In-Home Program into one three-part manual that covers eligibility, case management, and use of the automated assessment instrument.

The second day of training was directed to county DSS Adult Services case managers and supervisors and focused on the comprehensive assessment process. The assessment tool used for the SA In-Home Program is the Resident Assessment Instrument – Home Care (RAI-HC), which is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of elderly and disabled individuals receiving care in the home. At the beginning of the SA In-Home Program in 2000, the Division of Information and Resource Management (DIRM) and a contract vendor developed the software needed for the automated RAI-HC. Since September 2000, the DSS Adult Services case managers have been using the RAI-HC assessment instrument on a laptop, both to complete and document the assessment and to report program data to the state.

During the second day of training, the RAI-HC software was installed for the new counties on their laptops and DSS Adult Services case managers received training on the use of the software. Training also included discussion of the basic principles to be applied in using this assessment instrument with clients and their families, consideration of the client's cognitive status and communication skills, overview of the order in which the items in the assessment should be addressed, review of all domains covered by the assessment, and review on how to use the client assessment protocols for more in-depth assessments and for developing appropriate service plans with the client and family.

C. Ongoing Maintenance of the Assessment Instrument Software (RAI-HC)

The ability of aging or disabled adults to choose to safely remain in the community as an alternative to adult care home placement depends on several critical factors, such as available and affordable housing; their functional status and need for care and services; their informal support system of family and friends; and access to needed care and services from formal service providers. County DSS Adult Services case managers must conduct comprehensive assessments to identify the impact of the above factors on the lives of individuals requesting SA In-Home payments, and how they affect their ability to live at home safely.

The Division of Aging is currently working with DIRM to make technical modifications to the RAI-HC instrument so that it can be supported on the myriad of different software applications available in counties across the state. The level of technical support varies widely at the local level and ongoing interaction between state and county staff is required to ensure maintenance of the software.

DIRM provides technical support and training to the Division of Aging staff who administer the SA In-Home Program. Division staff in turn provide technical support and training to the county DSSs on the SA In-Home Program as well as consultation on the assessment instrument.

Maintenance of the software is a critical component of the SA In-Home Program. The RAI-HC instrument not only helps complete essential assessment functions but is also the source for reporting program data. Data gathered in the assessment process is critical in the strategic planning and analysis of the program. This data is compiled and reported when necessary for policy changes or recommendations to the General Assembly regarding expansion of the SA In-Home Program.

D. Development of Special Assistance In-Home Program Manual

The Special Assistance Policies and Procedures Manual addresses issuance of benefits to individuals who are residing in adult care homes. SA In-Home payments are made from the existing Special Assistance funds, but the payments are made to enable eligible individuals to live at home in the community. When the SA In-Home Program began as a demonstration project, limited modifications were made in the existing policies and procedures in order to make payments to eligible individuals living at home. A case management manual was developed for the county DSS Adult Services case managers completing the assessments, along with a User's Manual for the RAI-HC software.

With the expansion of the program, a new Special Assistance In-Home Policies and Procedures Manual was developed that compiled all information needed by the staff who work with the SA In-Home Program. The manual is divided into three parts: Eligibility, Case Management, and RAI-HC User's Manual. The Division of Aging is also finalizing efforts to include the SA In-Home Manual on the Department's website along with other program manuals. A copy of the SA In-Home Manual is included in this report in Appendix B.

E. Case Management

Case management for SA/In-Home applicants and recipients continues to be provided by county DSSs through an existing case management program funded by Medicaid, called At-Risk Case Management Services. Counties, not the state, provide the matching funds for this Medicaid service. Existing case management program rules are being followed for this case management service.

F. Federal Poverty Level as Need Standard

The need standard, or eligible income level, for SA In-Home payments is set at 100% of the federal poverty level. The federal poverty level as of January 1, 2004, is $749 per month for a family of one. This need standard is lower than the need standard for SA/Adult Care Home payments, which is currently $1,112 per month; this is 148% of the federal poverty level. The federal poverty level changes each year in April and the need standard is adjusted accordingly.

The federal poverty level was established as the need standard for the SA In-Home payments to be consistent with the eligibility income level for Medicaid for elderly and disabled adults. This ensures that all SA In-Home recipients are Medicaid eligible so they may utilize Medicaid covered community services, such as personal care services, to help them live at home. Medicaid coverage, along with the SA In-Home payment, is an essential element for giving individuals a choice of living at home rather than moving to an adult care home.

G. Modification of Eligibility Information System

SA payments are issued to eligible individuals via the automated Eligibility Information System (EIS). The expansion of the SA In-Home Program did not require any additional modifications to the Eligibility Information System (EIS). Periodic changes, such as a change in the federal poverty level, continue to require adjustments in the EIS system to ensure correct and timely issuance of benefits. The Division of Aging works with DIRM staff to ensure that the EIS system continues to support the program requirements.

H. Coordination with Medicaid Eligibility Policies and Procedures

The Division of Aging and the Division of Medical Assistance continue to work together to coordinate the SA In-Home eligibility policies and procedures with Medicaid eligibility policies and procedures.

Special Assistance recipients who live in adult care homes are automatically eligible for Medicaid. This provision is included in the Medicaid State Plan for North Carolina, since individuals covered by a state's Optional State Supplement program are automatically eligible for Medicaid coverage. Special Assistance is an Optional State Supplement and is considered to be an income supplement to the SSI program. The program is administered in accordance with federal SSI and Medicaid regulations in addition to state laws and rules that govern the program.

While SA In-Home recipients must be eligible for Medicaid, they are not automatically eligible for Medicaid, unless they are SSI recipients. SA In-Home recipients with incomes between the SSI income limit ($564 per month) and the federal poverty level ($749 per month) are not automatically eligible for Medicaid, even if they qualify for an SA In-Home payment.

The Division of Medical Assistance received an interpretation from the Center for Medicare and Medicaid Services (CMS) in June 2000 that since this is a "demonstration project" that is time limited, available to a limited number of individuals in specific counties, and is not included in the Medicaid State Plan as part of the statewide Optional State Supplement program, SA In-Home recipients cannot receive Medicaid coverage automatically. This means that SA In-Home recipients not already receiving Medicaid have to complete a separate Medicaid application to determine whether they are eligible for Medicaid.

III. Analysis of Costs

The following analysis of SA In-Home program costs was taken from data compiled jointly by the Division of Aging and the Division of Medical Assistance and presented in the Report on the CAP/DA Program to the General Assembly in January 2004.

The costs for SA In-Home (SA/IH) recipients are compared to the costs for SA recipients living in adult care homes (SA/ACH) in three primary areas: average SA payment amount; expenditures for case management services, and Medicaid expenditures for medical services.

The data used in this analysis was compiled for the fiscal year ending in June 2002 to be consistent with data used in the Division of Medical Assistance's analysis of costs for CAP/DA and nursing home care.

Average SA Payments

The General Assembly authorized a change in the methodology for calculating the SA/IH payment that became effective December 1, 2001. The new methodology allowed a slightly higher payment, causing the average payment to increase from SFY 2002 to SFY 2003.

Prior to December 1, 2001, the payment level was equal to the difference between the recipient's income and the income limit, which is set at 100% of the federal poverty level.

The current methodology requires that the maximum in-home payment may be up to, but no more than, one-half the payment the same recipient would receive if living in an adult care home. The payment may actually be less, depending on the needs assessment and the service plan developed by the case manager.

Table 1. Comparison of Average Monthly Payment for SA/ACH and SA/IH

	SFY 2002	SFY 2003
In-Home	$185.66	$221.96
Adult Care Home	$427.52	$455.20

Case Management Costs

The costs for case management services for SA/ACH and SA/IH recipients were evaluated separately from other costs because of the difference in the nature and frequency of the service for each group.

- Adult Care Home Case Management (ACH/CMS)

  ACH/CMS is directed to residents in adult care homes who are seriously impaired and require extensive or total assistance in order to have their needs adequately addressed. These residents are referred to as "heavy care" residents and qualify for Medicaid Enhanced Adult Care Home Personal Care (ACH/PC). The role of the county DSS case manager is multi-faceted and includes establishing that the resident meets the criteria for the enhanced payment, assessing the resident's broader health care needs, and working with the adult care home to arrange necessary services.

  The total budget for Adult Care Home Case Management Services for SFY02 was $5,616,624. A total of 7,419 recipients received ACH Case Management during the same period, for an average of $757 per ACH/CMS recipient per year.

  During SFY02, "heavy care" residents receiving ACH/CMS represented slightly less than 25% of the total number of SA recipients in adult care homes (7,419 out of 30,577 unduplicated recipients). Adult care home residents who are not eligible for Enhanced ACH/PC do not receive Adult Care Home Case Management Services.

- SA In-Home Case Management

  When an individual chooses to be considered for the SA In-Home Program as an alternative to placement, a county DSS case manager must complete a comprehensive assessment to determine if home-based services are appropriate and what services are needed to enable the individual to remain safely at home. The case manager develops an ongoing service plan and monitors the individual's status on a regular basis. This is a requirement for all recipients in the SA/IH program. Case management services ensure that the SA funds are used appropriately to reach the target population and to ensure positive outcomes for the recipients receiving services in the home.

  Case management services for SA/IH recipients are billed through Medicaid as At-Risk Case Management Services. Based on a review of Medicaid claims data for 193 SA/IH recipients eligible during the entire period July 1, 2001 through June 30, 2002, the average annual cost per SA/IH recipient was $572.

Medicaid Expenditures

The following chart compares Medicaid expenditures (other than case management) for SA/IH and SA/ACH recipients during SFY 2002. Please note that the number of recipients in the SA/ACH sample is different from the SA/IH sample.

Because the number of recipients participating in the SA/IH program is limited, Medicaid paid claims data was readily available for analysis for all 131 recipients who were eligible for SA/IH benefits during the entire fiscal year.

However, when compiling the data for the CAP/DA report, DMA used a statistically significant random sample of 75 recipients in each care setting to analyze and compare expenditures.

The Medicaid claims data for the 131 SA/IH recipients was then compared to the same random sample of 75 adult care home residents used in the comparison with nursing home and CAP/DA services earlier in the CAP/DA report. Annual costs are calculated on a "per recipient" basis by taking the annual expenditure and dividing it by the number in the sample.

Table 2. Medicaid Cost Comparison for SA/ACH and SA/IH Recipients SFY02

Service Category	Annual Costs for the SA/ACH Sample (n=75)	Average Annual Per SA/ACH Recipient Cost	Annual Costs for the SA/IH Program (n=131)	Average Annual Per SA/IH Recipient Cost
Pharmacy	$361,781	$4,824	$388,965	$2,969
MH/MR-DD Services*	-	-	-	-
NF/Hospital Payment	$167,712	$2,236	$171,636	$1,310
Case Management (HIV)	$1,671	$22	$154	$1
Adult Day Health	$0	$0	$0	$0
Home Health Nursing	$60,628	$808	$81,985	$626
In Home/Personal Care Aide	$257,814	$3,438	$474,291	$3,621
Home Health Supplies	$9,545	$127	$52,975	$404
Medical Procedures	$2,094	$28	$1,294	$10
Physician Visits	$68,663	$916	$92,402	$705
Dental	$13,496	$180	$9,003	$69
All Other Claims**	$18,938	$253	$14,349	$110
Total Medicaid Costs	$962,342	**$12,832**	$1,287,054	**$9,825**

*DHHS acknowledges that Medicaid recipients in all care settings receive mental health and mental retardation-developmentally disabled services (MH/MR-DD). Since specific medical and functional information for these recipients is not available, the costs for these services were not reflected in the tables and calculations for this report.

**Case management services (other than HIV case management) are not included in this chart and have been evaluated separately in the previous section.

Summary of Total Costs

The following is a summary of the total program costs for SA In-Home recipients compared to those for SA recipients in adult care homes.

The average monthly payment is converted to an annual amount and added to other program costs for the purposes of comparison. In addition to benefits received in the three primary areas of SA payment amount, case management services and Medicaid expenditures, the summary includes information on Food Stamps benefits.

The Special Assistance Demonstration Project Final Report to the General Assembly in January 2003 indicated that during the period September 2000 – August 2002, 49% of the SA/IH recipients received Food Stamps. The average allotment was $38 per month, which was converted to an annual amount. Food stamps are 100% federally funded.

Table 3. Average Total Costs for SA/ACH and SA/IH Recipients

	Average Annual SA Payment (SFY03)	Average Medicaid Expenditures Per Recipient (SFY02)	Average Case Management Costs (SFY02)	Average Food Stamps (9/00-8/02)	Total Average Annual Cost	**Total Average Monthly Cost**
SA/ACH	$5,130	**$12,832**	*$757	00	$18,719	***$1,560**
SA/IH	$2,228	**$9,825**	$572	$456	$13,081	**$1,090**

*As discussed in the section on Case Management Services above, slightly less than 25% of SA recipients in adult care homes receive Adult Care Home Case Management Services. For the remaining SA recipients who do not receive ACH/CMS, the average monthly cost would equal $1,497.

IV. Program Evaluation Plan

As required in S.L. 2003-284, Section 10.51(b), the Department will submit a report to the General Assembly by January 1, 2005. The report will include the following:

- A description of cost savings for individuals who choose the option of remaining in the home, with a complete fiscal analysis of county, state and federal costs.
- An evaluation of the level of case management needed by types of individuals.
- The geographic location of individuals receiving SA/IH payments.
- Information on income levels of SA/IH individuals and the impact on Medicaid.
- An analysis of the type and quantity of services provided to participants compared to those for adult care home residents.
- Findings and recommendations for continuing or expanding the in-home program.

A great deal of information on the individuals receiving SA In-Home payments is gathered and reported to the Division of Aging in the comprehensive assessment process conducted by the county DSS Adult Services case managers, using the RAI-HC automated assessment software. This data is the basis for information on the SA In-Home recipients, including demographic data, such as age, gender, race, marital status, and education; living arrangement information, such as where and with whom the individual lives and whether there is a caregiver and the amount of support he/she provides; physical and mental health and medication needs; cognitive patterns and the need for assistance with Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's).

The Department is currently working to improve the assessment instrument used to collect critical data on the functional status and level of acuity of adult care home residents. This will allow the Department to analyze and compare adult care home residents across other settings of care, such as nursing homes and home care. In the meantime, the Department has conducted assessments of residents of five selected adult care homes that are representative of different types and sizes of facilities. That data is being compiled for analysis and will be presented in the final report in January 2005.

The Division of Aging is working with the Division of Medical Assistance to compile data on the level of Medicaid services utilized by Special Assistance recipients living in the home and those living in adult care homes.

For the 22 original counties, data was gathered for the period September 2000 through August 2002 and reported in the January 2003 report to the General Assembly. An in-depth analysis of costs for SFY 2002 was presented earlier in this report and in the CAP/DA report. The Division of Aging is now working to compile data from SFY 2003 and SFY 2004. Analysis of all the data from the implementation of the SA In-Home program in September 2000 through mid-2004 will allow the Division of Aging to present a comprehensive analysis and comparison of costs, service needs and trends for adult care home residents and SA In-Home recipients in the report to be submitted to the General Assembly in January 2005.

V. Summary and Recommendations

As of January 1, 2004, there were 312 participants in the SA In-Home Program. Of those, 65% are aged 65 or older and 35% are disabled adults under age 65.

The SA In-Home Program did not accept new applications from July 1, 2002 until the expansion was approved by the General Assembly in June 2003. For some families, there was concern that individuals choosing to receive services at home might lose those benefits if this time-limited program was discontinued. Some recipients left the program due to normal attrition during this time, and the number of filled slots dropped.

With the General Assembly's approval of the expansion and the comprehensive training program for county DSSs, the number of individuals choosing to receive in-home payments as an alternative to placement in an adult care home is experiencing steady growth. The Division of Aging is closely watching the participation and will re-evaluate the slot allocations around mid-year in 2004 to ensure maximum usage of available slots.

The SA In-Home Program has received continuing support from the county DSS agencies. This program is an essential component in the continuum of care for aging and disabled adults in North Carolina. It provides an option that is cost effective when compared to institutional care, incorporates the principles of consumer directed care, and supports the Department's Olmstead Plan to provide options for aging and disabled individuals to live in the least restrictive setting possible.

The Department recommends the continuation of the SA In-Home Program at its present level through the biennium to allow time for a complete analysis of costs and benefits of the expanded program.

North Carolina Study Commission on Aging

Draft Recommendations

Overview

A. The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the LTC Insurance Tax Credit.

B. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

C. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

D. The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

E. The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

F. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

G. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

H. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

I. The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.

J. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

K. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to develop and deliver business basics training for adult day services providers with a goal of fostering successful and financially viable centers.

L. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Social Services Commission to consider adopting stronger rules related to the financial management of adult day services programs.

Detail

LTC Insurance Tax Credit

The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the LTC Insurance Tax Credit.

Bill Draft: 2003-SWz-32 *(Bill Drafts - page 1)*

Background:

- The tax credit is not currently in place for the 2004 tax year. (S.L. 1998-212, S. 29A.6(d) made the credit for premiums paid on long-term care insurance effective for taxable years beginning on or after January 1, 1999, and sunset the credit effective January 1, 2004.)
- On February 10, 2004, the Commission heard a presentation on long-term care insurance from Carla Obiol with the Seniors' Health Insurance Information Program (SHIIP), and presentations on issues related to the tax credit from Department of Revenue employees Karl Knapp, Tax Research Division, and Nancy Pomeranz, Personal Taxes Division.
- Restoration of the LTC Insurance Tax credit was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina.

Caring for the Mentally Ill in Long-Term Care Facilities

B. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Bill Draft: 2003-SHz-13 *(Bill Drafts - page 2)*

Background:

- Geriatric Mental Health Specialty Teams have been developed to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living on their own home or with family members. Individuals with geriatric-like needs are also served.
- The Geriatric Mental Health Specialty Teams are a contracted service through the Local Management Entities (LME). There are 20 Teams across NC and each one contracts with one or more LME's. These are funded with Mental Health Trust Fund dollars and these non-recurring funds are being replaced by recurring funds made available through hospital downsizing. As a Team delivers services to a facility, they file for reimbursement to the LME, which in turn seeks reimbursement from DHHS. Currently, the Fiscal Division staff reports that DHHS cannot report specific cost data on the Geriatric Mental Health Specialty Teams. Thus it may be difficult to come up with a cost figure to expand the teams at this point.
- On February 10, 2004, the Commission heard presentations on adult care home rules and caring for the mentally ill from Jim Upchurch, Division of Facility Services, DHHS; Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI); and Lou Wilson, NC Association Long Term Care Facilities.
- On March 9, 2004, the Commission heard a presentation on Geriatric Mental Health Specialty Teams from Bonnie Morell, Community Policy Section, Division MH/DD/SAS, DHHS.

C. ***The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.***

Bill Draft: 2003-SHz-10 *(Bill Drafts - page 4)*

Background:

- On February 10, 2004, the Commission heard presentations on adult care home rules and caring for the mentally ill from Jim Upchurch, Division of Facility Services, DHHS; Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI) and Lou Wilson, NC Association Long Term Care Facilities.

Criminal Record Checks

The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

Bill Draft: 2003-SWz-37 *(Bill Drafts - page 6)*

Background:

- State law currently requires criminal history checks of all applicants for employment with nursing homes, home health care agencies and adult care homes. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check would include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. However, under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This made it difficult for providers to comply with the State law. As a result, a moratorium on the national criminal history checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes other than those involving direct patient care and for applicants for all staff positions in adult care homes until January 1, 2004. S.L. 2003-284, Sec. 10.8E extended it to January 1, 2005.
- Access to national criminal record checks was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina.

Senior Center Funding

E. The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Bill Draft: 2003-SHz-6 *(Bill Drafts - page 10)*

Background:

- Senior Centers are resources within communities that typically provide nutrition, recreation, social and educational services, and comprehensive information and referral. The National Institute of Senior Centers defines a senior center as a place where "older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community."
- Prior to the 2002 Session, State funds for Senior Centers were $1,365,316. During the 2002 Session, funds were reduced by $381,000. (This budget option was identified for reduction by DHHS and included in the Governor's Budget at a recommended reduction of $200,000.) During the 2003 Session, $100,000 was restored, and the local match requirement was increased. To fully restore State funding to the prior level, an additional $281,000 would be needed.
- Support for and/or restoration of funding for Senior Centers was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina.

Senior Adult Housing

F. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Bill Draft: 2003-SHz-7 *(Bill Drafts - page 11)*

Background:

- The Housing Finance Agency helps seniors age in place by improving existing housing and working to develop new apartments for seniors. According to a March 23, 2004 presentation by Bob Kucab, Executive Director, applications for funding requests currently exceed available capital by 3:1. State funds help bring in outside funding and they are able to leverage $5 in development from every $1 the State invests. According to Bob Kucab, all State funds that they administer are invested in bricks and mortar, staff costs are paid from their revenue. State appropriations are currently down to $3M from a high of $9M.

Home and Community Care Block Grant

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate ,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Bill Draft: 2003-SHz-8 *(Bill Drafts - page 12)*

Background:

- Any person age 60 and older is eligible for services under the Home and Community Care Block Grant (HCCBG). The program places an emphasis on reaching those most in need of services (the Older Americans Act gives priority to serving the "socially and economically needy" -with particular attention to low-income minority elderly and older individuals residing in rural areas). Additionally, the OAA calls for reaching out to older individuals with severe disabilities limited English-speaking ability, and Alzheimer's disease or related disorders (and caregivers of such individuals). The HCCBG includes federal funds, State funds, local funds, and a client cost sharing component.
- Based on information furnished by the Division of Aging, State appropriations for the HCCBG were $25,128,469 for the 2002-2003 fiscal year. State appropriations were cut by $1,055,690 to $24,072,799 for the 2003-2004 fiscal year. State appropriations are currently slated to be reduced to $24,026,079 for the 2004-2005 fiscal year. An increase in federal Older Americans Act funds has helped to offset the decrease in State funding and overall funding of the program was down from the previous year only $341,603 for 2003-04. However, the Division anticipates a decrease in federal funding for 2004-2005, which would leave the overall total down another $389,974. Unless the General Assembly increases State appropriations, the total net funding for HCCBG would be down $731,577 for the period from 2002-03 to 2004-2005. The above recommendation represents a $1,000,000 funding increase for the 2004-2005 fiscal year.
- Support for and/or restoration of funding for the HCCBG was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina.

Medicaid Institutional Bias

H. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

Bill Draft: 2003-SWz-34 *(Bill Drafts - page 13)*

Background

- In Olmstead v. L.C., the United States Supreme Court concluded that inappropriate institutionalization of a person with a mental disability may be discrimination under ADA. The Final Report by The North Carolina Institute of Medicine Task Force on Long-Term Care recognized an institutional bias in Medicaid eligibility rules. The report states that with "different eligibility limits, individuals living at home who may have too much income to qualify for Medicaid coverage as long as they remain in their home, may qualify if they move into a more costly institutional or residential setting."

Guardianship

I. The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.

Bill Draft: 2003-SWz-33 *(Bill Drafts - page 14)*

Background:

- On February 10, 2004, the Commission heard a presentation on "Guardianship Reform in the Twenty-First Century" by John Saxon, Professor of Public Law and Government, UNC Chapel Hill. According to his presentation, the last substantive revision to the guardianship law was in 1977, the last consolidation and clarification was made in 1987. Since 1987, there have been efforts to review and revise the statutes but none resulting in change. As a result there are a number of issues that need review.

Adult Day Services

J. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day

for adult day and adult day health services.

Bill Draft: 2003-SHz-11 *(Bill Drafts - page 17)*

Background

- G.S. 131D-6 provides that adult day care enables people who would otherwise need full-time care away from their own residences to remain in their residences as long as possible. An adult day care program provides group care and supervision for physically or mentally disabled adults in a place other than their usual place of abode on a less than 24-hour basis. Adult day services provide a social model and a health model. Both programs provide a community setting that promotes social interaction, and physical and emotional well-being. Adult day health programs also offer health care services to meet the needs of individual participants. Nutritional meals and snacks are provided and transportation to and from the program may be provided or arranged when needed. Often these programs provide a safe stimulating environment while a primary caregiver is at work. Providers of adult day care must meet North Carolina State Standards for Certification. The Social Services Commission sets these standards.
- Based on a survey conducted by the North Carolina Adult Day Services Association, in conjunction with the Division of Aging, the average cost to operate an adult day program in North Carolina is $31.00 per day for social models and $44.00 per day for health models. Rates established by the Social Services Commission, effective December 8, 1997, provided the maximum reimbursement rate for the purchase of adult day services at $565 per month ($26.07 per day). Of this amount, $500 per month ($23.07) is for daily care and $65 per month ($3.00 per day) is for round trip transportation. The maximum reimbursement rate for the purchase of adult day health services is $715 per month ($33 per day). Of this amount, $650 per month is for daily care ($30.00 per day) and $65 per month ($3.00 per day) is for round trip transportation. In 1999 the Division of Aging considered approaching the Social Services Commission about a rate increase, however were advised by DHHS budget and analysis that there was little chance of a rate increase without an overall increase in the State Adult Day Care fund since a rate increase without a budget increase would result in a cut to services. S.L. 2003-284, Section 10.58 required the Social Services Commission to consider adopting rules increasing the rates for adult day centers and adult day health centers. However, any rate increase adopted by the Commission for adult day centers and adult day health are to be implemented within existing funds.

K. The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to develop and deliver business basics training for adult day services providers with a goal of fostering successful and financially viable centers.

Bill Draft: 2003-SHz-14 *(Bill Drafts - page 18)*

Background:

- The Division of Aging reports that adult day service programs in North Carolina have grown from two programs in 1973 to a peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. As a result, NC now has 113 programs in 60 counties. The majority of growth in adult day care at this time is in the larger metropolitan areas such as Mecklenburg and Guilford counties.
- Nancy Cox, Partners in Caregiving/Wake Forest University School of Medicine, made a presentation to the Commission on March 23, 2004 on adult day service predictors of success, benchmarks and trends based on a national study.

L. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Social Services Commission to consider adopting stronger rules related to the financial management of adult day services programs.

Bill Draft: 2003-SHz-14 *(Bill Drafts - page 18)*

Background:

- Under rules adopted by the Social Services Commission, DHHS is required to annually inspect and certify all adult care programs. All individuals, groups or organizations operating or wishing to operate an adult day or adult day health program must apply for a certificate to the county department of social services in the county where the program is operated. A designated social worker at the county department of social services supplies the necessary forms and a copy of the Standards for Certification, and makes a study of the program. The initial certification package is submitted through the county department of social services to the State Division of Aging. The Division of Aging issues the Certificate.
- Currently, among other things, the initial certification process requires a program policy statement, organizational diagram, job descriptions, and documentation showing planned expenditures and resources available to carry out the program of service for a 12-month period. Among other items, the renewal certification package requires an updated copy of the policy statement, organizational diagram, job descriptions, name and addresses of board members if applicable, and documentation showing planned expenditures and resources available to carry out the program of service for a 12-month period.

North Carolina Study Commission on Aging

Bill Drafts

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-32 [v.2] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/24/2004 4:31:49 PM

Short Title: Repeal Sunset/Long Term Care Ins. Tax Credit.	(Public)
Sponsors:	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON THE LONG TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Section 29A.6(d) of Chapter 212 of the 1998 Session Laws reads as rewritten:

"(d) Subsection (a) of this section is effective for taxable years beginning on or after ~~January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.~~January 1, 1999. The remainder of this section is effective when it becomes law. ~~G.S. 105-160.3(b)(7), as enacted by this act, is repealed effective for taxable years beginning on or after January 1, 2004.~~"

SECTION 2. This act is effective for taxable years beginning on or after January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-13 [v.2] (3/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/30/2004 2:30:43 PM

Short Title: Care for the Mentally Ill in LTC Facilities. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study expanding the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. As part of this study, the Department shall consider renaming the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

SECTION 2. While undertaking the study, the Department of Health and Human Services shall proceed with implementation of the following:

(1) Standardizing these criteria across all Geriatric Mental Health Specialty Teams:
   a. Team purpose,
   b. Eligibility for services,
   c. Screening processes,
   d. Referral processes,
   e. Forms, Training Manuals, Service Orders, and Authorizations.

(2) Tracking expenditure data for each Team and each Area Program/Local Management Entity.

(3) Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team.

SECTION 3. The Department of Health and Human Services shall submit an interim report to the North Carolina Study Commission on Aging by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The Department shall submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging by October 30, 2005.

SECTION 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-10 [v.8] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/6/2004 4:56:55 PM

Short Title: Study Mentally Ill LTC Resident Issues. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall work with long-term care providers and advocates for the mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The study shall include:

(1) Examining whether the mentally ill population should have separate residents' rights from those provided in the Adult Care Home Residents' Bill of Rights contained in Article 3, Chapter 131D of the General Statutes; and the Nursing Home Patients' Bill of Rights contained in Part 2, Article 6, Chapter 131E of the General Statutes.

(2) Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.

(3) Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.

(4) Examining the criteria for admission of mentally ill patients to long-term care facilities to ensure that the health and safety of all residents are safeguarded.

(5) Providing recommendations for improving the quality of care for the mentally ill in adult care homes including the potential cost associated with implementing the recommendations.

SECTION 2. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-37 [v.7] (4/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/12/2004 4:09:46 PM

Short Title: Adult Care Homes Criminal Records Check/Pilot. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PILOT PROGRAM TO CONDUCT NATIONAL CRIMINAL HISTORY RECORD CHECKS OF PERSONS SEEKING EMPLOYMENT TO PROVIDE DIRECT CARE IN ADULT CARE HOMES AND CONTRACT AGENCIES OF ADULT CARE HOMES, AND TO MAKE CONFORMING CHANGES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall establish a pilot program to review the criminal history records of applicants for positions not requiring an occupational license but requiring direct resident care in adult care homes and contract agencies of adult care homes. Pursuant to this program, criminal history record checks for the employees of adult care homes and contract agencies of adult care homes shall be conducted as provided in G.S. 131D-40, except for the following:

(1) At the time it submits the request for the criminal history record check to the Department of Justice, the adult care home or contract agency of the adult care home shall provide a copy of the request to the Department of Health and Human Services, Division of Facility Services. If the adult care home or contract agency of the adult care home receives the criminal history information from a private entity, then within two business days of receiving the criminal history information, the adult care home or contract agency shall forward the information to the Department of Health and Human Services, Division of Facility Services, for a determination as to whether the applicant should be disqualified from employment.

(2) Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for

employment positions not covered by Public Law 105-277 and State criminal history record checks to the Department of Health and Human Services, Division of Facility Services. Within five business days of receipt of the criminal history of the person, the Department of Health and Human Services, Division of Facility Services shall determine whether the applicant should be disqualified from employment, unless the Department is unable to determine within five business days the disposition or accuracy of the criminal history information obtained by the Department, in which case the Department shall make the determination as soon as possible after verifying the disposition or accuracy of the criminal history information. By the next business day following its determination, the Department shall notify the adult care home or contract agency of its determination, and shall also notify the applicant a written statement as to the Department's determination and the basis on which it was made. An applicant shall be disqualified from employment if the applicant's criminal history shows that:

(a) The applicant was convicted of any of the offenses of Homicide under Article 6 of Chapter 14 of the General Statutes or Rape and Other Sex Offenses under Article 7A of Chapter 14 of the General Statutes, or equivalent offenses under the laws of another state.

(b) The applicant was convicted of any other offenses listed in G.S. 131D-40(d) within 10 years prior to the date of application for employment, or equivalent offenses under the laws of another state.

(3) If the criminal history of the applicant reveals a conviction of any of the other offenses listed in G.S. 131D-40(d) more than 10 years prior to the date of application for employment, the Department of Health and Human Services shall obtain the public record document reflecting the offense and shall provide the public record of the conviction to the adult care home or contract agency of the adult care home, and the adult care home or contract agency shall determine whether the applicant should be employed after considering the factors contained in G.S. 131D-40(b).

(4) If the adult care home or contract agency of the adult care home disqualifies an applicant or terminates a conditional employee based on the Department's determination or on its own consideration, then the adult care home or contract agency may disclose public criminal history information or public information that in the Department's determination is relevant to the disqualification but shall not provide the criminal record check to the applicant. All information that the Department receives through checking the criminal history is privileged information and is not a public record but is for the

exclusive use of the Department and those persons authorized under this act and under federal law to receive the information.

(5) An adult care home or contract agency of an adult care home may employ an applicant conditionally prior to obtaining the Department's determination or making its own determination, but shall terminate immediately the conditional employment of an applicant upon receiving notification from the Department that the applicant is disqualified or upon making its own determination that the applicant is disqualified.

(6) The pilot program shall include notices to the applicant of the criminal history record check and of the applicant's right to appeal the Department's determination as a final agency decision pursuant to Chapter 150B of the General Statutes.

SECTION 2.(a) The Department of Health and Human Services shall collect the following information during the pilot program:

(1) The number of persons whose criminal histories were reviewed by the Department.

(2) The number of persons who were disqualified by the Department and nature of the disqualifying offenses.

(3) The cost of the pilot program.

(4) The length of time between initial requests for criminal history record checks and the notices sent from the Department as to its determination.

SECTION 2.(b) The Department of Health and Human Services shall convene a workgroup that shall include representatives of the Department of Justice, nursing homes, adult care homes, home care agencies, and contract agencies of nursing homes and adult care homes. The Department shall conduct meetings at least monthly during the pilot program to discuss the progress of the pilot programs and any problems encountered in conducting the program.

SECTION 2.(c) The Department shall report the information required under this section and report the progress of the pilot program and the activities of the workgroup, including any statutory changes needed to fully implement G.S. 131D-40 and G.S. 131E-265, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and to the North Carolina Study Commission on Aging on or before January 15, 2005.

SECTION 3. Section 10.8E of S.L. 2003-284 reads as rewritten:

"SECTION 10.8E. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131E-265 for nursing homes to conduct national criminal history record checks for employment positions other than those involving direct patient care shall become effective no earlier than ~~January 1, 2005.~~July 1, 2005. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131D-2 for adult care homes to conduct national criminal records checks for all staff

positions except for staff positions involving direct care of residents shall become effective no earlier than ~~January 1, 2005.~~July 1, 2005."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services for the 2004-2005 fiscal year the sum of one hundred fifty thousand dollars ($150,000) to implement the pilot program in this act.

SECTION 5. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-6 [v.5] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:23:32 AM

Short Title: Senior Center Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SENIOR CENTER DEVELOPMENT AND OUTREACH, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of two hundred eighty-one thousand dollars ($281,000) for the 2004-2005 fiscal year, for senior center outreach and development. State funds shall not exceed seventy-five percent (75%) of reimbursable costs.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-7 [v.4] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:24:19 AM

Short Title: Senior Adult Housing Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SENIOR ADULT HOUSING, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Housing Finance Agency the sum of one million dollars ($1,000,000) for the 2004-2005 fiscal year. These funds shall be used to provide independent housing with services for senior adults and shall be used to maximize federal funds.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-8 [v.5] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:25:15 AM

Short Title: HCCBG Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of one million dollars ($1,000,000) for the 2004-2005 fiscal year, for the Home and Community Care Block Grant.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-34 [v.3] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/29/2004 10:23:26 AM

Short Title:	DHHS Study/Medicaid Institutional Bias.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home. If the Department determines that a bias exists, the Department shall recommend ways to alleviate this bias. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 30, 2004.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-33 [v.6] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/5/2004 4:41:31 PM

Short Title: Legislative Study Comm./Guardianship. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is created the Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney.

SECTION 1.(b) The Commission shall consist of 15 members as follows:

(1) Four members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Four members of the Senate appointed by the President Pro Tempore of the Senate.

(3) The Director of the Administrative Office of the Courts, or the Director's designee.

(4) The Director of the Division of Aging in the Department of Health and Human Services, or the Director's designee.

(5) A county director of social services appointed by the President Pro Tempore of the Senate.

(6) A clerk of superior court appointed by the Speaker of the House of Representatives.

(7) A physician who specializes in geriatrics appointed by the President Pro Tempore of the Senate.

(8) An attorney who has experience in guardianship matters appointed by the Speaker of the House of Representatives.

(9) A representative of the Governor's Advocacy Council for Persons With Disabilities.

In addition, representatives designated by the following organizations shall serve as ex-officio, nonvoting members of the Commission:

(a) The North Carolina Bar Association.
(b) The Arc of North Carolina.
(c) North Carolina Guardianship Association.
(d) Alzheimer's Association – Western Chapter.
(e) Alzheimer's Association – Eastern Chapter.
(f) Carolina Legal Assistance.

The Speaker shall designate one Representative as cochair, and the President Pro Tempore shall designate one Senator as cochair. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment. The Commission shall expire upon delivering its final report.

The Commission, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet at any time upon the joint call of the cochairs. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02.

The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Commission in its work. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, and the expenses relating to the clerical employees shall be borne by the Commission. Members of the Commission shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 1.(c) In conducting the study, the Commission shall consider the following:

(1) Whether guardianship should be a remedy of last resort used only if less restrictive alternatives are insufficient.
(2) The definition of incompetency.
(3) Whether courts should be required to make express findings regarding the extent of a person's incapacity and limit the scope of the guardianship accordingly.
(4) Legal rights retained or lost as a result of being adjudicated incompetent.
(5) The proper role of attorneys and guardians ad litem in guardianship proceedings.
(6) The role of public human services agencies in providing guardianship services.
(7) Legal procedures and protections in guardianship proceedings.
(8) Public monitoring of guardianship.
(9) Funding for guardianship services provided by public and nonprofit agencies.

(10) Educating citizens with respect to guardianship and alternatives to guardianship.
(11) Prudent investor rules.
(12) Powers, duties, and liabilities of guardians.
(13) Review of the State's adult protective services law.
(14) Enactment of the Uniform Guardianship and Protective Proceedings Act (UGPPA).
(15) Whether guardianship statutes need revision to provide greater protection of the health and welfare of incapacitated adults.
(16) Whether the State should track the number of people under private guardianship and, if so, proposed methods for the tracking.

SECTION 2. The Legislative Study Commission on State Guardianship Laws may make an interim report to the 2005 General Assembly not later than the convening of the 2005 General Assembly, and shall make its final report to the 2005 General Assembly, Regular Session 2006 upon its convening.

SECTION 3. All State departments and agencies and local governments and their subdivisions shall furnish the Commission with any information in their possession or available to them.

SECTION 4. There is appropriated from the General Fund to the General Assembly the sum of thirty thousand dollars ($30,000) for the 2004-2005 fiscal year and the sum of thirty thousand dollars ($30,000) for the 2005-2006 fiscal year to carry out the purposes of this act.

SECTION 5. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-11 [v.4] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:17:48 AM

Short Title: Adult Day Care Rate Increase. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS AND TO REQUIRE THE SOCIAL SERVICES COMMISSION TO ADOPT A RATE INCREASE FOR ADULT DAY SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services an amount sufficient to increase the current minimum rates by no less than five dollars ($5.00) per day for adult day and adult day health services provided to clients.

SECTION 2. The Social Services Commission shall adopt rules increasing the minimum rates by five dollars ($5.00) per day for adult day centers, and by five dollars ($5.00) per day for adult day health centers.

SECTION 3. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-14 [v.2] (3/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 12:09:11 PM

Short Title: Business Basics for Adult Day Services. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEVELOPMENT AND DELIVERY OF BUSINESS BASICS TRAINING TO ADULT DAY SERVICES PROVIDERS, AND OTHER RELATED CHANGES, WITH A GOAL OF FOSTERING SUCCESSFUL AND FINANCIALLY VIABLE CENTERS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. In an effort to support and sustain adult day services in North Carolina, the Department of Human Resources shall pursue the following:

(1) Contract with a national adult day services program to develop training for adult day providers that may include:
   a. Presentation of research on recent trends and predictors of success in adult day and respite programs;
   b. Business plan development;
   c. Effective management of adult day slots in order to maximize receipts;
   d. Cost analysis, including identification of fixed and variable costs;
   e. Determination of break-even points; and
   f. Marketing services to target populations.

(2) Explore the possibility of forming collaborative training and support opportunities between the North Carolina Small Business Center Network of the North Carolina Community College System and adult day services program directors and operators.

(3) Determine whether assistance teams would be helpful for adult day centers identified as at-risk for closing.

(4) Examine the adult day certification process and determine whether there are any steps in the inspection or certification processes that could be combined or eliminated.

SECTION 2. The Department shall seek input from adult day associations and other interested parties during the evaluation and/or implementation of the items in Section 1 of this act and shall make a status report to the North Carolina Study Commission on Aging by October 1, 2005.

SECTION 3. The Social Services Commission shall consider adopting rules related to strengthening the financial management of adult day services programs. These rules may include:

(1) Requiring the submission of a business plan and a marketing plan in the initial certification package for adult day care programs.

(2) Requiring the submission of a financial statement as part of the renewal certification process for adult day care programs.

(3) Requiring adult day program directors and operators to have some financial or business management training, including training requirements specifically related to adult day program operation.

SECTION 4. This act is effective when it becomes law.

PROPOSED CHANGES TO 2003-SHz-10[v.8] –
Study Mentally Ill LTC Resident Issues

A. Delete subdivision (1), lines 11 through 16 and replace with the following:

"(1) Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities."

B. Add a new subdivision after subdivision (2), as follows:

"(3) Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living." [renumber remaining subdivisions accordingly]

C. Add a sentence at the end of Section 2, as follows:

"The Department of Health and Human Services shall include in this report how it defines "mentally ill" for purposes of this study.

Recommendations:

I) **Seek an RFP with General Assembly oversight to review Adult Care Home (ACH) rules and make recommendations for changes. The review should include, but not be limited to:**

- Are North Carolina Adult Care Home rules focused to:
  1. Support Assisted Living's philosophy of autonomy, dignity and maximum independence.
  2. Easy to understand.
  3. Directly measure resident satisfaction with services and environment.
  4. Regulate the behavior of the resident instead of giving them freedom of choice. DO rules give residents freedom of choice or regulate resident behavior.
  5. Gives appropriate guidance to facility operators according to needs and characteristics of residents served.
  6. Require extensive interpretation.
  7. Implementation attainable according to the number of mandated staff.

Any other areas deeded necessary in reconceptualizing standards to be outcome oriented as well as protect the resident.

II) **Regulatory Approach:**

1. Reorganize Adult Care Licensure Section, DFS, and require accountability directly to Assistant Secretary for **Long Term Care**:
   - Require Division Chief to report to the Assistant Secretary for Long Term Care monthly on progress of the mission
   - Require quarterly reports to North Carolina Study Commission on Aging of progress attained.
2. Clarify the Mission of Adult Care Licensure Section, DFS, to provide for a Consultation/Regulatory Assistance program to include:

- Quality Assurance, assisting providers with compliance of rules and protocols that result in a positive impact to direct care and resident choice will be the main focus of the program.
- A separate function to assure licensing and surveying for minimum health and safety requirements will be maintained.
- **Quality Assurance Sections**:
    - Will consist of Quality Assurance Specialist (QAS) whose primary responsibility will be to assess, monitor, train and provide resource material to the industry and to county DSS Quality Consultation Specialist (QCS). This section will have **no regulatory authority**.
- **Licensure and Surveying Section**:
    - This section will conduct licensing and surveying activities and **will have** regulatory authority.

3. The role of the Adult Home Specialist, at the local DSS level, will be changed to Quality Consultation Specialist (QCS), who will provide regulatory assistance to facilities under the supervision of the State Quality Assurance Specialist (QAS).
    - Quality Consultation Specialist (QCS) personnel will work collaboratively with Adult Care Home providers to:
        - Assess the needs of the facility to assure appropriateness of the service delivery system.
        - Provide focused, proactive information to improve outcomes and delivery of care by the provider.
        - Tracking data to show compliance or lack of compliance.
    - Consultants will make mutually desirable regular visits with an evaluative framework that focuses on:
        - Structure
        - Process
        - Outcome, and

- Quality Assurance tools that are consistent with the facility's needs.

4. The two sections shall be integrated, resulting in the regulatory section being used when the provider cannot and will not correct.

III) Enforcement System / Performance Improvement Process:

1. The Enforcement System must be objective, fair, uniform and accountable to the mission to enable the well-being and safety of residents.
2. Regulators, residents and providers benefit by a progressive system that first focuses on cooperative efforts between providers, regulators and consultants to correct deficiencies. The process should result in innovative and efficient solution and only move to prescriptive phases when providers cannot or will not correct deficiencies or when a resident is at imminent risk of harm.
3. The Regulatory Performance Improvement:
   - Process will use an escalating system of regulatory intervention
   - Process will have three phases:
     - Phase # 1 – Consultative Phase – The provider in consultation with the Quality Consultation Specialist (QCS) will develop a plan to correct deficiencies within a negotiated time. If the provider corrects the deficiencies satisfactorily and there is no harm to residents, there will be no further phases or negative actions.
     - Phase # 2 – Corrective Phase – The regulator, rather than the provider, will develop a corrective action plan (consistent with facility rules and laws) and a reasonable schedule for completion. If the provider corrects the deficiencies satisfactorily and there is no harm to residents, there will be no further phases or negative actions.

- Phase # 3 – Penalty Phase – If the provider cannot or will not implement the corrective action plan, the regulator may assess fines and impose other negative actions. (See Attachment # 1).

IV) Review and Change Current Laws:

- Review and change of current law will be required to enable the program. Changes would include:
  1. Better definition of accountability for "compliance."
  2. The Mission and Goals for the Program.
  3. Clear, non-duplicative and non-conflicting roles for all personnel (both state and local) involved.
  4. Training requirements for State and County personnel and the industry.
  5. The system, problem solving activities and quality indicators needed to implement the program.
  6. The protocols and format to be used by QA and QC Specialists for system analysis and review of care delivery system.
  7. Definition of negotiated risk protocols to include residents' responsibilities, including responsibility for adverse outcome associated with individual choices.
  8. Define an informal process for dispute resolution between providers and consultants and regulators.
  9. Spell out mechanisms to assure that Directed or Specific Plans by Regulators are:
     - Consistent from county to county
     - Do not exceed rules and laws
     - Have ample time for implementation, and
     - Recognize exorbitant costs associated with plans.

Current DFS Staff

- Raleigh and Black Mountain
  - 34 professionals

Recommendation

- Retain (2) RNs, dieticians and (2) Pharmacists as Quality Assurance Consultants
- Replace existing "professionals" with bachelor degree persons for Surveyors

Note: Savings from reduction in "Professional Staff" could be used to hire additional surveyors and Quality Assurance Specialists with no additional cost to State or Counties.

§ 131D-40. Criminal history record checks required for certain applicants for employment.

(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the adult care home or a contract agency of the adult care home shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the adult care home or the contract agency of the adult care home. If the adult care home or a contract agency of the adult care home disqualifies an applicant after consideration of the relevant factors, then the adult care home or the contract agency may disclose information contained in the criminal history record check that is relevant

to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An adult care home and an officer or employee of an adult care home that, in good faith, complies with this section is not liable for the failure of the home to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, "relevant offense" means a State crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of aged or disabled persons. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – An adult care home may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The adult care home shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The adult care home shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.

Agenda North Carolina Study Commission on Aging

April 27, 2004
10:00 AM
Legislative Office Building
Room 643

I. Welcome
Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair
Senator AB Swindell, Cochair

II. 2004 Draft Report
Dianna Jessup, Theresa Matula, and Susan Morgan, Commission Staff

III. Approval of the Report

IV. Approval of the Meeting Minutes

V. Adjourn

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Tuesday, April 27, 2004
10:00 A.M.
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, April 27, 2004 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator A. B. Swindell, Representative Debbie Clary, and Representative Edd Nye, Co-Chairs; Senators Austin Allran, Tony Moore, Joe Sam Queen; Representatives David Lewis, Jennifer Weiss, Gene Wilson; public members Brad Allen, Jan Elliott, Katherine Fox Price, Sam Marsh, Florence Soltys, and Linda Howard.

Theresa Matula, Dianna Jessup, Susan Morgan, and Gann Watson provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Nye presided at the meeting. He called the meeting to order and welcomed members and guests. He asked the members to review the minutes placed on their desks. Senator Moore made a motion to approve the minutes and Rep. Wilson seconded the motion. The minutes were approved.

Representative Nye asked Theresa Matula and Dianna Jessup to review the draft report and the proposed bills. Afterwards there was some discussion of some of the proposed bills.

The Commission approved the report. In closing, Representative Nye expressed his appreciation to members for their attendance and adjourned the meeting.

Representative Edd Nye, Co-Chair

Jo Bobbitt, Committee Assistant

Representative Debbie Clary, Co-Chair
Senator A. B. Swindell, Co-Chair

NORTH CAROLINA

STUDY COMMISSION ON AGING

DRAFT

REPORT TO THE GOVERNOR AND THE 2004 REGULAR SESSION OF THE 2003 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

April 27, 2004

To: Governor Michael Easley
Lieutenant Governor Beverly Perdue, President of the North Carolina Senate
Senator Marc Basnight, President Pro Tempore of the North Carolina Senate
Representative James Black, Speaker of the North Carolina House of Representatives
Representative Richard Morgan, Speaker of the North Carolina House of Representatives
Members of the 2003 General Assembly, Regular Session 2004

Attached is a report from the North Carolina Study Commission on Aging submitted to you pursuant to North Carolina General Statute §120-187. The North Carolina Study Commission on Aging presents to you findings and recommendations based on study conducted after the adjournment of the 2003 Regular Session of the 2003 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

Senator A.B. Swindell, IV
Co-Chair

Representative Debbie A. Clary
Co-Chair

Representative Edd Nye
Co-Chair

North Carolina Study Commission On Aging

2004 Membership List

President Pro Tempore's Appointments

Senator Albin B. Swindell IV, Co-Chair

Senator Austin M. Allran

Senator Charlie S. Dannelly

Senator Tony P. Moore

Senator Joe Sam Queen

Mr. Brad Allen

Ms. Jan Elliot

Mr. Sam Marsh

Speakers' Appointments

Representative Debbie A. Clary, Co-Chair

Representative Edd Nye, Co-Chair

Representative David R. Lewis

Representative Jennifer Weiss

Representative William Eugene Wilson

Ms. Katherine Fox Price

Ms. Florence Gray Soltys

Ms. Linda Howard

Ex Officio:
Mr. Jackie Sheppard, Assistant Secretary,
Long Term Care and Family Services,
Department of Health and Human Services

Clerk:
Jo Bobbitt
919/733-5477

Staff:
Theresa Matula
Dianna Jessup
Research Division
919/733-2578

Susan Morgan
Fiscal Research Division
919/733-4910

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(SHz-13) AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-15) AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SWz-37) AN ACT TO ESTABLISH A PILOT PROGRAM TO CONDUCT NATIONAL CRIMINAL HISTORY RECORD CHECKS OF PERSONS SEEKING EMPLOYMENT TO PROVIDE DIRECT CARE IN ADULT CARE HOMES AND CONTRACT AGENCIES OF ADULT CARE HOMES, AND TO MAKE CONFORMING CHANGES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-6) AN ACT TO APPROPRIATE FUNDS FOR SENIOR CENTER DEVELOPMENT AND OUTREACH, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-7) AN ACT TO APPROPRIATE FUNDS FOR SENIOR ADULT HOUSING, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-8) AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SWz-34)AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SWz-33) AN ACT TO ESTABLISH THE LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-11) AN ACT TO APPROPRIATE FUNDS AND TO REQUIRE THE SOCIAL SERVICES COMMISSION TO ADOPT A RATE INCREASE FOR ADULT DAY SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING

PREFACE

As outlined in Chapter 120, Article 21 of the North Carolina General Statutes, the North Carolina Study Commission on Aging is charged with studying and evaluating the existing system of delivery of State services to older adults and recommending an improved system of delivery to meet the present and future needs of older adults. The Commission consists of 17 members. Of these members, eight are appointed by the Speaker of the House of Representatives, eight are appointed by the President Pro Tempore of the Senate, and the Secretary of the Department of Health and Human Services or the Secretary's designee serves as an ex officio, non-voting member.

This report represents the work performed by the North Carolina Study Commission on Aging from the conclusion of the 2003 Session of the 2003 General Assembly until the convening of the 2004 Session of the 2003 General Assembly. The Study Commission on Aging met on five occasions to study a variety of topics concerning older adults including: guardianship, a long-term care insurance tax credit, caring for the mentally ill in long-term care facilities, prescription drug assistance, disease management, elder care housing, the long-term care workforce, adult day services, the Home and Community Care Block Grant, and criminal history record checks of long-term care employees. During the course of its study, the Commission also heard presentations by representatives from fourteen (14) organizations advocating on behalf of older adults in North Carolina.

EXECUTIVE SUMMARY

North Carolina General Statutes Chapter 143B, Article 3, Parts 14A. and 14B. establish North Carolina's Policy Act for the Aging, and Long-Term Care. The principles of the Policy Act for the Aging are to effectively utilize the resources of the State, to provide a better quality of life for senior citizens, and to assure older adults the right of choosing where and how they want to live. The Long-Term Care policy recognizes that traditional caregivers are increasingly employed outside the home and create a growing demand for improvement and expansion of home and community-based long-term care services to support and complement the services provided by informal caregivers. The long-term care policy provides that the public interest would best be served by a broad array of long-term care services that support persons who need services in the home or in the community whenever practicable, and that promote individual autonomy, dignity and choice. The provision also provides that institutional care will continue to be a critical part of the State's long-term care options and that services should promote individual dignity, autonomy, and a home-like environment.

The current size of North Carolina's older adult population, and trends indicating that this segment of the population will increase, indicate the importance of an intense and sustained focus on the support systems and services that North Carolina has in place for older adults. Study efforts undertaken during the 2003-2004 interim by the North Carolina Study Commission on Aging, sought to evaluate the existing system of services to older adults and to recommend improvements. In response to this study, the North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2004 Session of the 2003 General Assembly:

Recommendation 1
The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.

Recommendation 2
The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Recommendation 3
The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Recommendation 4
The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

Recommendation 5
The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Recommendation 6
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Recommendation 7
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Recommendation 8
The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

Recommendation 9
The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.

Recommendation 10
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

OLDER ADULTS IN NORTH CAROLINA: A PROFILE

Prepared by the Department of Health and Human Services, Division of Aging and Adult Services

Older Population Today

North Carolina ranks tenth among states in the number of persons age 65 and older and eleventh in the size of the entire population.[i] The fast pace of growth of the State's older population is evident in a recent US Census Bureau's release in which North Carolina was ranked fourth nationally in the increase of the number of older persons age 65+ (47,198 in NC) between April 2000 to July 2003. Only three other states (California, Texas, and Florida) reported a greater increase among their older populations. Even so, when combined with the equally strong growth in other age groups, the State continues to maintain an overall healthy demographic balance among the generations. Currently, North Carolina ranks thirty-third nationally in the percentage of the population that is 65 years of age and older (65+).

- North Carolina population age 65+ in 2004: 1,016,214 (12.1% of total population)
- North Carolina population age 85+ in 2004: 118,511 (1.4% of the total population)

North Carolina is rich in diversity, but its citizens face challenges because of the disparity that exists among all populations, including older adults. Some important differences among the State's older adults relate to gender, marital status, race/ethnicity, residence, rurality, disability, health status, and veteran status.

- Gender: Older women represent 59.8% of the 65+ age group and 74.0% of the 85+ age group.[ii] The higher rate of poverty among older women remains a primary issue today. For example, women age 75+ are twice as likely to be poor as men the same age.[iii]

- Marital Status: At age 65 and older, women are more than twice as likely to be unmarried as men in their age group.[iv] Data show that being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. According to the Social Security Administration, 50% of unmarried women rely on Social Security for 80% of their income and 25% rely on Social Security as their sole source of income.[v]

	Age 65-74	Age 75-84	Age 85+
Unmarried Women in NC	45.4%	65.8%	76.5%
Unmarried Men in NC	18.7%	25.2%	39.4%

Source: NC Division of Aging and Adult Services (2003). The Aging of North Carolina: The 2003-2007 North Carolina Aging Services Plan

- Ethnicity/Race: Altogether 18.1% of persons age 65+ are members of ethnic minority groups in North Carolina.[vi] Compared to the nation as a whole, North Carolina's population age 65+ includes a larger proportion who are African American (15.3% in NC to 8.3% nationally) and a smaller proportion of Latinos (0.6% in NC to 4.7% nationally). American Indians, Asian Americans, and other ethnic groups each account for 1% or less of the age group 65+. The statistics for African American and other older adults who are minority group members, in

North Carolina as well as nationally, show both a higher poverty rate and a lower life expectancy when compared with the white population.

	65+	White		Minority	
	Total	Male	Female	Male	Female
Below Poverty	13.2%	6.5%	12.9%	21.7%	30.3%
"Near Poor"(101-200% Poverty)	23.2%	–*	–*	–*	–*
Life Expectancy at Birth (years)	75.6	73.8	79.6	68.0	75.8
Life Expectancy at Age 65 (years)	17.1	15.4	18.9	13.8	17.8

**Information currently not available.*
Source: NC Division of Public Health (2002). Healthy Life Expectancy in North Carolina, 1996-2000.

- Residence: In North Carolina, 23.8% of all homeowners are age 65+, yet among older homeowners, over 61,000 reported incomes for 1999 that were below poverty.[vii] This figure represented 38% of the homeowners of all ages with income below poverty and exceeded the national average of 32.7%. Among renters age 65+ who provided information, 53%, or almost 48,000, spent more than 30% of their household income on rent. Furthermore, 5,000 North Carolina homeowners and renters age 65+ lacked complete plumbing facilities in their homes.[viii] Even more disturbing news is found in the statistics of emergency shelters—where the largest increase among the homeless between 2001 and 2002 in North Carolina were among those 55+.[ix] While the total population of homeless reported by shelters increased by 5% during this period, the elder homeless grew by 71% (totaling 3,494 persons in 2002).

- Rurality: Although the United States Census Bureau has not yet released figures specifically for the older population residing in rural areas, it is expected to easily exceed 39.8%, the rate for the total population.[x] In 2000, North Carolina's rural population (3,199,831) was almost as large as the one in Texas (3,647,539), the state with the largest number of rural residents in the nation. Not only was North Carolina's rural population among the largest in terms of numbers, but the state also reported the highest proportion (39.8%) of rural population among the 20 most populous states in the nation. While 11 other states reported higher proportions of rural population, ranging from 40.7% to 61.8%, all of these states are much smaller in total population than North Carolina. Thus, North Carolina is unique among more populous states in having so large a rural contingent. A 2002 report highlights a long list of challenges rural residents and their communities face—isolation by distance, lagging infrastructure, sparse resources that cannot adequately support education and other public services, and weak economic competitiveness.[xi]

- Disability: In North Carolina, 45.7% of the non-institutionalized civilian population age 65+ reported having one or more disablities—47.5% of women and 43.2% of men, according to the 2000 Census.[xii] The Census defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business."

- Health Status: In a statewide survey, over one third of people age 65+ say that their general health status is fair or poor, ranging from 34.1% for white women to 49.3% for minority women.[xiii] In the same survey, 18.4% (highest) of minority women and 4.4% (lowest) of white men age 65+ said that there was a time they could not see a doctor due to medical cost.

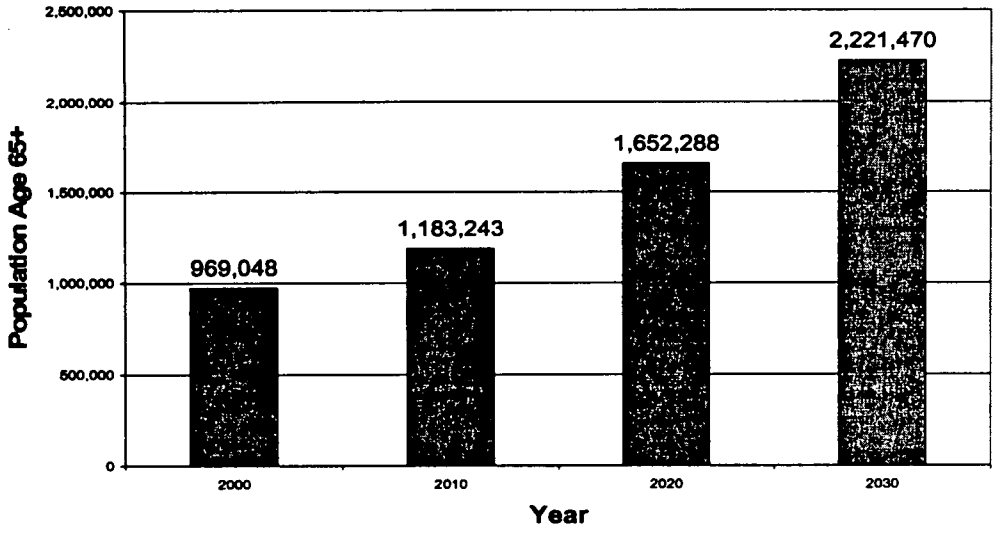
- Veteran Status: Of the 779,393 veterans living in North Carolina, 263,102, or 34%, were age 65 and older in 2000. Another 34% were Vietnam-era veterans (between 43 and 57 years old

in 2000). The population of veterans of the Vietnam-era contains proportionally more disabled members than the veterans' populations of earlier wars.[xiv] The Veterans Administration cites the aging of the veterans as a major challenge to its health care system in coming years.[xv]

North Carolina's Demographic Shift

Older adults are North Carolina's fastest growing population. By 2030, our senior population should exceed more than 2.2 million, comprising 17.9% of total population.[xvi] The median age climbs from 35.3 years in 2000 to 38.4 years in 2030.

Projected Growth of Population Age 65+ (2000 – 2030)



Why This Demographic Shift

A combination of improved life expectancy and lower birth rates contributes to a society's "aging". In North Carolina, as anywhere in the nation, the aging of the "Baby Boomers" (born between 1946 and 1964) will greatly accelerate this societal aging in coming years. Another factor in the State's aging is migration. North Carolina ranked sixth among the states with a net migration rate of 22.1 per 1,000 among persons age 65+, in the five-year period between 1995 and 2000. [Note: A positive net migration indicates that more older adults moved to North Carolina than left during that time.] Along with other Sunbelt states, North Carolina remains a popular destination for people of all ages, including seniors. Other southern states with high positive net migration among older adults include: Florida (56.9); South Carolina (33.6); Georgia (18.1); and Tennessee (15.2).

There are other important factors influencing the diverse experiences in demographic shifts among the State's 100 counties.[xvii] In 83 counties, the rate of increase among citizens age 65+ (22%) is expected to exceed the growth of the total population (18%).

- Rural-to-urban migration of young adults continues to age rural counties.
- Large metropolitan counties attract large numbers of persons from outside the State as well as from rural counties.
- The large metropolitan counties are experiencing greater growth among younger adults than they are among older adults.

- A large number of older adults with higher incomes are retiring in some western and coastal counties.

What Are the Implications of This Shift?

The aging of the population is a national and international trend, and North Carolina, like the rest of the world, must be prepared to reap the benefits and face the challenges of an older population. Government faces decisions about the allocation of public resources from a tax base that may experience slowed growth, especially in many aging rural counties. People must consider living and caregiving arrangements in light of smaller nuclear and extended families. The health, human service, employment, and education systems must adapt to the changing needs and interests of seniors of today and tomorrow. The business, faith communities, and others must identify and respond to the challenges and opportunities of these demographic shifts.

In the 2003-2007 State Aging Plan, the North Carolina Division of Aging and Adult Services introduced a new initiative–Senior-Friendly Communities–to raise awareness of the aging of our population and to promote the North Carolina communities becoming senior-friendly through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. A senior-friendly community in North Carolina will draw on the talents and resources of active seniors while enhancing services for those are vulnerable because of their health, economic hardships, social isolation, or other conditions. A senior-friendly community will bring together a wide range of issues and concerns (e.g., air quality, housing, long-term care services, employment, enrichment opportunities) that, as a whole, affect the quality of life of seniors and others in the community. Also, a senior-friendly community will assure stewardship of its resources to meet the needs of today's seniors, while helping baby boomers and younger generations prepare for the future.

For additional information on North Carolina aging demographics, please refer to Appendix A.

Sources of Information

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COMMISSION PROCEEDINGS

February 10, 2004

The North Carolina Study Commission on Aging met on Tuesday, February 10, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Edd Nye was the presiding Co-Chair. Following Commission member introductions and approval of the budget, Theresa Matula, Commission staff, provided an overview of the statutory basis for the Commission and its charge. By law, the Commission is required to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults. Mrs. Matula pointed out the specific duties of the Commission as they appear in G.S. 120-181, and the reporting requirements contained in G.S. 120-187.

Theresa Matula and Dianna Jessup, Commission staff, reviewed the status of the Commission's recommendations to the 2003 Session of the 2003 General Assembly and presented an overview of other legislation of interest to older adults Appendix B.

Karen Gottovi, Director, Division of Aging and Adult Services, Department of Health and Human Services (DHHS), presented an overview of the services available for older adults in North Carolina Appendix C. Mrs. Gottovi also presented *The Aging of North Carolina*, the 2003-2007 North Carolina Aging Services Plan. The Plan was submitted to the North Carolina General Assembly on March 1, 2003. Mrs. Gottovi pointed out that the 2003-2007 Plan builds upon the achievements of the 1999-2003 Plan as well as three other earlier plans developed in the 1990s (1991, 1993, and 1995) and provides a foundation for new developments. The Aging Services Plan is required by G.S. 143B-181.1A and the federal Older American Act.

John Saxon, Professor of Public Law and Government, University of North Carolina at Chapel Hill gave a presentation on guardianship laws. Appendix D. The presentation outlined the legal history of guardianship reform, the current law and issues that may need to be addressed, as well as and overview of the Uniform Guardianship and Protective Proceedings Act (UGPPA).

The North Carolina tax credit for long term care insurance expired for taxable years beginning on or after January 1, 2004. As a result, the Commission heard from Carla Obiol with the Department of Insurance's Seniors' Health Insurance Information Program (SHIIP), who gave an overview of long term care insurance. Her handouts included: *A Shopper's Guide to Long-Term Care Insurance* and *Facts About Long-Term Care Insurance In North Carolina* . Additionally, Karl Knapp from the Tax Research Division, and Nancy Pomeranz from the Personal Taxes Division, of the North Carolina Department of Revenue, made presentations on the tax treatment of long-term care insurance in selected states, and on the number of long-term care tax credits claimed in North Carolina Appendix E. Ms. Pomeranz discussed the error rate experienced on the long-term care tax credit and the Department's efforts to reduce that error rate. Some of the Department's efforts include informing taxpayers who made errors, and working with software vendors to improve the long-term care tax credit information in their programs.

The final item on the agenda concerned adult care home rules and caring for the mentally ill. The Commission heard presentations from Jim Upchurch, Division of Facility Services, Department of Health and Human Services Appendix F; Dottie Harrison, Board Member, NC

National Alliance for the Mentally Ill (NAMI); and Lou Wilson, NC Association of Long Term Care Facilities. Ms. Harrison addressed the consequences of the lack of appropriate housing for mentally ill individuals and her concerns for adequate staffing and training to care for mentally ill individuals in long-term care facilities. Ms. Wilson mentioned the use of the Geriatric Mental Health Specialty Teams and provided recommendations for improvement.

March 9, 2004

The North Carolina Study Commission on Aging met on Tuesday, March 9, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator A.B. Swindell was the presiding Co-Chair. Topics of this meeting included brief remarks by organizations advocating on behalf of older adults in North Carolina; disease management; NC Senior Care; the new Medicare prescription drug program; and geriatric mental health specialty teams.

The Commission heard from fifteen (15) individuals that represent, or advocate on behalf of, older adults in North Carolina. Each representative was allowed approximately three minutes to make a brief presentation on the issues affecting older adults in North Carolina. Staff presented the Commission members with a *Summary of Presentations by Organizations Representing Older Adults* Appendix G during the March 23, 2004 meeting. The legislative priorities/issues of concern that were mentioned with the greatest frequency were: Access to National Criminal Record Checks (6 responses); Restoration of the LTC Insurance Tax Credit (4 responses); Support for and/or Restoration of Funding for the home and Community Care Block Grant (HCCBG) (3 responses); Support for/and or Restoration of Funding for Senior Centers (3 responses); and Maintaining the Viability of the Community Alternatives Program for Disabled Adults (CAP/DA) (3 responses) Appendix G.

Alan Dobson, Chairman of Cabarrus Community Care; Chairman of Physician Advisory Group; and President/CEO of Cabarrus Family Medicine delivered a presentation on disease management. Community Care of North Carolina focuses on improved quality, utilization and cost effectiveness with thirteen (13) networks with more than 2,000 physicians and 417,000 enrollees. Dr. Dobson indicated that the primary goals of Community Care of North Carolina are to: Improve the care of the Medicaid population while controlling costs; and to Develop community based networks capable of managing populations. He pointed out that these goals are achieved by making sure people get the care when they need it; increasing local provider collaboration; obtaining quality care; implementing best practice guidelines; and managing Medicaid costs. Key program efforts for the aged and disabled include: diabetes, poly-pharmacy in skilled nursing facilities, poly-pharmacy for the disabled, and therapy services.

Michael Keough, from the Department of Health and Human Services, gave a presentation on the North Carolina Senior Care program. He first gave an overview of the program, which is designed specifically to provide assistance to North Carolina seniors (age 65 or older), diagnosed with one of three diseases (diabetes mellitus, cardiovascular disease, and chronic obstructive pulmonary disease); have an annual household income at or below 200% of the federal poverty level and no other prescription drug coverage. As of March 2004, there were 32,600 enrollees, representing all 100 counties. Outreach efforts include the distribution of 400,000 enrollment applications and an outreach grant with the General Baptist State Convention. Mr. Keough also presented information on the Medication Assistance Program in which 23 grantees cover 60 sites in 60 counties. The key components of the Medication Assistance Program include: Prescription Assistance (facilitating use of pharmaceutical manufacturers' free and low cost drug programs), and Medication Management including pharmacist evaluation of individual senior's drug

regimens. NC Senior Care is reviewing options to coordinate coverage with the recently enacted changes to the Medicare program.

Carla Obiol, Deputy Commissioner, Seniors' Health Insurance Information Program (SHIIP) made a presentation to the Commission on the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Act). Ms. Obiol gave an overview of the timetable of benefits, information on the Medicare Prescription Drug Discount Card and the Transitional Assistance Program, the discount card sponsor qualifications, Medicare Part D: Prescription Drug Plan (PDP), and outreach efforts by SHIIP and the Centers for Medicare & Medicaid Services (CMS). Provisions of the Act include a Medicare-approved Prescription Drug Discount Card, a Transitional Assistance Program, and Medicare Advantage from 2004-2005. It is anticipated that Medicare Part D: Prescription Drug Plan will be in place by 2006. Details are continuing to evolve and Ms. Obiol recommended the following resources: the Medicare Program: http://www.medicare.gov/ or http://www.cms.gov/ or 1-800-MEDICARE; and SHIIP http://www.ncshiip.com./ (*see Senior Citizens heading*).

This meeting concluded with a presentation on Geriatric Mental Health Specialty Teams from Dr. Bonnie Morell, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services. According to Dr. Morell, the Geriatric Mental Health Specialty Teams were developed to provide expertise and services throughout the State in recognition of the need for greater local capacity to address and serve the needs of older adults with mental illness. According to information presented, "The purpose of these teams is to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals, and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization." Appendix F

March 23, 2004

The North Carolina Study Commission on Aging met on Tuesday, March 23, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Debbie Clary was the presiding Co-Chair. Presentation topics for this meeting were elder housing, the long-term care workforce, adult day services, the Home and Community Care Block Grant (HCCBG), a report on CAP/DA, and criminal history record checks.

Bob Kucab, Executive Director of the North Carolina Housing Finance Agency, spoke to the Commission about the work of the agency. The purpose of the agency is to finance housing for persons who are not served by the private market. The agency helps seniors by improving their existing housing and by working to develop new apartments where seniors can have affordable rents, good living environments, and connections to community services. While the agency is involved in a number of projects, applications for funding exceed available capital by 3 to 1. Mr. Kucab requested an increase in the $3 million State appropriation for the Housing Trust Fund to aid the agency in its efforts.

Susan Harmuth from the Office of Long Term Care and Family Services, Department of Health and Human Services (DHHS), updated the Commission on the Department's long-term care workforce initiatives. She reported that employee turnover has been decreasing since 2000, but

it is still high. The Department is working on a variety of projects to combat this turnover. One of these projects is The Better Jobs/Better Care Demonstration. Under this demonstration, the State's Better Jobs/Better Care Partner Team is working to develop a uniform (and voluntary) set of expectations and criteria for use across home care, adult care homes and nursing facilities that relate to issues impacting the recruitment and retention of direct care workers. Major domain areas include safe and balanced workloads, training and career advancement opportunities, supportive workplaces, worker empowerment, peer mentoring, orientation, management support, coaching supervision, and reward and recognition.

Following Ms. Harmuth's presentation, the Commission heard several presentations concerning adult day and adult day health services. Nancy J. Cox, Director of Partners in Caregiving, Wake Forest University School of Medicine, presented information concerning the predictors of success for adult day programs from a marketing, financing, and programming perspective. Created in 1987 by The Robert Wood Johnson Foundation, Partners in Caregiving is a national adult day services program. The focus of Partners in Caregiving is to teach non-profit adult day centers the principles of business and marketing to be financially self-sufficient and not rely on grants. She presented the results of a recent national study of adult day services that showed the need for adult day service capacity building at the State level in three areas: increased public awareness in underutilized areas, increased availability in areas where the service is not currently an option for caregivers, and increased knowledge at the provider level regarding predictors of success.

Suzi Kennedy from the Life Enrichment Center of Cleveland County, Inc. spoke about the challenges of operating a successful adult day program. Ms. Kennedy showed pictures of the facilities in her area and presented the "Menu for Financial Success for the Life Enrichment Center." This Menu included: 1) a strong Board with effective committees; 2) diversified revenue streams (operating and non-operating); 3) a diversified population; 4) unbundling the services (i.e. transportation, personal care services, hair care); and 5) pre-billing for enrollment rather than attendance, for the levels of care, and for ancillary services. Ms. Kennedy stated that, "Without financial stability there can be no social good," and she pointed out that public reimbursement rates are often insufficient to cover the costs of running a program.

Steve Freedman from the Division of Aging and Adult Services, DHHS, was the final speaker on the subject of adult day services Appendix I. Mr. Freedman stated that there are currently 113 certified adult day and adult day health programs in the State, a decrease from the peak of 125 programs in 2000. The programs are currently located in 60 counties. The Division of Aging and Adult Services has been working with the North Carolina Adult Day Services Association to develop fiscal training for adult day programs. According to the Division, the aim of this project is to assist adult day programs with budgeting and help increase their understanding of service costs. Mr. Freedman also addressed reimbursement rates. Currently, the maximum reimbursement rate for adult day services is $26.07 per day, and $33.00 per day for adult day health services. According to the North Carolina Adult Day Services Association, the average cost to operate an adult day program is $31.00 per day, and for adult day health programs it is $44.00 per day. In the 2003 budget bill, the General Assembly directed the Social Services Commission to consider adopting rules to increase these rates within existing funds. A rate increase has not occurred.

Next, Dennis Streets from the Division of Aging and Adult Services, DHHS presented information concerning the Home and Community Care Block Grant Appendix H. The Home and Community Care Block Grant (HCCBG) was established by the General Assembly in 1992.

By consolidating several funding sources (i.e. the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations), the HCCBG helps to coordinate the service delivery system to meet the needs of seniors. The focus of the HCCBG is to support the frail elderly at home, assist with access to services and information, provide family caregiver relief and help seniors remain active. While there have been some increases in federal funds, State support has decreased. According to Mr. Streets, there are more than 6,500 unmet service needs, especially for home-delivered meals and in-home aide services.

Gary Fuquay, Division of Medical Assistance, DHHS, presented a report on the Community Alternatives Program for Disabled Adults (CAP/DA), required by S.L. 2003-284, Sec. 10.29B(b) and (c). The section basically required the Department to conduct a cost analysis of CAP/DA and the State/County Special Assistance In-Home program in relation to the per client cost of nursing homes and adult care homes. While the report attempted to provide cost comparisons, Mr. Fuquay warned that it is difficult to draw conclusions from the data because one cannot compare level of care indicators.

The Commission next heard from various speakers concerning national criminal history records checks of long-term care workers. John Aldridge from the North Carolina Attorney General's Office gave an overview of current law regarding who can receive the results of national criminal history records checks and for what purposes. Jackie Sheppard from the Office of Long-Term Care and Family Services, DHHS, gave an overview of what the state of Mississippi is doing to address this issue. Roger Manus, representing Friends of Residents in Long-Term Care, urged the Commission to look at Florida's system for conducting background checks. Stacy Flannery, representing the NC Health Care Facilities Association, presented the providers' concerns about this issue.

Finally, the meeting concluded with a brief presentation summarizing Appendix G the association presentations from the March 9 meeting. Chief among the issues raised by the associations was the current moratorium on national criminal history records checks of long-term care workers.

April 13, 2004

The North Carolina Study Commission on Aging met on Tuesday, April 13, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator A.B. Swindell was the presiding Co-Chair. During this meeting, the Commission heard a presentation from Jackie Franklin with the Division of Aging and Adult Services, Department of Health and Human Services, on the State/County Special Assistance In-Home program. The Commission discussed and initially approved recommendations to the Governor and the General Assembly. The Commission also directed the staff to prepare a draft report for review at the final meeting.

April 27, 2004

The North Carolina Study Commission on Aging met on Tuesday, April 27, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Members discussed and approved the Commission's Report to the Governor and to the 2004 Session of the 2003 General Assembly.

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this section to the Governor and the 2004 Session of the 2003 General Assembly. Each recommendation is followed by background information, and corresponding legislative proposals appear in Appendix J of this report.

Recommendation 1

The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.

Background

In 1997, the North Carolina Study Commission on Aging recommended that the 1997 General Assembly enact a 15% tax credit, up to a maximum of $350, on the premiums paid by the purchaser of long-term care insurance policies. According to the 1997 Commission report, the Office of State Budget and Management estimated that a 15% tax credit up to a maximum of $350 may result in a revenue loss of $17 million. The report further stated that, the average premium was $1,600, thus a 15% credit would be equal to $240. The report acknowledged that it was difficult to estimate the offsetting benefits of the tax credit in terms of reduced Medicaid payments, but that the cost of a year's stay in a North Carolina nursing home was $40,000. The Commission recommended this tax credit again in 1998, and the credit became Section 29A.6 of Session Law 1998-212. The tax credit was effective for taxable years beginning on or after January 1, 1999, and expired for taxable years beginning on or after January 1, 2004.

On January 16, 2003, the Department of Revenue prepared a memorandum for the Revenue Laws Study Committee on the status of the tax credit for premiums paid on long-term care insurance. The memorandum outlined the Department's review of some of the returns on which the credit was claimed. During this review, auditors found that some taxpayers, who were not eligible for the tax credits, claimed the tax credits; and that some taxpayers claimed long-term care credits greater than the cap of $350. The Department found that, "Of the 2,155 returns reviewed, only 192 contained allowable long-term care credits. Taxpayers were not eligible for the credits claimed on the remaining 1,963 returns in this group. As a group, therefore, over 90% of the returns incorrectly claimed the credit." Because this represented a sample, the Department indicated that they did not know the error rate for all returns claiming the credit. They attributed the high error rate to two possible factors: "One factor is the complicated nature of the credit and the other is confusion of this credit with the repealed child health insurance credit." Additionally, the memorandum indicated that, for tax year 2001, the credit reduced tax revenue by $10,367,883.

The 2003 North Carolina Study Commission on Aging recommended repealing the sunset on the long-term care insurance tax credit. In its 2003 report, the Commission expressed agreement with a statement from a Division of Aging's report, *Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance.* The Division's report stated that, "In addition to the public benefit of having a much larger segment of the adult population positioned to pay privately for long-term care in terms of the state's economic health, consumers and families benefit from the ability to pay privately through increased choice and flexibility in terms of the range of services and settings of care available." S.L. 1998-212, Section 29A.6(d) made the credit for premiums paid on long-term care insurance effective for taxable years beginning on

or after January 1, 1999, and sunset the credit effective January 1, 2004. The Commission's bills repealing the sunset were introduced during the 2003 Session, but were not successful and the tax credit was allowed to sunset. As a result, the tax credit is not currently in place for the 2004 tax year.

During the February 10, 2004 meeting, the Commission heard a presentation on long-term care insurance from Carla Obiol with the Seniors' Health Insurance Information Program (SHIIP), and presentations on issues related to the tax credit from Department of Revenue employees Karl Knapp, Tax Research Division, and Nancy Pomeranz, Personal Taxes Division Appendix E. Carla Obiol with the Department of Insurance's Seniors' Health Insurance Information Program (SHIIP), gave an overview of long-term care insurance. Her handouts included: *A Shopper's Guide to Long-Term Care Insurance* and *Facts About Long-Term Care Insurance In North Carolina*. Karl Knapp from the Tax Research Division, and Nancy Pomeranz from the Personal Taxes Division, of the North Carolina Department of Revenue, made presentations on the tax treatment of long-term care insurance in selected states, and on the number of long-term care tax credits claimed in North Carolina Appendix E. Ms. Pomeranz discussed the error rate experienced on the long-term care tax credit and the Department's efforts to reduce that error rate. The Department indicated that they had made progress in reducing the error rate on the long-term care insurance tax credit. Commission staff also obtained a chart Appendix E from the American Association of Health Plans-Health Insurance Association of America (AAHP-HIAA) depicting those states in the United States that offer tax incentives for the purchase of long-term care insurance. AAHP-HIAA is a national trade association representing the private sector in health care. The chart from AAHP-HIAA shows that 6 states offer tax credits and 16 states offer tax deductions. *(Note: The information in the AAHP-HIAA chart does vary from the Department of Revenue's information, which could be the result of different compilation dates.)*

According to information received by the Commission staff, on June 5, 2003, the Department of Revenue reported that they had audited 2,372 returns for the tax year 2002, and adjusted 650 to disallow the credit, representing a 27% error rate. This error rate was down considerably from the 90% error rate on the 2001 returns reported earlier by the Department. The Department attributed the decrease to: 1) informing tax preparers of the appropriate use of the credit; 2) clarifying instructions about eligibility for the credit; 3) improving the verbiage in software developers' tax packages; and 4) communicating with taxpayers whose credit was disallowed in 2001, to inform them of the eligibility criteria for the tax credit. An additional $279,628 was assessed on the 650 returns adjusted, and returns continue to be audited as resources permit. On November 3, 2003, the Department reported that they had processed 3,574,530 returns: 2,158,850 paper and 1,415,680 efiled. Of the total, there were 35,936 on which a credit for long-term care insurance was claimed for a total of $19,110,623.

The North Carolina Study Commission on Aging has supported the long-term care insurance tax credit since its inception and the current Commission continues to support it. The Commission scheduled presentations on this issue at the first meeting this interim, and restoration of the long-term care insurance tax credit was an item mentioned frequently during presentations on March 9, 2004, by organizations representing older adults in North Carolina. The Commission recommends that the General Assembly repeal the sunset on the long-term care insurance tax credit.

Recommendation 2

The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and

training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Background

On February 10, 2004, the Commission heard presentations on adult care home rules and caring for the mentally ill from Jim Upchurch, Division of Facility Services, Department of Health and Human Services (DHHS); Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI); and Lou Wilson, NC Association Long Term Care Facilities. On March 9, 2004, the Commission heard a presentation on Geriatric Mental Health Specialty Teams from Bonnie Morell, Community Policy Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services (DHHS). Appendix F

During her presentation, Ms. Wilson mentioned the use of the Geriatric Mental Health Specialty Teams. She indicated that while the intent of the program was positive, she believed, "The State has provided very little guidance for area mental health programs as to how the teams should be operated, thus the program has floundered in many areas of the state." She also stated that, "Area programs all over the State have developed criteria, protocol, policies and procedures that are unique to their area program. As a result, consumers and providers of services are expected to muddle through a system of inconsistency."

According to information provided by DHHS, Geriatric Mental Health Specialty Teams were developed to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living in their own home or with family members. Individuals with geriatric-like needs are also served. Dr. Morell noted that, "This is a fairly new program that is being implemented during a time of change in the public mental health system. Focus will be on identifying ways in which to support the work that is being done by the teams that have been put in place."

During her presentation on February 10, 2004, Ms. Wilson shared a recommendation for legislation. Ms. Wilson's recommendations include: 1) renaming the Teams to Long Term Care Facility Specialty Teams; 2) requiring all licensed adult care homes and nursing homes that serve individuals with a mental illness to participate in the program; 3) deleting the age requirement and the restrictions for residents to be at risk of psychiatric hospitalization and making services available for all persons with a mental illness who reside in adult care homes and nursing homes; 4) increasing the number of professionals on each team and/or decreasing the geographic areas that each team covers; 5) developing standardized criteria; 6) fully funding the program to support the individuals and facilities eligible for services; and 7) repealing the current adult care home special unit rule for persons with mental illnesses and create a new licensure law and rules that are more realistic.

According to information provided by staff in the General Assembly's Fiscal Research Division, the Geriatric Mental Health Specialty Teams are a contracted service through the Local

Management Entities (LME). There are 20 Teams across North Carolina and each one contracts with one or more LME's. These are funded with Mental Health Trust Fund dollars, and these non-recurring funds are being replaced by recurring funds made available through mental hospital downsizing. As a Team delivers services to a facility, they file for reimbursement with the LME, which in turn seeks reimbursement from DHHS. Currently, DHHS cannot report specific cost data on the Geriatric Mental Health Specialty Teams.

Based on the information presented to the Commission, the Commission recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Recommendation 3

The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Background

On February 10, 2004, the Commission heard presentations concerning caring for mentally ill individuals in long-term care facilities. One of the presenters was Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI). Ms. Harrison questioned whether adult care homes were appropriate housing options for mentally ill individuals, and she questioned the appropriateness of staffing and training at these facilities. Specifically, Ms. Harrison supported training on the appropriate administration of psychiatric medications, and training on appropriate interaction with residents based on their particular mental illness. Another presenter at the February meeting, Lou Wilson, Executive Director of the North Carolina Association of Long Term Care Facilities, stated that adult care home providers, "simply do not know how to muddle through the complex mental health systems, develop good rapports with mental health providers, provide mental health training for staff and recognize issues when specific residents are having difficulty." Ms. Wilson requested training for adult care home staff that will enable them to recognize symptoms of mental illness and urged the State, advocates, and the industry, to work together to ensure that individuals with mental illnesses receive the services they are entitled to receive.

During the March 9, 2004 meeting, Dr. Bonnie Morell shared information with the Commission on the Geriatric Mental Health Specialty Teams Appendix F. One of the purposes of these Teams is to provide support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living in their own home or with family members. Individuals with geriatric-like needs are also served.

In addition to other recommendations, Lou Wilson also requested the creation of a new licensure law and rules that are more realistic. During discussions at the April 13, 2004 meeting, Commission members voiced support for examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities. They

also supported examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support resident's freedom of choice, and whether they support the autonomy, dignity and independence philosophy of assisted living.

The Commission supports quality care for mentally ill individuals and elderly individuals and recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Recommendation 4

The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

Background

State law currently requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, and adult care homes. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. However, under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies other than those involving direct patient care and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

Access to national criminal history record checks was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina. On March 23, 2004, the Commission heard a presentation from John Aldridge of the North Carolina Attorney General's office on this issue. He reiterated that unless federal law provides otherwise, the results of a national criminal history record check can only be released to a governmental agency. Currently, federal law only permits these results to be released to nursing homes and home care agencies on applicants for positions that involve direct patient care. Therefore, in order to be able to conduct national criminal history record checks on applicants for positions in nursing homes and home care agencies that do not involve patient care and on applicants for positions in adult care homes, current State law would have to be changed to direct that the results be sent to a governmental agency.

The Commission recognizes that long-term care advocates and providers have legitimate concerns about the current status of national criminal history record checks. Roger Manus, President of Friends of Residents in Long Term Care, pointed out during the Commission's meeting on March 23, that people living in long-term care facilities are the vulnerable frail elderly and disabled that cannot defend themselves, and many cannot communicate when they

perceive a threat. Worst of all, they spend the night in these facilities when staffing levels decrease even further with greater potential and opportunity for abuse. It is important to ensure the safety of this vulnerable population. On the other hand, the Commission recognizes that employee turnover is high in long-term care facilities. It is important that providers be able to fill positions quickly and not have to wait an inordinate amount of time for a determination to be made by an agency about whether an applicant is disqualified because of the applicant's criminal background. Questions arose during the Commission's deliberations about the State's technological and staffing capacity to be able to turn around a determination of disqualification quickly.

The Commission recommends moving this issue forward by establishing a pilot program to conduct national criminal history record checks of workers in adult care homes and contract agencies of adult care homes who provide direct resident care and requiring the Department of Health and Human Services to collect information and meet regularly with providers and others to monitor the progress of the pilot to determine what is needed in order to fully implement the national criminal history record checks as the General Assembly intended.

Recommendation 5

The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Background

Senior Centers are resources within communities that typically provide nutrition, recreation, social and educational services, and comprehensive information and referral. The National Institute of Senior Centers defines a senior center as a place where "older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community." Prior to the 2002 Session, State funds for Senior Centers were $1,365,316. During the 2002 Session, funds were reduced by $381,000. During the 2003 Session, $100,000 was restored, and the local match requirement was increased.

Support for and/or restoration of funding for Senior Centers was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina Appendix G. To fully restore State funding to the prior level, an additional $281,000 would be needed. Therefore, the Commission recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Recommendation 6

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Background

The Housing Finance Agency mission is to create affordable housing opportunities for North Carolinians whose needs are not met by the market. This mission is accomplished through helping older individuals age in place by improving existing housing, and by working to develop new apartments for older adults. In the March 23, 2004 presentation, Bob Kucab, Executive

Director, stated that applications for funding requests currently exceed available capital by 3:1. State funds help bring in outside funding because the Housing Finance Agency is able to leverage $5 in development from every $1 the State invests. According to Mr. Kucab, all State funds that they administer are invested in bricks and mortar; staff costs are paid from their revenue. Mr. Kucab reported that, State appropriations are currently down to $3 million from a high of $9 million.

The Commission recognizes the need for new apartments with affordable rent, where older adults can enjoy safe and comfortable living environments, and connections to community services. Therefore, the Commission recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Recommendation 7

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Background

On March 23, 2004, Dennis Streets, Division of Aging and Adult Services, DHHS, made a presentation to the Commission on the Home and Community Care Block Grant (HCCBG) Appendix H. His presentation gave an overview of the program; eligibility criteria; and information on program utilization, availability, and needs. The HCCBG is established by G.S. 143B-181.1(a)(11). Mr. Streets pointed out that by "consolidating several funding sources (i.e., the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations)—some of which traditionally went to separate organizations—the HCCBG represented an important step toward establishing a well coordinated service delivery system to meet the needs of a rapidly growing older population." The HCCBG includes federal funds, State funds, local funds, and a client cost sharing component. The two principal purposes of the HCCBG are to give counties greater discretion, flexibility and authority in determining services, service levels and service providers; and to streamline and simplify the administration of services. The HCCBG focuses on: supporting frail elderly in their preference to be cared for at home; improving and maintaining the physical and mental health of older adults; assisting older adults and their caregivers with accessing services and information; providing relief to family caregivers so that they can continue their caregiving; and allowing older adults to remain actively engaged with their communities.

Any person age 60 and older is eligible for services under the HCCBG. The HCCBG program places an emphasis on reaching those most in need of services (the Older Americans Act (OAA) gives priority to serving the "socially and economically needy" -with particular attention to low-income minority elderly and older individuals residing in rural areas). Additionally, the OAA calls for reaching out to older individuals with severe disabilities, limited English-speaking ability, and Alzheimer's disease or related disorders (and caregivers of these individuals).

State appropriations for the HCCBG were $25,128,469 for the 2002-2003 fiscal year. State appropriations were cut by $1,055,690 to $24,072,799 for the 2003-2004 fiscal year. State appropriations are currently slated to be reduced to $24,026,079 for the 2004-2005 fiscal year. An increase in federal Older Americans Act funds has helped to offset the decrease in State funding and overall funding of the program was down from the previous year only $341,603 for

2003-2004. However, the Division anticipates a decrease in federal funding for 2004-2005, which would leave the overall total down another $389,974. Unless the General Assembly increases State appropriations, the total net funding for HCCBG would be down $731,577 for the period from 2002-2003 to 2004-2005.

Support for and/or restoration of funding for the HCCBG was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina Appendix G. The Commission recognizes the vital services that are provided under the HCCBG and recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Recommendation 8

The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

Background

The Final Report by The North Carolina Institute of Medicine Task Force on Long-Term Care reported an institutional bias in Medicaid eligibility rules. The report states that a reason public funding is weighted toward institutional care is that Medicaid and other public program rules make it easier for people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community. Under existing laws, individuals can qualify for either nursing home care or State-County Special Assistance for adult care homes with higher monthly incomes than they can if they want to obtain Medicaid coverage for health services provided in their own home. With these different income eligibility limits, individuals living at home who may have too much income to qualify for Medicaid coverage as long as they remain in their home, may qualify if they move into a more costly institutional or residential setting.

In Olmstead v. L.C., the United States Supreme Court concluded that inappropriate institutionalization of a person with a mental disability may be discrimination under ADA. The Commission recognizes that the law favors caring for an individual in the community rather than in an institution, and institutional care may be more costly than residential care. Therefore, the Commission recommends that the General Assembly direct the Department of Health and Human Services to study whether an institutional bias in Medicaid eligibility rules do in fact exist and if they do exist, to determine how to alleviate the bias.

Recommendation 9

The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.

Background

Guardianship is a legal relationship in which a person or agency (the guardian) is appointed by a court to make decisions and act on behalf of another person (the ward) with respect to the ward's personal or financial affairs because the ward, due to a specific mental or physical impairment, lacks sufficient capacity to make or communicate important decisions concerning his or her

person, family, or property or lacks sufficient capacity to manage his or her personal or financial affairs. Laws regarding guardianship for incapacitated adults attempt to strike a balance between preserving the legal rights, freedom, and autonomy of individuals vs. society's duty (parens patriae) to protect individuals who are unable to protect or care for themselves.

On February 10, 2004, the Commission heard a presentation on "Guardianship Reform in the Twenty-First Century" Appendix D by John Saxon, Professor of Public Law and Government, UNC Chapel Hill. According to his presentation, the last substantive revision to the guardianship law was in 1977, and the last consolidation and clarification was enacted in 1987. Since 1987, there have been efforts to review and revise the statutes, but none resulted in change. Current law consists of an assortment of statutes, some of which date back to the 1800s. As a result, there are a number of issues in the guardianship statutes that need review and updating, including interstate jurisdiction, the definition and standard of incapacity, due process, guardianship alternatives, limited guardianship, the guardian's powers, and the role of human service agencies.

Professor Saxon suggested that as an alternative to rewriting current law, North Carolina could adopt the Uniform Guardianship and Protective Proceedings Act (UGPPA). The UGPPA has been enacted in four states. The UGPPA authorizes two types of legal proceedings: guardianship proceedings to appoint guardian (guardian of the person) for a minor or incapacitated person; and protective proceedings regarding the property of a minor or a missing, absent, detained, or incapacitated person, including proceedings seeking the appointment of a conservator (i.e. guardian of the estate). Under the UGPPA, guardianship and conservatorship is viewed as last resort. A guardian or conservator may be appointed only if there are no other lesser restrictive alternatives that will meet the respondent's needs, and limited guardianship or conservatorship should be used whenever possible. According to Professor Saxon, the UGPPA is advantageous because it is modern, comprehensive, legally adequate, balanced, proven, and could be customized to address any issues that are unique to North Carolina.

The North Carolina Study Commission on Aging recognizes that the laws pertaining to guardianship are important for the protection of citizens who are unable to make personal decisions due to impairment or incapacity, and that these laws have not been thoroughly reviewed in 17 years. Therefore, the Commission recommends the General Assembly establish a Legislative Study Commission on State Guardianship Laws.

Recommendation 10

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

Background

North Carolina General Statute 131D-6 provides that adult day care enables people who would otherwise need full-time care away from their own residences to remain in their residences as long as possible. An adult day care program provides group care and supervision for physically or mentally disabled adults in a place other than their usual place of abode on a less than 24-hour basis. Adult day services include a social model and a health model. Both models provide a community setting that promotes social interaction, and physical and emotional well-being. Adult day health programs also offer health care services to meet the needs of individual participants. Nutritional meals and snacks are provided and transportation to and from the program may be provided or arranged when needed. Often these programs provide a safe

stimulating environment while a primary caregiver is at work. Providers of adult day care must meet North Carolina State Standards for Certification. The Social Services Commission sets these standards and the reimbursement rates paid for adult day and adult day health services.

During the March 23, 2004 meeting, the Commission heard from Nancy J. Cox, Director of Partners in Caregiving, Wake Forest University School of Medicine; Suzi Kennedy from the Life Enrichment Center of Cleveland County, Inc.; and Steve Freedman from the Division of Aging and Adult Services, DHHS Appendix I. The Commission received information on the predictors of success for adult day programs from a marketing, financing, and programming perspective; the challenges of operating a successful adult day program, particularly the insufficiency of public reimbursement rates to cover the costs of running a program; and the status of adult day programs across the State. During this meeting, Suzi Kennedy from the Life Enrichment Center of Cleveland County, Inc. spoke about the challenges of operating a successful adult day program and presented her menu for success at the Life Enrichment Center. Ms. Kennedy stated that, "Without financial stability there can be no social good," and she pointed out that public reimbursement rates are often insufficient to cover the costs of running a program.

Based on a survey conducted by the North Carolina Adult Day Services Association, in conjunction with the Division of Aging and Adult Services, the average cost to operate an adult day program in North Carolina is $31.00 per day for social models and $44.00 per day for health models. Rates established by the Social Services Commission, effective December 8, 1997, provided the maximum reimbursement rate for the purchase of adult day services at $565 per month ($26.07 per day). Of this amount, $500 per month ($23.07) is for daily care and $65 per month ($3.00 per day) is for round trip transportation. The maximum reimbursement rate for the purchase of adult day health services is $715 per month ($33 per day). Of this amount, $650 per month is for daily care ($30.00 per day) and $65 per month ($3.00 per day) is for round trip transportation. In 1999, the Division of Aging and Adult Services considered approaching the Social Services Commission about a rate increase; however, the Division was advised that there was little chance of a rate increase without an overall increase in the State Adult Day Care fund, since a rate increase without a budget increase would result in a cut to services. S.L. 2003-284, Section 10.58 required the Social Services Commission to consider adopting rules increasing the rates for adult day centers and adult day health centers. However, any rate increase adopted by the Commission for adult day centers and adult day health had to be implemented within existing funds.

The Commission supports adult day and adult day health programs and understands the important role they play in our communities. Therefore, the Commission recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

APPENDICES

APPENDIX A

North Carolina
Demographics of Aging

	NC	County Range
Total population, 2002[i]	8,323,946	4,170 - 734,403
Projected total population, 2020[ii]	10,966,139	4,706 - 1,102,003
Population age 60+, 2002[iii]	1,338,075	858 - 84,420
Population age 85+, 2002[3]	116,922	88 - 7,567
Baby boomers (as % of total population), 2000[3]	27.8%	20.6% - 32.4%
Rural population for all ages (as % of total population), 2000[iv]	39.8%	3.9% - 100%
Persons age 65+ without HS diploma (as % of age group), 2000[v]	41.6%	21.0% - 61.9%
Persons age 45-64 without HS diploma ("), 2000[5]	19.9%	8.7% - 36.7%
Persons age 65+ with graduate school education ("), 2000[5]	5.5%	1.1% - 18.7%
Persons age 45-64 with graduate school education ("), 2000[5]	8.8%	2.4% - 32.4%
Persons age 65+ with limited or no English ("), 2000[vi]	0.5%	0% - 3.8%
Grandparents raising grandchildren age less than 18, 2000[vii]	79,810	31 – 5,985
Veterans age 65+ (as % of age group), 2000[viii]	26.8%	16.2% - 37.7%

Distribution by Age[1, 2]	0-17	18-49	50-64	65-84	85+
Age groups, 2002	24.5%	47.6%	16.0%	10.5%	1.4%
Projection for 2020	23.1%	43.0%	18.8%	13.3%	1.7%
Growth, 2002-2020	124.3%	119.2%	155.5%	166.8%	162.4%

Distribution by Race/ Hispanic Origin[ix]	White	African American	Native American	Asian	Hispanic/ Latino
Population age 60+ (as % of age group), 2000	82.0%	16.0%	0.7%	0.5%	0.7%
Population age 45-59 ("), 2000	77.2%	18.9%	1.1%	1.2%	1.7%

Healthy Aging

	NC	County Range
Persons age 65+ in community with 0 disabilities* (as % of age group), 2000[x]	54.3%	40.2% - 66.8%
Persons age 65+ in community with 1 disability* ("), 2000[10]	20.6%	14.9% - 26.4%
Persons age 65+ in community with 2 or more disabilities* ("), 2000[10]	25.1%	17.0% - 34.6%

* The US Census Bureau defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for persons to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering."

Medicare beneficiaries immunized for influenza, 2000[xi]	43.5%	17.2% - 63.5%
Persons age 65+ living alone ("), 2000[xii]	28.3%	21.0% - 34.6%

Long-Term Care and Aging

	NC	County Range
Men age 65+ in nursing homes, 2000[xiii]	11,207	0 – 674
Women age 65+ in nursing homes, 2000[13]	33,630	0 – 2,445
Persons age 65+ in nursing homes per 1000, 1999[xiv]	42.2	25.4 – 89.1
Persons age 65+ in adult care homes per 1000, 1999[14]	36.5	0.0 – 67.8
CAP/DA* clients age 18+ per 1000 Medicaid eligibles, 1999[14]	36.0	8.4 – 200.0
PCS** clients age 18+ per 1000 Medicaid eligibles, 1999[14]	57.7	0.0 – 199.1
Adult day care/health clients age 60+ served per 1000, 1999[14]	1.0	0.0 – 5.0
In-home aides clients, age 60+ per 1000, 1999[14]	9.9	2.0 – 51.5
Medicaid-eligible persons age 65+, SFY 2002[xv]	152,300	131 – 7,198
Total Medicaid expenditures for persons age 65+, SFY 2002[16]	$1,665,538,382	$1,151,121- $79,755,555
The amount Medicaid spent on home-based care (CAP/DA, CAP/MR, home health, and PCS) for every $100 spent in nursing homes for clients age 60+, SFY 2002[xvi]	$41.5	$6.9 - $278.4
Special Assistance (SA) expenditures for persons age 60+ in adult care homes, SFY 2002[16]	$90,695,940	$37,987 - $4,035,646

Economic Security

	NC	County Range
Median household income for age group 55-64, 1999[xvii]	$42,250	$26,582 - $62,1
Median household income for age group 65-74, 1999[17]	$28,521	$16,335 - $41,540
Median household income for age group 75+, 1999[17]	$19,303	$11,195 - $33,822

Poverty	Age 55-64	Age 65-74	Age 75+
Persons below poverty (as % of age group), 1999 (NC) [xviii]	9.5%	10.5%	16.9%
Persons in 100-199% of poverty ("), 1999 (NC)[18]	12.9%	20.4%	27.1%

Social Security	NC	County Range
Total Social Security (SS) benefits for beneficiaries age 65+, 2000[xix]	$722 million	$0.4 – 50.7 million
SS beneficiaries age 65+ (as % of age group), 2000[xx]	94.8%	73.1% - 100.0%
Average monthly SS amount received by beneficiaries age 65+, 2000[19,20]	$786	$620 - $889
Medicare/Medicaid		
Medicare Part A enrollees age 65+ (as % of all enrollees), 2000[xxi]	77.0%	65.7% - 86.1%
Medicare/Medicaid dually eligible persons age 65+, 2001[xxii]	140,535	109 – 6,609
Labor Force		
Persons age 45-59 in labor force* (as % of total labor force), 2000[xxiii]	27.7%	21.7% - 35.8%
Persons age 60-64 in labor force* ("), 2000[23]	3.6%	2.5% - 6.9%
Persons age 65+ in labor force* ("), 2000[23]	3.5%	2.2% - 8.8%
Persons age 65+ In labor force* (as % of age group), 2000[23]	14.4%	8.9% - 21.1%
Unemployed persons age 65+ (as % of population age 65+ in labor Force*), 2000[23]	8.3%	0.0% - 40.7%

*Include both employed and job seekers

Senior-Friendly Communities

	NC	County Range
Homeowners age 45-64 (as % of age group), 2000[xxiv]	80.3%	70.9% - 89.6%
Homeowners age 65+ ("), 2000[24]	82.0%	72.0% - 91.4%
Households with persons age 60+ and without complete plumbing, 2000[xxv]	8,184	Undisclosed – 343
Home-delivered meals served to persons age 60+ per 1000, 1999[14]	18.6	0 – 58.5
Food Stamps		
Food Stamp clients age 60+, SFY 2001[xxvi]	66,832	66 – 3,893
Total Food Stamp expenditures for clients age 60+, SFY 2001[26]	$39,628,877	$23,963 - $3,177,499
Monthly Food Stamp expenditure per client age 60+, SFY 2001[26]	$49	$35 - $68
Transportation		
Householder age 55-64 without car (as % of age group), 2000[xxvii]	6.0%	1.0% - 15.9%
Householder age 65-74 without car ("), 2000[27]	9.0%	4.0% - 22.7%
Householder age 75+ without car ("), 2000[27]	21.3%	7.5% - 33.6%

Persons Providing Care	Age 18-44	Age 45-64	Age 65+
Persons providing regular care for adults age 60+ (as % of age group), 2000* [xxviii]	14.5%	23.8%	15.7%

*Only statewide information available at present

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APPENDIX B

North Carolina Study Commission on Aging
Recommendations
to the
2003 North Carolina General Assembly, 2003 Regular Session



Prepared by Staff for the
North Carolina Study Commission on Aging

February 9, 2004

Recommendation Status Report
North Carolina Study Commission on Aging

RECOMMENDATIONS	BILLS INTRODUCED	RESULTS
RECOMMENDATION 1 **The Commission finds that the Community Alternative Program for Disabled Adults (CAP/DA) is the cornerstone of community-based care for older adults and recommends that the General Assembly fund the program at a level sufficient to preserve the availability of community-based services offered through the program.**	N/A	CAP/DA funds for the 02/03 fiscal year are $255,000,000, funds were increased by approximately $61,000,000 last session.
RECOMMENDATION 2 **The Commission recommends that the 2002 Session of the 2001 General Assembly direct the Department of Health and Human Services to study ways to establish a group health insurance purchasing arrangement for long-term care staff.**	H 1559 S 1196	**S.L. 2002-180, Sec. 5.2 (SB 98, Sec. 5.2)** **Group Health Insurance for Long-Term Care Staff Study** The Department of Health and Human Services, in consultation with the Department of Insurance, shall study ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and nonresidential long-term care facilities and agencies, as described in Recommendation #22 of the Institute of Medicine's (IOM) Long-Term Care Task Force Final Report of January 2001. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging on or before January 1, 2003.
RECOMMENDATION 3 **The Commission recommends that the General Assembly direct the Department of Health and Human Services to study ways the State can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens.**	H 1560 S 1199	**S.L. 2002-180, Sec. 5.1 (SB 98, Sec. 5.1)** **Prescription Drug Access/Coordination** The Department of Health and Human Services shall study ways the State can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens. In undertaking this study, the Department shall consider the coordination and facilitation methods being implemented by other states. On or before January 1, 2003, the Department shall report its findings and recommendations to the North Carolina Study Commission on Aging. The report shall include the following: (1) A description of the various coordination and facilitation methods considered. (2) A description of the coordination and facilitation methods of other states.

		(3) A recommendation as to the best way to coordinate and facilitate access in this State, which shall include the reasons for the recommendation, a fiscal analysis of the cost of the recommendation, and whether any legislation is necessary to implement the recommendation.
RECOMMENDATION 4 **The Commission recommends the General Assembly establish a Legislative Study Commission on State Guardianship Laws.**	H 246 S 179	No action taken on this issue.
RECOMMENDATION 5 **The Commission recommends the General Assembly pursue ways in which national criminal record checks may be obtained and reviewed by long-term care facilities to effectuate State policy and to protect facility residents.**	H 1561 S 1264	**S.L. 2002-180, Sec. 2.1A (SB 98, Sec. 2.1A)** **Study Issues Related to Criminal History Record Checks of Employees of Long-Term Care Providers** The Legislative Research Commission may study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substance abuse services authorities, and the problems federal restrictions pose for effective and efficient implementation of State-required criminal record checks. The study may include the following: (1) Ways in which national record checks may be obtained and reviewed for these facilities to effectuate State policies and protections of facility residents, and the advantages, disadvantages, and costs of various approaches to implementation. (2) A review of ways in which national record checks are obtained by the Division of Child Development, Department of Health and Human Services, and other State agencies, and related costs to the State. (3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions. (4) Other issues relevant to State requirements for criminal history record checks in long-term care facilities. For each of the topics the Legislative Research Commission decides to study, the Commission may report its findings, together with any recommended legislation, to the 2003 General Assembly.

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2003 Session

Prepared by Staff for the:
North Carolina Study Commission on Aging

February 10, 2004

Continuing Care Retirement/Technical Changes

S.L. 2003-193 (HB 253) makes various technical changes to the statutes that regulate continuing care retirement communities (CCRCs). These facilities provide housing and health-related services either for life or for a period in excess of one year. CCRCs provide independent living and also offer nursing home or adult care home level of care. Because CCRCs include contractual requirements where, for certain fees, the facility agrees to provide health care coverage over a given period of time, they are considered an insurance product and are regulated by the Department of Insurance under Article 64 of Chapter 58.

The act makes the following changes to the statutes:

- Repeals an unused, and likely unusable, provision allowing for a continuing care retirement facility that is accredited under a process approved by the Commissioner to be issued a license based on that accreditation.
- Replaces the word "facility" with "provider" to clarify that it is the provider that operates the facility that is responsible for meeting the various statutory requirements.
- Clarifies language governing operating reserves for continuing care retirement facilities and providers, including:
  1. Changing the wording to reflect the fact that a provider is to calculate and maintain a separate operating reserve for each continuing care facility operated by the provider.
  2. Changing the words "annual statement" to "disclosure statement."
  3. Changing the words "invested cash" to "cash equivalents."
- Makes the following changes governing the rights of residents of continuing care retirement facilities to organize:
  4. Changes "registered under this Article" to "operated by a provider licensed under this Article" in G.S. 58-64-40(a). No entity is "registered" under G.S. 58-64.
  5. Makes gender neutral corrections.
  6. Clarifies that the governing body of a provider must hold semi-annual meetings with the residents of each facility operated by the provider.
- Makes various changes governing supervision, rehabilitation and liquidation of continuing care retirement providers including:
  7. Replacing the word "projected" with "forecasted".
  8. Amending the statute as necessary to accommodate the fact that a provider can own or operate more than one facility.
- Amends the provision on receiverships, to reflect the fact that the Commissioner would be appointed as receiver for a provider not a facility.
- Replaces the word "agreements" with "contracts" for consistency of wording within Article 64.
- Removes unnecessary language to conform with the removal of the "accredited facility" provision.
- Amends the provision, governing civil liability, to:
  9. Remove the misleading words "facility, or person violating this Article" because the provider is the entity entering into a contract for continuing care, not the facility or other person.
  10. Remove the words "or person liable" because the provider is the only entity that is required to deliver a disclosure statement to the contracting party.
  11. Remove the words "facility, or person" since payment is made to the provider, and the provider is the entity responsible for the dissemination of the disclosure statement.

This act became effective June 12, 2003. (DJ)

Senior Cares Program Administration

S.L. 2003-284, Sec. 10.5 (HB 397, Sec. 10.5) provides that the Department of Health and Human Services may administer the "Senior Cares" prescription drug access program approved by the Health and Wellness Trust Fund Commission and funded from the Health and Wellness Trust Fund.

This section became effective July 1, 2003. (TM)

Effective Date of Long-Term Care Criminal Record Checks for Employment Positions

S.L. 2003-284, Sec. 10.8E (HB 397, Sec. 10.8E) continues the suspension of the requirements of G.S. 131E-265 for nursing homes and G.S. 131D-2 for adult care homes to conduct national criminal history checks for certain employees until January 1, 2005. These requirements were also suspended during the last biennium.

This section became effective July 1, 2003. (DJ)

Implement a Pilot Project for Long-Term Care Community Service Coordination

S.L. 2003-284, Sec. 10.8F (HB 397, Sec. 10.8F) requires the Department of Health and Human Services to implement a communications and coordination initiative to support local coordination of long-term care, and to pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. The initiative must eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services. For those counties that voluntarily participate, the local long-term care coordination initiative must aid in the development of core services, coordinate local services, and streamline access to services. The Department of Health and Human Services must submit an interim report on the pilot project for local long-term care coordination to the North Carolina Study Commission on Aging by October 1, 2004 and a final report by October 1, 2005.

The Institute of Medicine Long-Term Care Task Force found that "long-term care services are often fragmented, duplicative, complex, and not consumer-friendly and that many counties lack needed core long-term care services." In response to this finding, and a report presented in accordance with S.L. 2001-491, Part XXII, the North Carolina Study Commission on Aging's 2003 report to the General Assembly and the Governor made a recommendation that the General Assembly fund a pilot project on long-term care local lead agencies. This provision is in response to that recommendation.

This section became effective July 1, 2003. (TM)

Medicare Enrollment Required

S.L. 2003-284, Sec. 10.27 (HB 397, Sec. 10.27) directs the Department of Health and Human Services to require Medicaid recipients who qualify for Medicare to enroll in Medicare in order to pay medical expenses that qualify for payment under Medicare Part B. Medicare is the federally sponsored health insurance program for persons aged 65 or older and for certain disabled persons under age 65. Medicare Part B pays for doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. In order to obtain coverage under Medicare Part B, an eligible person must pay a premium. Requiring eligible persons to enroll in Medicare will shift health care costs from the Medicaid program (which is paid in part with State and local funds) to the Medicare program (which is paid entirely with federal funds).

This section became effective July 1, 2003. (DJ)

Medicaid Assessment Program for Skilled Nursing Facilities

S.L. 2003-284, Sec. 10.28 (HB 397, Sec. 10.28) directs the Secretary of Health and Human Services to implement a Medicaid assessment program for skilled nursing facilities effective October 1, 2003. The assessment program applies to skilled nursing facilities licensed under Chapter 131E of the General Statutes and must be imposed in a manner consistent with federal regulations under 42 C.F.R. Part 433, Subpart B. Funds realized from assessments imposed shall:

- Be used only to draw down federal Medicaid matching funds for implementing the new reimbursement plan for nursing homes and for increasing nursing facility rates in accordance with the plan,
- Be used to pay 100% of the nonfederal share for the new reimbursement plan for nursing homes; and
- Not be used to supplant State funds appropriated for nursing facility services.

This section became effective July 1, 2003. (TM)

Rename North Carolina Heart Disease and Stroke Prevention Task Force

S.L. 2003-284, Sec. 10.33B (HB 397, Sec. 10.33B) renames the North Carolina Heart Disease and Stroke Prevention Task Force. The new name is the Justus-Warren Heart Disease and Stroke Prevention Task Force.

This section became effective July 1, 2003. (SA)

Senior Center Outreach

S.L. 2003-284, Sec. 10.42 (HB 397, Sec. 10.42) provides that the funds appropriated to the Department of Health and Human Services, Division of Aging, for the 2003-2005 fiscal biennium, shall be allocated by October 1 of each fiscal year and used by the Division of Aging to enhance senior center programs in the following ways:

- To expand the outreach capacity of senior centers to reach unserved or underserved areas; or
- To provide start-up funds for new senior centers. However, prior to funds being allocated for start-up funds for a new senior center, the county commissioners of the county in which the new center will be located shall:
  12. Formally endorse the need for such a center;
  13. Formally agree on the sponsoring agency for the center; and
  14. Make a formal commitment to use local funds to support the ongoing operation of the center.

Additionally, State funding shall not exceed 75% of reimbursable costs.

This section became effective July 1, 2003. (TM)

Adult Care Home Model for Community-Based Services

S.L. 2003-284, Sec. 10.43 (HB 397, Sec. 10.43) requires the Department of Health and Human Services to develop a model project for delivering community-based mental health, developmental disabilities, and substance abuse housing and services through adult care homes that have excess capacity. The model must be designed for implementation on a pilot basis and address the following:

- Services that will be provided by the facility or under contract with the facility, including assistance with daily medication.

- Access of clients to mental health, developmental disabilities, and substance abuse services provided in the community, including transportation to services outside of the client's residence in the adult care home facility.
- Physical plant additions or changes necessary to provide for independent living of residents.
- Methods for assuring quality of services, resident safety, and cost-effectiveness.
- Consistency with the Department's Olmstead plan, other policies on community-integration, and disability plans adopted by the State.

The Department must submit a final report on the development of the model to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on or before March 1, 2004. The report shall address the following:

- Proposed time and location for implementation of the pilot.
- Proposed number of residents to be placed and services to be provided directly by the facility or under contract with the facility.
- Method for evaluating the pilot, including services provided, on a regular basis.
- A description of the living environment for each resident and a comparison of how the living environment compares to that of other residents in the adult care home.
- Changes to State law necessary to implement the pilot.
- Projected cost to the State for pilot and statewide implementation.

This section provides that the development of this model is in response to the State policy to provide appropriate services to clients in the least restrictive and most appropriate environment and with the United States Supreme Court Decision in Olmstead vs. L.C. & E.W.

This section became effective July 1, 2003. (TM)

Special Assistance In-Home Program

S.L. 2003-284, Sec. 10.51 (HB 397, Sec. 10.51) allows the Department of Health and Human Services to use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals with in-home living arrangements. These payments may be made for up to 800 individuals during the 2003-2004 fiscal year and the 2004-2005 fiscal year. The standard monthly payment to individuals enrolled in the Special Assistance in-home program shall be 50% of the monthly payment the individual would receive, if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. For State fiscal year 2003-2004, qualified individuals shall not receive payments at rates less than they would have been eligible to receive in State fiscal year 2002-2003. The Department must implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program, would seek placement in an adult care home facility; and shall include the use of a functional assessment. This in-home option must be available to all counties on a voluntary basis; and to the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State.

The Department is required to report on or before January 1, 2004, and on or before January 1, 2005, to the cochairs of the House of Representatives Appropriations Committee, the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the cochairs of the Senate Appropriations Committee on Health and Human Services. This report shall include the following information:

- A description of cost savings that result from allowing individuals eligible for State-County Special Assistance the option of remaining in the home.
- A complete fiscal analysis of the in-home option to include all federal, State, and local funds expended.
- How much case management is needed and which types of individuals are most in need of case management.

- The geographic location of individuals receiving payments under this section.
- A description of the services purchased with these payments.
- A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.
- Findings and recommendations as to the feasibility of continuing or expanding the in-home program.
- The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes.

Additionally, the Department shall incorporate data collection tools designed to compare quality of life among institutionalized versus noninstitutionalized populations (i.e., an individual's perception of his or her own health and well-being, years of healthy life, and activity limitations). To the extent national standards are available, the Department shall utilize those standards. These provisions are based on recommendations from the North Carolina Study Commission on Aging.

This section became effective July 1, 2003. (TM)

State/County Special Assistance Transfer of Assets

S.L. 2003-284, Sec. 10.53 (HB 397, Sec. 10.53) codifies the provision adopted in last year's budget providing that Supplemental Security Income (SSI) policy concerning transfer of assets and estate recovery applies to applicants for State-county Special Assistance and repeals current codified law on the issue. The provision also requires the Department of Health and Human Services to continue reviewing whether policy for State-county Special Assistance should be changed to permit an assisted living facility to accept from a family member of a resident who qualifies for State-county Special Assistance payment for the difference in the monthly rate for room, board, and services available. The Department must report its activities on this policy review by March 1, 2004 to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

This section became effective July 1, 2003. (DJ)

Social Services Commission Rules on Rate-Setting For Adult Day Centers and Adult Day Health Centers

S.L. 2003-284, Sec. 10.58 (HB 397, Sec. 10.58) provides that the Social Services Commission shall consider adopting rules increasing the rates for adult day centers and adult day health centers and that any rate increase shall be implemented within existing funds.

This section became effective July 1, 2003. (TM)

Nursing Home/Medication Errors

S.L. 2003-393 (SB 1016) requires every nursing home to establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The Advisory Committee will have the following duties:

- Assess the facility's pharmaceutical management system and practices and identify areas at high risk for medication-related errors.
- Review the facility's pharmaceutical management goals and ensure these goals are being met.
- Review, investigate, and respond to facility incident reports and resident grievances.
- Identify goals and recommendations for the implementation of best practices.

- Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system.
- Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the NC Nursing Practice Act.
- Develop specifications for self-administration of drugs by qualified patients in accordance with law.

As part of its requirement to minimize risk of medication-related error, the act requires every nursing home quality assurance committee to undertake the following:

- Educate and make the patient and the patient's family members aware of all the medications the patient is using.
- Increase prescription legibility.
- Minimize confusion in prescription drug labeling and packaging.
- Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.
- To the extent practicable, implement proven medication safety practices.
- Educate facility staff engaged in medication administration.
- Implement a system to accurately identify recipients before any drug is administered.
- Implement policies and procedures designed to improve accuracy in medication administration and in documentation.
- Implement policies and procedures for the self-administration of medication.
- Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.
- Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

The act also requires nursing home to provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors for all nonphysician personnel involved in direct patient care.

A new statute enacted in this act requires consultant pharmacists of nursing homes to undertake certain drug regimen reviews, make reports concerning drug irregularities, drug product defects and adverse drug reactions, ensure proper documentation of allergies and adverse effects, and ensure that drugs that are not specifically limited as to duration of use or number of doses are controlled by automatic stop orders.

Finally, the act requires the Secretary of Health and Human Services to contract with a public or private entity to develop and implement a Medication Error Quality Initiative. As part of the Initiative, each nursing home must report annually on the nursing home's medication-related errors. The report submitted by each nursing home would not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The contracting entity would analyze the reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor would retain its confidentiality and would not be subject to discovery or use in any civil action as provided under the act.

This act becomes effective January 1, 2004. (DJ)

Audit of CAP/DA Programs by State Auditor

S.L. 2003-284, Sec. 10.29B (HB 397, Sec. 10.29B) directs the State Auditor to perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA), provided that State funds are appropriated for this purpose. The audit shall build upon the results of the study conducted by the North Carolina Institute of Medicine, in accordance with Section 10.16(c) of S.L. 2002-126, and provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor shall report the results of the audit to the North Carolina Study Commission on Aging by January 1, 2004.

This section also directs the Department of Health and Human Services to review, on a pilot basis, a selected number of CAP/DA programs to determine compliance with eligibility requirements for the program. Additionally, the Department shall continue to examine aspects of CAP/DA including: the current assessment process; an analysis of per-client costs in CAP/DA to per-client costs in nursing homes and adult care homes; per-participant costs for the State-County In-Home Program; an analysis of per-person costs for personal care services through Medicaid; the monitoring of quality of care for CAP/DA clients; the current waiting list procedures. The Department is required to make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004.

This section became effective July 1, 2003. (TM)

Staff Contributing to this publication: Sandra Alley (SA), Dianna Jessup (DJ), and Theresa Matula (TM).

Studies and Reports Related to Aging

Study/Report	Entities Involved	Reporting Date	Reference
Report on the pilot project for local long-term care coordination.	DHHS to Aging Study Commission	Interim report 10/1/04 Final report 10/1/05	S.L. 2003-284 (HB 397), Sec. 10.8.F.(b)
Report on examination of CAP/DA that includes certain cost comparisons	DHHS to Aging Study Commission	1/1/04	S.L. 2003-284 (HB 397), Sec. 10.29B.
Report on development of the adult care home model for community-based services	DHHS to HHS and FRD	3/1/04	S.L. 2003-284 (HB 397), Sec. 10.43.(b)
Report on the Special Assistance In-Home Demonstration Program	DHHS to HHS	1/1/04 and 1/1/05	S.L. 2003-284 (HB 397), Sec. 10.51(b)
DHHS to review whether policy for Special Assistance should be changed to permit an assisted living facility to accept from a family member of a resident who qualifies for the program payment for the difference in the monthly rate.	DHHS to HHS and FRD	3/1/04	S.L. 2003-284 (HB 397), Sec. 10.53(c)
DHHS to review activities and costs related to the provision of care in adult care homes and determine what costs may be considered to properly maximize allowable reimbursement available through Medicaid and may transfer funds from DSS to DMA to draw down federal Medicaid funds.	DHHS to HHS and FRD	As funds are transferred and rates are modified	

Abbreviations:
DHHS: the Department of Health & Human Services
FRD: Fiscal Research Division
HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services

APPENDIX C

Overview of Aging Services & State Aging Plan

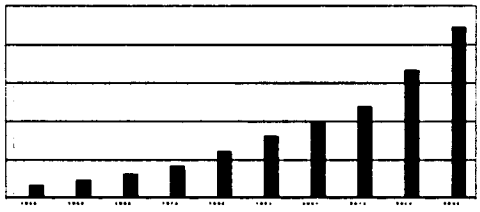
N.C.G.S. 143B-181.1A

prepared by
Division of Aging, N.C. Department of Health and Human Services
for the
Study Commission on Aging

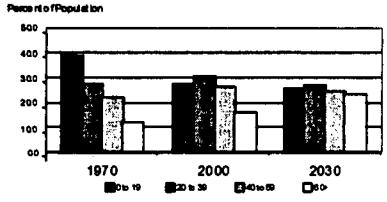
The Aging of North Carolina—General Organization of Plan

- Aging NC
- Healthy Aging
- Long-Term Care and Aging
- Economic Security
- Senior-Friendly Communities
- Priorities of Senior Advocates
- State Agencies—Major Activities and Future Directions

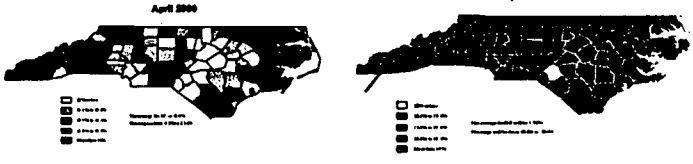
Actual and Projected Population Age 65 and Older, North Carolina, 1940 to 2030



The Aging of North Carolina's Population, 1970 to 2030



Percent of Population Age 65+ in NC



State Plan Themes

- *Draw upon the talents and resources of active seniors*
- *Enhance services for vulnerable seniors*
- *Value diversity while addressing disparity*
- *Be responsible stewards of resources*
- *Help baby boomers prepare for their future.*

Healthy Aging

Healthy aging is the development and maintenance of optimal *physical, mental, and social well-being and function* in older adults. *Individuals, government, and communities* share responsibilities in promoting and maintaining *attitudes and behaviors* known to advance and preserve health and well-being among older adults by providing or using health and other appropriate services effectively to *prevent or minimize the impact of acute and chronic disease on function.*

Economic Security

Economic security is the capacity to sustain a relatively stable economic status given a normal decline of functioning and health over old age. This view was well expressed by a senior advocate: "In my opinion, we seniors are economically secure when we are free from fear or doubt about our ability to pay for necessities such as health and long-term care expenses, housing, and leisure and enrichment activities."

State Resources for Older Adults

DHHS

Divisions
- Aging
- Facility Services
- MH/DD/SAS
- Medical Assistance
- Public Health
- Services for the Blind
- Services for the Deaf & Hard of Hearing
- Social Services
- Vocational Rehabilitation

Offices
- Citizen Services
- Economic Opportunity
- Long-Term Care & Olmstead
- Research, Demonstrations, & Rural Health

Other
- Department of Administration
- Department of Commerce
- Department of Community Colleges
- Department of Correction
- Department of Insurance [SHIIP]
- Department of Transportation [EDTAP]
- Office of the Governor
- Attorney General's Office
- NC Colleges & Universities

Expenditures by Agency

Agency	Total FY 02-03 Expenditures	Percent of Total Expenditures
Medical Assistance	$2,128,691,981	84.0%
Mental Health	$ 170,974,608	6.8%
Social Services	$ 162,341,632	6.4%
Aging	$ 60,279,814	2.4%
Other Agencies	$ 11,619,234	< 1%
TOTAL	$2,533,907,269	100%

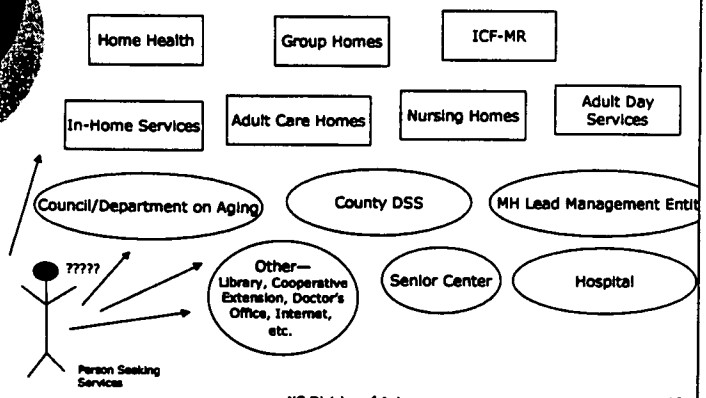
Long Term Care

North Carolina's policy for long-term care is to support *older adults and people with disabilities* needing long-term care and *their families,* in making their own *choices* with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the *least restrictive setting.*

Senior Advocate Priorities

- Maintain CAP-DA as a viable service
- Implement national criminal background checks for LTC employees
- Support the Home and Community Care Block Grant
- Make permanent the State Income Tax Credit for LTC Insurance premiums
- Support Senior Centers

How Citizens Learn about and Locate Services and Supports



Senior-Friendly Communities

A *senior-friendly community* offers a wide range of social and economic opportunities and supports for seniors; values their contributions to the community; is serious about physical layout and local planning; respects and supports seniors' desire and effort to live independently; and acknowledges the primary role that families, friends, and neighbors play in the lives of older adults and enhances their capacity for caring.

APPENDIX D

Guardianship Reform in the Twenty-First Century

John L. Saxon
Institute of Government
The University of North Carolina at Chapel Hill
February, 2004

Guardianship Reform: Where Have We Been?

Legal History

- **1837**
  - **Idiots & lunatics**
- **1868**
  - **Clerk of superior court**
- **1879**
  - **Inebriates & asylum inmates**

Legal History

- **1933**
  - **Sterilization of mentally retarded**
- **1973**
  - **Adult protective services**

Legal History

- **1977**
  - **G.S. Ch. 35, Art. 1A**
    - **Rud Turnbull, Institute of Government**
  - **First *substantive* reform**
    - **Due process**
    - **Modernized definitions & standards**
    - **Introduced limited guardianship**
    - **Human services agencies**
  - ***Partial & incomplete* reform**

Legal History

- **1982**
  - **DHR Task Force**
- **1984**
  - **AOC & DSS Study Committee**
- **1987**
  - **G.S. Ch. 35A enacted**
    - **Consolidated & clarified existing laws**
    - **Extended 1977 guardianship reform**
    - **Few substantive changes**

Legal History

- 1990-94
  - AOC & DHR Task Force
  - LRC Study Committee
  - H 451
- 2001
  - Proposed legislative study

Guardianship Reform: Where Are We Now?

Current Law

- G.S. Ch. 35A
  - Minors
    - "Standby" guardians
  - Incompetent adults
    - Legal standard & due process
    - Priorities & qualifications; public agencies
    - Powers & duties; limited guardianship
    - Bond & accounting; estate management

Current Issues

- Statutory authority
  - Legal hodge podge
    - Piece-meal revision
    - Some statutes date back to 1800s
- Jurisdiction
  - Interstate
- Incapacity
  - Definition & standard

Current Issues

- Due process
  - Role of GAL/attorney
- Guardianship alternatives
  - Least restrictive alternative
- Limited guardianship
  - Partial incapacity
  - Rights retained by ward

Current Issues

- Guardian's powers
  - Person vs. property
  - Standard for decisionmaking
  - End of life
- Human services agencies
  - Conflict of interest
  - Funding

Guardianship Reform: Where Should We Go?

UGPPA

- Uniform Guardianship & Protective Proceedings Act (UGPPA)
  - 1982: NCCUSL
  - 1997 revised
    - Prof. Rhoda Billings (Wake Forest Law)
    - ABA Task Force on Guardianship Reform
    - Enacted by four states (AL, CO, MN, MT)

UGPPA

- Scope
  - Minors & incapacitated adults
  - Guardians & conservators
- Intent
  - Guardianship is last resort
    - Least restrictive alternative
  - Limited guardianship preferred
    - Tailored to ward's incapacity
  - Input from ward when possible

UGPPA

- Incapacitated person
  - Functional definition
    - Unable to receive & evaluate info or make or communicate decisions to extent that lacks ability, even with appropriate assistance, to provide for personal health, safety, or care
    - Unable to manage property & business affairs due to impaired ability to receive & evaluate info or make decisions

UGPPA

- Jurisdiction
  - Domicile
    - Interstate
- Authority to appoint
  - Court
  - Spouse or parent
    - Unless objection

UGPPA

- Due process
  - Court-appointed visitor
    - Appointment of counsel
  - Professional evaluation
  - Respondent must be present
    - Unless excused by court
  - Clear & convincing evidence
    - No jury

UGPPA

- Court-appointed guardian
  - Priorities
    - Existing guardian, nominee, agent, spouse, child, etc.
    - Public or nonprofit agency *if no one else is available and agency is not providing other services to ward*
- Emergency guardian
  - Temporary substitute guardian

UGPPA

- Guardian's powers
  - Expend income for ward's care
  - Bring action for ward's support
  - Consent to medical treatment
  - Consent to marriage or divorce
  - Delegate authority (limited time)
  - May not revoke health care directive
  - May not commit to mental institution

UGPPA

- Conservator's powers
  - Make or revoke will or gifts
    - With court approval
  - Invest
  - Sell, lease, or exchange property
    - Without court approval

UGPPA

- Decisionmaking
  - Ward's expressed wishes
  - Substituted judgment when known
    - What would ward have done?
  - Best interest
  - Prudent investor
- Monitoring
  - Guardians & conservators

UGPPA

- Advantages
  - Modern
  - Comprehensive
  - Legally adequate
  - Balanced
  - Proven
  - Can be customized
- Disadvantages
  - Lack of interest
  - No champion
  - Preference for what is known & familiar
  - Preference for incremental reform vs. overhaul
  - Need to pull all players together

Guardianship Reform in the Twenty-First Century

John L. Saxon
Institute of Government
The University of North Carolina at Chapel Hill
February, 2004

APPENDIX E

Tax Treatment of Long-term Care Insurance in Selected States

State	Deduction Or Credit	Covered Payments	Percentage Limitation	Cap	Refundable
North Carolina	**Credit**	**Premiums for taxpayer, spouse, or dependent that were not deducted from Federal Income.**	**15%**	**$350 per insurance contract**	**No**
Colorado	Credit	Premiums for taxpayer and spouse. Tapayers must have an income of less than $50,000 if filing for one policy, or $100,000 if filing for two policies.	25%	$150 per policy	No
Kentucky	Deduction	Premiums paid that were not deducted from Federal income.	No	No	---
Maine					
Individual	Deduction	Premiums paid for insurance meeting Federal definition or approved by Bureau of Insurance that were not taken as an itemized deduction.	No	No	---
Employers	Credit	Employer payments on behalf of employees for insurance meeting Federal definition or approved by Bureau of Insurance.	20%	$5000 or $100 per employee	No
Maryland	Credit	Premiums for taxpayer or spouse/parent/child, but insured must be Maryland resident.	No	Age <41 - $240 Age 41-50 -$450 Over 50 - $500	No
Minnesota	Credit	Premiums paid on policies with a lifetime benefit of $100,000 or more for taxpayer or spouse that were not deducted from Federal income.	25%	$100 per beneficiary	No
Missouri	Deduction	Nonreimbursed payments that were not deducted from Federal income	50%	No	---
Oregon					
Individual	Credit	Premiums paid for taxpayer or taxpayer's dependents/parents that were not deducted from Federal income.	15%	$500	No
Employers	Credit	Employer payments on behalf of employees.	15%	$500	No
New York	Credit	Premiums paid for policies approved by Insurance Department	10%	No	No
Utah	Deduction	Premiums paid that were not deducted from Federal income.	No	No	---
Wisconsin	Deduction	Premiums paid for insurance for taxpayers or spouse that were not taken as an itemized deduction. The portion covering the spouse is not allowed if it was taken as part of the federal self-employed health insurance deduction.	No	No	---

LONG-TERM CARE CREDITS CLAIMED FOR TY 2002*

	Single		Married, Joint/Widow		Married, Separate		Head of Household		Total	
NC Taxable Income**	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***
0 or less	521	$122,988	935	$295,118	17	$3,275	127	$16,975	1,600	$438,356
$1 - $2000	417	$91,505	392	$110,394	17	$1,920	109	$16,821	935	$220,640
$2001 - $4000	401	$81,932	450	$123,518	7	$1,486	242	$34,600	1,100	$241,536
$4001 - $6000	335	$64,486	415	$117,418	8	$843	251	$39,057	1,009	$221,804
$6001 - $10000	577	$114,324	773	$201,165	28	$3,568	644	$101,203	2,022	$420,260
$10001 - $10625	113	$22,203	133	$38,802	6	$1,576	91	$13,376	343	$75,957
$10626 - $12750	267	$48,472	412	$113,027	21	$1,908	362	$57,707	1,062	$221,114
$12751 - $15000	277	$53,355	456	$120,152	16	$1,695	319	$46,949	1,068	$222,151
$15001 - $17000	263	$44,718	376	$95,461	10	$1,718	254	$35,211	903	$177,108
$17001 - $20000	354	$61,156	556	$150,371	20	$2,172	273	$39,757	1,203	$253,456
$20001 - $21250	145	$22,816	221	$57,884	10	$795	102	$17,726	478	$99,221
$21251 - $25000	350	$59,508	597	$142,818	25	$3,404	210	$31,092	1,182	$236,822
$25001 - $30000	455	$69,995	867	$208,483	26	$4,588	235	$30,818	1,583	$313,884
$30001 - $40000	645	$97,010	1,611	$344,770	45	$5,437	277	$32,122	2,578	$479,339
$40001 - $50000	442	$69,741	1,528	$307,054	21	$2,656	116	$15,595	2,107	$395,046
$50001 - $60000	295	$45,488	1,330	$259,031	28	$4,697	74	$8,288	1,727	$317,504
$60001 - $75000	263	$35,965	1,525	$290,962	13	$2,355	36	$4,261	1,837	$333,543
$75001 - $100000	218	$36,240	1,688	$322,404	9	1,158	38	$4,492	1,953	$364,294
$100001 or more	194	$34,722	2,590	$582,046	14	1,630	28	$2,215	2,826	$620,613
Total	**6,532**	**$1,176,624**	**16,855**	**$3,880,878**	**341**	**$46,881**	**3,788**	**$548,265**	**27,516**	**$5,652,648**

* As of 6/4/2003

** NC Taxable Income is net of deductions and exemptions, and so generally is lower than Federal Adjusted Growth Income.

*** The total credits figure does not equate to the revenue loss resulting from the credits. For some taxpayers, the loss of revenue is less than the amount claimed because the taxpayers' tax liabilities are less than the amount of credit claimed.

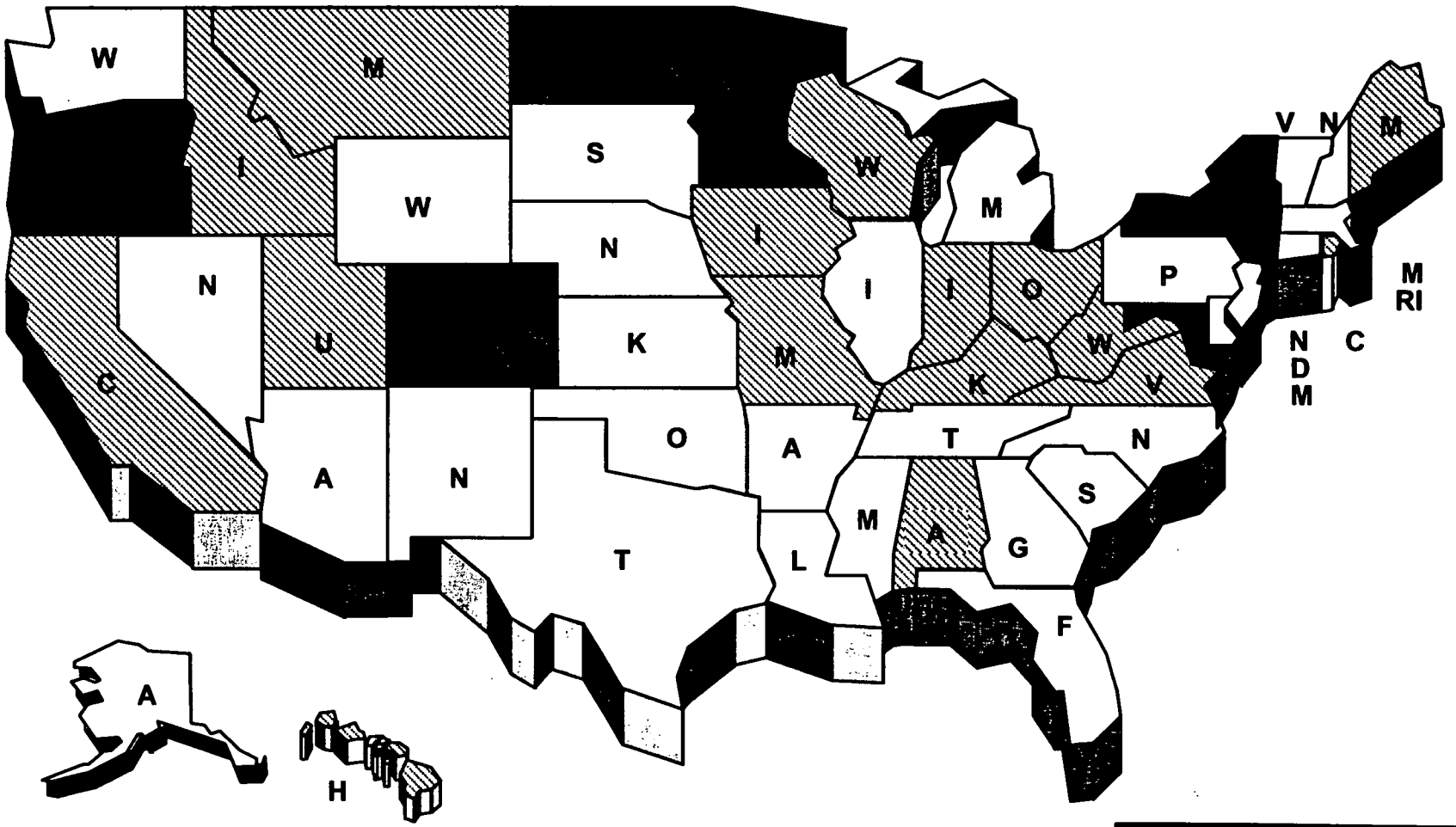
	TY 1999		TY 2000		TY 2001		TY 2002*	
NC Taxable Income**	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***
0 or less	660	$158,224	943	$213,424	1,649	$371,479	1,600	$438,356
$1 - $2000	534	$111,716	847	$184,369	1,253	$248,366	935	$220,640
$2001 - $4000	650	$123,884	1,046	$198,996	1,686	$323,110	1,100	$241,536
$4001 - $6000	652	$127,916	995	$209,193	1,827	$361,001	1,009	$221,804
$6001 - $10000	1,360	$267,030	2,295	$469,771	3,854	$744,112	2,022	$420,260
$10001 - $10625	194	$37,588	357	$78,495	603	$118,452	343	$75,957
$10626 - $12750	659	$130,533	1,207	$247,471	2,036	$395,327	1,062	$221,114
$12751 - $15000	719	$138,890	1,176	$236,633	2,202	$433,797	1,068	$222,151
$15001 - $17000	604	$107,037	1,038	$211,505	1,756	$342,794	903	$177,108
$17001 - $20000	828	$159,257	1,380	$264,818	2,541	$513,190	1,203	$253,456
$20001 - $21250	348	$64,353	538	$105,361	954	$181,526	478	$99,221
$21251 - $25000	981	$179,826	1,526	$286,941	2,603	$511,179	1,182	$236,822
$25001 - $30000	1,254	$238,298	1,951	$377,389	3,225	$637,547	1,583	$313,884
$30001 - $40000	2,093	$393,524	3,110	$594,739	5,534	$1,089,419	2,578	$479,339
$40001 - $50000	1,716	$333,050	2,461	$454,831	4,569	$888,289	2,107	$395,046
$50001 - $60000	1,410	$255,631	1,887	$358,738	3,543	$697,196	1,727	$317,504
$60001 - $75000	1,521	$281,700	1,885	$370,370	3,670	$717,692	1,837	$333,543
$75001 - $100000	1,797	$365,488	1,614	$368,173	3,319	$663,873	1,953	$364,294
$100001 or more	3,049	$707,509	2,950	$743,398	5,135	$1,129,534	2,826	$620,613
Total	21,029	$ 4,181,454	29,206	$ 5,974,615	51,959	$ 10,367,883	27,516	$ 5,652,648

* As of 6/4/2003

** NC Taxable Income is net of deductions and exemptions, and so generally is lower than Federal Adjusted Growth Income.

*** The total credits figure does not equate to the revenue loss resulting from the credits. For some taxpayers, the loss of revenue is less than the amount claimed because the taxpayers' tax liabilities are less than the amount of credit claimed.

State Tax Incentives for Purchase of LTCI



APPENDIX F

MENTALLY ILL POPULATION IN
ADULT CARE HOMES IN N.C.

(Data self-reported and taken from renewal licensure applications for 2003)

Population Data for Adult Care Homes (7 or more beds)								
	18-24	**25-34**	**35-49**	**50-64**	**65-74**	**75-84**	**85+**	**ALL**
MI	60	219	1143	1500	992	689	315	4918
MR/DD	33	97	314	544	321	153	54	1516
TOTALS	93	316	1457	2044	1313	842	369	6434

Total licensed beds from adult care home data	**33,729**
Total residents in adult care homes	**24,811**
Percentage of residents with an MI diagnosis	**19.82%**
Percentage of Residents with MR/DD diagnosis	6.11%
Combined Percentage for both diagnoses	25.93%
Total number of reporting adult care homes	**606**
Number of adult care homes with MI residents	**428**
Percentage of adult care homes with MI residents	**70.63%**
Number of adult care homes with MR/DD residents	348
Percentage of adult care homes MR/DD residents	57.43%
Number of adult care homes with either diagnosis	538
Percentage of adult care homes with either diagnosis	88.78%

Population Data for Family Care Homes (2-6 beds)								
	18-24	**25-34**	**35-49**	**50-64**	**65-74**	**75-84**	**85+**	**ALL**
MI	46	103	452	360	161	60	18	1200
MR/DD	27	63	176	198	87	28	5	584
TOTALS	73	166	628	558	248	88	23	1784

Total licensed beds from family care home data	**3503**
Total residents in family care homes	**2797**
Percentage of residents with an MI diagnosis	**42.90%**
Percentage of Residents with MR/DD diagnosis	20.88%
Combined Percentage for both diagnoses	63.78%

Total number of reporting family care homes	**624**
Number of family care homes with MI residents	**392**
Percentage of family care homes with MI residents	**62.82%**
Number of family care homes with MR/DD residents	261
Percentage of family care homes MR/DD residents	41.83%
Number of family care homes with either diagnosis	479
Percentage of family care homes with either diagnosis	76.76%
Total licensed beds from all care home data	**37,232**
Total residents in all care homes	**27,608**
Percentage of residents with an MI diagnosis	**22.16%**
Percentage of Residents with MR/DD diagnosis	7.61%
Combined Percentage for both diagnoses	29.77%
Total number of reporting all care homes	**1230**
Number of all care homes with MI residents	**820**
Percentage of all care homes with MI residents	**66.67%**
Number of all care homes with MR/DD residents	609
Percentage of all care homes MR/DD residents	49.51%
Number of all care homes with either diagnosis	1017
Percentage of all care homes with either diagnosis	82.68%

Adult Care Rules Related to Mentally Ill Residents

Admission of Residents (10A NCAC 13G .0701)

- Prohibits admission of persons for treatment of mental illness
- Prohibits admission of persons who pose direct threat to the health or safety of others

Medical Examination (10A NCAC 13G .0702)

- Have to arrange for examination by physician of any new resident who was an inpatient of a psychiatric facility within the 12 months prior to admission

Personal Care Training and Competence (10A NCAC 13G .0502

- 80 hour training
- 25 hour training (Family Care Homes only)

Training includes 5 hours training on interventions to reduce behavioral problems

Special Care Units* for Mental Health Disorders (10A NCAC 13F .1401)

- Provides for a closed unit for up to 12 beds for persons with a mental health disability
- Requires additional training for staff
- Requires assessment and care planning review and case management by area mental health program

*Currently none licensed in N.C.

Provided by Jim Upchurch, Division of Facility Services, DHHS

Geriatric Mental Health Specialty Teams

North Carolina Study Commission on Aging
March 9, 2004

Bonnie Morell, Dr.PH, Community Policy Section, Division MH/DD/SAS, Dept of Health and Human Services

Background

- 20 programs were given start-up MH Trust Funds in FY 02-03 as part of the preparation to increase community capacity to serve older adults prior to reducing the number of geriatric beds in State Psychiatric hospitals.

Purpose of the teams

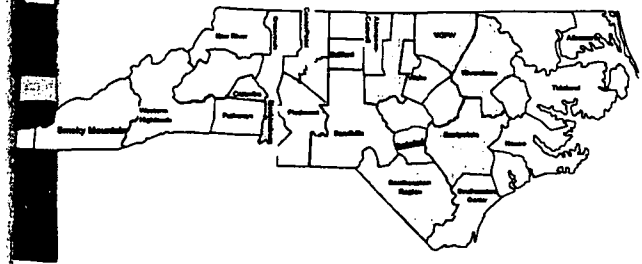
- Assist with transition to the community
- Provide consultation and technical assistance to nursing facilities and adult care homes regarding the needs of older persons with mental illness
- Link individuals with ongoing treatment or case management needs with local mental health services

Services are provided to

- Older adults who are returning to the community from State hospital geriatric units that are to be closed
- Older adults who are currently in the community who have mental health treatment needs who may be at risk of hospitalization

Location of teams

- Teams provide services in more than one local program in order to make services available throughout the State.



Background and training

- Each team is to have a nurse and a masters level mental health clinician with geriatric experience
- Two meetings have been held this year to identify training needs
- Resource information about training and networking opportunities will be put on the web

Effectiveness and Feedback

- Division of Mental Health is collecting data about the types of services being provided
- Feedback indicates that the teams have linked with the Aging Ombudsman staff, contributed to successful returns to the community, and provided help to facilities regarding residents' needs and behaviors.

Next Steps

- This is a fairly new program that is being implemented during a time of change in the public mental health system.
- Focus will be on identifying ways in which to support the work that is being done by the teams that have been put in place.

Geriatric Mental Health Specialty Team Model and Guidelines

Background: A need for greater local capacity to address the needs of older adults with mental illness was recognized as plans were developed to increase community capacity to serve older adults and to reduce reliance on State hospital services in SFY 02-03. At that time, funding was provided to develop twenty community-based geriatric mental health specialty teams that would be available to provide expertise and services throughout the State.

Purpose: The purpose of these teams is to increase the ability of older adults with mental illness to live successfully in their communities by:

1. assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals, and
2. providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

This is to be accomplished by providing training and consultation to the staff serving the identified individuals, developing linkages with community providers serving older individuals and providing time limited specific direct services to the identified individuals.

Team Description: The teams are to consist minimally of a registered nurse and a masters prepared therapist and are to supplement current area program/LME capacity to serve adults, age 60 and over. The teams are to provide the majority of services where the individual lives rather than in an office/clinic setting. Team duties and activities may be assigned based on each team member's professional skills and abilities. Team members may perform some activities together when the situation calls for the professional skills of more than one team member. Team members must have the ability to communicate frequently and to meet face to face as needed.

Target Population: The target population includes:

1. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, who are in a state psychiatric hospital and who are preparing to return to the community to reside in a nursing home, adult care home or family residence
2. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, currently residing in a nursing home or adult care home who have mental health service/treatment needs and who may be at risk of psychiatric hospitalization.
3. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness who have significant mental health service or treatment needs and who may be at risk of psychiatric hospitalization and who are living with in their own home or with family members.

Team Activities:
Examples of the types of activities the team may provide ***to assist with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals*** include, but are not limited to, the following:

- provide information to AP/LME and state hospital regarding strengths and capabilities of nursing homes and adult care homes for individual discharge planning;
- assist in discharge planning with hospital staff and area program/LME and referral to identified service providers that have the ability to provide specific treatments, rehabilitative services and/or residential setting that are needed by the individual.
- provide consultative support to staff in the transition of individuals from state hospital to facility;
- provide consultation with staff, individual and family identifying interventions to ensure transition to community, alleviate behaviors that may threaten placement
- providing crisis-oriented face-to-face to the individual or phone support during normal work hours and liaison with crisis services as needed to prevent hospitalization or disruption of placement

Examples of the types of activities the team may provide ***to assist nursing homes, adult care homes, and other agencies or caregivers/families*** that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization include, but are not limited to, the following:

- provide case consultation with staff, individual and family regarding behaviors that may result in hospitalization or need for more intensive services
- assist staff to assess behaviors;
- provide input and support in the development of intervention plans;
- model for staff appropriate implementation of intervention plans as needed;
- provide services such as referrals to community services, assistance with obtaining benefits, time limited case management and/or time limited treatment and support services
- review of medication regime and educate staff in communication with psychiatrist, physician and pharmacist
- educate facility staff, other agencies and families on issues on such topics as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population
- provide resource information and identify ongoing training resources for staff
- provide a session of new staff orientation on such topics as individual rights;

Note: These funded Gero Specialty Teams are <u>not</u> expected to be primarily providers of direct services such as case management, community based service (CBS) or treatment services, but may do so on a time limited basis to assist in the transition to the community or to prevent hospitalization. If the individual requires on going direct services, the team will contact the area program/LME and request the individual be referred to a provider of such services whenever such a provider is available in the community. The Gero Specialty Team intent is not to replace needed treatment, rehabilitative or support services. These time limited direct services will be provided

only for identified individuals (i.e. those who meet age and diagnostic criteria and/or have been discharged from a state hospital).

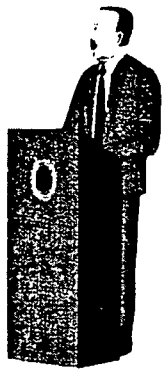
Area Program/LME responsibilities. Each of the area programs/LMEs that received State funding for a Geriatric Mental Health Specialty Team is responsible for:

- ensuring that the team, whether as an area program service or as a contracted service, provides and documents services in a way that is consistent with all Division requirements including, but not limited to, human rights, training, confidentiality, client records, and reporting
- having an identified AP/LME person who is responsible for the team's operation, if operated by the AP/LME or having a primary contact person who is responsible for communication, problem solving, prompt payment, and oversight if the team is contracted out.
- establishing an agreement about how team services will be made available to other catchment area(s) if the allocation indicated that the team is to serve more than the funded area program/LME. This agreement should specify access to service parameters including how referrals will be made to the team and expectations regarding reporting, documenting, and billing for client specific direct services.

Questions about the Geriatric Mental Health Specialty Team model and guidelines from AP/LMEs should be directed to Debbie Webster, NC Div MH/DD/SAS, Community Policy Section, Best Practice Team, 3005 Mail Service Center, Raleigh, NC 27699-3005
Phone 919 715-2774
Email Debbie.Webster@ncmail.net

APPENDIX G

Summary of Presentations
by
Organizations Representing Older Adults



Prepared for the
North Carolina Study Commission on Aging

March 23, 2004

The following organizations made brief presentations on March 9, 2004, to the North Carolina Study Commission on Aging

Friends of Residents
June Brotherton

NC Assisted Living Association
Jerry Cooper

NC Adult Day Services Association
Teresa Johnson

NC Senior Games
Cindy Trumbower

Governor's Advisory Council on Aging
Ann Johnson

National Association of Social Workers – NC Chapter, Aging Unit
Kathy Lowe

Alzheimer's Association, Mountain Region
Joe Connolly

Alzheimer's Association, Eastern Region
Alice Watkins

AARP
Von Valletta

NC Coalition on Aging
Jean Reaves

NC Health Care Facilities Association
Stacy Flannery

NC Senior Citizens Association
Tom Southern

NC Senior Tar Heel Legislature
Vernon Dull

NC Dental Society – Committee on Aging/Access Dental Care
Bill Milner

Association for Home and Hospice Care of North Carolina
Jim Edgerton

ISSUE FREQUENCY

Each organization's legislative priorities/issues of concern are summarized and presented in a table format on the following pages.

The number of organizations that mentioned the issue is in parentheses ( ) next to the issue.

The individual issues presented were grouped in the following broad categories: Community-Based Issues, Facilities Issues, Workforce Issues, and Other.

For Summary Purposes, the issues with the highest frequency were:

- **Access to National Criminal Record Checks** *(6)*
- **Restoration of the LTC Insurance Tax Credit** *(4)*
- **Support for and/or Restoration of Funding for the Home and Community Care Block Grant (HCCBG)** *(3)*
- **Support for and/or Restoration of Funding for Senior Centers** *(3)*
- **Maintaining the Viability of the Community Alternatives Program for Disabled Adults (CAP/DA)** *(3)*

	Friends of Residents	AARP	NC Assisted Living Assoc.	NC Coalition on Aging	NC Adult Day Services Assoc.	NC Health Care Facilities Assoc.	NC Senior Games	NC Senior Citizens Assoc.	Governors Advisory Council on Aging	NC Senior Tar Heel Legislature	National Assoc. of Social Workers – NC Chapter, Aging Unit	Dental Care	NC Dental Society – Com on Aging/Access	Alzheimer's Association, Mountain Region	Assoc. for Home and Hospice Care of NC	Alzheimer's Association, Eastern Region
COMMUNITY-BASED ISSUES																
Support for/Restoration of Funding HCCBG *(3)*				x					x	x						
Support for/Restoration of Funding for Senior Centers *(3)*									x	x	x					
Maintain the Viability of CAP/DA *(3)*				x					x	x						
Funding Support for Home Care Services in the Medicaid Program *(1)*															x	
Support SA In-home *(1)*															x	
Remove Institutional Bias *(1)*															x	
Expand Use of Medicaid Funds for Adult Day Services *(2)*				x	x											
Funding Support for NC Senior Games *(1)*							x									
Support for Respite Care Programs *(2)*														x		x
Support for Community-Based Assistance Programs *(1)*																x
FACILITIES ISSUES																
Expressed Concern Over Mixed Populations in LTC Facilities *(1)*	x						*									
Discharge Rules-Maintain Due Process for Adult Care Home Residents *(1)*	x															
Maintain Licensure Rule Enforcement Consistency From County to County *(1)*			x													
Concern Over Professional Liability Insurance Increases for Providers *(1)*			x													
Increased Funding for Individuals in Alzheimer's/Dementia Units *(1)*			x													
WORKFORCE ISSUES																
Access to National Criminal Record Checks *(6)*	x	x		x		x			x	x						
Increase Salaries and Benefits for Direct Care Workers *(2)*		x							x							
Examine the Shortage of Nursing Workforce (Nursing Asst. to RN) *(1)*						x										
Support for Nurse Aide Training *(1)*						x										
Insure Adequate LTC Staffing Levels *(1)*	x															

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OTHER ISSUES																
Restore LTC Insurance Tax Credit *(4)*		x		x					x	x						
Guardianship Mediation Initiative *(1)*									x							
Establish Creative Funding Options for Direct Care Dental Services*(1)*													x			
Establish Task Force to Review Oral Health Standard of Care for Special Care Populations *(1)*													x			
Increase State Revenues to Provide Services for the Elderly and Disabled *(2)*		x							x							
Establish Governor's Commission on Efficiency and Effectiveness *(1)*								x								
Enact a Taxpayer's Bill of Rights *(1)*								x								
Malpractice Reform (1)								x								
Tax Reform – Consumption Sales Tax to Replace Income Tax *(1)*								x								
Ensure execution of DHHS Plan for Information and Assistance is Supportive of Older and Disabled Adults *(1)*									x							
Establish DHHS Office to Address Housing Needs of Vulnerable Citizens *(1)*									x							
Transportation Services for the Elderly *(1)*											x					
Professional Care Coordination - Emphasis on Social Workers*(1)*											x					
Prescription Drug Assistance *(1)*											x					
Strengthen LTC Ombudsman Program *(1)*									x							
Maintain funding for State & Regional Ombudsmen, Case Managers, & Adult Care Spec. *(1)*	x															
Maintain Medicare/Medicaid Funding *(1)*	x															
Oppose Cap-non-economic damages for victims of medical malpractice & to shielding nursing home inspection reports from use as evidence*(1)*		x														
Payday loans – longer repayment, lower interest, allow installment payments *(1)*		x														
Support "Transfer on Death" to Facilitate Securities Transfer *(1)*		x														

** On March 24, 2004, the NC Health Care Facilities Association asked to be added to the line indicating that this item was an issue of interest to them.*

APPENDIX H

Presentation to NC Study Commission on Aging
March 23, 2004

Overview of Home and Community Care Block Grant (HCCBG)

- General Assembly established HCCBG in July 1992
- Combined federal Older Americans Act, SSBG in support of respite, and relevant State Appropriations
- Gave counties greater discretion and authority in determining services, service levels, and providers
- Counties choose from among 18 eligible services
- Focus is on supporting frail elderly at home, improving physical & mental health, assisting with access to services & information, providing family caregiver relief, and helping seniors remain active

Making a Difference—Who Is Served?

- 71% are women
- 33% are minority
- 68% are age 75+
- 46% live alone
- 66% are at risk of malnutrition
- 67% are unable to manage on their own
- 26% have 2+ ADL limits; 13% are very frail
- 50% reportedly low income

Making a Difference—Are the funds used wisely?

- Of the 18 services, 13 are clearly 'core' long-term care services
- 92% of the funds over which counties have discretion go to 'core' LTC services
- The relationship between need and service is strong—the services profile is logical
- Providers are efficient and accountable
- Performance outcome measures are positive

Status of Funding, Utilization, Service Availability, and Need

- Some Federal increase since 2000 while State support has decreased; $343,000 decrease in Federal Funds for FFY 04-05
- Statewide utilization/expenditure rate is very high
- Service unit costs have generally increased
- Decline in clients served and service units; some decrease in counties offering services
- More than 6,500 unmet service needs, especially for home-delivered meals and in-home aide services

Forces Affecting Future of HCCBG

- Demographics—growth in # of seniors—changing family structure
- Movement toward supporting people in least restrictive setting
- Federal budget deficit and effect on domestic programs

What It Will Take to Respond—What Happens If We Don't

- $9.3 million needed to address current wait list
- Efforts to assure effective screening and targeting of resources and cost-sharing
- Could affect other services and funding sources
- Could undermine existing provider infrastructure in face of growing need

Advocates' View

"Restore the $1 million in funding cut in 2003 from the Home and Community Care Block Grant."—

Governor's Advisory Council on Aging and NC Senior Tar Heel Legislature

Facts about the Home and Community Care Block Grant (HCCBG)

History and Purpose of HCCBG

In effect since July 1, 1992, the Home and Community Care Block Grant (HCCBG) was established by the General Assembly (G.S. 143B-181.1(a)(11), on the recommendation of the DHHS Advisory Committee on Home and Community Care and with the support of the N.C. Association of County Commissioners. By consolidating several funding sources (i.e., the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations)—some of which traditionally went to separate organizations—the HCCBG represented an important step toward establishing a well coordinated service delivery system to meet the needs of a rapidly growing older population. By offering a broad range of services designed to improve the quality of life of older adults, the HCCBG has explicitly focused on:

1. supporting frail elderly in their preference to be cared for at home;
2. improving and maintaining the physical and mental health of older adults;
3. assisting older adults and their caregivers with accessing services and information;
4. providing relief to family caregivers so that they can continue their caregiving; and
5. allowing older adults to remain actively engaged with their communities.

The two principal purposes of the HCCBG are to:

- *Give counties greater discretion, flexibility, and authority* in determining services, service levels, and service providers. With direct input from older adults in the planning and decision-making process, County Commissioners approve an annual funding plan that defines services to be provided, the funding levels for these services, and the community agencies to provide these services. Counties can select from among the following 18 eligible services under the HCCBG (see pages 8-11 for a description of these services):

Adult Day Care	Health Screening	Mental Health Counseling
Adult Day Health Care	Home Delivered Meals	Senior Center Operations
Care Management	Housing and Home Improvement	Senior Companion
Congregate Nutrition	Information and Assistance	Skilled Home (Health) Care
Group Respite	In-Home Aide (levels I-IV)	Transportation (General and Medical)
Health Promotion and Disease Prevention	Institutional Respite Care	Volunteer Program Development

In advocating for the HCCBG, Patrice Roesler of the N.C. Association of County Commissioners stated that it "accomplishes a long-range goal of the Association in that it gives counties decision-making authority in regards to funding and services for the elderly, and allows county commissioners direct participation in determining the needs and priorities for their areas." She adds that "it gives Commissioners the opportunity to coordinate this money with other resources to maximize the effect."

- *Streamline and simplify the administration of services*, seen as especially important as aging budgets are reduced or become static while demand for services grows. This includes establishing a *single set of policies and procedures* for in-home and community-based services funded under the HCCBG (e.g., *uniform definitions and standards for services, consolidated reporting on services and units, and consistent eligibility requirements*). It is also a process intended to ease re-budgeting locally and statewide to assure maximum use of available resources. In SFY 02-03, 97.9% of allocated funds were expended.

In establishing the HCCBG, the General Assembly also amended G.S. 143B-181.1(a)(10) in 1992 to require the Division of Aging to use *a sliding fee scale, based on the client's ability to pay for home and community-based services.* Effective July 1, 1992, the Division of Aging instituted a voluntary cost-sharing policy for the HCCBG that includes use of a sliding fee scale to guide participant contributions that support the publicized cost of the service. As stipulated by State statute, these contributions are used to extend the availability of in-home and community-based services. This policy is still in effect, and in SFY 02-03 resulted in contributions of nearly $2.4 million.

HCCBG's Track Record

Emphasis on Core LTC Services

While the HCCBG funds support a wide range of activities designed to develop and maintain optimal physical, mental, and social well-being and function in older adults—ranging from senior centers and health screening to in-home aide and home-delivered meals—counties are continuing to emphasize services to those who are most in need of home and community care to remain living independently. *As of fiscal year 2002-03, counties elected to use 80% of the HCCBG funds to support "core LTC services." If you exclude the funds for congregate nutrition, which are required by the Older Americans Act, the percent targeted to "core LTC services" increases to 92%.*

Of the 18 fundable HCCBG services, 13 are clearly among the "Core Services" as identified in Recommendation #11 of the 2001 Institute of Medicine Long-Term Care Plan for North Carolina (see page 12). The other services (i.e., Congregate Nutrition, Senior Centers, Health Promotion and Disease Prevention, Health Screening, and Volunteer Program Development) are arguably supportive of persons needing long-term care as well as their family caregivers. For example, results from a 2001 survey of senior centers in North Carolina show that nearly a quarter (23%) of senior center participants are 80 and older; about 1 in 12 participants (8%) need help to get around (i.e., use a walker, wheelchair, or help from another person); and about 5% reportedly have some dementia. More than half of the state's senior centers report an increase in frail participants.

The following findings from the Division's 2002 Performance Outcome Measurements Project also illustrate the importance of nutrition services, including 'non-core' congregate meals, for the physical health and emotional well-being of vulnerable seniors:

- 87% of congregate site participants were at risk of malnutrition, including 33% at high risk; 100% of those receiving home-delivered meals were found to be at risk, including 77% at high risk.
- 66% of congregate participants report that the meal they receive represents at least half of their daily consumption.

- 83% of congregate participants say visiting with friends is a major reason for their participation, and 72% of home-delivered clients cite interacting with the person who delivers the meal as important to them.

These additional findings from the Performance Outcome Measurements Project show the vulnerability of many HCCBG clients:

- 21% of congregate and 78% of home-delivered meal clients have difficulty going outside the house for shopping or doctors' offices. 21% of congregate participants cannot drive a car.
- 36% of congregate and 72% of home-delivered meal clients have problems walking.
- 30% of congregate and 72% of home-delivered meal clients cannot do their own housework.

Emphasis on Serving the Most Needy

While any person age 60 and older is eligible for services under the HCCBG, the program places an emphasis on reaching those most in need of services. This begins with the requirement of the Older Americans Act (OAA) to give priority to serving the "socially and economically needy" (with particular attention to low-income minority elderly and older individuals residing in rural areas). Additionally, the OAA calls for reaching out to older individuals with severe disabilities, limited English-speaking ability, and Alzheimer's disease or related disorders (and caregivers of such individuals). In fact, the HCCBG funding formula, approved by the U.S. Administration on Aging, is based on the following criteria: # of persons age 60 and older (50%), # of 60+ who live at or below poverty (30%), # of non-white persons 60+ (10%), and # of 60+ persons who live in rural areas (10%). Additionally, the HCCBG provides $42,930 annually to each county as its equal base allocation. The formula's rural factor and its base allocation are generally considered helpful in directing funds to the sparsely populated rural counties and in reducing abrupt fluctuations in funds allocation.

State service standards for the HCCBG also give priority to serving Adult Protective Services (APS) clients, those at risk of APS, and those who otherwise are most impaired. Providers use these various screening and targeting criteria in determining whom to serve with available resources. Finally, in allocating additional funds for the HCCBG, the General Assembly has indicated its support of serving older persons who are not eligible for Medicaid and who are on the waiting list for these services.

Nearly half (49.5%) of the 60,621 different clients receiving at least one HCCBG service in SFY 02-03 were reportedly low income. At the time of registering for HCCBG services, clients are informed of the federal poverty figure. Those who self-report their income as less than this amount are considered 'low income.' Those receiving congregate meals are the least likely to report living at or below poverty (41%). Significantly, congregate participants contribute the most to the cost of service through voluntary cost-sharing under the HCCBG (providing more than $1 million, or about 14% of the total expenditure for this service in SFY 02-03).

It is believed that many of the other recipients of HCCBG services are among the so-called "near poor"—those with income just above the poverty level, making them ineligible for Medicaid but having to struggle with paying for such necessities as prescription drugs

and utilities. This is the group that the General Assembly has especially wanted to reach through their additional appropriations to the HCCBG. According to the 2000 Census, 13.2% of North Carolinians age 65 and older (and 11.13% of 60+) had incomes below the poverty level in 1999 ($7,990 for an individual; $10,075 for a couple). An additional 36% were at "near poverty" with incomes between 100 and 200% of poverty. Even though HCCBG providers do not substantiate income information, service statistics suggest that HCCBG services are reaching a high percentage of poor and near-poor elderly. A higher percentage of women, minorities, older-old, rural residents, those living alone, and the frail have low income. The following HCCBG service profile from SFY 2002-03 suggests the success of this targeting:

- 71% of HCCBG participants are women;
- 33% are minority;
- 68% are age 75 or older;
- 46% live alone;
- 50% are low income;
- Nearly two-thirds (64%) are at risk of malnutrition; and
- Two-thirds (67%) are unable to manage on their own because of inability to perform basic self-care tasks (e.g., dressing, bathing, eating), limitations in instrumental activities of daily living (e.g., shopping, housekeeping, preparing meals), and/or cognitive impairment. 26% have 2 or more ADL limitations while 13% have 3 or more ADL limitations that suggests they are very frail [much higher for such services as in-home aide and home-delivered meals].

Access Services and Information

A major frustration for many people is not knowing whom to call when there is a question or problem. Their frustration is made worse when they are referred from one organization to another and still are not helped. Thus, it is not surprising to find from the Division's 2002 survey of family caregivers (cited below) that more than two-thirds (69%) want a central place to call for information, and more than half (57%) want help dealing with agencies/bureaucracies to get services. For seniors themselves, such experiences can create personally devastating consequences. This is why the state's Long-Term Care Plan, Olmstead Plan, and Aging Services Plan have made development of a more effective system for information and assistance (I&A) a priority. Support of I&A in the HCCBG, though, has been minimal because of other pressing demands. In fact, the HCCBG funds for I&A declined by 4% between SFY 2001-02 ($1.7 million in expenditures) and SFY 2002-03 ($1.6 million, budgeted). The number of counties using HCCBG funds for I&A dropped from 44 in SFY 2001-02 to 36 currently. A similar decline of 3% in funding is evident in Care Management, another important access service. On the other hand, transportation, another, albeit different form of access service, increased by 4% from $6 million in SFY 2001-02 to $6.25 million in SFY 2002-03.

Relieve Family Caregivers

Families are the key providers of care, but there are many stresses associated with this caregiving. Results from a Division-sponsored question in the 2003 NC Behavioral Risk-Factor Surveillance System (BRFSS) Survey show that more than 1 in 4 adults report providing regular care or assistance to an older family member or friend. Nearly 1 in 5 HCCBG clients (19.5%) report that the services they receive provide some relief to their caregivers. While some clients do not have a caregiver, this is believed to be a very conservative figure for those who do.

The following findings from the Division's 2002 Performance Outcome Measurements Project illustrate the importance of HCCBG services for caregivers as well as seniors:

- *'Not enough time for self' or 'family' and 'stress' are major burdens for at least 30% of the caregivers helped by HCCBG services.*
- Various forms of in-home aide services (including respite), care management, and information about services are the principal HCCBG services provided to caregivers. 94% are satisfied with the services they receive, including 66% who are 'very satisfied.'
- *97% of caregivers report that the services help them to be a better caregiver, with 84% saying 'they help a lot.'*
- *88% of caregivers report that the services enable them to provide care for a longer time*, which is important to avoiding more costly and restrictive interventions.
- More than one-third of caregivers want additional help with housekeeping (49%), respite or adult day services (39%), help with ADLs/personal care (38%), and transportation (35%).

Active Engagement

The primary means of supporting active engagement through the HCCBG are through general transportation, congregate meal site, senior centers, and volunteer development. The importance of this support is evident in the aforementioned statistics on congregate meal participants. More than one in five congregate participants cannot drive and have difficulty navigating outside the house, and 83% of congregate participants say visiting with friends at the site is very important to them.

While support of activities to allow older adults to remain actively engaged is an important goal and can be accomplished through a number of means, it certainly appears that counties make the difficult choice to put priority on HCCBG services that help the most at risk.

Profile of HCCBG Services

Below is a list of the services funded under the HCCBG for which clients are reported to the Division of Aging through its Aging Resources Management System (ARMS). The information that describes the "average client" is based on at least 50% of the older adults receiving the HCCBG service. Under the HCCBG, 'economically needy' is self-reported by clients based on whether their income is at or below the federal poverty level ($8,980 for 2003). Clients are also assessed using several functional criteria that include: activities of daily living (ADLs), which describe basic self-care tasks (e.g., bathing, dressing, grooming, moving around the house, and eating; and instrumental activities of daily living (IADLs), which describe basic tasks essential to living independently (e.g., cooking meals, housekeeping, laundry, paying bills, shopping, and using the telephone.)

Adult day care (ADC) provides an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. *The average client is 81 years old, female, economically needy, has limitations with 1+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 37% are cognitively impaired. Among ADC clients, 65% report that the services they receive relieve their caregiver. 46 counties currently fund ADC under the HCCBG.

Adult day health (ADH) services are similar to adult day care in providing an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. In addition, ADH providers offer health care services to meet the needs of individual participants. *The average client is 85 years old, female, economically needy, has limitations with 2+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 45% are cognitively impaired. Among ADH clients, 73% report that the services they receive relieve their caregiver. 31 counties currently fund ADH under the HCCBG.

Care management incorporates case finding, assessment, care planning, negotiation, care plan implementation, monitoring, and advocacy to assist clients and their families with complex needs in obtaining appropriate services. *The average client is 81 years old, female, has limitations with 3+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 10 counties currently fund care management under the HCCBG.

Congregate nutrition is a service where a meal (typically lunch), offering one-third of the recommended daily dietary allowance, is provided in a group setting. *The average client is 76 years old, female, and does not have limitations in ADLs or IADLs.* Nearly half (46%) live alone and 44% are at risk of malnutrition. 99 counties currently fund congregate meals under the HCCBG.

Group respite is a service that trains volunteers to offer temporary, part-time relief to unpaid, primary caregivers of cognitively or physically impaired older adults and to provide meaningful social and recreational activities for those receiving care. *The average client is 82 years old, female, has limitations with 1+ ADLs and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* Nearly half are economically needy (48%). 8 counties currently fund group respite.

Home-delivered meals is a service that provides a meal (typically lunch), offering one-third of the recommended daily dietary allowance, to a home-bound older adult. *The average client is 81 years old, female, has limitations with 1+ ADLs and 3+ IADLs, and is at risk of malnutrition.* Nearly half (49%) live alone, and 57% are economically needy. 97 counties currently fund home-delivered meals under the HCCBG.

Home health is skilled health care prescribed by a physician that is provided in the home of an older adult in need of skilled nursing; physical, occupational, and/or speech therapy; medical social services; and/or nutrition care. *The average client is 81 years old, female, economically needy, has limitations with 2+ ADLs and 3+ IADLs, and is at risk of malnutrition.* One county currently funds home health under the HCCBG.

Housing and home improvement is a service that assists older adults with obtaining or retaining adequate housing and basic furnishings, by providing information about available options for housing and housing with services and how to finance them; assisting with finding and relocating to alternative housing; and providing labor and/or materials for minor renovations and/or repair of dwellings to remedy conditions that create a risk to personal health and safety. *The average client is 77 years old, female, economically needy, has limitations with 2+ ADLs and 2+ IADLs, and is at risk of malnutrition.* 38% live alone. 36 counties currently fund this service.

In-home aide (level 1) is a service that provides assistance with basic home management tasks, such as housekeeping, cooking, shopping, and bill paying to enable the older adult to remain at home as long as possible. *The average client is 82 years old, female, lives alone, has limitations with 3+ IADLs, and is at risk of malnutrition.* 29% are cognitively impaired, and 48% are economically needy. 76 counties currently fund level 1 under the HCCBG.

In-home aide (level 2) is a service that provides support to persons/families who predominately require assistance with basic personal care (bathing, shaving, toileting, and personal hygiene) and associated home management tasks. *The average client is 82 years old, female, has limitations with 2+ ADLS and 3+ IADLs, and is at risk of malnutrition.* 37% are cognitively impaired, 39% live alone, and 45% are economically needy. 88 counties currently fund level 2.

In-home aide (level 3) is a service that provides intensive education and support to persons/families in carrying out home management tasks and improving family functioning skills, or provides substantial ADL support to individuals/families who require assistance with health and personal care tasks. *The average client is 81 years old, female, has limitations with 3+ ADLs and 3+ IADLs, and is at high risk of malnutrition.* 34% are cognitively impaired, 26% live alone, and 43% are economically needy. 49 counties currently fund level 3 under the HCCBG.

In-home aide (level 4) is a service that provides a wide range of educational and supportive services to persons/families who are in crisis or who require long-term assistance with complex home management tasks and family functioning skills. *The average client is 75 years old, female, economically needy, has limitations in 1+ ADLs and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* One county currently funds level 4 under the HCCBG.

Institutional respite is a service that temporarily places older adults, who require constant care and/or supervision, out of their homes to provide their unpaid, primary caregiver with relief from caregiving responsibilities. *The average client is 82 years old, female, has limitations in 1+ ADLS and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* 49% are economically needy. One county currently funds this service under the HCCBG.

The Senior Companion program offers a part-time stipend volunteer opportunity for low-income persons 60 years of age or older who provide support, task assistance, and/or companionship to other adults with exceptional needs (developmental disabilities,

functional impairments, or persons who have other special needs for companionship). *The average senior companion is 78 years old, female, economically needy, lives alone, and is at risk of malnutrition.* 7 counties currently fund this program under the HCCBG.

General transportation is a service that provides travel to and/or from community resources, nutrition sites, and other places where older adults need access to services and activities necessary for daily living. *The average client is 78 years old, female, economically needy, lives alone, has limitations in 1+ IADLs, and is at risk of malnutrition.* 97 counties currently fund this program under the HCCBG.

Medical transportation is a service that provides travel to medical appointments. *The average client is 78 years old, female, economically needy, lives alone, has limitations in 1+ ADLs and 1+ IADLs, and is at risk of malnutrition.* 50 counties currently fund this service under the HCCBG.

Other HCCBG Services [non-unit]

Health Screening is a service that provides general medical testing, screening, and referral to promote the early detection and prevention of health problems in older adults. Two counties currently fund this service under the HCCBG. This service is also supported in some counties under Title III-D of the Older Americans Act.

Health Promotion and Disease Prevention is a service category that promotes the health and wellness of eligible older adults. One county currently funds this under the HCCBG; however, many counties receive funds under Title III-D of the Older Americans Act for this purpose.

Information and Assistance is a service that assists older adults, their families, and others acting on their behalf in their efforts to acquire information about programs and services and to assist older persons with obtaining appropriate services to meet their needs. 36 counties currently fund this service under the HCCBG.

Mental Health Counseling is a service that incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems. No counties currently fund this service under the HCCBG.

Senior Center Operation supports provision of a broad spectrum of services and activities for older adults. The primary objectives of a multipurpose senior center are: the centralized provision of services that address the special needs of older adults; opportunities for older adults to become more involved in the community; and the prevention of loneliness and premature institutionalization by promoting personal independence and wellness. 51 counties currently fund the operation of senior centers under the HCCBG.

Volunteer Program Development supports the development and operation of a systematic program for volunteer participation. The service involves volunteers of all ages in providing services to older adults while also providing community service opportunities for older adults. 9 counties currently fund this service under the HCCBG.

HCCBG Services and LTC 'Core Services'

HCCBG Services	*LTC Core Services*[1]
Adult Day Care	*Adult Day Care*
Adult Day Health	*Adult Day Health*
Care Management	*Care Management for High-Risk or Complex Conditions*
Congregate Nutrition	
Group Respite	*Respite Care*
Home Promotion and Disease Prevention	
Health Screening	
Home-Delivered Meals	*Home-Delivered Meals*
Home Health	*Home Health*
Housing & Home Improvement	*Housing & Home Repair and Modification*
Information & Assistance	*LTC Information & Assistance*
In-Home Aide {Levels 1, 2, 3 and 4}	*In-Home Aide Services*
Institutional Respite	*Respite Care*
Senior Centers	
Senior Companion	*Respite/Attendant Care*
Transportation, General	*Transportation*
Transportation, Medical	*Transportation*
Volunteer Program Development	
	Adult Care Homes
	Durable Medical Equipment and Supplies
	Medical Alert or Related Services
	Nursing Homes
	Adult Protective Services
	Guardianship

[1] The Institute of Medicine Long-Term Care Task Force recommended that every North Carolinian should have access, either in the county of residence or within reasonable distance from the county, to the services identified in the right-hand column of the table. In addition, the Task Force said that "older adults and people with disabilities need other medical, mental health, dental, vision, and hearing services to meet specific health and functional needs. Individuals who have functional, medical, or cognitive impairments may also need guardianship services or protective services to ensure that their long-term care needs are being met." [Recommendation #11 in the Task Force's Final Report]

Summary of Home and Community Care Block Grant Bugeted Funding SFY 99-00 through SFY 04-05
Federal, State, Local Funding & Client Cost Sharing
Division of Aging and Adult Services
March, 2004
July 1, 1999 through June 30, 2005

	99-00		00-01		01-02		02-03		03-04		04-05		00-05 % Variance
Fed. Older Americans Act	14,774,992	30.01%	15,684,346	31.24%	17,660,615 *	34.64%	18,333,029	34.80%	19,081,277	36.45%	18,738,003	36.06%	126.82%
Fed. Social Services Block Grant	1,909,077	3.88%	1,909,077	3.80%	1,834,077	3.60%	1,834,077	3.48%	1,834,077	3.50%	1,834,077	3.53%	96.07%
State Appropriations	25,533,005	51.87%	25,418,695	50.62%	24,191,821 **	47.45%	25,128,469	47.69%	24,072,779 ***	45.99%	24,026,079	46.24%	94.10%
Required Local Match	4,690,786	9.53%	4,779,124	9.52%	4,854,057	9.52%	5,032,842	9.55%	4,998,681	9.55%	4,998,681	9.62%	106.56%
Client Cost Sharing	2,321,695	4.72%	2,421,185	4.82%	2,446,052	4.80%	2,360,150	4.48%	2,360,150 ****	4.51%	2,360,150	4.54%	101.66%
Total	49,229,565	100.00%	50,212,427	100.00%	50,986,622	100.00%	52,688,567	100.00%	52,346,964	100.00%	51,956,990	100.00%	105.54%
Unduplicated Clients Served	66,253		63,809		61,790		60,601		58,921 ****				
Total Units Provided	8,333,217		8,132,622		7,952,080		7,804,632		7,281,380 ****				

* $1,000,000 in FFY 03 OAA funds allocated to offset loss of $1,008,273 in state appropriations

** SFY 01-02 state appropriations reduced by $1,008,273 in 3/02 reduction was non-recurring

*** Includes recurring reduction of $1,000,000 in state appropriations effective July 1, 2003

**** Projections of 03-04 client cost sharing, clients served, and units to be provided reflect annualized estimates based on December 03 activity

APPENDIX I

Adult Day Services in Brief

Adult day care and adult day health services are part of the continuum of long-term care for older and disabled adults in North Carolina. They offer a means for an impaired adult to get out of the house during the day into a safe and supervised environment, an opportunity for group involvement and individually planned services, and activities directed toward stabilization or improvement of self-care. The programs also provide a critical period of respite for family caregivers, enabling them to continue their responsibilities more effectively.

Definition

- Day care services for adults is the provision of an organized program of services during the day in a community group setting for the purpose of supporting adults' personal independence, and promoting their social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, a nutritious meal and snacks as appropriate to the program, and referral to and assistance in using other community resources.

- The health care component of adult day health services distinguishes it from adult day care, which also provides a structured program of activities and services during the day for aging, disabled and handicapped adults. As part of the structured program of activities and services, participants enrolled in adult day health also require daily nursing supervision. Participation in adult day health can enable such persons to achieve and maintain their optimum level of independence and can support family members and other caregivers who are providing full-time care to frail adults living at home.

- Adult day health care programs and combination adult day care/adult day health programs include an on-site RN or LPN for a minimum of 4 hours daily.

- Providers of adult day services must meet North Carolina state Standards for Certification, which are administrative rules (10A NCAC 06R and 10A NCAC 06S) set by the Social Services Commission and enforced by the Division of Aging and Adult Services.

Program Information

- There are currently 113 certified programs in the state (3/17/04).
  - 57 are adult day care programs
  - 54 are combination adult day care and adult day health programs
  - 2 are adult day health programs
- Certified adult day services are located in 60 counties.
- On any given week day approximately 3272 slots for participants are available at adult day services in North Carolina.

History/Development

- Adult day service has grown in North Carolina from two programs in 1973 to its peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. Although some programs would close, others would open. In many cases, the program that closed reopened under a new organization. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. As a result, we now have 113 programs in 60 counties. The majority of growth in adult day care at this time is in the larger metropolitan areas such as Mecklenburg and Guilford counties.
- In 1999 the Division of Aging considered approaching the social services commission about a rate increase, however were advised by DHHS budget and analysis that there was little chance of a rate increase without an overall increase in the State Adult Day Care fund since a rate increase without a budget increase would result in a cut to services.

Funding Information

Adult Day Care Expenditures **SFY 02-03**
Proration of In-Home Services for agreement with BD-701, dated 6/29/03 03/17/2004

Home and Community Care Block Grant
 # Funded Providers as of 3/17/04: 59

	Federal	State	Local	Total	Exp. %	Clients Over 60
Adult Day Care	857,023	536,744	154,863	1,548,630	52.44%	652
Adult Day Health	777,269	486,795	140,452	1,404,516	47.56%	516
	1,634,292	1,023,539	295,315	2,953,146	100.00%	1,168
	55.34%	34.66%	10.00%	100.00%		

State Adult Day Care Fund
 # Funded Counties as of 3/17/04: 65

	Federal	State	Local	Total	Exp. %	Clients Under 60	Clients Over 60	Clients Total
Adult Day Care	1,534,080	521,540	293,660	2,349,280	74.15%	242	811	1,053
Adult Day Health	534,808	181,818	102,375	819,001	25.85%	72	295	367
	2,068,888	703,358	396,035	3,168,281	100.00%	314	1,106	1,420
	65.30%	22.20%	12.50%	100.00%				

Adult Day Services Total

	Federal	State	Local	Total	Exp. %	Clients Under 60	Clients Over 60	Clients Total
Adult Day Care	2,391,103	1,058,284	448,523	3,897,910	63.68%	242	1,463	1,705
Adult Day Health	1,312,077	668,613	242,827	2,223,517	36.32%	72	811	883
	3,703,180	1,726,897	691,350	6,121,427	100.00%	314	2,274	2,588
	60.50%	28.21%	11.29%	100.00%				

Funding Information *(continued)*

- The maximum reimbursement rate for the purchase of adult day services is $565 per month ($26.07 per day). Of this amount, $500 per month ($23.07) is for daily care and $65 per month ($3.00 per day) is for round trip transportation.
- The maximum reimbursement rate for the purchase of adult day health services is $715 per month ($33 per day). Of this amount, $650 per month is for daily care ($30.00 per day) and $65 per month ($3.00 per day) is for round trip transportation.
- These rates were established by the Social Services Commission effective December 8, 1997.

Cost Information

According to the North Carolina Adult Day Services Association, the average cost to operate an adult day program in North Carolina was $31.00 per day for social programs and $44.00 per day for health models.[1] Public reimbursements fall short of that amount, leaving a deficit for non-private pay participants of sometimes 50% or more. Businesses such as adult day care programs must charge fees equal to or greater than their cost to at least break even.

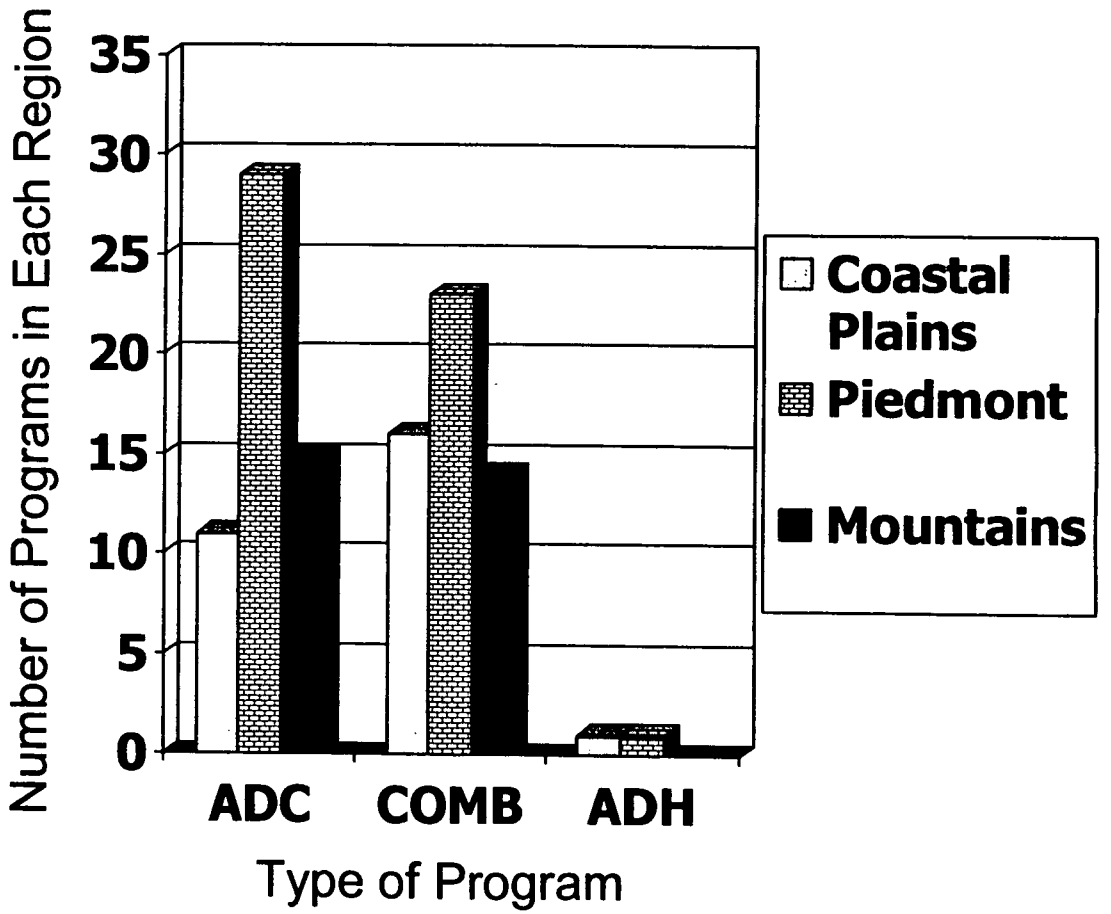
Current Initiatives

- In 2003 a special provision was introduced to the North Carolina General Assembly (House Bill 397) as follows: "The Social Services Commission shall consider adopting rules increasing the rates for adult day centers and adult day health centers. Any rate increase adopted by the Social Services Commission for adult day centers and adult day health centers shall be implemented within existing funds."

- The Division of Aging has been working closely with the North Carolina Adult Day Services Association to develop fiscal training for adult day programs. The aim of this project is to assist adult day programs with budgeting and help increase their understanding of service costs. Adult day care programs who have participated in the training will mentor other programs to understand the revenue stream and develop a business plan to balance their budget.

The Types of Programs and Geographic Location in North Carolina

- Adult Day Care Programs (57)
- Combination Adult Day Care and Adult Day Health Programs(54)
- Adult Day Health Programs (2)



Staffing Ratios

The 2001 session of the General Assembly Senate Bill 1115 requested a report on staffing requirements in long-term care facilities, including adult day service programs. In response, the Division of Aging and Adult Services prepared a report, the highlights of which are below.

Number of staff required per resident [participant]

Adult Day Care Homes 1:6
Adult Day Care Centers 1:8
Adult Day Health Centers and Adult Day Health Homes 1:5
Adult Day Care/Day Health Combination Programs 1:6

A national study of Adult Day Services conducted by the Robert Wood Johnson Foundation found the following national staffing averages:

Social model 1:7.3
Medical model 1:7.8
Combination 1:7.4

History, Rationale and Justification for Existing Ratios

The North Carolina Adult Day Care Services Standards for Certification, which dictate the existing staff ratios, were adapted from child day care regulations and originally in place in 1974, prior to mandatory certification. In 1986, legislation passed requiring the certification of all adult day care programs. The social services commission was responsible for establishing the initial rules and regulations. During this time, the Division of Social Services served as the certifying agency and responded to any concerns with regard to program certification and/or operation. This responsibility transferred to the Division of Aging in July of 1998.

The current rationale and justification is based on the Standards and Guidelines for Adult Day Services determined by the National Adult Day Services Association. In the revised 1997 recommendations, this guideline suggests a MINIMUM of 1:6 for programs offering "core services" (comparable to adult day care services) and suggests a staff--participant ratio of 1:4 when providing "enhanced and/or intensive services" (comparable to adult day health and adult day care/day health combination services.) Furthermore, the North Carolina ratios are in keeping with the national average as evidenced by the Robert Wood Johnson Foundation study previously cited.

Staff Requirements

The Standards for certification do not detail specific staff requirements except for the program director and the health care coordinator. The health care coordinator, a RN or LPN, is only required to be present 4 hours per day in programs that have the health care component. Other staff positions are not mandated by the Standards and will vary from program to program.

Adult Day Services
Program Closings 2001 - 2003

Adult Day Services	County	Closing Date	Reason Provided for Closing
*DayBreak Adult Day Services (ADC/ADH)	Lenoir	1/31/2001	Not cost effective.
Quality Life Center (ADC)	Harnett	2/28/2001	Not financially feasible to stay open.
Abundant Life Community Outreach (ADC)	Onslow	3/29/2001	Decided not to recertify. No participants. Budget would not allow program to operate.
Sumtymers Adult Day Health Center (ADC/ADH)	Haywood	5/31/2001	Closed for personal and financial reasons.
The Day Center at Stanly Manor (ADC/ADH)	Stanly	5/11/2001	Continued financial losses and lack of adequate funding sources.
Mabel's Hope (ADC)	Montgomery	8/17/2001	Program could not comply with standards and decided to discontinue the service.
Covington House (ADC)	New Hanover	11/1/2001	Program closed because they did not submit recertification documents.
Loving Years ADHC, Inc. (ADC)	Cabarrus	11/30/2001	Not financial feasible.
Emma's Loving Care (ADC)	Randolph	11/30/2001	Program was not operating according to standards. The operator had to close the business.
Adult Development Center (ADC)	Warren	12/31/2001	Financial reasons.
Day Star ADHC (ADC/ADH)	Forsyth	2/1/2002	Closed because continued violation of standards (rules).
Richmond Adult Day Health Center (ADC/ADH)	Richmond	3/4/2002	Financial reasons.
Creative Choices (ADC/ADH)	Wayne	3/31/2002	Financial reasons. Low participant enrollment.
Adult Life Program-Newton (ADC/ADH)	Catawba	6/30/2002	Had to relocate.
*Jackson County Adult Day Care (ADC)	Jackson	7/31/2002	The parent organization indicated that it was not financially feasible to continue program.
Bethel PALS (ADC/ADH)	Mecklenburg	8/31/2002	Low enrollment, freeze on CAP-DA program.
*Blue Ridge Adult Day Care (ADC/ADH)	Yancey	10/31/2002	The owner stated that the operation could not support itself.
Gem Recreation (ADC)	Dare	11/1/2002	Financial reasons -- decided to open as a respite program instead.
Penick-Elder Kare (ADC/ADH)	Moore	11/15/2002	It is no longer financial feasible to support the program

Adult Day Services
Program Closings 2001 - 2003
(Continued)

Adult Day Services	County	Closing Date	Reason Provided for Closing
Southern Wake Adult Day Care (ADC)	Wake	12/31/2002	The director stated that he could not financially maintain the program any longer
Tender Care Adult Day Health (ADC/ADH)	Craven	1/31/2003	Financial reasons. Program losing money
Helping Hands (ADC/ADH)	Cherokee	6/30/2003	Financial reasons (The parent organization was struggling financially)
Rex Adult Day Center (ADC/ADH)	Wake	6/30/2003	Financial reasons
Grace Unity Adult Day Care (ADC)	Robeson	9/30/2003	Decided not to recertify
Adult Quality of Life Center (ADC)	Stokes	10/02/2003	Financial reasons

* Indicates that the program has reopened under new ownership or organization

ADULT DAY SERVICES FUNDING FACT SHEET

The following is a list of possible funding sources for certified programs. This is a general list and all sources may not apply or be available in your area. **Automatic funding is not guaranteed.**

NORTH CAROLINA HOME AND COMMUNITY CARE BLOCK GRANT

- Older Americans Act funding and other state and local funds are combined into this block grant to support home and community-based services.
- Available for participants age 60 and older.
- Administered through Area Agencies on Aging.
- Contact the lead agency in your county or your regional Area Agency on Aging.

NORTH CAROLINA STATE ADULT DAY CARE FUND

- Funds allocated to counties by the North Carolina Division of Aging.
- Administered through county Departments of Social Services to purchase Adult Day Services for eligible participants.
- Contact your local Department of Social Services for more information.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

- This program reimburses non-residential adult day programs designed to meet the needs of the frail elderly and functionally impaired adults for nutritious meals and snacks. Facilities can be public or private non-profit organizations. The nutritional plan must follow USDA standards.
- Program payments are based on individual enrollee income eligibility as determined by USDA guidelines.
- Administered by the North Carolina Division of Women's and Children's Health.
- Contact the Special Nutrition Programs Unit at the NC Division of Public Health at 919-715-1926 for more information.

PRIVATE PAY / OUT OF POCKET PAYMENTS

- Set the top fee equal to or greater than the cost of services.
- Give everyone the opportunity to pay what the service actually costs, allowing for discounts on a case by case basis.

MEDICAID – COMMUNITY ALTERNATIVES PROGRAM (CAP)

- Certified Adult Day Programs with the Day Health component are possibly eligible for reimbursement under CAP for Disabled Adults (CAP/DA), Mental Retardation/Developmental Disabilities (CAP/MR-DD), or AIDS (CAP/AIDS).
- Administered by the North Carolina Division of Medical Assistance (DMA). Contact DMA at 919-733-6775 for more information.

VETERANS ADMINISTRATION

For Adult Day Health only.

- Administered through area Veterans Administration Hospitals and/or outpatient clinics.
- Contracted reimbursement for qualifying veterans.
- Contact your area VA for more information.

MEDICARE PART B

- This covers only the services listed below. It does not cover the daily cost of Adult Day Care/Day Health services.
- Covers out-patient or partial hospitalization mental health services by licensed clinical social workers or psychologists for assessment and psychotherapeutic treatment.
- Covers out-patient restorative and functional maintenance rehabilitation by licensed physical therapists, occupational therapists, and/or speech therapists or approved personnel.
- Covers psychiatrist and physician visits.

UNITED WAY

- Contact the local agency for specific requirement for obtaining funds and/or becoming a member agency.

TITLE V (SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM, SCSEP)

- This program is designed to address the income and employment needs of economically disadvantaged individuals age 55 and older.
- Title V workers can be employed in an adult day service center as long as the adult center is not-for-profit.
- This program is administered by various agencies. Contact your regional Area Agency on Aging for more information.

GRANTS AND FOUNDATION FUNDING

- Start up, operating, capital and special projects funding.
- For more information, contact The Foundation Center, 79 Fifth Avenue, Dept. MF, New York, NY 10003-3076, (800) 424-9836. This organization publishes the National Guide to Funding in Aging.
- Check for a local foundation center or library which carry many publications on funding opportunities.

COMMUNITY DEVELOPMENT BLOCK GRANTS

- Administered through city governments.
- The Housing and Community Development Act of 1974 authorizes some funding for the construction and improvement of facilities.
- Contact the area field office of the US Department of Housing and Urban Development for more information.

AREA MENTAL HEALTH/ DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE PROGRAMS (MH/DD/SA)

- Adult day centers can possibly contract with Area MH/DD/SA Programs who reimburse for adult day services for the older and younger MR/DD population.
- Some Area Programs are especially interested in the health services provided in adult day centers.

CITY/ COUNTY GENERAL FUNDS

- Many localities use discretionary money to fund human services agencies. Call your local government office for more information.

CHURCHES / CIVIC ORGANIZATIONS

- These organizations may offer sponsorship, space or scholarships for clients.

APPENDIX J

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-32 [v.2] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/24/2004 4:31:49 PM

Short Title: Repeal Sunset/Long Term Care Ins. Tax Credit.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON THE LONG TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Section 29A.6(d) of Chapter 212 of the 1998 Session Laws reads as rewritten:

"(d) Subsection (a) of this section is effective for taxable years beginning on or after ~~January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.~~January 1, 1999. The remainder of this section is effective when it becomes law. ~~G.S. 105-160.3(b)(7), as enacted by this act, is repealed effective for taxable years beginning on or after January 1, 2004.~~"

SECTION 2. This act is effective for taxable years beginning on or after January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-13 [v.3] (3/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2004 10:17:24 AM

Short Title: Care for the Mentally Ill in LTC Facilities. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study expanding the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. As part of this study, the Department shall consider renaming the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

SECTION 2. While undertaking the study, the Department of Health and Human Services shall proceed with implementation of the following:

(1) Standardizing these criteria across all Geriatric Mental Health Specialty Teams:
   a. Team purpose,
   b. Eligibility for services,
   c. Screening processes,
   d. Referral processes,
   e. Forms, Training Manuals, Service Orders, and Authorizations.

(2) Tracking expenditure data for each Team and each Area Program/Local Management Entity.

(3) Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team.

SECTION 3. The Department of Health and Human Services shall submit an interim report to the North Carolina Study Commission on Aging by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The Department shall submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging by October 30, 2005.

SECTION 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-15 [v.5] (4/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2004 4:56:28 PM

Short Title: Study Mentally Ill LTC Resident Issues. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall work with long-term care providers and advocates for the elderly, and the mentally ill, to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The study shall include:

(1) Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities.

(2) Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.

(3) Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support resident's freedom of choice, and whether they support the autonomy, dignity and independence philosophy of assisted living.

(4) Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.

(5) Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents are safeguarded.

(6) Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations.

SECTION 2. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The Department of Health and Human Services shall include in this report how it defines "mentally ill" for purposes of this study.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-16 [v.2] (4/16)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/19/2004 5:32:35 PM

Short Title: Study Mentally Ill LTC Resident Issues. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall work with long-term care providers and advocates for the elderly, and the mentally ill, to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The study shall include:

(1) Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities.

(2) Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.

(3) Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support resident's freedom of choice, and whether they support the autonomy, dignity and independence philosophy of assisted living.

(4) Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.

(5) Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents are safeguarded.

(6) Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations.

SECTION 2. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The Department of Health and Human Services shall include in this report how it defines "mentally ill" for purposes of this study.

SECTION 3. The Department of Health and Human Services may use up to one hundred fifty thousand dollars ($150,000) of funds appropriated to it for the 2004-2005 fiscal year to contract for the study required in this act.

SECTION 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-37 [v.7] (4/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/12/2004 4:09:46 PM

Short Title: Adult Care Homes Criminal Records Check/Pilot. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PILOT PROGRAM TO CONDUCT NATIONAL CRIMINAL HISTORY RECORD CHECKS OF PERSONS SEEKING EMPLOYMENT TO PROVIDE DIRECT CARE IN ADULT CARE HOMES AND CONTRACT AGENCIES OF ADULT CARE HOMES, AND TO MAKE CONFORMING CHANGES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall establish a pilot program to review the criminal history records of applicants for positions not requiring an occupational license but requiring direct resident care in adult care homes and contract agencies of adult care homes. Pursuant to this program, criminal history record checks for the employees of adult care homes and contract agencies of adult care homes shall be conducted as provided in G.S. 131D-40, except for the following:

(1) At the time it submits the request for the criminal history record check to the Department of Justice, the adult care home or contract agency of the adult care home shall provide a copy of the request to the Department of Health and Human Services, Division of Facility Services. If the adult care home or contract agency of the adult care home receives the criminal history information from a private entity, then within two business days of receiving the criminal history information, the adult care home or contract agency shall forward the information to the Department of Health and Human Services, Division of Facility Services, for a determination as to whether the applicant should be disqualified from employment.

(2) Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for

employment positions not covered by Public Law 105-277 and State criminal history record checks to the Department of Health and Human Services, Division of Facility Services. Within five business days of receipt of the criminal history of the person, the Department of Health and Human Services, Division of Facility Services shall determine whether the applicant should be disqualified from employment, unless the Department is unable to determine within five business days the disposition or accuracy of the criminal history information obtained by the Department, in which case the Department shall make the determination as soon as possible after verifying the disposition or accuracy of the criminal history information. By the next business day following its determination, the Department shall notify the adult care home or contract agency of its determination, and shall also notify the applicant a written statement as to the Department's determination and the basis on which it was made. An applicant shall be disqualified from employment if the applicant's criminal history shows that:

(a) The applicant was convicted of any of the offenses of Homicide under Article 6 of Chapter 14 of the General Statutes or Rape and Other Sex Offenses under Article 7A of Chapter 14 of the General Statutes, or equivalent offenses under the laws of another state.

(b) The applicant was convicted of any other offenses listed in G.S. 131D-40(d) within 10 years prior to the date of application for employment, or equivalent offenses under the laws of another state.

(3) If the criminal history of the applicant reveals a conviction of any of the other offenses listed in G.S. 131D-40(d) more than 10 years prior to the date of application for employment, the Department of Health and Human Services shall obtain the public record document reflecting the offense and shall provide the public record of the conviction to the adult care home or contract agency of the adult care home, and the adult care home or contract agency shall determine whether the applicant should be employed after considering the factors contained in G.S. 131D-40(b).

(4) If the adult care home or contract agency of the adult care home disqualifies an applicant or terminates a conditional employee based on the Department's determination or on its own consideration, then the adult care home or contract agency may disclose public criminal history information or public information that in the Department's determination is relevant to the disqualification but shall not provide the criminal record check to the applicant. All information that the Department receives through checking the criminal history is privileged information and is not a public record but is for the

exclusive use of the Department and those persons authorized under this act and under federal law to receive the information.

(5) An adult care home or contract agency of an adult care home may employ an applicant conditionally prior to obtaining the Department's determination or making its own determination, but shall terminate immediately the conditional employment of an applicant upon receiving notification from the Department that the applicant is disqualified or upon making its own determination that the applicant is disqualified.

(6) The pilot program shall include notices to the applicant of the criminal history record check and of the applicant's right to appeal the Department's determination as a final agency decision pursuant to Chapter 150B of the General Statutes.

SECTION 2.(a) The Department of Health and Human Services shall collect the following information during the pilot program:

(1) The number of persons whose criminal histories were reviewed by the Department.

(2) The number of persons who were disqualified by the Department and nature of the disqualifying offenses.

(3) The cost of the pilot program.

(4) The length of time between initial requests for criminal history record checks and the notices sent from the Department as to its determination.

SECTION 2.(b) The Department of Health and Human Services shall convene a workgroup that shall include representatives of the Department of Justice, nursing homes, adult care homes, home care agencies, and contract agencies of nursing homes and adult care homes. The Department shall conduct meetings at least monthly during the pilot program to discuss the progress of the pilot programs and any problems encountered in conducting the program.

SECTION 2.(c) The Department shall report the information required under this section and report the progress of the pilot program and the activities of the workgroup, including any statutory changes needed to fully implement G.S. 131D-40 and G.S. 131E-265, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and to the North Carolina Study Commission on Aging on or before January 15, 2005.

SECTION 3. Section 10.8E of S.L. 2003-284 reads as rewritten:

"SECTION 10.8E. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131E-265 for nursing homes to conduct national criminal history record checks for employment positions other than those involving direct patient care shall become effective no earlier than ~~January 1, 2005.~~July 1, 2005. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131D-2 for adult care homes to conduct national criminal records checks for all staff

positions except for staff positions involving direct care of residents shall become effective no earlier than ~~January 1, 2005.~~July 1, 2005."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services for the 2004-2005 fiscal year the sum of one hundred fifty thousand dollars ($150,000) to implement the pilot program in this act.

SECTION 5. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-6 [v.5] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:23:32 AM

Short Title: Senior Center Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SENIOR CENTER DEVELOPMENT AND OUTREACH, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of two hundred eighty-one thousand dollars ($281,000) for the 2004-2005 fiscal year, for senior center outreach and development. State funds shall not exceed seventy-five percent (75%) of reimbursable costs.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-7 [v.4] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:24:19 AM

Short Title: Senior Adult Housing Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SENIOR ADULT HOUSING, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Housing Finance Agency the sum of one million dollars ($1,000,000) for the 2004-2005 fiscal year. These funds shall be used to provide independent housing with services for senior adults and shall be used to maximize federal funds.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-8 [v.5] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:25:15 AM

Short Title: HCCBG Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of one million dollars ($1,000,000) for the 2004-2005 fiscal year, for the Home and Community Care Block Grant.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-34 [v.4] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/19/2004 11:59:25 AM

Short Title: DHHS Study/Medicaid Institutional Bias. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTRACT WITH A THIRD PARTY TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall contract with an independent third party to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and if a bias is found, to determine and recommend ways to alleviate the bias. The independent third party with whom the Department shall contract shall have documented experience in conducting similar studies. The study shall include consideration of all in-home services paid under the State's Medicaid program, including CAP/DA, home health and personal care services. The Department shall report the results of the study to the North Carolina Study Commission on Aging by October 30, 2004.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one hundred fifty thousand dollars ($150,000) for the 2004-2005 fiscal year to fund the study in this act.

SECTION 3. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SWz-33 [v.7] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/19/2004 4:12:14 PM

Short Title: Legislative Study Comm./Guardianship. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is created the Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney.

SECTION 1.(b) The Commission shall consist of 15 members as follows:

(1) Four members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Four members of the Senate appointed by the President Pro Tempore of the Senate.

(3) The Director of the Administrative Office of the Courts, or the Director's designee.

(4) The Director of the Division of Aging in the Department of Health and Human Services, or the Director's designee.

(5) A county director of social services appointed by the President Pro Tempore of the Senate.

(6) A clerk of superior court appointed by the Speaker of the House of Representatives.

(7) A physician who specializes in geriatrics appointed by the President Pro Tempore of the Senate.

(8) An attorney who has experience in guardianship matters appointed by the Speaker of the House of Representatives.

(9) A representative of the Governor's Advocacy Council for Persons With Disabilities.

In addition, representatives designated by the following organizations shall serve as ex-officio, nonvoting members of the Commission:

(a) The North Carolina Bar Association.
(b) The Arc of North Carolina.
(c) North Carolina Guardianship Association.
(d) Alzheimer's Association – Western Chapter.
(e) Alzheimer's Association – Eastern Chapter.
(f) Carolina Legal Assistance.
(g) The Area Agencies on Aging.

The Speaker shall designate one Representative as cochair, and the President Pro Tempore shall designate one Senator as cochair. Vacancies on the Commission shall be filled by the same appointing authority as made the initial appointment. The Commission shall expire upon delivering its final report.

The Commission, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet at any time upon the joint call of the cochairs. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02.

The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Commission in its work. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, and the expenses relating to the clerical employees shall be borne by the Commission. Members of the Commission shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 1.(c) In conducting the study, the Commission shall consider the following:

(1) Whether guardianship should be a remedy of last resort used only if less restrictive alternatives are insufficient.
(2) The definition of incompetency.
(3) Whether courts should be required to make express findings regarding the extent of a person's incapacity and limit the scope of the guardianship accordingly.
(4) Legal rights retained or lost as a result of being adjudicated incompetent.
(5) The proper role of attorneys and guardians ad litem in guardianship proceedings.
(6) The role of public human services agencies in providing guardianship services.
(7) Legal procedures and protections in guardianship proceedings.
(8) Public monitoring of guardianship.

(9) Funding for guardianship services provided by public and nonprofit agencies.
(10) Educating citizens with respect to guardianship and alternatives to guardianship.
(11) Prudent investor rules.
(12) Powers, duties, and liabilities of guardians.
(13) Review of the State's adult protective services law.
(14) Enactment of the Uniform Guardianship and Protective Proceedings Act (UGPPA).
(15) Whether guardianship statutes need revision to provide greater protection of the health and welfare of incapacitated adults.
(16) Whether the State should track the number of people under private guardianship and, if so, proposed methods for the tracking.

SECTION 2. The Legislative Study Commission on State Guardianship Laws may make an interim report to the 2005 General Assembly not later than the convening of the 2005 General Assembly, and shall make its final report to the 2005 General Assembly, Regular Session 2006 upon its convening.

SECTION 3. All State departments and agencies and local governments and their subdivisions shall furnish the Commission with any information in their possession or available to them.

SECTION 4. There is appropriated from the General Fund to the General Assembly the sum of thirty thousand dollars ($30,000) for the 2004-2005 fiscal year and the sum of thirty thousand dollars ($30,000) for the 2005-2006 fiscal year to carry out the purposes of this act.

SECTION 5. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-SHz-11 [v.4] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:17:48 AM

Short Title: Adult Day Care Rate Increase. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS AND TO REQUIRE THE SOCIAL SERVICES COMMISSION TO ADOPT A RATE INCREASE FOR ADULT DAY SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services an amount sufficient to increase the current minimum rates by no less than five dollars ($5.00) per day for adult day and adult day health services provided to clients.

SECTION 2. The Social Services Commission shall adopt rules increasing the minimum rates by five dollars ($5.00) per day for adult day centers, and by five dollars ($5.00) per day for adult day health centers.

SECTION 3. This act becomes effective July 1, 2004.

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — **April 27, 2004**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby C. Emanuelson	Nat'l MS Society
[illegible] Bethel	NC Div. of Aging & Ad. Service
Kathie Smith	AHHC of NC
June Brotherton	Friends of Residents in Long Term Care
Mary Cyrus	Division of Aging + Adult Ser.
Suzanne Merrill	" " " "
Ann B. Johnson	Gov. Advisory Council
ASANDRA SKINNER	CCPS
Phyllis Daw	DFS
[illegible] Gordon	NCALA
Stacy Flannery	NCHCFA
John Bowdish	AstraZeneca
Polly Williams	Justice Center / Coalition on Aging
BILL PRICE	JORDAN PRICE LAW FIRM
Elizabeth Dalton	Ombudsman
Lou B. Wilson	NCALTCF
Evelyn Hawthorne	EHOR

North Carolina
Study Commission On Aging

April 27, 2004

To: Governor Michael Easley
Lieutenant Governor Beverly Perdue, President of the North Carolina Senate
Senator Marc Basnight, President Pro Tempore of the North Carolina Senate
Representative James Black, Speaker of the North Carolina House of Representatives
Representative Richard Morgan, Speaker of the North Carolina House of Representatives
Members of the 2003 General Assembly, Regular Session 2004

Attached is a report from the North Carolina Study Commission on Aging submitted to you pursuant to North Carolina General Statute §120-187. The North Carolina Study Commission on Aging presents to you findings and recommendations based on study conducted after the adjournment of the 2003 Regular Session of the 2003 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

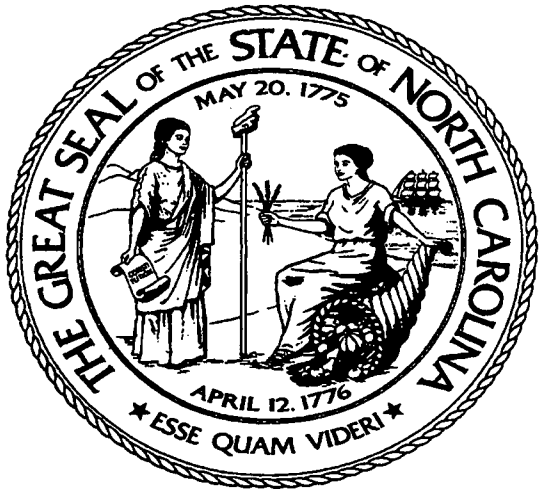
Senator A.B. Swindell, IV
Co-Chair

Representative Debbie A. Clary
Co-Chair

Representative Edd Nye
Co-Chair

NORTH CAROLINA

STUDY COMMISSION ON AGING



REPORT TO THE GOVERNOR AND THE 2004 REGULAR SESSION OF THE 2003 GENERAL ASSEMBLY

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MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING
PUBLIC HEARING

Thursday, October 21, 2004
10:30 A.M.
First Baptist Church Christian Outreach Center, Cherryville, NC

The North Carolina Study Commission on Aging held a public hearing on Thursday, October 21, 2004 at 10:30 A. M. at the First Baptist Church Christian Outreach Center in Cherryville, NC. Members present were: Representative Debbie Clary, Senator A. B. Swindell, and Representative Edd Nye, Co-Chairs; Senators Charlie Dannelly, Austin Allran; public members Katherine Fox Price and Jan Elliott.

Theresa Matula, Dianna Jessup, and Shawn Parker provided staff support to the meeting. Shirley Winstead, Legislative Assistant to Rep. Clary, attended and assisted with the meeting. House Sergeant-At-Arms staff, Dusty Rhodes and Frank Prevo provided assistance at the meeting.

The public hearing was held to give the public an opportunity to address the Commission on issues facing older adults in North Carolina. In conjunction with the hearing, the local Area Agency on Aging had volunteers at the meeting to offer an education and enrollment opportunity for the Senior Care prescription drug program.

A sign-up sheet listing the names of those who addressed the Commission is attached and made a part of these minutes. (See Attachment No. 1)

Representative Clary presided at the public hearing and after welcoming everyone; she introduced the Mayor of Cherryville, Bob Allstell, and asked him to make some comments. He welcomed everyone to the city and asked a member of the audience, Thelma Stellers, to open the hearing with a prayer. He stated that Rep. Clary, who represents the district, is a staunch supporter of the community and expressed his appreciation for all she has done for Cherryville.

Rep. Clary spoke briefly and expressed the importance of the Commission on Aging. She then asked the members of the Commission and staff to introduce themselves. After these introductions, Rep. Clary stated that the presentations would begin.

PRESENTATIONS

Mary Beth Davis, with the Charlotte Mecklenburg Senior Games Board of Directors, addressed the Commission and thanked the General Assembly and the Division of Aging for their support for the statewide health promotion program. (See Attachment 2) She explained that Senior Games are a year-round, statewide health promotion, wellness and

prevention program. North Carolina has the largest Senior Olympic program in the nation serving over 50,000 participants in all 100 counties. The program offers over 643 different activities for adults who are 55 or older. It keeps seniors healthy.

Gayla Woody, Aging Program Administrator with Centralina Area Agency on Aging addressed the Commission and expressed concerns about the State not being prepared for the retirement of baby boomers born from 1946 to 1964. (See Attachment 3) She talked about the need for senior friendly communities. She reviewed primary categories of concern. She stated that obesity is a great concern and needs to be a focus of senior centers. Guardianship, prescription drugs, physical environment, economy, and resource planning are also of concern.

Faye Kennedy of Shelby, N.C. spoke on Senior Games. She explained that she is 77 years old and has osteoarthritis. She won a medal in croquet and participates in track and other games. The Senior Games are very important and she appreciates them.

Ann Williams of Fulton, N.C. spoke on Senior Games and stated how much she enjoyed them. It is great fellowship and nice to compete and get out of the home for a while to see people. She has had a hip replacement, but participates in all the games she can.

Hester Haynes of Bessemer City, N.C. spoke in support of Senior Games. She is a retired schoolteacher and physical education teacher. She reserves time in April, September and October to participate in the State games. She travels to other states representing North Carolina in competing against other states. She has set three State records in the Games. She showed the members the 20 medals she has received and she challenged seniors to participate.

Julia Dellinger of Lawndale, N.C. told the members that she is 90 years old and she was speaking in support of the Senior Games. She got involved in the Games when she was age 75. They are a pleasure to her and have kept her from the "rocking chair". She said people do not get too old to play, but they get too old when they quit playing. She is looking forward to the Games continuing.

Mayor Bob Allstell spoke again to thank the members of the Commission who are elected officials for their service to the State. Rep. Clary thanked him for his hospitality.

Judy Bean of Cherryville, N.C. was the next speaker. Rep. Clary noted that Ms. Bean had previously served on the Commission on Aging. She has been a nursing home administrator for 34 years and she has seen a lot of changes during that time. She had two issues of concern. The first issue concerns mental health patients being placed in nursing home facilities. She would like for the Commission to recommend that the Division of Mental Health work with long-term care providers to establish licensure under mental health and to have their own inspections. Nursing home facilities already have over 1300 patient regulations. The second issue of concern to her was the workforce issue. She would like for community colleges to handle the increases in need for training nurse aids and offer associate degrees in nursing.

Rep. Clary recognized Rep. Bob England who was present at the meeting. Rep. England represents part of Cleveland County and all of Rutherford County.

Barbara Dillard, of Gastonia, N.C. with the Gaston County Department of Social Services, briefly addressed the Commission and spoke on the CAP-DA Program. There is a need in Gaston County for these services and she thanked the members for their support.

Peg Argent of Belmont, N.C. discussed the SA In-Home program. This program provides an option to going to an assisted living facility. They currently have 18 slots and are asking for on-going support for the slots. Around $100.00 per month is provided, but it is causing people to lose food stamps. The money comes from the State and it has to be counted as income by the federal government. It is a new and slow-growing program.

Brenda Yeatman, Administrator of the Adult Services Division of Gaston County Department of Social Services, spoke on In-Home Aid Services. In 1990, they merged their adult services with their aging services. These services are to assist people to be able to stay at home by having support caregivers. They usually have 400 to 500 people each year who do not receive services.

Kirk Poteat, Social Worker with Cleveland County, discussed In-Home Services. He said the SA Program is expanding in the State. They have a waiting list of about 40 people in the program right now. The amount received is about $250.00 per month, per client for his SA Program.

Beth Moss, Gaston County Division of Social Services, Adult Protective Services Supervisor. She told the members that it is a disservice to the elderly to have to be placed in a facility with some of the mentally ill clients. Rep. Nye said she was correct that there is a major issue of clients coming out of psychiatric hospitals and going into nursing homes. Under the Umstead Law if the client wants to go into the community, they have to be allowed to go, but he isn't sure the adult care homes are the best place to put them. Rep. Clary commented that there is an ongoing study that the Commission asked for from the last session to look at the issue and the report is due in December to the Commission.

Rep. Clary recognized Bonnie Rombke, Jean Hoyle and Vergie Hoyle, the SHIP volunteers, and expressed appreciation on behalf of the Commission for them being there.

Julie Wray of Shelby, N.C. was the last presenter and talked about concerns with nursing homes and also about CAP slots. She is concerned about the ratio of staff to client in nursing homes, and would like for it to be addressed.

Senator Swindell thanked the presenters and said that in 1977 he was appointed by Carl Stewart to the first legislative study committee on aging. He stated the State and nation have come a long way from the county homes. He said he appreciated all speakers, as well as the Senior Games representatives for coming out in force to represent the Senior Games and also for all their comments. Senator Dannelly agreed.

Rep. Nye expressed how valuable the information they had presented was to the Commission. He said it seems like need more services are needed. He thanked them all for their efforts and noted how impressed he was with the Senior Games.

Rep. Clary ended the hearing by expressing appreciation to Rev. Tim Lowery for the use of the facility and for his assistance in helping make the public hearing a success.

The public hearing adjourned at 12:30 P.M.

Jo Bobbitt

Representative Debbie Clary, Co-Chair

Jo Bobbitt, Committee Assistant

Senator A. B. Swindell, Co-Chair
Representative Edd Nye, Co-Chair

North Carolina
Study Commission On Aging
DRAFT

PRESS RELEASE September 2004

COMMISSION TO HOLD PUBLIC HEARING IN CHERRYVILLE, NC

Raleigh – The public is invited to address the North Carolina Study Commission on Aging during a public hearing on issues facing older adults in North Carolina. In conjunction with the hearing, the local Area Agency on Aging is offering an education and enrollment opportunity on the Senior Care prescription drug program. These events will take place on **Thursday, October 21, 2004 from 10:30 a.m. until 12:30 p.m.** at the **First Baptist Church Christian Outreach Center**, 301 East 1st Street, Cherryville, NC.

The Commission Co-chairs, Representative Debbie Clary, Representative Edd Nye, and Senator A.B. Swindell, invite older adults, family caregivers, agency representatives, service providers, and members of the public with experience in issues related to aging to attend. The North Carolina Study Commission on Aging was created in 1987 to study and evaluate the system of State services delivered to older adults and to recommend an improved system to meet the present and future needs of older adults in North Carolina. The Commission includes: members of the North Carolina House of Representatives; members of the North Carolina Senate; and providers of health, mental health, or social services to older adults.

Each year the Commission examines a variety of issues and makes recommendations to the General Assembly and the Governor on ways to improve the delivery of services to older adults in North Carolina. As part of the information gathering process, the Commission members are interested in public input on ways to improve the quality and delivery of care for older adults in North Carolina, including: community-based long-term care, long-term care facilities, senior centers, adult day care, housing, transportation, and Alzheimer's disease and related dementia. Individuals who wish to address the Commission may sign-up immediately prior to the hearing and are asked to limit comments to five minutes. Speakers are also asked to furnish a written copy of their comments if possible.

Prescription drug costs are a major concern for many older adults. At the public hearing, the Centralina Council of Governments' Area Agency on Aging will sponsor an information and enrollment opportunity for older adults interested in North Carolina Senior Care (http://www.ncseniorcare.com). Senior Care is a prescription drug assistance program that may pay up to $1200 of covered prescription drug costs per benefit period. It is available for NC residents; 65 years of age and older; with an annual income for 2004 of $23,275 or less if single, divorced or widowed, or $31,225 or less if married. Individuals must also have no other prescription drug insurance including Medicaid.

For more information, contact Gayla Woody at the Centralina Council of Governments' Area Agency on Aging (704) 372-2416, or Theresa Matula or Dianna Jessup, Commission Staff, (919) 733-2578.

NOTES

North Carolina Study Commission on Aging

CHERRYVILLE PUBLIC HEARING
October 21, 2004

I. **Welcome and Brief Background on Commission**

Representative Debbie Clary, Cochair

II. **Introductions of Commission CoChairs and Members**

III. **Introductions of Other Legislators/Officials In Audience**

IV. **Remind Public of :**

- **Sign-Up Sheet**
- **5 Minute Time Limit**
- **Comments in Writing to Staff**

V. **Call Each Member of the Public that Signed Up to Speak**

VI. **Ask if Anyone Else Would Like to Speak (who did not sign-up)**

VII. **Thank:**
Tim Lowry, Minister of Education and the First Baptist Church
Gayla Woody, AAA
Senior Care and SHIIP Volunteers

VIII **Next Hearing:**
October 26, 2004 from 1:00 – 3:00 in Wilson

House Pages

1. Name: _____

   County: _____

   Sponsor: _____

2. Name: _____

   County: _____

   Sponsor: _____

3. Name: _____

   County: _____

   Sponsor: _____

4. Name: _____

   County: _____

   Sponsor: _____

5. Name: _____

   County: _____

   Sponsor: _____

Sgt-At-Arms

1. Name: Dusty Rhodes
2. Name: FRANK PREVO
3. Name: _____
4. Name: _____

Attachment 1

Mayo

SIGN- UP TO SPEAK DURING THE HEARING

Those who wish to speak during the hearing need to sign-up and will be called in the order they signed up. **You do not need to sign this list if you do not wish to speak.** Speakers will be allowed 5 minutes and are asked to furnish their comments in writing if possible. The Commission will use the information you share to guide them in making recommendations regarding services for older adults in North Carolina.

Thank you for coming!

	Your Name	City of Residence	Issue of Concern
1.	MaryBeth Davis	Charlotte	Continued support of Senior Games
2.	Gayda S. Woody	Gastonia	Planning for Senior Friendly Comm
3.	Kaye Kennedy	COA Shelby	Senior Games
4.	Linda Williams	COA Fullton	"
5.	Hester Haynes	COA (Bessemer City)	Senior Games
6.	Julia Bellinger	COA Lawndale	Senior Games
7.	Judy B Beam	Cherryville	Mental Health / Workforce Issue
8.	Barbara Dillard	Gastonia	CAP-DA
9.	Peg Argent	Belmont	SA IN HOME
10.	Brenda Yeatman	Gastonia	In Home Services
11.	Kirk Poteat	Cleveland	in home services, SA in home, Rx program
12.			
13.	Mayor Bob Austell	Cherryville	
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SIGN- UP TO SPEAK
DURING THE HEARING

Those who wish to speak during the hearing need to sign-up and will be called in the order they signed up. **You do not need to sign this list if you do not wish to speak.** Speakers will be allowed 5 minutes and are asked to furnish their comments in writing if possible. The Commission will use the information you share to guide them in making recommendations regarding services for older adults in North Carolina.

Thank you for coming!

Your Name	City of Residence	Issue of Concern
1. ✓ Beth Moss	Clemmville	Adult Care Homes
2. ✓ Julie Wray	Shelby	CAP slots, Nursing Homes
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Attachment 2

MEMORANDUM

TO: North Carolina Study Commission on Aging
Representative Debbie Clary, Representative Edd Nye, Senator A.B. Swindell

FROM: Charlotte Mecklenburg Senior Games Board of Directors
Representative Mary Beth Davis, Wellness Coordinator speaking

DATE: 10-21-04

SUBJECT: NC Study Commission on Aging Public Hearing Comments to speak.

- N.C. is lucky to have our Senior Games program and we thank the **General Assembly** and the **Division of Aging** for their support of this statewide health promotion program. Senior Games continues to grow and spread the message that "prevention is a wise investment" and will save on future health care expenditures.

- People of all ages are impacted in our communities by the Senior Games program. The participants' example of "staying active and involved" is contagious to children, grandchildren, friends and spectators.

- Senior Games is a year-round, statewide health promotion, wellness and prevention program. It has a positive impact on people of all ages.

- North Carolina has the largest (and best) Senior Olympic program in the nation serving over 50,000 participants in all 100 counties.

- Senior Games is a family program that offers over 64 different activities for adults 55 years of age and better.

- Senior Games is an inexpensive prescription for a healthy, motivated and active lifestyle that saves our limited health care dollars. It keeps seniors healthy.

- For the same amount of money it costs to put just 3 people in a nursing home, Senior Games can serve over 50,000 people in North Carolina each year!

- Prevention is effective and affordable in N.C. ....thanks to Senior Games!

- Senior Games has made a difference in my family's life. My father-in-law will be 85 years young the end of this month. He has come through hip replacement surgeries, cancer and a continuous struggle with arthritis because Senior Games has instilled in him a focus to remain active despite the challenges of getting older.

Attachment 3

I am Gayla Woody, Aging Program Administrator with Centralina Area Agency on Aging which covers Anson, Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly and Union counties.

Dr. Ken Dychtwald, noted psychologist and gerontologist, makes the statement on his Demography is Destination video, "We weren't prepared for the 77 million baby boomers born from 1946 to 1964. We did not have enough diapers, hospitals, houses, pediatricians, schools, books, teachers or anything else for all of these children. If we are not careful, we will not be prepared for the retirement of these boomers."

We can no longer close our eyes to what is coming with the aging of the baby boomers. North Carolina must aggressively address some of the issues that are facing us right now.

- By 2030, Americans 65+ will more than double to 70 million people - 20 % of the population
- A Met Life study noted that caregiving costs our nation $11.6 billion in lost work, reduced pensions, and lost income
- In 1950 there were 7.5 workers to every 1 retiree. By 2030 there is expected to be around 2.8 workers per retiree
- Baby Boomers currently comprise about 60% of the prime-age workforce (25 to 54)

I know that you have heard these and many more statistics before. However, the first of the Baby Boomers are expected to retire in the next few years. There is much work to be done.

The North Carolina Division of Aging and Adult Services included a chapter on Senior Friendly communities in their 2004-2008 State Plan. A senior friendly community addresses eight primary categories: Physical Environment, health, Economy, Technology, Safety/Security/ Social/cultural involvement; Services/Support and Resource Planning/Stewardship. I want to talk a little more specifically about a few of these areas:

1) Services and Support. This area includes a variety of areas like information and assistance, prescription drug assistance, home and community based services, senior centers, guardianship, caregiver support. I could talk the rest of the day about the need for many of these services.
   - Home and community based services – two years ago we lost one million dollars. Thank you so much for championing the legislation to put money back into these services. But it is not enough. We are still below the funding level before the cut and we continue to have lengthy waiting list for our services.

- Your support of senior centers is very much appreciated --- I am very excited about the funding available to build a senior center here in Gaston County. But it is not enough --- if we are going to have a focal point network of senior centers available in our state for the Baby Boomers, there is much work to be done to change the way many of us are currently doing business.
- Guardianship – there is much work yet to be done in this area. Your leadership in helping us take a long hard look and begin to map out strategies to make change happen is critical and we thank you. Let us work quickly to revitalize the Guardianship program in North Carolina to better serve those who need a caregiver and do not have family members able to assist.
- Prescription Drugs. All of North Carolina will participate in an Enrollment Day for our statewide program, Senior Care, on October 26. Today we have applications available for anyone who may be interested. Thank you for your leadership in adding needed benefits to this program. North Carolina will be joining other states around the country to educate older adults about these programs.
- Long Term care. The ombudsman program is provided through the Area Agency for residents of long term care facilities. Our region has approximately 16,000 beds with only 3.4 ombudsmen. The national average is 2000 beds per Ombudsman. Our state is currently advocating with CMS to allow Medicaid funds to be used to help support Ombudsman. Other states are already doing it. This would be a great benefit to North Carolina.

2) Physical Environment. This category includes things like transportation, air/water quality, housing/ land use, road safety, shopping and zoning.
   - We can't talk about the needs of older adults without talking about transportation. Many of our communities continue to struggle to provide adequate transportation for seniors. We must continue to look at how we provide transportation in our state. And, because our older adults are not made from a "cookie cutter" our transportation services cannot be a "one size fits all". We must have transportation services that are diverse enough to meet the needs of many different older adults
   - I am very pleased to see that the NC Senior Tar Heel Legislature has as one of its priorities Air and water quality. They are requesting that NC General Assembly provide funding for incentive grants to communities. Much of North Carolina is at risk to loose federal dollars because we have been designated as non-attainment areas. The health risks as a result of poor air is well documented and is especially life-threatening to many seniors who may already be suffering from diseases like emphysema or lung disease. We must find ways to become better stewards
   - Adequate and affordable housing continues to rank high on our lists of concerns for seniors. I think the Baby Boomers are going to provide

an interesting challenge for our communities. I believe that Baby boomers will "downsize" into smaller homes in which to retire. As we talk about this whole category of Physical Environment, smaller homes with mixed use housing which includes shopping and other necessary services will be a whole different way to plan communities.

3) Economy. This category talks about age discrimination, financial planning, job training, long-term care costs, health care costs and others. There seems to be a debate now about whether Baby boomers will be more affluent than past retirees or because of less attention to savings, they will be less affluent. But either way, there are a couple of critical areas North Carolina must address.
    - Job Training. With fewer younger workers, our state will need the help of older workers and I believe, that many of our retirees will be interested in continuing to work. We need to begin now to find ways to take advantage of the tremendous resources from this workforce and at the same time, find incentives for retirees to be retrained to work in areas experiencing workforce shortages. Already our state is addressing workforce shortage issues with our certified nursing assists in long term care facilities and in home aids working in our community programs.
    - Health care costs and long term care costs continue to escalate at alarming rates. We encourage our Baby Boomers to have adequate insurance to help with these costs. Just last night I received an email from a 63-year-old man with heart problems. He had been paying for life insurance to support his wife for the past twenty years hoping that this would provide for her at his death. His insurance company informed him they would be terminating his insurance.
4) Resource Planning is the last category I want to address today. This area talks about community needs assessment, planning coordination, and public and private funding sources.
    - Mecklenburg County is one of the counties in my region and received one of the Long Term Care Planning Grants from two years ago. I have had the opportunity to work with them and one of my other counties, Rowan, has begun a planning initiative also. I hope to have the opportunity to share with you some of our experiences a little later in the month. But for now, I want you to know how exciting it has been to see both of these communities looking at how to plan for the future. In the past much of our planning was within the aging network. Both of these initiatives are crossing the silos to work with different disciplines: the community planners, the police, the businesses, governments, social services, hospitals, and many more. I was very excited to learn yesterday from Sandy Markwood, Executive Director of the National Association of Area Agencies on Aging, that we will be advocating for the reauthorization of

the Older Americans Act to include a new title. This will be Title VIII for Community Planning --- just what we are doing in Rowan and Mecklenburg. This is an important function that I would like to see in all 100 counties of North Carolina. But it won't and can't happen without support.

I thank you for your time and willingness to listen to our visions and concerns for the future of North Carolina. I appreciate YOUR leadership and vision for a Senior Friendly North Carolina.

Gayla S. Woody
Aging Program Administrator
Centralina Area Agency on Aging
P.O. Box 35008
Charlotte, NC 28235
704-348-2727
gwoody@centralina.org

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING
PUBLIC HEARING

Tuesday, October 26, 2004
1:00 P.M.
Wilson County Agricultural Center, Wilson, NC

The North Carolina Study Commission on Aging held a public hearing on Tuesday, October 26, 2004 at 1:00 P.M. at the Wilson County Agricultural Center in Wilson, NC. Members present were Senator A. B. Swindell and Representative Edd Nye, Co-Chairs; Senator Charlie Dannelly, Representative Jennifer Weiss, Brad Allen, and Jackie Sheppard.

Dianna Jessup and Shawn Parker provided staff support to the meeting. Staff from both the House and Senate Sergeant-At-Arms assisted with the meeting.

Members of the legislative delegation that represent the area were invited to attend the hearing, and Senator Clark Jenkins and Representative Joe Tolson were in attendance.

Representative Nye opened the hearing for Senator Swindell. He greeted those in attendance and announced that Senator Swindell, who was to Chair the hearing, was expected to arrive shortly and explained that Senator Swindell had been in Rocky Mount introducing President Pro-Tempore of the Senate, Marc Basnight at a luncheon.

Representative Nye asked for introductions by the members of the Commission and staff. Senator Swindell arrived and told the audience how pleased he was with the large number in attendance. He told them the significance of why they were there was that the members take their input from the citizens of North Carolina and what they have to say is what makes things happen. He emphasized that the members of the Commission care about citizens of North Carolina and the senior citizens. He thanked them for being there and expressed his appreciation to the members of the Commission and staff. He then asked the members to continue introducing themselves.

Karen Gottovi, Director of the Division on Aging and Adult Services, Department of Health and Human Services was present and was asked if she would like to make a statement. She expressed her pleasure at seeing so many people there. She stated that her job is to see that their programs are funded and that the funds are spent appropriately so they can get the best services possible.

Senator Swindell then stated that they would try to keep the presentations to five minutes each and he then asked the first presenter to come forward. A sign-up sheet listing the names of those who addressed the Commission is attached and made a part of these minutes. (See Attachment A-1) Some of the presenters provided notes and handouts and, they also are attached to these minutes.

PRESENTATIONS

Barbara Joyner of Wilson County Department of Social Services spoke on the issue of Medicaid. (See Attachment 1) The poverty level has steadily increased each year, but the medically needy income limit of $220 ($317 for a couple) has not increased since 1990. In NC, the medically needy income limit is adjusted when the Work First payment standard changes. Over the past decade the emphasis in Work First has been to get people off welfare and into the workforce. She stated that by allowing more seniors and disabled adults to qualify for Medicaid benefits and receive the ongoing medical care that they need, there will be a corresponding decrease in the catastrophic costs of hospitalization and nursing home placement.

Carol Wright with the Wilson County Department of Social Services presented her concern that as a result of the Mental Health Reform, there are no adequate places in the community for people with mental illnesses to go. (See Attachment 2) A lot of them are being placed in rest homes. The staff in these facilities has not received additional training to be able to cope with people who have mental illness. Many of the mental health patients are younger adults that have been mainstreamed in the rest homes with the elderly.

Barbara Massey with the Wilson County Department of Social Services spoke concerning chronically ill adults under age 65 who are in an ongoing crisis with medication. (See Attachment 3) They are sick and unable to work but have not been deemed disabled. Without disability or a job, they are unable to pay for the medication that is needed. They have multiple prescription needs that are extremely high in cost. This is a need, a gap, where people are in need of services and have nowhere to turn.

Tommy Hawkins, Mayor of Saratoga, NC and delegate to the Wilson County Senior Tar Heel Legislature. He reviewed the five priority issues for the Senior Legislature. (See Attachment 4)

Helen Walter from Greenville, NC, a retired nurse, spoke on Senior Games. (See Attachment 5) She is involved in basketball, softball, badminton and table tennis. She has met a wonderful group of friends and they encourage each other to have fun and keep active. Participants often begin going to the gym as a result of their involvement in the Games.

Carolyn Fulghum of Greenville, NC spoke on Senior Games. She told the members that the Games help keep her physically strong and mentally alert. She participates in several different sports and sets goals for herself.

Dick Roundtree, Jr. President, Wilson Council on Aging and Legislative Chairman for the AARP in Wilson, stated that the jobs available in the area for young people have no benefits and their parents have to take responsibility for them. He also expressed a need for prescription drug assistance for seniors.

Jean Reaves, President, NC Coalition on Aging, Legislative Chairman NC Adult Day Services Association and Legislative Director, American Veterans, spoke concerning the needs of North Carolina's aged and disabled adult population. (See Attachment 8)

Cynthia Davis, Mid-East Commission Area Agency on Aging, made a presentation on the needs of seniors in Eastern North Carolina. (See Attachment 9) As seniors age at home, there continues to be a great need for in-home services. More funding is needed for these programs so our seniors can enjoy their years in their homes.

Sally Williamson, Caregiver Resource Specialist with Mid-East Area Agency on Aging spoke on behalf of the members of the Senior Advisory Committee regarding their needs and concerns. (See Attachment 10)

Jane Reel, a retired teacher, spoke in support of the Senior Games. (See Attachment 11)

Alice Keene, Director, Community Schools and Recreation, thanked the Commission for support of the NC Senior Games Program and its network of 53 Local Games across the State. (See Attachment 12) The program continues to be a national model for a health promotion and wellness program for citizens 55 years of age and older, and through its services has conserved both human and financial resources.

Marvin Rouse, Edgecombe County Director of Social Services, spoke on services for the elderly. He investigates and evaluates reports of abuse to elders. One of the problems they face is when they see a need for a service that is not available. They are responsible for the guardianship for those that are not able to make decisions for themselves.

Agnes Moore, Nash County Council on Aging, thanked the members for holding the hearing in the district. She said it was important to continue to fund the Senior Centers.

Gordon Campbell, Tarboro, NC, expressed his request for support of the Senior Games. More people need to become involved so they can benefit from the healthy lifestyle.

Heather Proctor, Rock Mount Area Agency on Aging, Upper Coastal Plains Council of Government addressed the members. She discussed the challenges of the baby boom generation. (See Attachment 12)

Rev. Elbert Lee, Member of Governor's Advisory Council on Aging, (See Attachment 13)recommended full implementation of Senate Bill 10, strengthening regulatory oversight, and strengthening transportation services for seniors

Gene Parker, Rocky Mount, NC, spoke concerning Senior Centers and Senior Games. (See Attachment 14)

Armeta Coley, Rocky Mount, NC, Regional Ombudsman form Upper Coastal Plains Council of Government talked to the members about staffing in adult care homes. (See Attachment 15)

Bernard Haselrig, Greenville, NC, represented the Pitt/ Greenville Senior Games program. He and his wife are both involved in the Games. He thanked the members and encouraged them to please continue the funding and support.

Judith Moss, Tarboro, NC, spoke in support of the Senior Games. The Games aim to keep the elderly population healthy. She is a participant and a volunteer with the Games.

Stacy Nelson, Director of Aging Services for Nash County, asked for help in assisting the older adults in our communities to age in their own homes as long as possible. She asked for funding for Senior-Friendly Communities. (See Attachment 16)

Rudolph Becton, Magnolia, NC, told the members how much his health had improved since he became involved in Senior Games.

Theresa Holley, Greenville, NC, works with Parks and Recreations and discussed health promotion. The senior citizens that participate in the Senior Games are healthier.

Amy Farmer and Dollie Parker, Rocky Mount, NC, work at a Senior Center as service assistances under the Title V program. They expressed how quality of living goes past retirement years. The Center offers many resources.

Beverly Wheeler, Greenville, NC, Board Member, Friends of Residence in Long Term Care spoke in behalf of this organization. They support the rights of citizens in these facilities. (See Attachment 17) She spoke in support of in-home services to allow people to remain at home.

Connie Richardson, MedLink coordinator for the Upper Coastal Plain Area Agency on Aging, shared the concerns of their Agency. (See Attachment 18)

Doris Howington, Rocky Mount, NC, discussed Adult Day Health Care. She thanked the members for their support in increasing the reimbursement fee by $5.00.

Barbara Blackston, Executive Director of Wilson Community Improvement Association, Inc. and the Gee Corbett Village Wilson Senior Center Stand. (See Attachment 19) Transportation is a very big issue among senior citizens. Approximately 16% of seniors age 65 and older are without a car.

Denise Boswell, PhD, Gerontologist and Urban Planner- currently- Principal Planner for City of Rocky Mount was there to present testimony on the creation of Senior-Friendly Communities across North Carolina. (See Attachment 20)

Greg Godard, Executive Director of Coastal Plains Council of Government, was there representing the Area Agencies on Aging. He asked for support in funding for the Home and Community Care Block Grant.

Senator Swindell recognized Betty McCain, former Secretary of Cultural Resources, and she spoke concerning the Wilson Long Term Care Internet Project. The Projects goal is it to put the Internet in nursing homes in Wilson County. They train seniors through the Community College System. This will allow them to email their grandchildren and friends. This will be wonderful to help them with depression. Senator Swindell then recognized Representative Joe Tolson, and he expressed support for the Program stating that it will do mentally what the Senior Games will do for the seniors physically.

Jean Reaves, Halifax County, Roanoke Valley Adult Day Center introduced her board members in the audience and expressed there were many people there to echo what the speakers had said.

The members expressed their appreciation to the speakers and audience. Senator Swindell thanked everyone who helped organize the hearing.

The hearing ended at 4:00 p.m.

Jo Bobbitt

Senator Swindell, Co-Chair

Jo Bobbitt, Commission Assistant

Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

SIGN- UP TO SPEAK
DURING THE HEARING

Those who wish to speak during the hearing need to sign-up and will be called in the order they signed up. **You do not need to sign this list if you do not wish to speak.** Speakers will be allowed 5 minutes and are asked to furnish their comments in writing if possible. The Commission will use the information you share to guide them in making recommendations regarding services for older adults in North Carolina.

Thank you for coming!

Your Name	City of Residence	Issue of Concern
1. Barbara Joyner	Wilson	Medicaid
2. Carol Wright, Bard Massey	Wilson	Adult Care Hom
3. Tommy Hawkins	SARATOGA	Senior Tarheel delegate
4. Helen Walters	Greenville	Senior Games
5. CAROLYN FULGHUM	GREENVILLE	SENIOR GAMES
6. DICK ROUNTREE JR	WILSON	SENIOR-CHILDREN
7. Jean Beaves	Weldon	ADC/DHC
8. Cynthia Davis	Chocowinity	All county issues in Reg Q
9. Sallie Williamson	Blount's Creek	" " " "
10. Jane Reel	Greenville	Senior Games
11. Alice Keene	Greenville	Health Promotion
12. MARVIN E. Rouse	Edgecombe City DSS	Services to Elderly
13. Agnes Moore	Nash County	Senior Concerns
14. Gail Campbell	TARBORO	Senior Games
15. Heather Proctor	Rocky Mount	Area Agency on Aging Concerns
16. Rev. Elbert Lee	Advocacy on Aging	Rocky Mount Reg
17. GENE PARKER	ROCKY MOUNT	SENIOR CENTER, Adult Care
18. Arneta Coley	Rocky Mount	Ombudsman - Staffing - Home
19. Bernard Hasdrig	Greenville	Senior Games
20. Judith Moss	Tarboro	Sr. Games
21. Stacie Nelson	Nashville	Senior Friendly Communities
22. Rudolph Beaton	Wilmington, NC	Senior Games
23. Theresa Holley	Greenville	Health Promotion
24. Dollie Parker	Rocky Mount	Title V Older Workers
25. Amy Farmer	Rocky Mount	Title V Older Workers
26. Beverley Wheeler	Greenville	Residents in Long-term Care
27. Connie Richardson	NASH	Prescription drugs
28. Boris Hovington	Rocky Mount	Adult Day Health Care
29. Barbara Blackston	Wilson	Senior Services
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36. ~~Mary M. Brooks~~	~~Rocky Mount AARP~~	
37. DENISE BOSWELL	Rocky Mount	senior-friendlycommunities
38. GREG GODARD	" "	ggodard@ncpcog.org
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NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27603

November 1, 2004

Ms. Connie Bailey
Wilson County Agricultural Center
1806 South Goldsboro Street
Wilson, NC 27893

Dear Connie:

On behalf of the North Carolina Study Commission on Aging, we would like to thank Wilson County Agricultural Center for providing us with such a wonderful facility in which to hold our public hearing.

We especially would like to thank you, Connie, for your assistance in getting the room set up and for the hospitality you extended to the Commission staff. The accommodations for our public hearing were superior and your Center is certainly a wonderful asset for Wilson and surrounding communities. The information that the Commission gathers during our hearings will enable North Carolina to better serve older adults in your community and across the State.

Thank you again for the use of your facility and for the service you provide to your community.

Sincerely,

N. C. Senator A. B. Swindell

N. C. Representative Edd Nye

N. C. Representative Debbie Clary

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27603

November 1, 2004

Ms. Heather Proctor
Director
Area Agency on Aging
1309 South Wesleyan Blvd.
Rocky Mount, NC 27803

Dear Heather:

Thank you for the assistance that you provided the North Carolina Study Commission on Aging in making the Wilson public hearing such a success. We appreciate your efforts in making area residents and providers aware of the public hearing. We also appreciate those who took their time to be there for the sharing of information on the Senior Care prescription drug program.

The information that the Commission gathers during our hearings will enable North Carolina to better serve older adults in their community and across the State. The Area Agencies on Aging are such an integral part of the services we provide these individuals and their family members. Not only do we appreciate your assistance with our public hearing, but also we recognize the fine job that you do every day at the Upper Coastal Plain Council of Governments' Area Agency on Aging.

Again, we thank you and appreciate your involvement in the public hearing.

Sincerely,

N.C. Senator A. B. Swindell

N.C. Representative Edd Nye

N. C. Representative Debbie Clary

NOTES

North Carolina Study Commission on Aging

WILSON PUBLIC HEARING
October 26, 2004

I. **Welcome and Brief Background on Commission**

Senator AB Swindell, Co-Chair

II. **Introductions of Commission Co-Chairs and Members**

III. **Introductions of Other Legislators/Officials In Audience**

IV. **Remind Public of :**

- **Sign-Up Sheet**
- **5 Minute Time Limit**
- **Comments in Writing to Staff**

V. **Call Each Member of the Public that Signed Up to Speak**

VI. **Ask if Anyone Else Would Like to Speak (who did not sign-up)**

VII. **Thank:**
Wilson County Agricultural Center
Heather Proctor, AAA Director
Senior Care and SHIIP Volunteers

VIII **Next Commission Meeting:**
October 27, 2004 at 10:00

Jo Bobbitt (Rep. Nye)

From: Greg Godard [ggodard@ucpcog.org]

Sent: Wednesday, October 27, 2004 2:14 PM

To: Sen. A.B. Swindell; Jo Bobbitt (Rep. Nye); Rep. Debbie Clary; Rep. Edd Nye

Cc: Heather Proctor; ctracy@mccog.org; Dee Freeman (Dee Freeman); ncregions@mindspring.com; Becky Heron; Patrice; Karen Gottovi; Dennis Streets (Dennis Streets); Sen. Clark Jenkins; Sen. Robert Lee Holloman; Sen. Tony P. Moore; Rep. Bill Daughtridge, Jr.; Rep. Howard Hunter; Rep. Jean Farmer-Butterfield; Rep. Joe Tolson; Rep. John Hall; Rep. Lucy T. Allen

Subject: RECOMMENDATIONS TO AGING STUDY COMMISSION AT PUBLIC HEARING

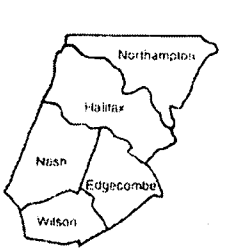
Importance: High

Please see the attached letters of recommendation to the NC Aging Study Commission on presentation made on Tuesday, October 26, 2004 in Wilson by Greg Godard.

Edgecombe
Halifax
Nash
Northampton
Wilson
[redacted]nties

UPPER COASTAL PLAIN

1309 WESLEYAN BLVD.
P.O. DRAWER 2748
ROCKY MOUNT, NORTH CAROLINA 27082-2748
TELEPHONE (252) 446-0411
FAX (252) 446 5651



October 26, 2004

Presentation at Public Hearing in Wilson on October 26, 2004

Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair
North Carolina Study Commission on Aging

RE: RECOMMENDATIONS ON IMPORTANT AREAS OF CONCERN

NUMBER 1: Support legislation to increase state funding by $4 million for Home and Community Care Based Aging Services in 2005.

Background:

NC Division on Aging reports that there are 7300 senior adults on waiting list statewide in October 2004. It is estimated by NCDOA that it would take $9 million to address this need. In the Upper Coastal Plain region alone we have 710 seniors on waiting list for services.

NUMBER 2: Support legislation to increase state funding by $424,000 for administrative support for the Area Agencies on Aging which was cut during the 2003 session of the general assembly.

Background:

The Study Commission on Aging in 2001 supported legislation to increase administrative support funding for AAAs to $900,000. This increase addressed the staffing needs of the agencies in their efforts to enhance technical and programmatic support for aging services providers, county lead agencies, senior centers and in many cases development of direct services to seniors on a regional basis. In the case of Upper Coastal Plain AAA, we hired a full-time Information and Assistance/Referral Specialist to assist our counties, senior citizens, and their caregivers and created a database of all services and programs available. Due to the budget cut, this position has been reclassified as part-time. AAAs also have a major responsibility to the state (NCDOA) for the administration and monitoring of both state and federal funds in the delivery of direct services and programs in our counties and regions.

These two recommendations are supported by the North Carolina Area Agencies on Aging (17), the North Carolina Regional Council Executive Directors Association (17), the North Carolina Joint Regional Forum (17), and North Carolina Association of County Commissioners. Thank you for your consideration.

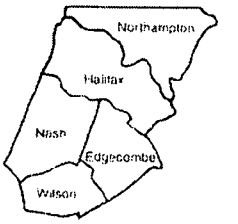
Greg Godard

Greg Godard, Executive Director
Upper Coastal Plain Council of Governments
Vice-President, North Carolina Regional Councils Executive Directors Association

Edgecombe
Halifax
Nash
Northampton
Wilson
[redacted]unties

UPPER COASTAL PLAIN

1309 WESLEYAN BLVD.
P.O. DRAWER 2748
ROCKY MOUNT, NORTH CAROLINA 27082-2748
TELEPHONE (252) 446-0411
FAX (252) 446 5651



October 26, 2004

Presentation at Public Hearing in Wilson on October 26, 2004

Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair
North Carolina Study Commission on Aging

RE: RECOMMENDATION TO SUPPORT LEGISLATION ALLOWING A TAX CREDIT FOR THE PARTIAL COST OF LONG TERM CARE INSURANCE PREMIUM

BACKGROUND:

Legislature let sunset a law allowing a partial tax credit for the cost of long term care insurance premiums on July 1, 2004. Please consider recommending to the legislature a reinstatement of this provision in the state tax code. This is an excellent incentive, especially to baby boomers like myself, to purchase this type policy to assist with my health care needs in retirement years. Individuals should be encouraged to purchase this insurance so that many can be less dependent on public supported services and private sector benefits can be used without costs to the public.

[redacted]uld recommend a 30% tax credit on the total annual premium up to a maximum of $400 per year.

Thank you for your consideration and support.

Greg Godard

Greg Godard (age 52)
3905 Rasberry Drive
Wilson, NC 27896

Senior Tar Heel Legislature
Priorities for 2005 Legislative Session

On October 6, 2004, the delegates to the Senior Legislature selected five priority issues for action by the General Assembly in the 2005 legislative session. These issues are:

1. Strengthen efforts to protect the quality of our state's air, water, and soil and appropriate $10 million in grant funds for communities to address environmental contamination.

2. Increase funding for home and community based services for older adults by $5 million.

3. Enact legislation for a permanent long-term care insurance tax credit.

4. Increase funding for senior centers by $3 million.

5. Modify North Carolina General Statutes to better support grandparents and other family members raising minor kinfolk (children).

"SPARKLERS" FOR GRANT APPLICATION ENHANCEMENT

OUR INTELLECT IS OUR MOST PRIZED PERSONAL POSSESSION

IT BECOMES MORE IMPORTANT AS WE AGE

USE IT DON'T LOSE IT

Lifelong learning is the key to keeping your mind fit... especially so when you don't get out to keep in touch.

Continue to master your own destiny, not become a victim of your history.

The wind and waves are always on the side of the ablest Navigator who knows and has the opportunity to make the right choices.

Now is the time to roll together the past, present and future.

Strive for health and independence for older infirm people through collaboration among researchers, scholars, heath care professionals, staff and volunteers.

Join us as we open a new doorway for the human sprit.

Use of personalized Internet access can in some ways meet the needs of mankind in physical, mental and spiritual ways.

The uncertain economy should not be a barrier to opening the windows for those who need it most.

Out primary purpose shouldn't be to stay alive as long as you can but to savor every opportunity for joy, productivity, and fulfilment.

The latar years for the infirm can also serve as a time of renewal to explore their options and prospects, especially if you possess the gift of a good mind.

The web has the power to deal with declines and to provide action to maintain your health.

The latar years can be the richest time of your life, if you want them to be - the choice is up to you... create a life style that you value and keep yourself reasonably busy.

How many members in your organization, or congregation who are sick and shut in have home internet access?

How many of the healthy members of your group have web experience and can serve as teachers to help the infirm and shut-ins overcome their feelings of loneliness

Never squander time, its all you have to spend.

The web is the most rapidly growing communication medium in history.

Accept your limitations with dignity. Don't look back with anger.

Medically Needy Category for Medicaid

NC is one of 35 states plus the District of Columbia that allows seniors and disabled adults whose income is above the federal poverty level to attempt to qualify for Medicaid by meeting a deductible, also known as a spend down. A senior or disabled adult who has income of $796 a month can receive full Medicaid benefits. However, his next-door neighbor whose income is $797 a month has to meet a deductible of $3210 in a 6-month period before he can receive Medicaid. This is b/c we compare his income to a diff. standard. The poverty level has steadily increased each year, but the medically needy income limit of $242 ($317 for a couple) has not increased since 1990. In NC the medically needy income limit is adjusted when the Work First (formerly known as AFDC) payment standard changes. Over the past decade the emphasis in Work First has been to get people off welfare and into the workforce. Accordingly, there has been no legislative action to increase the Work First payment amount. We believe the medically needy limit should not be bound by the old AFDC standard, but should be increased in conjunction with the increase in the federal poverty level. By allowing more seniors and disabled adults to qualify for Medicaid benefits and receive the ongoing medical care that they need, we believe there will be a corresponding decrease in the catastrophic costs of hospitalization and nursing home ~~costs~~. placement.

To: Concern for Aging Commission

From: Wilson County Department of Social Services

As a result of the Mental Health Reform, there are no adequate places in the community for people with mental illnesses to go. A lot of them are being placed in our Rest Homes. The rest homes have typically provided care for our elderly residents or residents with physical disabilities. The staff in these facilities has received no additional training to be able to cope with people who have mental illness. Staff are not trained in mental health issues and are unaware of the symptoms that these residents are experiencing or any problems they are having until after someone has been hurt or until that resident is again in need of extensive mental health services. So many of the mental health patients are younger adults that have been mainstreamed in the rest homes with the elderly. There have even been instances of death in the facilities because the staff is untrained to deal with this population from the mental health hospitals.

We have Chronically ill adults under age 65 who

~~Many customers between the age of 40 and 60~~ are in an ongoing crisis with medication. They are sick and unable to work but have not been deemed disabled. Without disability or a job, they are unable to pay for the medication that is needed. These customers have ~~been prescribed and have to obtain more than one~~ multiple prescription that is extremely high in cost. They do not meet our criteria for emergency assistance because this is an on-going need. Social Services do not have the funding to assist them every month. They are being forced to choose which medications they will get and which ones they will go without due to the high costs. There are also situations where customers need to go to the doctor and are required to have the money up front before they are seen. If we assist with the initial visit, then the money for the treatment, prescriptions, or referrals to a specialist is not available. Therefore, the customer will go without the medical attention that they really need.

This is a need, a gap, where people are in need of source & no where to turn to

Tommy Hawkins
4

Senior Tar Heel Legislature
Priorities for 2005 Legislative Session

On October 6, 2004, the delegates to the Senior Legislature selected five priority issues for action by the General Assembly in the 2005 legislative session. These issues are:

1. Strengthen efforts to protect the quality of our state's air, water, and soil and appropriate $10 million in grant funds for communities to address environmental contamination.

2. Increase funding for home and community based services for older adults by $5 million.

3. Enact legislation for a permanent long-term care insurance tax credit.

4. Increase funding for senior centers by $3 million.

5. Modify North Carolina General Statutes to better support grandparents and other family members raising minor kinfolk (children).

#5

I am Helen Walter, a retired nurse.

I have been interested and involved in wellness and fitness all of my life.

When I retired in 1993 I looked, for about a year, for a way to be active and stay fit. I didn't want to sit and watch TV and do hand work all the time.

A friend invited me to play badminton in the Senior Games program and I haven't looked back. Playing basketball, softball, badminton and table tennis I have found a wonderful group of friends. We encourage each other to have fun and keep going.

Today we read about the big problem of our population being over weight and the health problems and costs we face because of it. Our Senior Games participants set an example for people of all ages; our families, friends and neighbors.

In Greenville we are allowed to practice badminton at the ECU Student Recreation Center , a very nice facility. The director of that facility believes that we are a great example for the student body.

We know that prevention is much less expensive than the costs of treatment and care.

Let me close with a couple of observations.

1. Many of our new participants in Senior Games realize they need to "Get in Shape"!! They begin going to the gym and "working out".

2. How many other programs do we have where people can't wait to age a couple or three years so they can get envolved in an activity.!!! They say, "I'm 53 and I can't wait". How wonderful!!!!

I want to thank the N. C. General Assembly and the Division of Aging for all the support they have given in the past. And ask that they continue to support this statewide health-promotion program.

Helen F. Walter
112 Avon Lane
Greenville, NC 27858

Jean Reaves, President North Carolina Coalition on Aging, Legislative Chairman North Carolina Adult Day Services Assoc, and Legislative Director American Veterans. Each of these volunteer roles has a very common thread. That is, my responsibility within each of these roles is to bring to your attention the needs of North Carolina's aged and disabled adult population.

I would like to call your attention to the fact that aging is an industry. It is an industry made up of many small businesses providing much needed services to a very specialized population. These services range from safe convenient senior housing, to transportation. These services include quality Senior Centers that provide resources to seniors and their caregivers as well as providing a wide array of educational and social programs to healthy senior. These small businesses include personal care service providers, meals on wheels programs and a positive and therapeutic alternative to full residential placement through North Carolina's 82 adult day centers. Just last week North Carolina hosted the Southeastern States at our annual aging conference. Josphina Carbineau, Assistant Secretary of Aging, Department of HHS, addressed the group. The assistant secretary stated very clearly that we must learn to put the clients front and center and allow the system to build around them and their needs. She further went on to state that we needed to allow these predominantly small business owners who provide a wide range of services the opportunity to build strong public/private partnerships. The assistant secretary shared that these community-based services are normally cost effective and WE have a responsibility to ensure they also reflect a meaningful quality of life. After all of the Nations 8 million seniors 3 million receive services from one of these small business the providers offering community based services vs institutional care.

You have come here to eastern North Carolina to allow for these public comments. Realizing the rural complexity of eastern North Carolina do you also realize that NC's rural population relates to the rural population of Texas? With this thought then we also need to look at other aspects of rural NC. We spoke earlier of public/private partnerships for small business aging providers. This is not impossible in rural NC but it is very difficult and takes much creativity and determination. I would challenge you to step outside the norm and look at encouragements to the limited private business leaders in rural NC to reach out to these small not-for-profit service providers and form those partnerships. I further encourage you to realize that many of the textile workers that no long have mills to go to are the professional caregivers working in these small businesses. In many cases they are making less money then they were in the mills with limited benefits but yet they are doing these difficult and compassionate tasks all day long every day. It is time for North Carolina to take seriously the needs of a fragile and developing Aging Industry along with balancing the special and distinct needs of the population they serve.

Lt Gov Beverly Perdue also addressed the SE4A conference last week. She spoke of firing up the engine and getting NC up to speed with the rising numbers of seniors and disabled. NC is 5th in the nation as a choice for retiring seniors. It is 2nd only to Fl within the southeastern states. We can no long sit on the sideline and hope that the numbers will change or that some miracle will happen. I ask you to act responsibly and put in place such incentives as a Long Term Care tax credit. We also need reasonable reimbursement rates for adult day service programs that are offering choices to families. We need to address NC institutional bias by

allowing Medicaid reimbursements to fund those community based programs that offer alternatives to NC's population that are trapped in institutional care.

In closing I would like to share with you that NC has 800,000 veterans. Of that number 13% receive some form of service connected disability compensation, in dollars and cents that relates to almost 2 billion dollars that goes back into NC economy. NC also has 4 VA medical centers and 2 Veterans Nursing Homes. I implore you to realize the resource these facilities provide and encourage you to look at partnerships with the VA and the populations they serve. I further ask you to accept as fact the numbers of NC citizen soldiers who have and will return from Iraq and Afghanistan and will very probably drastically increase that 13% of disabled veterans population. Not all of these men and women will return with visible scars and missing limbs. Many of them will return with PTSD and other deep and hidden wounds. I beg you to provide the leadership through your elected roles in The North Carolina General Assembly to ensure our NC National Guard Command is given whatever means necessary to meet the needs of our NC citizens soldiers. Now more than ever our aging citizens and our disabled adult population, including our disabled veterans, need concrete leadership to stabilize a willing industry that will provide quality services for a well identified population.

Comments to
Study Commission on Aging

Hello. My name is Cynthia Davis and I work for the Mid-East Commission Area Agency on Aging. I appreciate this opportunity to speak to the Study Commission on Aging on what I see are needs of seniors in Eastern North Carolina.

As our seniors age at home, we continue to see great needs for in-home services – respite, in-home aides, home delivered meals, medical transportation, home adaptation and modification, and caregiver supports. More funding is needed for these programs so our seniors can enjoy their years in their homes.

Often, we face challenges in delivering these services to our seniors at home because of their remote location, the limited manpower available to perform these tasks, little available funding, & limited volunteer power. It can be a struggle on how to serve these seniors who do not live close to the boundaries of our towns. We seek out partnerships with faith communities and attempt to develop non-traditional ways to address the needs of seniors in rural NC. Please help us find ways to overcome obstacles and serve our rural seniors so their quality of life is not compromised because of where they live and the difficulty in delivering services and resources.

Today is Senior Care Sign Up Day and I am happy to report that every Senior Center in our region is participating in this effort to help

seniors lower their cost of medications. Fortunately, the program recently expanded eligibility requirements and opened the door to many more seniors in need. Although generous in its financial assistance, when coupled with the soaring costs of medicines, it won't take long for many seniors to exhaust their benefits.

We operate a Medication Assistance Program and the vast numbers of seniors needing assistance in managing their medications, and making applications and reapplications to pharmaceutical programs to assist in free and reduced medications is overwhelming. The costs of prescription drugs continue to overburden seniors. Assist us to continue programs for seniors that help them in managing their medications and reducing their costs of prescriptions.

We are fortunate to have one of the best Senior Games programs in the state in our region – Greenville/Pitt County Senior Games. They do a great job in heath and wellness activities throughout our region. We want to strengthen the presence of health and wellness activities in ALL of our counties so all of our seniors can participate in these healthy lifestyles. Funding needs to be strong to help us accomplish this.

Safe and affordable housing continues to be a problem for our seniors. We receive many calls from seniors needing assistance in repairing their homes – needing roofs, windows, and floors. Sadly, there are not enough resources in our area to help these seniors.

Home repair programs, whether publicly assisted or volunteer based, must reach out to seniors in our rural areas.

We are also receiving an increase in the number of seniors seeking out reverse mortgages as a means of staying at home, or as a means of supplementing their income, or to take out an existing mortgage they can no longer pay in an effort to remain in their house. Whereas some consumer protections are in place now, we need to be mindful that these protections remain strong and responsive to our seniors as they are faced with making difficult choices.

Thank you,
Cynthia Davis
Mid-East Commission
Area Agency on Aging
252-974-1835

10.
Sally Williamson

Hello, my name is Sallie Williamson. I am a Caregiver Resource Specialist with Mid-East Area Agency on Aging. I would like to thank the NC Study Commission on Aging for giving me this opportunity to speak on behalf of the members of our Senior Advisory Committee Members regarding their needs and concerns. Our Committee conducted a county by county forum on March 25th to prioritize issues facing Older Adults and Their Family Caregivers. Although there are many pages of needs, I will try to summarize the results. Counties that took part in this forum were Beaufort, Bertie, Hertford, Martin and Pitt.

There is a great concern among all the counties that there is a lack of availability of in-home services for seniors. Many require income testing to qualify and a 2-year waiting list is not uncommon. Those that are fortunate to be able to pay for this service often find that no help is available. These limited options to keep older adults in their home may be responsible for causing premature placement in an institutional setting. Lack of sliding scale fee services options with those that have some ability to pay and "no affordable options for those "who fall through the cracks cause caregiver burnout as well as lack of care choices.

Volunteer training and retention is a big issue. Many of our counties are rural and there is not enough volunteer coordination and development to provide some services such as meals-on-wheels that may be available. Because of this seniors feel geographically isolated. This type of scenario presents these seniors with limited resources and opportunities that often hinder the opportunity to make ample choices and possibilities. Volunteers could close gaps for seniors who have no way to get groceries, shop and need transportation to their doctor's appointments.

There is a great need to raise the level of public awareness about both needs and services for older adults. Many adults feel that there is a lack if basic information about services and how to disseminate information. Local newspapers and TV media should be encouraged to advocate and to educate the general public about the needs and services available in their community on an on-going basis. More information should be made available to the general public regarding bills before the legislature and where that representative stands on that issue.

Senior Games is a wonderful program for seniors. Our delegates feel that this program should be expanded. As many adults as possible should be

given more opportunity for secure walking and physical activities in their local communities.

Thank you
Sallie Williamson, Caregiver Resource Specialist
Mid-East Commission
252-974-1837

Hello, my name is Jane Reel.
I am a retired teacher who is part of the fastest growing segment of the population.
No, not retired school teachers, but the baby boomers.
We baby boomers could be part of the worst health care crisis our country, our state has ever seen if preventive health measures are not taken now.
A few years ago, as I began considering retirement, I took notice of what activities were available for retirees. You see, I have been active all of my life and did not want to change now or ever. I had no desire to become a couch potato, watching TV and doing crossword puzzles. I wanted to be active, physically and mentally. I wanted to remain healthy.
I found out about the Senior Games program and just how big it is in North Carolina. Before I even turned 55, I got involved playing basketball and badminton.
Those "seniors" ranging in age from 55 to 92 showed me many things about life. They reminded me that you are only as old as you feel, both mentally and physically. I looked forward to being around them, talking with them, and learning from them. They inspired me. I couldn't wait to become 55 and be a true participant in the senior games.
I have now completed my first year and have competed, even winning my first medals.
But the medals are just icing on the cake.
What I have gotten from my participation is a whole new outlook on life. I am in better shape physically then I have been in years. I have extra energy, a sharper mind. My doctor doesn't say comeback tomorrow, but I'll see you next year. My grandchildren have a completely different concept of what a grandma should be. I have new friendships, but above all I am having FUN.
Today I am a healthy 56 year old. And just like all baby boomers I want to be healthy when I am 70, when I am 90, and God willing when I turn 100.
No, I don't want the state to be taking care of me. I want to be an active participant in society for as long as I am able.
I surely don't want to see a health crisis, but it can happen if my generation does not remain active. Continued funding of programs designed for seniors is a giant step. I only wish there were more programs being funded. Every community in North Carolina should have programs available to seniors. Pitt County is an excellent model.
Before I close, I would like to say thank you to all people involved in the senior games. Keep up the excellent work. Thanks for enriching my life and the life of so many others.

Thank you
Jane Reel
Greenville, NC

12 Alice Keene

Pitt County Schools

1717 West Fifth Street
Greenville, North Carolina 27834
http://schools.eastnet.ecu.edu/pitt/

TEL: 252-830-4200
FAX: 252-830-4239

Michael D. Priddy, Ed.D.
Superintendent

October 26, 2004

Dear Senator A. B. Swindell, Representative Debbie Clary, Representative Edd Nye, and Members of the Legislative Study Commission:

On behalf of the Pitt County Community Schools and Recreation Department and the Greenville/Pitt County Senior Games Program, I would like to thank you for your dedication and commitment to the older adults in our state. We know that yours is a difficult job as you set priorities in meeting tremendous needs with limited resources. Today we come to thank you especially for your support for the North Carolina Senior Games Program and its network of 53 Local Games across this great state. This program continues to be a national model for a health promotion and wellness program for citizens 55 years of age and older, and through its services has conserved both human and financial resources.

It has been my great blessing in life to be involved in Senior Games since the establishment of the program in 1983. As a member of the Board of Directors and as a Local Coordinator, I have experienced first hand the real value of this program. Senior Games was the first program that included incentives for healthy, active seniors as well as the less active seniors. With over 40 competitive events, SilverArts, SilverStriders, and SilverLiners there is truly something for everyone. In addition to competitive events, workshops, clinics and training sessions are held throughout the year to provide educational opportunities for seniors and program staff. On a local level, programs have become year-round with practice sessions, health fairs, exercise classes, art classes, and special events. This has made a tremendous impact on the physical, mental, spiritual, and social well being of our seniors.

The North Carolina Division of Aging and its staff had the vision for the Senior Games Program back in 1983. They enlisted the ideas and support of many other agencies, but they established the Program and gave it a strong foundation in this state and across the nation. The Division has continued to play a critical role in the development and expansion of the Program over the years. While one of the strengths of the Senior Games Program lies in its interagency foundation, we believe that the funding should remain with the Division that finds its sole focus on seniors...The Division of Aging and Adult Services.

The benefits of the Senior Games Program and other health promotion programs go far beyond the seniors themselves. Staff, volunteers, and families are learning a new way of aging. Through their experiences they see what being active and involved throughout a lifetime can mean to the quality of life. Families are enjoying fun and exciting times at the horseshoe courts, at the track, at the swimming pool or watching grandmom or grandpop performing on stage, instead of spending time sitting by their bed. Seniors are having fun, making new friends, learning new skills, taking pride in their accomplishments, and in so doing are remaining healthier, happier and more independent throughout their lifetime. This my friends saves dollars, but far more importantly adds quality to the lives of the seniors in North Carolina!

We thank you for giving us this opportunity to share our thoughts and insights as local service providers. With the rapidly increasing number of seniors in our state, we must find ways to keep our citizens healthier and more involved throughout their lifetime. Our past experience has shown us that the Senior Games Program provides one of the most successful avenues for accomplishing this mission. Therefore, we ask that you recommend continued funding for health promotion and wellness programs and the North Carolina Senior Games Programs.

Sincere regards,

Alice F. Keene

Alice F. Keene, Director
Community Schools and Recreation

Good Afternoon. I would like to thank you Senator Swindell, ~~Representative Clary~~, Representative Nye and Commission Members for the opportunity to present to you today. I am Heather Proctor, Area Agency on Aging Director with Upper Coastal Plain Council of Governments which serves Edgecombe, Halifax, Nash, Northampton and Wilson counties.

Between 1946 and 1964, 77 million babies were born. In just two short years, the oldest of this baby boom generation will become eligible for services under the Federal Older Americans Act. Seven years from now, these same individuals will greatly expand the number of Medicare beneficiaries. People are living longer and living healthier; presenting both challenges and opportunities for North Carolina.

The Challenges:

- We can't talk about the challenges facing aging advocates in North Carolina without addressing transportation. Many communities throughout my region and across the state and nation face critical challenges in meeting the transportation needs of our senior adults. A recent study completed for the Special Committee on Aging – US Senate states that "The US population is aging, and access to transportation via automobile or other modes, is critical to helping individuals remain independent as they age". In North Carolina we must plan for alternatives to driving as seniors age, we must accommodate seniors' varied mobility needs by examining the restraints placed on transportation funding and aging advocates must embrace coordination among programs to better meet the needs of our senior adults. We must do more!

- Senior Centers are critical and your support in this area is greatly appreciated. The Division of Aging and Adult Services, with their implementation of the Center of Excellence and Center of Merit process and the Ann Johnson Institute for Senior Center Management Certification is revolutionizing the professionalism of senior centers. The baby boom generation will make senior centers their focal point for services and activities. Additional funding and continuous service improvement is critical. We must do more!

- Prescription Drugs continue to be a major concern for our senior adults and their family caregivers. Thank you for supporting the expansion of the North Carolina Senior Care Program. In North Carolina, we are proud to be able to say we have one of the best prescription drug programs in the nation. Today we hope to register thousands of senior adults for the NC Senior Care Program as all 100 counties are participating in the sign up day. We have held an event in four of our counties this morning and we are available to assist seniors here this afternoon. We have a regional MedLink Program that assists senior adults in securing low or no cost prescription drugs. Through a grant from the Health & Wellness Trust Fund we have been able to increase our assistance. However, we must do more!

- Adult day care provides an organized program of services during the day for the purpose of supporting the personal independence of senior adults and promoting their social, physical, and emotional well-being. The recent increase to the reimbursement rate for adult day services is greatly appreciated, but for Wilson County it came too late. Stately Oaks Adult Day

Center closed their doors on June 30th and Wilson County residents needing adult day care are now participating in services offered in Rocky Mount. Transportation is an issue. Reimbursement is an issue. We must do more!

- My time with you today is limited and it is impossible to address every challenge facing aging advocates in North Carolina. I will end this part of my presentation with one last challenge; it is one of the most critical points I can make. Our seniors benefit from many existing programs. However, these programs need additional funding not only to meet the upcoming needs of the baby boomers, but to meet current needs. In North Carolina, there are over 7300 individuals on waiting lists and there are over 700 in our region alone. Two years ago, we lost one million dollars in home and community based services. Some of this funding has been restored, however it is not enough. We must not only return to our previous funding level, but surpass that amount. I agree with the North Carolina Institute of Medicine's Long Term Care Report which states that "Every North Carolinian should have access, either in the county or within a reasonable distance to a set of core long term care services." We must do more!

The Opportunities:

- Family Caregivers in North Carolina and across the nation are the key to effectively caring for senior adults. Family caregivers, who include adult family members or other individuals acting as care providers are the core of a long term care system that will provide for baby boomers as they age. The Family Caregiver Support Program has been an

exceptional addition to Area Agencies on Aging across North Carolina. We continue to learn more, expand our outreach to family caregivers and increase caregiver services. North Carolina must embrace the opportunity to build a system that supports family caregivers and therefore makes caring for our baby boomers an achievable goal.

- North Carolina also has the opportunity to build on the Division of Aging and Adult Services Senior-Friendly Communities initiative. In our region, we have made this initiative the focus of our four-year plan. The Division of Aging and Adult Services states that the focus of a senior-friendly community initiative is individuals, neighborhoods, agencies, organizations and programs – public and private – collaborating to remove barriers to services and opportunities and improve the quality of life for older adults wherever they live. Senior-Friendly communities
    - understand and accommodate the special needs of seniors, especially the most vulnerable
    - they assure social and economic opportunities in employment, volunteering and community services,
    - they facilitate independence through services such as transportation
    - they guarantee suitable and affordable housing

- they encourage meaningful activity with a wide range of civic, cultural, educational, spiritual, and recreational opportunities

- they provide access to well-coordinated supportive services

- and they support people's independence in planning and managing their own lives

I personally believe that meeting the goals of the Senior-Friendly Communities initiative is the best opportunity I have to care for senior adults in my region now and in the future. I ask for your help in support of both my regional initiative and the statewide initiative.

It is critical for us, as aging advocates, to understand the challenges of the baby boom generation and most importantly to turn these challenges into opportunities for our senior adults, their family caregivers and North Carolina.

Again, I thank you for your time today and for your daily commitment to North Carolina's senior adult population.

Heather Proctor, Director
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Upper Coastal Plain Council of Governments
PO Drawer 2748
Rocky Mount, NC 27803
252-446-0411 ext. 235
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Remarks to N.C. Study Commission on Aging -10/22/04
Rev. Elbert Lee
Member of Governor's Advisory Council on Aging
October 26, 2004

Senator Swindell, Representative Clary, Representative Nye and Commission Members. I am Elbert Lee from Rocky Mount and a member of the Governor's Advisory Council on Aging. The Council is an appointed body that studies issues of importance to our state's older citizens and makes recommendations to the Governor and the Secretary of the Department of Health and Human Services about how to address identified needs. At our Council meeting last week, we selected recommendations for the 2005 legislative session which are being forwarded to Governor Easley and Secretary Hooker Odom. I would like to share some of these key recommendations with you today. They are as follows:

- Take steps to fully implement the provisions of Senate Bill 10 which was passed in 1999. The focus of this legislation was on improving quality of care, increasing the protection of residents in long-term care, and strengthening regulatory oversight of practices in the long-term care industry.

- Take steps to strengthen transportation services for older and disabled adults. The Council held a transportation forum in the spring of this year and has developed a series of recommendations related to transportation which are being transmitted to the Governor and Secretary Hooker Odom this week.

- Reinstitute the tax credit for long-term care insurance which expired December 31, 2003. We thank this Commission for proposing legislation last year to continue the tax credit, and we trust that you will again have this on your agenda.

- Increase the Homestead Property Tax Exemption by increasing the income eligibility level to $25,000. We also propose that revenue loss due to the exemption be shared 50% by the State and 50% by the counties. The last time the exemption was increased was in 2002 when it was increased from $15,000 to $18,000. A provision was also included to increase the income eligibility level each year to the nearest $100 based on annual cost of-of-living adjustments used in calculating Social Security benefits.

- Increase funding for Senior Centers of Merit and Senior Centers of Excellence which seek to make their communities more senior friendly.

- Continue efforts to strengthen the long-term care direct care workforce.

- Appropriate $2 million to expand funding for the Home and Community Care Block Grant.

- Appropriate $2 million each year of the biennium to provide indoor plumbing for older adults without these facilities. According to the information provided by the North Carolina State Data Center from the Census 2000 data, there are 8,184 households headed by persons age 60 and older without complete indoor plumbing in our state.

- Increase funding for adult day/adult day health care services in the State and take steps to continue to enhance the staff capacity of adult day care/day health care centers. We know that you will be receiving a report on adult day care at one of your upcoming meetings.

- Ensure the continuing viability of the Community Alternatives Program for Disabled Adults (CAP/DA).

- Expand the State/County Special Assistance In-Home program so that any older or disabled adult who qualifies for this program has the option of participating in the program.

- Increase the asset limit for Medicaid eligibility for aged, blind, and disabled persons from $2,000 to $6,000 for an individual and from $3,000 to $9,000 for a couple. These asset levels have not been changed in 20 years.

Thank you for giving me the opportunity to address you today. On behalf of the Governor's Advisory Council on Aging, thank you for your work for our State's older citizens.

Lene Parker
4629 Laurel Ft Trl. Rd
Rocky Mount, NC 27804

The City of Rocky Mount will be obtaining the YMCA Building downtown, on Church St as a Senior Center by September of 2005.

In the past years Senior Centers received agencies for the start up of their Senior Centers.

Our Concerns from the Senior Adults in the City of Rocky Mount, which serves both Nash & Edgecombe residents. Will this money be available for us to start a Senior Center?

Benefits arrived from Senior Centers are fitness, fun, friendship, a place for training for Senior Games, a place for Arts & Crafts for Seniors, a place to develope friendships, (~~prevention~~ depression).

A healthy senior will stay out of the nursing home.

Presentation to the NC Study Commission on Aging
By
Armeta Coley, Regional Ombudsman

I would like to thank the members of the study commission for providing me an opportunity to speak with you today, regarding staffing in Adult Care Homes on behalf of Adult Care Home Residents, Families and the Ombudsman Program,

Currently the minimum staffing requirement for Adult Care Homes is 1 personal care Aide to 20 Residents for 1st and 2nd Shift and 1 personal care aide for 30 Residents 3rd Shift except Special Care Units. Staffing for Adult Care Homes has not changed in many years. Senate Bill 10 which passed in 1999 did establish rules which allows for additional staff for Special Care Units within Adult Care Homes.

Currently there are a large number of individuals with Mental Health Diagnoses and Developmental Disabilities residing in Adult Care Homes and many of the residents have special care needs.

According to a Medicaid Provider Bullentin that was sent to Nursing Home in June 2004 the rates for long term care facilities were changed to a case mix payment system. Case mix is a payment system where the facility payment rate is based on the medical needs of all the patients rather than the old method of reimbursement which was based on the level of Care. Due to the new reimbursement system we only have one level of care. Therefore, we no longer have Intermediate Level of Care. Residents who have resided in nursing homes for many years at the ICF level of care are now being discharged to Adult Care Homes. Adult Care Homes are admitting residents that are sicker. Therefore, we are seeing sicker residents in additional to the large number of residents with mental health diagnoses in Adult Care Homes. Staffing is a great concern in Adult Care Homes and staff to resident ratio needs to be increased.

I am Judith Moss from Tarboro and am here to ask for your support for the North Carolina Senior Games program whose focus and purpose is keeping the aging population of North Carolina healthy, both physically and mentally, into their later years.

I have been involved with the Senior Games for ten years and it has been the best thing that I have done in that time. I am a participant, volunteer and state ambassador. I'm a late blooming athlete and artist, involved in activities I never expected to do. But most of all, I am at this time a healthy 66 year old who requires no prescription medications despite genes that include hypertension, diabetes, and cancer. I credit Senior Games with helping me to maintain this level of health.

As one of over 65,000 participants in the 53 local organizations in our 100 counties, I'd like to thank the General Assembly and the Division of Aging for their support which makes this program a reality. We hope that our focus on the prevention of health problems through a healthy, active lifestyle helps to reduce the number of NC residents who will require nursing home care. Statistics show that the amount of money needed annually to care for 3 people in a nursing facility can be used by Senior Games program to serve over 50,000 NC residents during the same one year period. We hope to reach many more senior adults in our state.

We are also seeing our oldest participants continuing to participate for many years. During the State Finals just completed last weekend, we had 27 participants 90 years of age and better. And these numbers are increasing.

Each of your was given a state flyer and a log book for our national award winning walking program, SilverStriders. We invite you to use it to keep a record of your own walking for exercise. As one of the easiest exercise activities, we hope to add many more participants in this part of our program.

Again, thank you for your continued support of the Senior Games program and we hope that with your help we'll be able to involve many more of our state's seniors. This will give us more opportunities to share the idea of preventing health problems being better than treating health problems. We look forward to being a partner with you in the finding ways to reduce future health care expenses.

2004

21

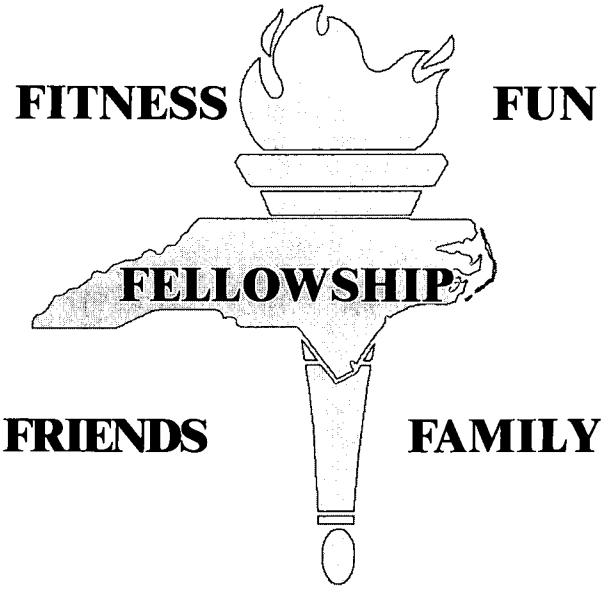
NORTH CAROLINA
Senior Games

Join Us for a Celebration of the Human Spirit

North Carolina Senior Games began in 1983 with a vision to create a year round health promotion and education program for adults 55 years of age and better.

LOCAL SENIOR GAMES

There are over 50,000 participants statewide in 53 Local Games that serve all 100 counties across the state.



Senior Games is a wellness and prevention program to keep the body, mind and spirit fit while enjoying the company of friends, family, spectators and volunteers.

Passing the Torch to Future Generations...

NCSG Silver Legacies

Help provide a year round health promotion and education program for adults 55 years of age and better by including North Carolina Senior Games in your estate plan. For more details on giving opportunities, contact NCSG.

SILVERARTS

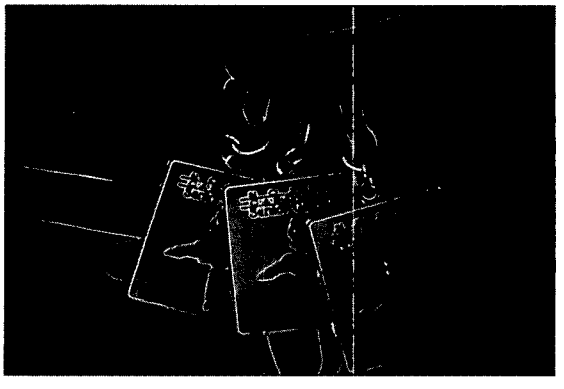
NCSG's Heritage, Visual, Performing and Literary Arts programs and Cheerleader program.

SILVERSTRIDERS

NCSG's national award winning walking program.

SILVER CLASSIC

NCSG's special events program.



STATE FINALS

September 27th - October 3rd, Raleigh

Softball Tournament
Walnut Creek Softball Complex, Raleigh
September 15th - 17th

Golf Tournament
Winston Salem
October 11th - 12th

Basketball Tournament
East Carolina University, Greenville
October 22nd - 24th

PO Box 33590, Raleigh NC 27636 (919) 851-5456 www.ncseniorgames.org

2004 LOCAL SENIOR GAMES

Call the Local Coordinator in your area to find out how you can be a part of Senior Games.

LOCAL GAME	LOCATION	DATES	LOCAL COORDINATOR	TELEPHONE #
Alamance-Burlington Sr Games	Burlington	April 19-May 11	Jane Smith	336-222-5135
Albemarle Sr Games	Elizabeth City	April 12-15	Lynne Raisor	252-426-5753
Asheville-Buncombe Sr Games	Asheville	May 10-14	Dee Black	828-350-2051
Blue Ridge Sr Games	Wilkesboro	April 26-May 19	Angela Fisher	336-670-2644
Brunswick Co Gator Sr Games	Bolivia	April 15-May 6	Khrystye Wilson	800-222-4790
Cabarrus Sr Games	Concord	April 14-May 28	Mike Murphy	704-920-3484
Carteret Co Sr Games	Morehead City	May 3-7	Rachel Sension	252-808-4067
Caswell Co Sr Games	Yanceyville	May 10-21	Tommy Duncan	336-694-4449
* Charlotte Mecklenburg Sr Games	Charlotte	April 24-May 8	HC Woody Woodward	704-529-2847
Chatham Co Sr Games	Pittsboro,Siler City	April 23	Kelly Gordon	919-542-4512
Cleveland Co Sr Games	Shelby	March 3-May 15	Shirley Bridges	704-482-3488
Davie Co Sr Games	Mocksville	March 3-May 15	Sandra Boyette	336-751-2325
* Down East Sr Games	Rocky Mount	May 3-14	Alberta Pettaway	252-641-4263
Durham Sr Games	Durham	April 19-May 1	Chaunesti Lyon	919-560-4355
Far West Sr Games	Bryson City	May 5-14	Kathy Posey	828-488-6159
* Four Seasons Sr Games	Hendersonville	May 3-15	Bridgette Galloway	828-697-4884
* Greater Greensboro Sr Games	Greensboro	April 5-26	Cindy Hipp	336-375-2237
Greater High Point Sr Games	High Point	April 29-May 14	Dennis Eaton	336-883-3584
Greenville-Pitt Sr Games	Greenville	April 12-29	Alice Keene	252-830-4217
Haywood Co Sr Games	Canton, Waynesville	May 3-21	Shirley Topper	828-452-2370
High Country Sr Games	Boone	May17-June 12	Holly Goodwin	828-264-9511
Iredell Statesville Sr Games	Statesville	May 8-15	Greg Roane	704-878-3429
Johnston Co Sr Games	Clayton, Selma, Benson, Smithfield	April 19-30	Larry Bailey	919-553-5777
Land Of Waterfalls Sr Games	Brevard	April 20-May 8	Rick Pangle	828-884-3156
Lumber River Sr Games	Pembroke	April 26-May 1	Jennifer Hall	910-618-5533
* Macon Co Sr Games	Franklin	April 28-May 15	Teresa Holbrooks	828-349-2090
Madison Co Sr Games	Mars Hill	April 22	John Hough	828-689-5728
* McDowell Co Sr Games	Marion	May 7-20	Lisa Wylie	828-652-8953
Mid Carolina Sr Games	Fayetteville	March 24-April 8	Tracy Davis	910-323-4191
* Neuse River Sr Games	New Bern	Arpil 27-May 8	Rusty Cotton	252-636-6606
Onslow Sr Games	Jacksonville	April 26-May 1	Mike Wetzel	910-347-5332
Orange Co Sr Games	Carrboro, Chapel Hill, Hillsborough	May 3-23	Karen Berry	919-918-7372
* Outer Banks Sr Games	Kill Devil Hills	April 19-May 1	Brandi Rheubottom	252-475-5635
Pender Sr Games	Burgaw	April 19-23	Rebecca Blanks	910-259-9119
* Piedmont Plus Sr Games	Winston-Salem	April 26-30	Edith Bailey	336-727-2505
Raleigh Wake Sr Games	Raleigh, Cary, Garner	April 5-16	Steve White	919-831-6851
Randolph Co Sr Games	Asheboro	April 17-27	Foster Hughes	336-626-1240
* Region K Senior Games	Henderson	March 30-May 18	Steve Norwood	252-436-2052
Rockingham Co Sr Games	Madison,Eden,Reidsville, Mayodan	May 6-14	Iris Carter	336-548-2789
Rutherford Co Sr Games	Spindale	April 2-16	Diana Brooks	828-287-6409
Salisbury Rowan Sr Games	Salisbury	April 19-23	Susan Carpenter	704-637-3120
* Scotland Co Sr Games	Laurinburg	May 3-14	Carol McCall	910-277-2550
Smoky Mountain Sr Games	Sylva	April 19-30	Dora Caldwell	828-293-3053
Sr Games By The Sea	Wilmington	April 12-30	Annette Crumpton	910-452-6410
Sr Games In The Pines	Southern Pines	April 19-May 7	Pam Smith	910-692-7376
Sr Games Of Lee Co	Sanford	May 13-22	Jimmy Solomon	919-776-0501
Sr Games Of Richmond Co	Hamlet, Rockingham	April 19-May 10	Susan Sellers	910-582-7985
Thom-Davidson-Lex Sr Games	Thomasville, Lexington	May 3-14	Thessia Everhart	336-474-2754
Unifour Sr Games	Hickory	April 19-May 7	Steve Jones	828-324-1200
* Union Co Sr Games	Monroe	May 3-29	Neal Robertson	704-843-3919
Uwharrie Sr Games	Albemarle, Troy	April 24-30	Toby Thorpe	704-984-9560
Wayne Co Sr Games	Goldsboro	April 26-30	Stasia Fields	919-739-7486
Yadkin Valley Sr Games	Elkin,Yadkinville, Pilot Mtn, Mt. Airy	May 10-28	Vonda Martin	336-368-2012

*Indicates "Closed Game" – only accepts participants from their geographical area.

For information about your Local Senior Games:

North Carolina Senior Games
PO Box 33590, Raleigh, NC 27636
(919) 851-5456
www.ncseniorgames.org

NASH COUNTY

NASHVILLE, NORTH CAROLINA 27856

J. CLAUDE MAYO, JR., CHRM.
BOARD OF COMMISSIONERS

ROBERT M. MURPHY
COUNTY MANAGER

VINCE DURHAM
ATTORNEY

WAYNE MOORE
CLERK TO BOARD

Nash County Aging Department

October 26, 2004

Dear Study Commission on Aging:

I would like to express to you what a phenomenal working experience I have had in the aging field in North Carolina. I moved to the state in May of 2000, and shortly thereafter I was offered the position of Aging Coordinator for Nash County. Today I serve as the Aging Services Director for the Nash County Aging Department and oversee the Nash County Senior Center as well as 7 other core services provided in the county.

In May 2004, just weeks prior to the Nash County Senior Center's third birthday, the center was certified as a Center of Excellence. The thorough standards and guidelines provided by the certification process have been instrumental in developing our agency as the focal point for aging services in Nash County. This initiative has been well received by many centers across the state. Although the certification process was launched with the hope of funding being attached, statewide so many centers have stepped up knowing there was a possibility that those funds may not be available. This is owed to the fact that aging professionals care. We care about the work we do on a daily basis, and we are concerned about the future provision of services to an aging population.

I have also had the privilege to participate in the Ann Johnson Institute for Senior Center Management. In March 2004 I was honored to be among the first thirty-five to graduate and receive my certificate. The North Carolina Division of Aging and Adult Services has done an extraordinary job in providing not only the guiding policies and written structure for Senior Centers, but also to provide aging service professionals with distinctive training. The Ann Johnson Institute for Senior Center Management provides in depth training and invaluable networking among aging professionals.

I want to thank the Study Commission on Aging for all of your past efforts in aging and particularly any support you have provided for the two initiatives I just mentioned. Furthermore, I would like to make a plea for your future attention and support to include funding for Senior Friendly Communities. It is no secret that our population is aging, but we have yet to develop the planning and economic growth partnerships necessary to prepare for our aging communities. The Division of Aging and Adult Services has made outstanding strides to cultivate strong, educated leaders in the aging field. Help us. Empower us to go into our communities and foster these partnerships by designating funds for Senior Friendly Community development. Funds would address a unique and diverse set of needs for individual communities including areas such as the physical environment, health, economy, technology, safety and security, and others. Since I entered this state just over four years ago, the aging profession has made great progress within aging. Help us. Empower us to step outside of our agencies to educate and advocate for future growth and development of communities that address the needs of an aging population. Help us. Empower us to assist the older adults in our communities to age in their own homes as long as possible.

Thank you,

COMMISSIONERS: Lou M. Richardson, District #1; Fred Belfield, Jr., District #2; Billy Morgan, District #3; Tommy May, District #4; Jay Alford, District #5; J. Claude Mayo, Jr., District #6; Randy Stewart, District #7.

Approved by Public Policy Committee 8-17-04
Public Policy
Short- and Long-Term Advocacy Goals

I **Consumer Choice/No Institutional Bias**

- ***Consumer choice***
  - Remove limits for CAP and in-home assistance; consumers should not be forced into an institution because no CAP slots are available
  - Maximize non-institutional options
- ***Funding Streams***
  - Expand HCCBG to encompass those who are close to Medicaid eligible, but not currently eligible
  - Expand CAP/DA
  - Expand in-home care/SA
  - Expand regular Medicaid to include adult day health as a regularly covered service without having to be eligible for CAP/DA outside of waiver program
  - Expand eligibility for Medicaid-funded personal care to individuals in adult day care
- ***Pre-Admission Screening***
  - Mandate pre-admission screening for both full-pay and Medicaid before they enter a long term care facility
  - Conduct financial screening first by a qualified independent reviewer – if it costs more to maintain resident at home, do not need to proceed
- ***Develop an adequate core set of services in each county***
  - Implement core services plan developed by the Division of Aging in the Department of Health and Human Services
  - Ensure counties are funded adequately to provide monitoring and oversight to assure that consumer choice elders receive the services funded and are not exploited or abused
- ***Make complete information about facilities, facility ownership, performance audits and violations/penalties readily available to the public online within 30 days***

II **Enforcement/Monitoring**

- ***Keep monitoring for adult care homes local***
- ***Develop minimum staffing and training and maximum workload standards for adult home specialists***
- ***Develop and implement a system for rated licenses for nursing homes and adult care homes***
- ***Develop and implement performance-based reimbursement reform for adult care homes***
- ***Enforce laws related to accountability/transparency in use of Medicaid funds***
  - Conduct biannual audits of adult care homes by the State Auditor, to include the financial implications of related enterprises operated by the same corporation that operates the facility
  - Develop an objective cost model for adult care homes that determines actual cost of adult care home care and develop reimbursement models based on cost models
- ***Require that each county's emergency services unit develop an emergency/disaster plan for special populations residing in their counties, whether located in long-term care facilities or at home***
- ***Fund and develop process for implementing the temporary management law currently in the state statutes***
- ***Modify state law to require DFS to deny a license to homes that are part of chains with persistent problems***

III **Staffing**

- ***Require adequate staff training, based on individual resident needs***
- ***Provide adequate pay and health insurance for direct care staff to increase retention and improve quality of care***
- ***Improve staff-to-resident ratio***
  - Base staff-to-resident ratio on resident assessment
  - Increase minimum staffing requirement, to include providing sufficient staff to meet the needs of residents
- ***Mandate drug testing for all long term care employees***
- ***Improve staff working conditions, to include limiting the number of consecutive hours worked by nurses, med techs, and CNAs***

IV **Mixed Populations**

- ***Meet adequately the needs of medically diverse populations in appropriate settings and appropriate groupings through appropriate reimbursement structures, resulting in adequate assessment, diversion and specialized services for these populations.***
  - **Mental Health Units**
    - When a person's mental health needs override physical care needs, the person should be served in settings licensed by G.S. 122-C, administered through the State Mental Health Commission
    - When a person's physical care needs override mental health needs, that person should be served by an adult care home/nursing home
    - When determining how the needs of aggressive persons or sexual offenders will be met, a Pre-Admission Screening and Resident Review (PASARR)-type evaluation should be conducted to determine whether the overriding patient need is physical care or mental health care, aimed at identifying an appropriate long-term care setting that meets residents' needs
  - **Special Care Units**
    - DFS should adhere to the regulations as written related to locked units or groupings of patients with Alzheimer's or related dementias, not as the regulations have been interpreted in the past.
      - Therefore, state law requires that a locked unit should be deemed to be a special care unit.
      - Designation as a special care unit should also require enhanced staffing, training and activities to meet the needs of the residents.
    - Use Medicaid and Special Assistance funding to improve the reimbursement structure for those units that meet the higher standards, thus enhancing the safety and health of residents, increasing staffing and improving bed availability.

Thank you for giving me the opportunity to share with you my concerns. I am Connie Richardson, MedLink Coordinator for the Upper Coastal Plain Area Agency on Aging. I am charged with assisting senior adults in securing low or no cost prescription drugs. It is a charge that I find personally and professionally rewarding.

It is not a secret that low income senior adults who do not have drug insurance coverage cannot afford the many prescription drugs that are necessary for them to improve their quality of life.

As a result these seniors either cut back on the prescribed medications or do not take the medications they need at all simply because they cannot afford them. They have to choose between paying the heating bill, buying food or paying their rent over filling their prescriptions. In most cases the prescription goes unfilled and the senior's health declines. This decline in health reduces the quality of life for that senior adult and tremendously increases healthcare costs across the board – a "LOSE-LOSE" situation.

Medicines saves lives, increases mortality of our senior adults, empowers them to live independently, hold down a job and be active in the community, improving their quality of life. Medicine can also prevent or delay illnesses and disease that will in turn save billions of dollars in healthcare costs across the board when hospitalization, surgery and admission to long term care facilities are avoided or delayed. Billions of dollars will be saved in Medicare expenses alone.

Another problem is that living in rural eastern North Carolina many senior adults, especially those disabled and homebound, are not aware of the programs available to them nor do they have the training, technology or capability

to access them. One of our biggest challenges is in disseminating information on the many programs available to assist with the cost of prescription drugs. We desperately need funding that will include outreach as an eligible expense. All of our grants require it, but none of them allow it as an eligible expense.

I spoke today to personally praise the North Carolina Senior Care Program sponsored by the Health & Wellness Trust Fund Commission. With its recent changes, it is now a program that I am very excited about and proud to promote. I hope that as we progress to the year 2006, we continue to take a look at the prescription drug needs of our senior adults. It is still unknown what the future will hold, but I feel confident that in North Carolina we will continue to help our seniors with their prescription drug needs.

Presentation
North Carolina Study Commission on Aging
October 26, 2004

Good Afternoon:

I'm Barbara Blackston, Executive Director of Wilson Community Improvement Association, Inc. and the Gee Corbett Village Wilson Senior Center. The elderly is one of the fastest growing age groups of Wilson County. In Wilson and Wilson County the aging population is 12,957 for persons 60 years and older, equaled to 17% of the population. A recent study shows that if the growing trend continues by the year 2020, 33% of our population will be persons 65 years and older. Therefore, we must begin to make meaningful preparation to care for our elderly citizens.

Since 1971 WCIA's philosophy and efforts have been to remove all older people from a life of isolation, loneliness, despair and place them back into the main stream of life. Many improvements for our elderly citizens have been made thanks to you and others. However, due to the growing population there is a greater need for transportation, senior centers, affordable housing, and senior outreach

Transportation is a very big issue among our senior citizens. Approximately 16 % of seniors age 65 and older are without a car. If ~~chose~~ they or are able to walk to the bus stop it would only take them to a certain point and drop them off. A round trip cab fare from ~~my~~ office to the health department is estimated to be around $14.00 WCIA's bus provides daily service to our nutritional program, grocery store or doctor's office. There is no charge but

recommend a fifty cents donation. By the end of the month that appears to be to be a bit much. Please continue to fund the Senior Transportation Program.
Senior Centers not only provide a focal point for services, information and referrals. It also provides a place where older adults can participate in social, health and wellness, recreational and volunteer activities. There are a lot of families with more space in their recreation rooms than seniors have in their center at Gee Corbett Village. It takes a lot of juggling to make things happen. Sewing machines used for sewing classes and crafts have no permanent home. Each time they are used they have to come off the shelf be set up and broken down and stored until the next class. The exercise equipment which requires considerable space is pushed into a corner during group activities. Seminars on health issues often include a video; we can't set the room up theater style because we need the tables for lunch and other activities. So people with hearing and sight limitations sometimes miss a lot of the program. There is a tremendous need for more senior centers and expansion of existing centers.

Many Americans dream of owning a home. Many seniors dream of maintaining decent, safe and affordable housing. Seniors need housing for all levels of income and physical needs. They need support services that enable them to remain in their home. There needs to be more affordable nursing homes and retirement communities. Many elderly citizens are house rich and cash poor and are unaware of the reverse mortgage program. Many Programs rely on a bank as a solution to Repairs.
Lastly we need to increase the public awareness of services to older persons through information and referral to other agencies, telephone reassurance or just friendly visits. To do this we must increase staff and funding to the service providers.
In my conclusion let me introduce you to two seniors. One we'll call Jill the other Ann. Jill receives $800 a month and Ann $500. There monthly obligations are similar except that Ann receives a blue card for her medicines and Jill does not. By the time we

deducted recurring monthly obligations very little was left over. During the course of the conversation she mentions that she had fallen and was unable to get up until someone came to check on her. I asked wouldn't it be nice to have an emergency alert system. She wanted to know if she would have to pay for it. Perhaps a little I responded. And she replied, the table was in the way. She ended the call with thank you for calling and I expect to hear from you soon. I would like to thank you for listening and I ~~hope to hear from you soon~~. Ask that you continue to provide adequate funding for Senior Transportation, Senior Centers & affordable housing -

Aging Study Commission Public Hearing
October 26, 2004

Denise Boswell, Ph.D.
252-972-1108
boswelld@ci.rocky-mount.nc.us

→ introduce self – Gerontologist/Planner
currently – Principal Planner for City of Rocky Mount
Ph.D. in Urban Studies with a specialization in Gerontology

Spent 1997-2001 researching and writing about the topic of elder-friendly/senior-friendly community building and specifically what urban or community planners could do to make places (communities, towns, and cities) better able to accommodate the unique needs of older residents. In 2001-2003 was a faculty member in the Gerontology Dept at Towson University in MD and among several, developed and taught a course in Community Planning for an Aging Society. Relocated to my home state in May 2003 and since March of this year have made 4 major presentations on various aspects of the important of making our communities more S-F. So I come with a level of expertise on this most important topic.

→ reason here – to present testimony on an issue of extreme importance not only to the quality of life and successful aging of our current and future older residents but also to the economic well-being of our State – the creation of Senior-Friendly Communities across North Carolina.

I feel strongly enough about the need for us to address this issue that I took my lunch hour and drove down to Wilson to speak with you today and to ask you to encourage the legislature to move this initiative forward as a priority in the upcoming session; in other words, to make it a <u>focus</u> of our State so that we will serve as a model for other states in our Nation.

The Division of Aging and Adult Services wisely and with foresight introduced this initiative in the 2003-07 State Aging Services Plan. They indicated their commitment to implementing the S-FC concept statewide by including an entire chapter in the document. There are currently 5-6 of the 17 AAA who have begun to move forward with this critical program.

→ why important - all of my research and writing indicates that North Carolina needs to take a serious look at how we can successfully implement this initiative across every part of our State

demographics - You know the current and projected demographics of NC. Along with the current and future older population, we also know people are just living longer.

Migration of retirees to our State – we are now in the top five states for receiving people age 60 and older (along with Florida, Arizona, California, and Texas).

If communities across our State become known as being "friendly" to older people, then it will only attract or entice more individuals to decide to move here after retirement and perhaps before.

In other words, this initiative will help not only current and future seniors but it will also enhance our economy significantly as more people are attracted to relocate here. Also, it's important to remember that **making places more S-F creates better communities for all**. In other words, S-Friendliness benefits children and young families in a variety of ways. For instance, with more seniors desiring to live in NC, we can draw upon the wealth of talents and resources of active older adults. We will have a larger volunteer pool to provide intergenerational opportunities for younger folks. In other words, it will result in a win-win situation for everyone.

But **timing is critical**, since we know the first of the Boomers will begin retiring in 2012 – a mere 8 years from now. Let's commit to making our State elder-ready. It will take time and focus to move this initiative forward and I believe you have the wisdom and foresight to do what is necessary.

→ conclusion

I am here today to ask you to please carry the message back to Raleigh of the critical importance of focusing on the Senior-Friendly Communities initiative NOW so that we will be prepared for the changes that will inevitably come to our state as our population ages and as more retirees move here. This will give us a grand opportunity to be PROACTIVE and therefore, put North Carolina where we belong -- in the forefront of this issue.

Thank you for providing this opportunity for me to express myself to you on a topic that I believe in my heart and in my mind is of absolute importance to all North Carolinians.

WAITING LISTS* UPPER COASTAL PLAIN REGION AS OF: 10.26.04

Home Delivered Meals 179

Congregate Nutrition 43

Housing & Home Improvement 167

Legal Services 5

Adult Day Care / Day Health 6

Transportation 15

In-Home Aide Services 295

710

#'s reflect our region's waiting list

* Wilson, Nash, Edgecombe, Northampton, Halifax Counties

exceptional addition to Area Agencies on Aging across North Carolina. We continue to learn more, expand our outreach to family caregivers and increase caregiver services. North Carolina must embrace the opportunity to build a system that supports family caregivers and therefore makes caring for our baby boomers an achievable goal.

- North Carolina also has the opportunity to build on the Division of Aging and Adult Services Senior-Friendly Communities initiative. In our region, we have made this initiative the focus of our four-year plan. The Division of Aging and Adult Services states that the focus of a senior-friendly community initiative is individuals, neighborhoods, agencies, organizations and programs – public and private – collaborating to remove barriers to services and opportunities and improve the quality of life for older adults wherever they live. Senior-Friendly communities
    - understand and accommodate the special needs of seniors, especially the most vulnerable
    - they assure social and economic opportunities in employment, volunteering and community services,
    - they facilitate independence through services such as transportation
    - they guarantee suitable and affordable housing

Northampton Co. Dept. Social Services - Paula Arrington
P.O. Box 157
Jackson, NC 27845

(1) With the New Mental Health Reform & Privatization there is a need for more money to put in the Guardianship Program for staff time. Often times when DSS is named Guardian for a ward there is NOT sufficient staff time to accomplish this task. Therefore Social Workers have to incorporate this in their ongoing caseload. In Northampton County the Clerk of Court has started a rotation system with DSS, Mental Health & Health Department in assigning wards. However the majority of the cases still remain with DSS.

(2) Please continue to fund CAP-DA. At the present time Northampton County has a waiting list for approximately 150 cases. The State has been gracious in awarding additional slots to all those counties who so desired. Northampton County was awarded 16 slots.

Northampton Co. AAA – Paula Arrington

(3.) I would like to echo all that has been said about the Senior Games. Northampton Co. Seniors are participating in these games and are excited about participating. In 3 years I will be a senior citizen and I can't wait to be a part of all they do in these games.

(4.) I would also ask that the financial penalties be re-assessed for adult care homes with Type B & Type A ~~penalties~~ violations. Sometimes they are too low. Make these homes accountable. On the other hand I would like to commend the Division of Facility Services for their technical assistance and support during the time Northampton Co ~~we~~ was monitoring a facility where a penalty has been assessed.

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Wednesday, October 27, 2004
10:00 A.M.
Legislative Office Building, Room 643

The North Carolina Study Commission on Aging met on Wednesday October 27, 2004 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator A. B. Swindell, Representative Debbie Clary, and Representative Edd Nye, Co-Chairs; Senators Charlie Dannelly and Austin Allran; Representatives Jennifer Weiss, David Lewis, Gene Wilson and Beverly Earle; public members Brad Allen, Jan Elliott, Linda Howard, Katherine Fox Price, and Florence Soltys.

Dianna Jessup and Shawn Parker, Commission staff, Research Division, NCGA, were present and provided staff support. A visitor's registration form is attached and made a part of the minutes. (See Attachment 1)

Representative Nye presided, and after calling the meeting to order, he welcomed everyone in attendance. He then asked Ms. Jessup to address the Commission concerning items II and III of the Agenda. (See Attachment 2)

Review and Approval of 2004-2005 Commission Budget (See Attachment 3)

Ms. Jessup reviewed the 2004-2005 Commission Budget Estimate. Rep. Nye asked for a motion for the approval of the budget. A motion was made by Rep. Weiss and passed by voice vote.

Status of 2004 Aging Study Commission Recommendations (See Attachment 4)

Ms. Jessup presented the Commission recommendations to the members. The Commission has been very successful in having its recommendations implemented. Out of ten recommendations, nine were enacted during the 2004 Session by the General Assembly. The one that was not acted upon was to repeal the sunset on the long-term care insurance premium tax credit.

2004 Legislation on Interest to Senior Citizens
(See Attachment 5)

Ms. Jessup noted the handout titled, Summary of Substantive Legislation Related to Aging that was given to each member. This lists all the substantive legislation from the 2004 Session that was enacted.

Community Alternatives Program for Disabled Adults (CAP/DA) Audit Report
(See Attachments 6,7, and 8)

Ms. Janet Hayes, Office of the State Auditor, came before the Commission and reviewed and explained the Audit Report. She said that Denise Roberts and Joe Turlington from the Auditor's office were also in attendance. In summary, the major issues were revealed by the audit.

1. The CAP/DA manual has not been updated to reflect recent changes. Recommendation was that DMA management should take steps to assure that the update incorporates changes that have occurred with the implementation of AQUIP. Other recent organizational and programmatic changes should also be reflected in the manual.

2. DMA CAP/DA job descriptions do not reflect current job duties. Recommendation was that their Human Resources section should review and update all job descriptions for the Facility and Community Care Section to ensure that the descriptions are consistent with actual job responsibilities. DMA should also request a formal OSP classification study of positions relating to the CAP/DA function.

3. Training opportunities for local lead agencies have been curtailed due to budget cuts. Recommendation was that DMA should explore ways to offer more cost-effective training tailored to fit the needs of the local lead agencies. One possibility to consider would be the use of Internet teleconferencing options offered by the State's Information Highway sites. DMA should also consider re-instituting the CAP/DA conferences and Medicaid fairs once staff and funding are available.

4. Service provider billings are being paid without case manager approval. Recommendation was for DMA to amend the current EDS contract to require that the payment system include controls to prevent payment of provider billings that have not been approved by the local case manager. Further, to encourage all providers to submit CAP/DA claims (and other Medicaid claims) electronically, DMA should work with local lead agencies to establish an electronic approval process for claims. DMA should also require the new contract with Affiliated Computer Systems for Medicaid payments (effective July 1, 2005) to include controls to prevent unapproved payment of provider billings.

5. Local lead agencies' program policies are inconsistent. Recommendation was that DMA should develop model program policies for all aspects of the CAP/DA program to

assist local lead agencies in preparing or updating their policies for CAP/DA. Once established, all local lead agencies should use the standardized policy guidelines developed by DMA to develop local policies and procedures for the CAP/DA program.

6. Local lead agencies do not maintain uniform client case management notes. Recommendation was noted that DMA should develop more specific guidance for local lead agencies to use in recording monthly case management notes and other pertinent information. To improve the efficiency of the program, case management notes and other program documentation should be done in an electronic format whenever possible. Once developed, all local lead agencies should take steps to assure that the minimum data is recorded in case notes. DMA program consultants should check for the minimum data as part of the monitoring reviews.

7. Case manager service hours charged by local lead agencies vary considerably. Recommendation was that DMA should analyze data from AQUIP, once fully implemented, showing the number of hours charged by all local lead agencies for annual assessments and monthly case management services. Using the analysis, DMA should develop guidelines that establish normal parameters on the number of case management hours charged by local lead agencies. These guidelines should consider the type of lead agency. Once developed, local lead agencies should adhere to the guidelines for case management hours and document any exceptions. DMA program consultants should include a review of case management hours charged as part of the monitoring reviews.

Rep. Nye stated that there needed to be some funds appropriated for an in-depth study to be able to track the recommendations being made in the report. Ms. Hayes agreed and said that was the Auditor's recommendation. Rep. Earle expressed that she hoped the Commission would indeed recommend funding of $150,000 for the cost to look at the medical and clinical side of the program. Some people are getting more services than needed while others are not getting the services they need.

North Carolina Senior Care Program Update

Michael Keough, Department of Health and Human Services, presented a slide presentation showing an update on the Senior Care Program. The idea was to try to get low-income enrollees enrolled to make use of federal money before any State money is expended on an individual. This creates a credit of $600 per calendar year for 2004 and 2005 for anyone at or below 135% of the federal poverty level. There are 40 discount Medicare discount cards that are approved to do business in North Carolina. A bid was put out and 11 responded expressing interest in working with them to serve these eligible individuals. In July, the legislature allowed them to enroll these seniors. This allowed them to have one card to cover both federal and State. In June they selected a card, Community Care Rx, to work with Senior Care. They increased their benefit from $600 to $1200 per year. The total enrollees to date were 53,442. Members commented that this Program is more user-friendly because it provides more coverage and it is a good service for the many low-income seniors in the State.

Interim Report on the Pilot Project for LTC Community Service Coordination
(See Attachment 9)

Julie Bell, Division of Aging and Adult Services, Department of Health and Human Services, stated they would be updating the members on their interim report titled, Interim Report The DHHS Communications and Coordination Initiative. She reviewed the background information. This was a pilot project that the legislature asked them to undertake. It is a two-year project and the final report will be presented next year. The two pilot programs are Mecklenburg and New Hanover Counties. Recommendations #11 and #16 were the recommendations they have focused on.

Status of Seniors Initiative
(See Attachment 10)

John Highfill, Adult Services Section, Mecklenburg County Department of Social Services, reviewed his handout, **Status of Seniors Initiative.** Mecklenburg is the first pilot program. This is an ongoing community strategic planning process that regularly reviews the quality of life for all seniors in Charlotte-Mecklenburg.

Rowan County Planning Initiative
Planning for Seniors and Adults with Disabilities
(See Attachment 11)

Gayla Woody, Centralina Council of Governments Area Agency on Aging, reviewed the **Rowan County Planning Initiative Planning for Seniors and Adults with Disabilities** handout. The Rowan County Board of Commissioners endorses the initiative. There are some similarities and some differences between Mecklenburg and Rowan. A basic planning notebook has been a great asset. This provides for some information they can all work from. Some similarities are that they chose workgroups and have chosen to do a community event. The county commissioners are involved. The State has provided training, which has been very helpful.

Steve Freedman, Division of Aging and Adult Services, Department of Health and Human Services, was the last person to address the Commission concerning the Interim Report on the Pilot Project for LTC Community Service Coordination. He spoke concerning the evaluation plan for the Project and what the Division sees for future services. They are being assisted in the evaluation by The Jordan Institute of Families at UNC School of Social Work. They want to see what works with these pilot programs and what does not work so they can share this information with the other counties. There have been 22 services identified. They want to see if there has been increased communication and technical assistance between the State and local interest. They are trying to provide for a planning network for them to be able to work on planning together.

Rep. Nye announced that the next meeting of the Commission would be on November 10, 2004 at 10:00 A.M. in Room 643 of the Legislative Office Building

The meeting adjourned at 12:10 P.M.

Representative Edd Nye, Co-Chair

Jo Bobbitt, Commission Assistant

Representative Debbie Clary, Co-Chair
Senator A. B. Swindell, Co-Chair

Agenda

North Carolina Study Commission on Aging

Wednesday, October 27, 2004
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator AB Swindell, Cochair
Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair

II. Review and Approval of 2004-2005 Commission Budget

Dianna Jessup, Commission Staff, Research Division, NCGA

III. 2004 Legislation of Interest to Senior Citizens

Status of 2004 Aging Study Commission Recommendations

Dianna Jessup, Commission Staff, Research Division, NCGA

IV. Community Alternatives Program for Disabled Adults (CAP/DA) Audit Report (S.L. 2003-284, Sec. 10.29B(a))

Janet Hayes, Office of the State Auditor

V. North Carolina Senior Care Program Update

Michael Keough, Department of Health and Human Services

VI. Interim Report on the Pilot Project for LTC Community Service Coordination (S.L. 2003-284, Sec. 10.8F)

Julie Bell, Division of Agingand Adult Services, Department of Health and Human Services
Steve Freedman, Division of Aging and Adult Services, Department of Health and Human Services
John Highfill, Adult Services Section, Mecklenburg County Department of Social Services
Gayla Woody, Centralina Council of Governments Area Agency on Aging

VII. Next Meeting:

November 10, 2004 at 10:00 a.m. in Room 643

Attachment 3

NORTH CAROLINA STUDY COMMISSION ON AGING

2004-2005 COMMISSION BUDGET ESTIMATE

1.	Legislative Members Subsistence $104 x 10 (*number of legislative members*) x 1 ½ (*Half of members using two days subsistence*) x 6 (*number of meetings and public hearings*)	$9,360
2.	Non-Legislative Members Subsistence $102.75 x 6 (*number of non-legislative members*) x 1 ½ (*Half of members using two days subsistence*) x 6 (*number of meetings and public hearings*)	$5,549
3.	Travel Expenses $58.00 * x 10 (*number of GA members*) x 6 (*number of meetings*) $50.00 ** x 6 (*number of public members*) x 6 (*number of meetings*) * Average 200 miles round trip x $.29 = $58.00 ** Average 200 miles round trip x $.25 = $50.00	$5,280
4.	Clerical Staff Average of $613 ** x 6 (*number of meetings*) ** $613 = average salary with benefits for 5 day work week	$3,678
5.	Professional Staff (To be used if other than legislative professional staff is employed)	$0
6.	Special Travel and Expenses	$500
7.	Postage and Telephone	$500
8.	Supplies	$250
9.	Copying and Printing	$1,000
10.	Reserve	$13,883
TOTAL		**$40,000**

Note: The Commission had $36,845 in unexpended funds for fiscal year 2004.

Rev. 10/18/04

2004 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2003 North Carolina General Assembly, 2004 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

October 27, 2004

Attachment 4

2004 *Recommendation Status Report*

RECOMMENDATION	RESULT
Recommendation 1 **The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.**	There were a number of bills that addressed this issue, including HB 1489 and SB 1146 introduced on behalf of the Commission. However, none of the bills were enacted and the tax credit expired for taxable years beginning on or after January 1, 2004.
Recommendation 2 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.**	S.L. 2004-144 (SB 1148) requires DHHS to study the mission of the Geriatric Mental Health Specialty Teams. Representatives from Area Authorities, Local Management Entities, adult care home and nursing home industries, and other appropriate stakeholders, must be included in the process. As part of this study, the Department must consider whether to create two separate teams to provide services to geriatric mental health residents who are part of the targeted population and to provide services to non-geriatric residents who are part of the targeted population in long-term care facilities; and/or to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission. The act requires the Department to standardize the following criteria across all mental health specialty teams: team purpose; eligibility for services; Screening processes; referral processes; and forms, training manuals, service orders, and authorizations. Any of these standards that are currently established shall be immediately implemented, and a time line for implementation of the remaining criteria shall be provided in the interim report. Additionally, the act requires the Department to proceed immediately with implementation of the following: Tracking expenditure data for each Team and each Area Program/Local Management Entity; Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team; and Tracking the use of clinicians with and without formal specialty training in mental health and geriatric mental health on the specialty teams. DHHS is required to submit an interim report to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The final report on its standardization and tracking efforts, and the results of its study, shall be submitted to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2005.

RECOMMENDATION	RESULT
Recommendation 3 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.**	S.L. 2004-124, Sec. 10.2 (HB 1414, Sec. 10.2) requires DHHS to work with long-term care providers and advocates for the elderly and mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The following issues shall be included in the study: Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities; Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served; Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living; Determining the most effective way to identify mentally ill individuals that have mental health treatment needs; Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents is safeguarded; Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations; and Identifying specific problems that exist due to mixing aging and mentally ill populations. DHHS is required to report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The report must also include how the Department defined "mentally ill" for purposes of the study.

RECOMMENDATION	RESULT
Recommendation 4 **The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.**	S.L. 2004-124, Sec. 10.19D (HB 1414, Sec. 10.19D) amends the statutes governing criminal records checks for nursing homes, home care agencies, contract agencies for nursing homes and home care agencies, adult care homes, contract agencies of adult care homes, and area mental health authorities (collectively, "providers"). State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies, other than those involving direct patient care, and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005. This section requires the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". Pursuant to federal law, the Department will be permitted to provide notice to the provider that an applicant has a criminal record elsewhere. The Department will not be permitted to reveal the contents of that record. It will be the employer's responsibility to follow up on the information to obtain the public record of that crime. This section also appropriates funds to the Department of Health and Human Services and the Department of Justice to expedite the criminal history check process and amends the term "relevant offense" to include any state or federal criminal history of conviction or pending indictment of a crime. The part of the section that amends the national criminal history check process becomes effective January 1, 2005. The remainder of the section became effective July 1, 2004.

RECOMMENDATION	RESULT
Recommendation 5 **The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.**	S.L. 2004-124 provides $281,000 in recurring funds and $1,550,000 in non-recurring funds for 2004-05 for Senior Centers.
Recommendation 6 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.**	S.L. 2004-124, appropriates $3 M to the Housing Trust Fund (HTF) for FY 2004-05, however, none of the appropriation was specifically set aside for independent housing with services. The General Assembly appropriated a total of $4,750,945 for each FY of the 2003-05 biennium, of which $3 M was intended for the HTF and $1.75 M for the HOME match. (The HOME program is a Federal block grant that provides formula grants to States and localities that communities use (often in partnership with local nonprofit groups) to fund a wide range of activities that build, buy, and/or rehabilitate affordable housing for rent or homeownership for low-income households.)
Recommendation 7 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.**	S.L. 2004-124 restored $800,000 (of the previous $1 million reduction) for the Home and Community Care Block Grant.
Recommendation 8 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.**	S.L. 2004-124, Sec. 10.13 (HB 1414, Sec. 10.13) requires DHHS to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. The study must include consideration of all in-home services paid under the State's Medicaid program. The Department must report the results of the study to the North Carolina Study Commission on Aging by January 2005.

RECOMMENDATION	RESULT
Recommendation 9 **The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.**	S.L. 2004-161, Part XLV (SB 1152, Part XLV) creates the Legislative Study Commission on State Guardianship Laws. The North Carolina Study Commission on Aging recommended this Commission. The Commission will consist of 16 members, including members of the Senate and House of Representatives; the Director of the Administrative Office of the Courts; the Director of the Division of Aging in the Department of Health and Human Services; a county director of social services; a clerk of superior court; a physician who specializes in geriatrics; an attorney who has experience in guardianship matters; a representative of the Governor's Advocacy Council for Persons With Disabilities; and an area authority or county program director for mental health, developmental disabilities, and substance abuse services. In addition to these members, representatives of the North Carolina Bar Association, the Arc of North Carolina, North Guardianship Association, Alzheimer's Association – Western and Eastern Chapters, Carolina Legal Assistance, Area Agencies on Aging, County Departments of Aging, and Friends of Residents in Long Term Care will serve as ex-officio, nonvoting members. The Commission is charged with reviewing State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney. The Commission may make an interim report to the 2005 General Assembly upon its convening and must make its final report to the 2006 Regular Session of the 2005 General Assembly, upon its convening.
Recommendation 10 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.**	S.L. 2004-124 provides funding to increase the daily rate by $5.00 for Adult Day Care and Adult Day Health Care Additionally, S.L. 2004-124, Sec. 10.21 (HB 1414, Sec. 10.21) requires the Department of Health and Human Services to contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant is required to study the current method of reimbursement for adult day services and to make recommendations for changes to the reimbursement methodology. Up to $250,000 of the funds appropriated to the Department may be used to implement this study. This section requires that a final report be submitted to the North Carolina Study Commission on Aging by January 1, 2005.

Attachment 5

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2004 Session

Prepared by Staff for the:
North Carolina Study Commission on Aging

October 27, 2004

Enacted Legislation

Downtown Adult Residential Facility

S.L. 2004-2 (SB 623) provides a one-year extension of deadlines to meet conditions set forth in Section 3 of S.L. 2001-234 entitling certain "specially impacted" adult care homes that qualified for an exemption from the moratorium on new adult day care homes established in S.L. 1997-443 to continue to develop the beds authorized by the exemption. The specific deadline changes are from June 1, 2004 to June 1, 2005 and from December 1, 2004 to December 1, 2005. A specially impacted adult care home is defined as an adult care home that qualified for an exemption under S.L. 2000-67, Section 11.9 (a) and is 10 stories or more in height, located within a municipal service district created under Article 23 of Chapter 160A of the General Statutes, located within 100 yards of a mixed use building more than 10 stories tall that will be opened for occupancy after May 26, 2004, located within 100 yards of an office building that is more than 20 stories tall, and some of the residents of which are to be relocated to a facility in the same county but not on a college campus. One facility where the occupants of the building are relocated is to continue to have the same status under S.L. 2000-67, Sec. 11.9 (a) as the facility from where the occupants came.

This section became effective May 26, 2004. (BR)

Centralize Criminal Record Check Functions

S.L. 2004-124, Sec. 10.1 (HB 1414, Sec. 10.1) requires the Department of Health and Human Services to consolidate all activities within the Department related to coordinating and processing criminal record checks required by law beginning January 1, 2005. The Department is to report the details of the implementation plan to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on or before January 1, 2005.

This section became effective July 1, 2004. (EC)

Automatic Enrollment Medicare Prescription Drug Discount Card

S.L. 2004-124, Sec. 10.2B (HB 1414, Sec. 10.2B) gives the Department of Health and Human Services authority to enroll senior citizens in the federal Medicare Prescription Drug Discount Program. Current and future participants in the State's Senior Care Prescription Drug Assistance Program whose income is not more than 135% of the federal poverty level are eligible for automatic enrollment in the Medicare Drug Program; however, those individuals must have an opportunity to decline automatic enrollment if they choose. This section also provides that the State's Senior Care Prescription Drug Assistance Program will be the payor of last resort.

This section became effective July 1, 2004. (TM)

Community Alternatives Programs

S.L. 2004-124, Sec. 10.9 (HB 1414, Sec. 10.9) directs the Department of Health and Human Services to ensure the following:

- Expenditures for Community Alternatives Programs (CAP) do not exceed the budget for these programs;

- CAP slots are fully allocated and filled in a timely manner; and
- Budgeted expenditures are not limited by the non-allocation of or delays in filling CAP slots.

Additionally, the section specifies that services provided by the Community Alternatives Program for Disabled Adults shall be provided for the 2004-2005 fiscal year to any eligible person who entered a nursing facility on or before June 1, 2004, within the existing availability of the county allocation, or within the existing availability of services.

This section became effective July 1, 2004. (SP)

PACE Pilot Program Funds

S.L. 2004-124, Sec. 10.12 (HB 1414, Sec. 10.12) requires the Department of Health and Human Services, Division of Medical Assistance, to develop a pilot program to implement the Program for All-Inclusive Care for the Elderly (PACE). One pilot site shall be planned for the southeastern area of the State and the other for the western area of the State. The Division is required to design the pilot program to access federal Medicaid and Medicare dollars to provide acute and long-term care services for older patients through the use of interdisciplinary teams. Upon implementation, the PACE pilot program may include the following: physician visits, drugs, rehabilitation services, personal care services, hospitalization, and nursing home care. The PACE program may also offer social services intervention, case management, respite care, or extended home care nursing. This section authorizes the Division to use $123,156 of the funds appropriated for the 2004-2005 fiscal year, to support two positions in the Division of Medical Assistance to develop the pilot programs and to contract for actuarial analysis as part of the development of the pilot programs.

On March 1, 2005, the Department must report on the development of PACE pilot program to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services. The report will include services proposed to be offered under the pilot program, administrative structure of the pilot program, number of Medicare and Medicaid eligible recipients anticipated to receive services from the PACE pilot sites, and the projected savings to the State from PACE pilot program implementation.

Finally, this section clarifies that nothing obligates the General Assembly to appropriate funds to implement the PACE program statewide.

This section became effective July 1, 2004. (TM)

Long-Term Care Facility Criminal Record Checks

S.L. 2004-124, Sec. 10.19D (HB 1414, Sec. 10.19D) amends the statutes governing criminal records checks for nursing homes, home care agencies, contract agencies for nursing homes and home care agencies, adult care homes, contract agencies of adult care homes, and area mental health authorities (collectively, "providers"). State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required.

Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be

released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies, other than those involving direct patient care, and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

This section requires the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". Pursuant to federal law, the Department will be permitted to provide notice to the provider that an applicant has a criminal record elsewhere. The Department will not be permitted to reveal the contents of that record. It will be the employer's responsibility to follow up on the information to obtain the public record of that crime.

This section also appropriates funds to the Department of Health and Human Services and the Department of Justice to expedite the criminal history check process and amends the term "relevant offense" to include any state or federal criminal history of conviction or pending indictment of a crime.

The part of the section that amends the national criminal history check process becomes effective January 1, 2005. The remainder of the section became effective July 1, 2004. (DJ)

State/County Special Assistance

S.L. 2004-124, Sec. 10.21A (HB 1414, Sec. 10.21A) establishes the maximum monthly rate for residents in adult care home facilities as $1,084 per month per resident unless adjusted by the Department in accordance with Section 10.52(f) of S.L. 2003-284. This rate is effective October 1, 2004.

This section became effective July 1, 2004. (TM)

Health Care Personnel Registry Changes

S.L. 2004-203, Sec. 52 (HB 281, Sec. 52) makes changes to conform the Health Care Personnel Registry to federal law governing the Nurse Aide I Registry program. During the 2000 Regular Session legislation was enacted that standardized the reporting requirements of both these registry programs, conforming them to the federal reporting requirements. All covered facilities and agencies will report using the current standardized reporting requirements that apply to nursing homes (federal law). In 2000, the federal requirement to allow a nurse aide to submit a rebuttal statement that would be included on the Nurse Aide Registry was not included in the legislative change. In addition, the federal statute changed after the passage of this 2000 law to include a process to allow nurse aides to petition the state to have a single finding of neglect removed from the Nurse Aide Registry when certain requirements were met. This section became effective August 17, 2004. (EC)

Studies

Legislative Research Commission

Care and Safety of Residents of Residential Facilities Study

S.L. 2004-161, Sec. 2.1(8)b (SB 1152, Sec. 2.1(8)b) provides that the Legislative Research Commission may study the care and safety of residents of residential care facilities. If the Commission elects to study this issue, they may report findings, together with any recommended legislation, to the 2005 General Assembly upon its convening.

This section became effective August 2, 2004. (TM)

New/Independent Studies/Commissions

Legislative Study Commission on State Guardianship Laws

S.L. 2004-161, Part XLV (SB 1152, Part XLV) creates the Legislative Study Commission on State Guardianship Laws. The North Carolina Study Commission on Aging recommended this Commission. The Commission will consist of 16 members, including members of the Senate and House of Representatives; the Director of the Administrative Office of the Courts; the Director of the Division of Aging in the Department of Health and Human Services; a county director of social services; a clerk of superior court; a physician who specializes in geriatrics; an attorney who has experience in guardianship matters; a representative of the Governor's Advocacy Council for Persons With Disabilities; and an area authority or county program director for mental health, developmental disabilities, and substance abuse services. In addition to these members, representatives of the North Carolina Bar Association, the Arc of North Carolina, North Guardianship Association, Alzheimer's Association – Western and Eastern Chapters, Carolina Legal Assistance, Area Agencies on Aging, County Departments of Aging, and Friends of Residents in Long Term Care will serve as ex-officio, nonvoting members. The Commission is charged with reviewing State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney. The Commission may make an interim report to the 2005 General Assembly upon its convening and must make its final report to the 2006 Regular Session of the 2005 General Assembly, upon its convening.

This part became effective August 2, 2004. (DJ)

Referrals to Existing Commissions/Committees

Long-Term Care Remediation

S.L. 2004-161, Sec. 23.2 (SB 1152, Sec. 23.2) provides that the North Carolina Study Commission on Aging may study the feasibility of implementing a remediation program for long-term care facilities in North Carolina, similar to the Collaborative Remediation Project in Michigan. The Commission may report its findings, together with any recommended legislation to the 2005 General Assembly upon its convening.

This section became effective August 2, 2004. (SP)

Mentally Ill Long-Term Care Residents

S.L. 2004-161, Sec. 23.3 (SB 1152, Sec. 23.3) provides that the North Carolina Study Commission on Aging may study issues related to mentally ill residents in long-term care facilities. The Commission may report its findings, together with any recommended legislation to the 2005 General Assembly upon its convening.

This section became effective August 2, 2004. However, **Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities** was also referred to the Department of Health and Human Services in S.L. 2004-124, Sec. 10.2. (HB 1414, Sec. 10.2). (See *Referrals to Departments, Agencies, Etc.*, under the *Studies* Heading in this Chapter.) S.L. 2004-161 Section 54.1 (SB 1152, Section 54.1) provides that if a study is authorized in both S.L. 2004-161 and S.L. 2004-124 (HB 1414), the study shall be implemented in accordance with HB 1414 as ratified. Therefore, the study contained in S.L. 2004-124, Sec. 10.2 will be implemented instead of the study authorized by this section. (SP)

Referrals to Departments, Agencies, Etc.

Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities

S.L. 2004-124, Sec. 10.2 (HB 1414, Sec. 10.2) requires the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The following issues shall be included in the study:

- Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities;
- Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served;
- Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living;
- Determining the most effective way to identify mentally ill individuals that have mental health treatment needs;
- Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents is safeguarded;
- Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations; and
- Identifying specific problems that exist due to mixing aging and mentally ill populations.

The Department is required to report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The report must also include how the Department defined "mentally ill" for purposes of the study.

This section became effective July 1, 2004.

Note: A study on **Mentally Ill Long-Term Care Residents** was also referred to the North Carolina Study Commission on Aging in S.L. 2004-161, Sec. 23.3 (SB 1152, Sec. 23.3). See

Referrals to Existing Commissions/Committees under the *Studies* Heading in this Chapter. However, S.L. 2004-161 Section 54.1 (SB 1152, Section 54.1) provides that if a study is authorized in both S.L. 2004-161 and S.L. 2004-124 (HB 1414), the study shall be implemented in accordance with HB 1414 as ratified. Therefore, the study contained in this section will be implemented instead of the study authorized by S.L. 2004-124, Sec. 10.2. (TM)

DHHS Study Medicaid Institutional Bias

S.L. 2004-124, Sec. 10.13 (HB 1414, Sec. 10.13) requires the Department of Health and Human Services to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. The study must include consideration of all in-home services paid under the State's Medicaid program. The Department must report the results of the study to the North Carolina Study Commission on Aging by January 2005.

This section became effective July 1, 2004. (DJ)

Adult Day Service Training and Reimbursement Methodology

S.L. 2004-124, Sec. 10.21 (HB 1414, Sec. 10.21) requires the Department of Health and Human Services to contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant is required to study the current method of reimbursement for adult day services and to make recommendations for changes to the reimbursement methodology. Up to $250,000 of the funds appropriated to the Department may be used to implement this study. This section requires that a final report be submitted to the North Carolina Study Commission on Aging by January 1, 2005.

This section became effective July 1, 2004. (TM)

Care for the Mentally Ill in Long Term Care Facilities

S.L. 2004-144 (SB 1148) requires the Department of Health and Human Services to study the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. The Department must include representatives from Area Authorities, Local Management Entities, the adult care home and the nursing home industries, and other appropriate stakeholders in the process.

As part of this study, the Department must consider whether to create two separate teams to provide services to geriatric mental health residents who are part of the targeted population and to provide services to non-geriatric residents who are part of the targeted population in long-term care facilities; and/or to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

The act requires the Department to standardize the following criteria across all mental health specialty teams:

- Team purpose;
- Eligibility for services;
- Screening processes;
- Referral processes; and
- Forms, Training Manuals, Service Orders, and Authorizations.

Any of these standards that are currently established shall be immediately implemented, and a time line for implementation of the remaining criteria shall be provided in the interim report.

Additionally, the act requires the Department to proceed immediately with implementation of the following:

- Tracking expenditure data for each Team and each Area Program/Local Management Entity;
- Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team; and
- Tracking the use of clinicians with and without formal specialty training in mental health and geriatric mental health on the specialty teams.

The act also requires the Department to submit an interim report to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The Department is required to submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2005.

This act became effective July 29, 2004. (TM)

Studies and Reports Related to Aging

Study/Report	Entities Involved	Reporting Date	Reference
Report on the pilot project for local long-term care coordination.	DHHS to Aging Study Commission	Interim report 10/1/04 Final report 10/1/05	S.L. 2003-284 (HB 397), Sec. 10.8.F.(b)
Report on the Special Assistance In-Home Demonstration Program	DHHS to HHS	1/1/04 and 1/1/05	S.L. 2003-284 (HB 397), Sec. 10.51(b)
Report on standardization and tracking efforts and the study of the mission of Geriatric Mental Health Specialty Teams	DHHS to Aging Study Commission and Joint Legislative Oversight Committee on MH/DD/SA	Interim report 10/30/04 Final report 10/30/05	S.L. 2004-144 (SB 1148), Sec. 4
Report findings on issues related to mentally ill residents of long-term care facilities	DHHS to Aging Study Commission	10/1/05	S.L. 2004-124 (HB 1414), Sec. 10.2
Report on independent study of institutional bias in the Medicaid program	DHHS to Aging Study Commission	January, 2005	S.L. 2004-124 (HB 1414), Sec. 10.13
Report on reimbursement methodology for adult day services	DHHS (contracting with consultant) to Aging Study Commission	1/1/05	S.L. 2004-124 (HB 1414), Sec. 10.21

Abbreviations:
DHHS: the Department of Health & Human Services
FRD: Fiscal Research Division
HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services
MH/DD/SA: Mental Health, Developmental Disabilities, and Substance Abuse Services

Janet Hayes

SUMMARY OF MAJOR FINDINGS and RECOMMENDATIONS

FROM THE PERFORMANCE AUDIT OF

"THE STATE ENERGY POLICY COUNCIL AND THE STATE ENERGY OFFICE"

Issued July 2004

Attachment 6

CAP/DA in North Carolina

- Federal waiver allows community alternative programs
  - Cost effective alternative to institutional care
  - Program must remain cost neutral under waiver terms
- NC began offering CAP/DA in 1982:
  - All counties offering program as of 1995

GOAL: To provide needed support to older and physically disabled adults in their own homes to delay or prevent nursing facility placement.

DIVISION OF MEDICAL ASSISTANCE (DMA)

- Administers CAP/DA at state level
- Oversees and monitors 96 local lead agencies
- Served 11,727 clients for FY2004
- Total budget = $217.8 million
  - 65.73% federal, $132.6 million
  - 29.13% state, $58.8 million
  - 5.14% local, $10.4 million





MAJOR CONCLUSIONS:

1: Goals and Objectives

Division of Medical Assistance operating within CAP/DA federal waiver guidelines.

2. Program Assessment

Division of Medical Assistance developing monitoring / assessment program.

MAJOR RECOMMENDATIONS:

1

Provide more detailed guidance for local lead agencies.

a) Update CAP/DA manual
- ☐ Reflect recent changes
- ☐ Provide more standard policies, forms
  - o Client case management notes
  - o Case manager hours
  - o Waiting lists

b) Provide more training for locals
- ☐ Include in budget request

c) Add computer edits for payment approval

2

Assess medical/clinical quality and adequacy of actions.

a) General Assembly should provide funds to OSA to complete audit

b) DMA consultants should perform annual on-site reviews
- ☐ Use AQUIP for most monitoring

c) Improve technology use at locals to improve efficiency
- ☐ Use laptop computers for input on-site during client visits
- ☐ Reduce time for paperwork

AGENCY RESPONSE:

DMA agrees with findings; taking steps to implement.

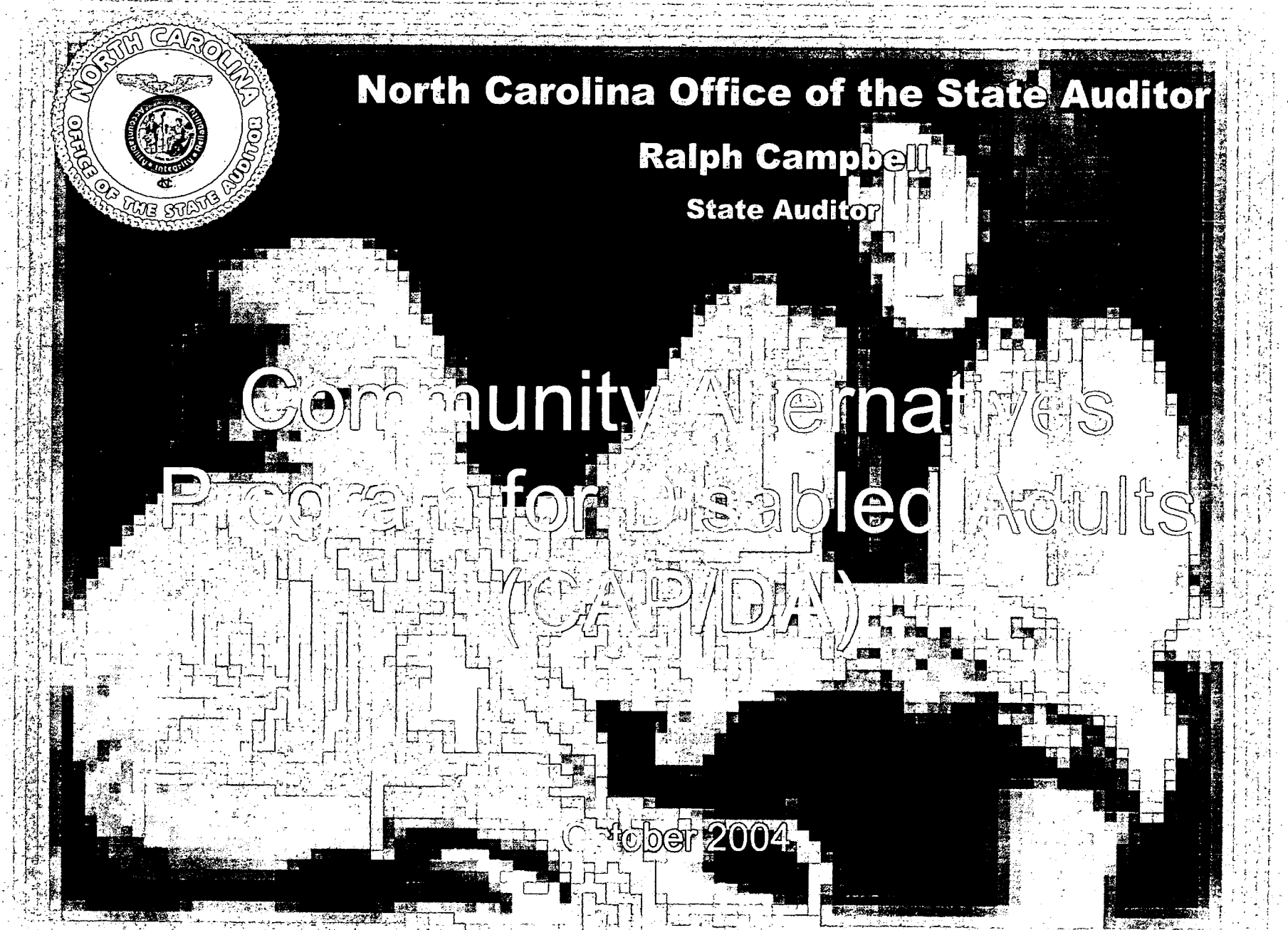
DMA agrees with findings; revising monitoring procedures.

OFFICE OF THE STATE AUDITOR

Ralph Campbell, Jr.
State Auditor

September 2004

Attachment 7



Objectives

1. To determine guidelines and goals used to implement and administer CAP/DA

2. To identify program assessments used by CAP/DA program

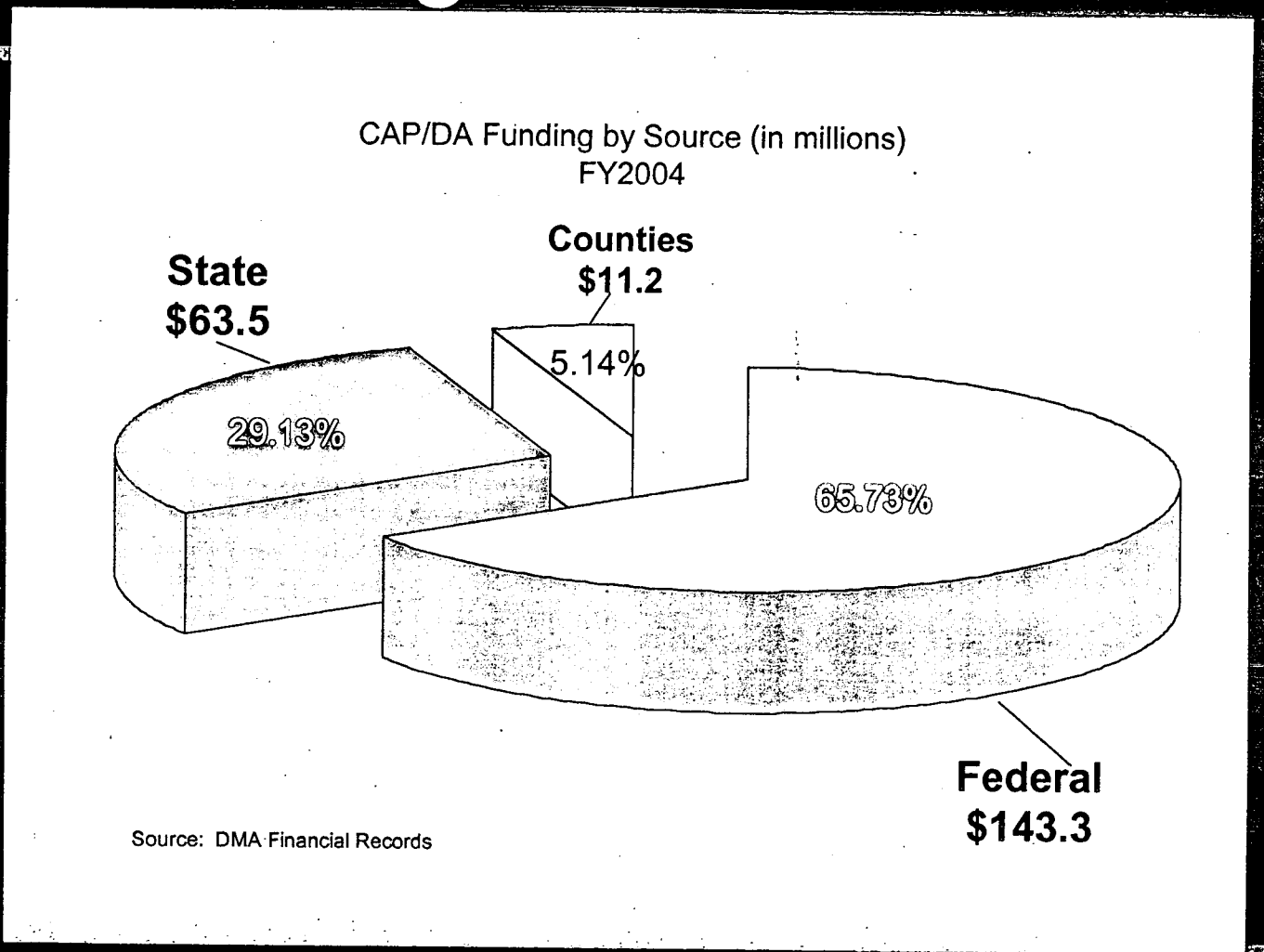
Scope

- DHHS Division of Medical Assistance
  - CAP/DA program
- Visits to 24 local lead agencies
- Limited to actions taken to
  - Implement and
  - Administer program

Program Overview

- CAP/DA began in NC in 1982
- Offered as a county option
- Covers all counties since 1995
- CAP/DA positions now part of unit responsible for
  - CAP/DA
  - Adult Care Homes
  - Personal Care Services

CAP/DA Budget



Clients and Costs

Fiscal Year	# Clients	Avg. Daily Cost *	Total Expenditures (in millions)
2004	11,727	$47.14	$201.8
2003	10,716	$47.22	$184.7
2002	11,137	$52.00	$211.4
2001	12,243	$43.79	$195.7

* Does not include non-CAP/DA waiver services such as durable medical equipment, prescription drugs, etc.
Source: DMA records

Objective 1: Guidelines and Goals

Conclusions:

- Federal waiver outlines guidelines
- DHHS in compliance with guidelines
- Operational changes could improve administration of program

Objective 1: Guidelines and Goals

Findings and Recommendations: State Administration

- CAP/DA Manual not updated; job descriptions not current.

  Update to reflect recent changes; request OSP classification study.

- Budget cuts curtailed training to locals.

  Explore ways to offer more cost-effective training.

- Service provider bills paid without approval.

  Establish electronic approval for claims.

Objective 1: Guidelines and Goals

Findings and Recommendations: Local Administration

- Program policies inconsistent.
  - DMA develop model program policies.
- Client case management notes not uniform.
  - Use electronic format where possible; DMA give more specific guidance.
- Case manager service hours vary.
  - Establish normal parameters for hours; DMA review during monitoring visits.
- Waiting list information not consistent.
  - Continue developing standard waiting list policy.

Objective 2: Program Assessment

Conclusions:

- DMA has made considerable progress in addressing prior recommendations
- Monitoring negatively affected by budget cuts
- AQUIP will improve monitoring and assessments
- Administrative efficiency could by enhanced through use of laptops

Objective 2: Program Assessment

Findings and Recommendations:

- Annual on-site reviews not performed.

  Establish process to determine which locals should be reviewed first; re-evaluate objectives of reviews.

- Laptops for local case managers could improve efficiency.

  Encourage locals to employ computer technology where possible.

Issue for Further Study

- HB397-10.29B.(a) directed the State Auditor to supply information to determine
  - Whether CAP/DA was operating within
    - Guidelines
    - Program goals
- No funds provided for outside assistance
  - To assess medical and clinical quality and adequacy

Recommendation: Provide funds to complete audit

Issue for Further Study

- Under direction of OSA, subject matter experts would
  - Conduct qualifications review of local lead agency personnel and providers
  - Conduct documents review to determine
    - Medical justification
    - Adequacy/completeness of plans of care
    - Comparison of services provided to services needed
  - Conduct in-home visits with sample of clients
- Estimated costs = $150,000

Major Issues

1. DHHS operating within federal waiver guidelines
   - Locals need more detailed guidance
2. DHHS developing monitoring and assessment program (AQUIP)
   - Need to perform annual on-site reviews
   - Improve technology use at locals
3. Need outside assessment of medical / clinical quality and adequacy of actions

Attachment 8

STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA)

Located within the Division of Medical Assistance
Department of Health and Human Services

OCTOBER 2004

OFFICE OF THE STATE AUDITOR
RALPH CAMPBELL, JR.

Interim Report
The NC DHHS Communications and Coordination Initiative

Prepared for the North Carolina Study Commission on Aging
By the NC Division of Aging and Adult Services
October 1, 2004

Background Information

At the recommendation of the Study Commission on Aging, the Studies Act of 2001 (S.L. 2001-491, Section 22.1), directed the Department of Health and Human Services, Division of Aging, to study whether counties should designate local lead agencies to organize a local long-term care (LTC) planning process as described in Recommendation 16 of the Institute of Medicine's (IOM) Long-Term Care Task Force Report. Further, the Department was to consider how a lead agency for local LTC planning would relate to other requirements for county planning and LTC, specifically addressing the IOM Task Force recommendations pertaining to local planning and LTC services. The study was due to the General Assembly by the convening of the 2003 General Assembly. To complete the study, which can be found in Appendix A, the Division of Aging (now the Division of Aging and Adult Services) researched planning activities at the local level in North Carolina pertaining to older adults and younger adults with disabilities. The Division of Aging recommended that:

- Counties should be encouraged, rather than required, to designate local lead agencies to organize a local LTC planning process.
- Any effort to promote lead agencies and local LTC planning should take into account the existing infrastructure for planning already present in counties across the state.
- The Division of Aging should work with the LTC Cabinet to implement the *Communications and Coordination Initiative* (a pilot project that would give counties the structure and technical assistance needed to develop and implement a local LTC planning process).
- The possibility of providing State funding to counties to designate local lead agents and undertake LTC planning processes should be considered in the future, when the timing is right.

Session Law 2003-284, Section 10.8F

Session Law 2003-284, Section 10.8 F, calls upon on the Department of Health and Human Services to:

> "implement a communications and coordination initiative to support local coordination of long-term care and shall pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. For those counties that voluntarily participate, the local long-term care coordination initiative shall aid in the development of core services, coordinate local services, and streamline access to services."

> DHHS is to submit an interim report on the pilot project by October, 2004 and the final report by October 2005.

In response to this legislative mandate, recommendations by the North Carolina Institute of Medicine, and the interests of various stakeholders, the NC Division of Aging and Adult Services developed the *Communications and Coordination Initiative* with assistance and guidance from the DHHS Long-Term Care Cabinet and a State Team composed of representatives from all DHHS Divisions with long-term care (LTC) responsibilities, including the:

- Division of Aging and Adult Services,
- Division of Facility Services,
- Division of Information Resource Management,
- Division of Medical Assistance,
- Division of Mental Health/Developmental Disabilities/Substance Abuse Services,
- Division of Public Health,
- Division of Services for the Blind,
- Division of Services for the Deaf and Hard of Hearing, and
- Division of Vocational Rehabilitation.

The Initiative is designed to assist two *volunteer* (no funding is available for participation in the Initiative) pilot communities in evaluating their LTC services and in identifying and implementing strategies to strengthen LTC services for older and disabled adults. The Initiative will also promote coordination between the state and local levels.

Pilot Site Selection

On June 4, 2003, Lynda McDaniel, former Assistant Secretary for Long Term Care and Family Services, released a Request for Proposals (RFP) which can be found in Appendix B, to counties and regions interested in participating in the Communications and Coordination Initiative. Proposals were due on July 23, 2003 and required an endorsement letter by the community's Board of County Commissioners. The following communities submitted proposals:

- Cabarrus County (proposed lead agent: Cabarrus County Department of Aging)
- Lincoln and Cleveland Counties (proposed lead agent: Pathways MH/DD/SAS Area Authority)
- Mecklenburg County (proposed lead agent: Mecklenburg County Department of Social Services)
- New Hanover County (proposed lead agent: New Hanover Department of Aging)
- Wake County (proposed lead agent: Wake County Human Services and Resources for Seniors, Inc.)

The LTC Cabinet chose New Hanover and Mecklenburg Counties to participate based on their capacity and willingness to undertake such a project. The Division of Aging and Adult Services held an introductory meeting with the pilot lead agents on October 9, 2003 that included

background information and an orientation to the Initiative. Half-day, one-on-one meetings with the lead agents occurred on October 23 and 24, 2003 to give the counties more individualized and targeted attention.

Pilot Site Activities to Date

Contact information for the two pilot sites can be found in Appendix C.

Mecklenburg County's Status of Seniors Initiative (SOSI)

Lead Agent: The Services for Adults Division of the Mecklenburg County Department of Social Services is the lead agent for Mecklenburg County's pilot project, and they are working closely with the Centralina Council of Governments' Area Agency on Aging which is headquartered in Charlotte.

Goal: The SOSI planning process was developed to build upon work already completed within the county to gather extensive information for a May 2002 *Status of Seniors* report to the Board of County Commissioners (the full report can be found on the SOSI website at http://statusofseniors.charmeck.org). SOSI expects the end-result of their pilot project to be the creation of an ongoing dynamic process of community strategic planning that every service organization in the county can use in order to set organizational priorities and allocate resources, especially in regards to preparing for the aging of the Baby Boomers. They also anticipate that the project will increase communication and coordination among providers, policy officials, and the private sector. Finally, they hope the pilot project will lead to a Senior-Friendly community that values dignity and independence for all older adults.

Progress: The SOSI project developed a Steering Committee (representing public, for-profit, and not-for-profit providers and organizations, advocates, and consumers) and an Executive Advisory Board (consisting of people in positions with the ability to champion the recommendations of the committee, such as local executives, former legislators, major media publishers and personalities, and the Chancellor of UNC-Charlotte) to lead the effort. The Steering Committee also created a Public Relations Committee which oversaw development of the project website, secured numerous articles in local papers and television coverage of major events, and created press packets on the SOSI project.

SOSI developed its vision and mission statements:

> ***Vision:*** To foster a senior-friendly community that values dignity and independence for all older adults.
>
> ***Mission:*** To engage the community in creating a dynamic plan that enhances the quality of life for older adults by focusing resources on their needs.

The Steering Committee hosted a kick-off strategic planning workshop on November 10, 2003 to promote the Initiative and recruit volunteers. The event attracted over 150 people and included

the breakout of individuals into work groups to begin studying and developing recommendations for the five priority areas:

- facilities and institutions,
- in-home support services (includes information and referral, case management, home health, in-home aide, respite care, adult day care, and adult day health),
- leisure/recreation/socialization services,
- transportation, and
- food and nutrition.

The Division of Aging and Adult Services trained the Steering Team and subcommittee leaders on the use of the Core LTC Service Evaluation Tools (described in the section below on the Department of Health and Human Services' Efforts) and assisted them in developing their vision and mission statements in a training session on December 3, 2003.

From December 2003 - March 2004, the five work groups individually met several times a month to evaluate their respective services (many using the Core LTC Evaluation Tools) and to determine the major barriers and gaps in services. Each work group developed a set of six to ten recommendations for its respective service area. Collectively, the five work groups generated over 30 recommendations. The Steering Team reviewed the recommendations, and in some cases edited and combined recommendations, for use in the March event (please see below in the section on The SOSI Planning Report).

In addition, two outside teams conducted research on the SOSI's priority issues. A team from UNC-Charlotte's Leadership Charlotte Class XXV surveyed human resources directors of local employers about workplace programs for caregivers and the impact of aging on the future workforce. Students from the Master of Public Administration program at UNC-Charlotte also researched transportation, care costs, public safety, and service provision to older adults. These two outside teams each prepared a report with their findings (which can be found on the SOSI website) to inform the planning process.

The SOSI Planning Report: On March 17, 2004, a diverse group of people from all segments of the community (with over 70 people in attendance) met to hear and complete a process to rank, in order of importance, the key service-specific recommendations from the five subcommittees. This ranking formed the basis of the project's Planning Report which was developed by the SOSI with assistance from the Lee Institute and presented to the Mecklenburg County Board of County Commissioners on May 5, 2004 and the United Way Community Work Board on May 19, 2004. The report will also be presented to the Charlotte Chamber and the Charlotte City Council. The Planning Report can be found on the SOSI website.

The Planning Report details the leading concerns realized during the planning process, including:

- The **lack of a centralized structure** for ongoing research, coordinated planning, implementation, and shared accountability leads to fragmentation and inefficiencies among service providers to older adults.

- **Services remain unfamiliar to and underutilized** by older adults, family caregivers, professionals, and the general public.
- Factors such as income eligibility requirements, inflexible programs, waiting lists, and critical workforce shortages **severely restrict the number of LTC options**. As a result, nursing homes and other institutions often become the only affordable option for older adults and their families.
- **Informal caregivers continue to be the primary source of care** for older adults in Mecklenburg County. However, caregivers **need sustained support** to continue in this important role.
- **Services for older adults are limited in scope** in the county and fail to provide options that meet the interests, skills, and needs of a diverse older adult population.
- Many older adults in Mecklenburg County live in **fear of crime**.
- **Access to vital services is limited** for older adults who do not drive and/or who have special needs.

In the Planning Report, SOSI recommends that:

- A **multi-functional organization should be established to serve as a focal point** for strategic planning, information and assistance, care/case management, education, and advocacy.
- Development of systemic, integrated approaches for educating and communicating with key stakeholders about the implications of aging and the availability of services for seniors.
- **Resources for the LTC system should be redistributed** to promote the availability of home care as an alternative to institutional care and to eliminate gaps in the LTC system.
- The **role of informal and family caregivers should be magnified** as a vital part of the LTC system.
- **Options for older adults should be broadened**.
- A **crime prevention program and educational campaign**, with a focus on older adults, should be developed in high-density areas.
- The **transportation system should be transformed** to create an expanded and coordinated range of senior-friendly travel options.

During the overall planning process, an estimated 400 volunteers from across the county dedicated more than 3,600 collective hours to the project.

The Robert Wood Johnson's Community Partnerships Grant Program: SOSI submitted a letter of intent to the 2004 Robert Wood Johnson Community Partnerships grant program and was subsequently invited to submit a full proposal. Out of a total of 486 applicants to the grant program from across the nation, only 28 (including both Mecklenburg County/SOSI and New Hanover County/BRC proposals) were selected to submit a full proposal. Unfortunately the SOSI proposal was not funded.

Future Activities: Between now and October 2005, SOSI will:

- Refine the Planning Report recommendations above and develop implementation strategies for each. SOSI members have begun a process for refining strategies and developing outcome measures. The committee is also identifying specific actions and tasks, engaging stakeholders, and soliciting resources to implement the recommendations.
- Promote the Planning Report to the public and raise awareness of the issues within Mecklenburg County.
- Initiate a work group to bring the interests of younger adults with disabilities into the county's SOSI planning process. SOSI will compare the services for older adults and younger adults with disabilities to identify duplication or gaps and to seek ways to integrate services and opportunities.
- Initiate a work group to study and develop recommendations that will enhance the physical environment to make the community more senior friendly, and improve the quality of life of older adults.
- Engage civic leaders and other diverse stakeholders in SOSI, including professionals from the legal, financial, higher education, and faith communities.
- Examine additional core LTC services from the Institute of Medicine Report, recommendation 11, that impact the lives of older adults and younger adults with disabilities in Mecklenburg County. Members anticipate that mental health will be one of the new issues analyzed.

New Hanover County's Building a Responsive Community Project (BRC Committee)

Lead Agent: The New Hanover County Department of Aging is the lead agent for the New Hanover County pilot project. The lead agent is working hand-in-hand with the Cape Fear Council of Governments' Area Agency on Aging which is headquartered in Wilmington. They have named their pilot project *Building a Responsive Community, Making a Difference.*

Goal: The *Building a Responsive Community, Making a Difference* committee expects that participation in the Communications and Coordination Initiative will result in:

- a stronger, more efficient and effective local service network;
- innovative solutions to long-standing LTC issues and barriers;
- empowered and knowledgeable consumers;
- increased opportunities for community agencies to work together towards common goals; and
- a county plan to reduce fragmentation and duplication of services.

Progress: The Building a Responsive Community, Making a Difference committee began meeting in November, 2003. The committee has a broad and diverse membership. They have been especially successful in involving consumers, advocates, and providers of both aging services and services for younger adults with disabilities.

The committee has a core leadership team, composed of consumers and staff from the New Hanover Department of Aging (Initiative lead agent), the Cape Fear Council of Governments' Area Agency on Aging, the New Hanover County Department of Social Services, the

Southeastern Mental Health Association, WAVE Transit, and the Wilmington Housing Authority. The presiding Chair of the committee is a consumer.

In late 2003, the full committee prioritized the LTC services that they will evaluate during the first year of their LTC planning process:

1. Transportation
2. Mental Health Services
3. Housing
4. Home Health Services
5. In-Home Aide Services

The BRC committee expects to evaluate other core LTC services in future years. Between December 2003 and March 2004, the committee's meetings were made-up entirely of educational sessions on the priority LTC services. The educational sessions allowed committee members to learn about the intricate details of each service and start with an equal and solid baseline of knowledge.

On March 8, 2004, the Division of Aging and Adult Services trained the BRC committee on the use of the Core LTC Service Evaluation Tools. In addition, the Division of Aging and Adult Services held a second training session on May 10, 2004 to assist the committee in developing their vision and mission statements:

> ***Vision:*** To build a responsive community that recognizes the needs and choices of aging and disabled adults.
>
> ***Mission:*** To partner with consumers, families, providers, and community to create a responsible plan that enhances and values independence, personal choices, and dignity for aging and disabled adults.

Beginning in June, the full BRC committee broke into subcommittees based on the priority services already identified above. Each subcommittee is currently working to evaluate its respective service and then to develop strategic action steps based on the results of the evaluation. The full committee continues to meet once a month to ensure coordination between subcommittees on common issues, barriers, and proposed action steps.

The Robert Wood Johnson's Community Partnerships Grant Program: The BRC committee submitted a letter of intent to the 2004 Robert Wood Johnson Community Partnerships grant program and was subsequently invited to submit a full proposal. As mentioned in the Mecklenburg County section, out of 486 applicants to the grant program, only 28 were selected to submit a full proposal. Although, the New Hanover proposal was not funded, the committee has incorporated some of the ideas from the proposal into their current planning process.

Future Activities: The committee is holding a public forum on September 27, 2004. The goals of the public forum are to further increase consumer and provider input into the process, to increase the knowledge of and gain support from local elected officials, and to gather data from

the community on the priority services. Publicity efforts will be substantial, and the committee is hoping to secure a local TV personality to be part of the meeting.

The committee will continue its subcommittee work in evaluating and analyzing its priority issues. They will write and publicize their strategic plan, based on the results of the subcommittee's work and the public forum, by the end of December 2004.

Non-Pilot Project Sites

Although not selected to be a Communications and Coordination Initiative pilot site, two other communities have begun developing local LTC planning processes and are in contact with the Division of Aging and Adult Services:

Rowan County: At the impetus of the Rowan County Senior Services Department and the Rowan County Department of Social Services, and with technical assistance from the Centralina Council of Governments' Area Agency on Aging, Rowan County has developed a taskforce to determine and promote the county's ability to assist all older and disabled adults. The taskforce has developed its vision and mission statements:

> ***Vision:*** Rowan County will be a healthy, safe, and kind community of opportunities for older adults and adults with disabilities.
>
> ***Mission:*** The Rowan Planning Initiative seeks to enrich the lives of older adults and adults with disabilities through community collaboration that will:
>
> - Protect health, safety, and independence,
> - Promote creativity, wellness, and self-determination,
> - Identify and prioritize needs and resources,
> - Address needs with established and innovative services/activities, and
> - Deliver services in an efficient and cost effective manner.

Accessibility of information, advocacy, affordable medical services, and housing are the priority issues that will be addressed in this first year of planning. A subcommittee for each priority issue has been developed, and conveners have been selected. Fifteen (15) Core LTC Service Evaluation Tools will be used to analyze and evaluate key LTC services under the priority issues.

The taskforce has received favorable press coverage, which has helped draw additional members. Taskforce members also made a presentation to the Rowan County Board of Commissioners on February 25, 2004 and asked for the Commissioners to make the taskforce a "priority goal" for the coming year.

The Division of Aging and Adult Services trained the taskforce on strategic planning, effectively involving consumers in the planning process, the use of the Core LTC Service Evaluation Tools, and finding and using data for planning activities on September 1, 2004.

Lincoln/Gaston/Cleveland Counties: Pathways MH/DD/SAS Area Authority, the Mental Health Local Management Entity for a three-county area, is coordinating the

Lincoln/Gaston/Cleveland planning committee for LTC. Pathways MH/DD/SAS Area Authority was one of the original applicants to the Communications and Coordination Initiative.

Identified areas of importance include the financial struggles of many older and disabled adults (especially those whose income is just above Medicaid limits), transportation to and from rural areas, availability and appropriateness of residential placements for younger adults with mental illness, and outreach to older adults who do not speak English. The committee has begun meeting, plans to use the Core LTC Service Evaluation tools, and keeps the Division of Aging and Adult Services informed of their progress.

Efforts of the Department of Health and Human Services

In addition to providing extensive technical assistance and training to the pilot sites, the Division of Aging and Adult Services, with assistance from the State Team, developed three key resources for use by the pilot sites as well as by any other community interested in developing a local LTC planning process:

- ***The DHHS Communications and Coordination Initiative Webpage:*** The Division of Aging and Adult Services created a webpage as part of the state's LTC website to house all of the products and resources developed as a result of the Communications and Coordination Initiative so that other communities could benefit. The webpage includes the Core LTC Service Evaluation Tools and a link to a Planning Basics Notebook as well as general information on the Initiative and links to county-specific data and information. It can be found at:

  http://www.dhhs.state.nc.us/ltc/localplanning.htm

- ***The Core LTC Service Evaluation Tools:*** The Division of Aging and Adult Services drafted core service evaluation tools for 22 LTC services (all of the LTC services listed in recommendation 11 of the Institute of Medicine's Final Report on LTC as well as three additional services - hospice, social and recreational services, and assistive technology) that were later developed into final versions by the State Team. The core LTC service evaluation tools were designed to assist counties in assessing the existence, adequacy, accessibility, efficiency, equity, and effectiveness/quality of each of the 22 LTC services. Questions in the tools make use of both hard data and the general community's perceptions and knowledge. The pilot sites have been testing the usefulness of the tools, and changes will be made based on the pilot sites' recommendations. The tools as well as instructions for use are available to the public on the Communications and Coordination Initiative's website. The Division of Aging and Adult Services has and will continue to make communities aware of the tools through public speaking opportunities.

- ***Planning Basics Notebook:*** The Division of Aging and Adult Services developed a Planning Basics resource notebook for communities interested in developing LTC planning processes. The resource includes over 300 pages of information for lead agents on topics such as strategic planning, support for the process, leadership skills, meeting management, involving the community in planning, assembling a successful team,

gathering and using data, and products of planning activities. The Planning Basics Notebook is available for download on the Communications and Coordination Initiative website.

In addition, DAAS held a videoconference on May 11, 2004 to give the State Team additional opportunities to provide technical assistance to the pilot projects as well as to enable the pilot projects to interact and learn from each other. Videoconference sites included UNC-Charlotte, UNC-Wilmington, and UNC-Chapel Hill. Jackie Sheppard, the Assistant Secretary for Long-Term Care and Family Services, was in attendance and spoke to the communities about the importance of their work. As a result of discussions at the videoconference, the Division of Aging and Adult Services, with assistance from the State Team, developed a listing of DHHS Initiatives and Projects that the pilot sites and any other community interested in LTC planning may find useful in coordinating efforts and streamlining planning activities.

Evaluation Activities

DAAS has asked the Jordan Institute of Families at UNC-Chapel Hill to assist with the evaluation of the Communications and Coordination Initiative since they are a third, uninterested party. Tools for phase I of the evaluation, found in Appendix D, will focus on documenting the actual planning process as well as the opportunities and barriers to developing a local LTC planning process for older adults and younger adults with disabilities. In addition, the process will evaluate the extent to which the pilot projects:

- aided in the development of core LTC services,
- caused local planning activities and LTC services to become more streamlined, accessible, and coordinated,
- allowed consumers increased input into LTC planning, and
- increased communication and technical assistance between the State and local interests in the two pilot counties.

Phase I of the evaluation will be completed by the end of the year (2004).

Phase II of the evaluation will be completed before the final report to the Study Commission on Aging in October 2005. It will consist of:

- documenting the continued planning efforts of the pilot projects (if their committees continue planning activities after the pilot is complete),
- analyzing the strategic plans developed by the pilot projects,
- documenting the implementation activities of the pilot projects,
- determining the usefulness of the technical assistance provided by the State,
- evaluating the activities and commitment of the pilot lead agents, and
- assessing the usefulness of the Core LTC Service Evaluation Tools and the Planning Basics Notebook.

Appendix A
2003 Report to the
NC Study Commission on Aging
Regarding S.B. 166 (H.B. 161)

Report to the North Carolina Study Commission on Aging on Designating Local Lead Agencies to Lead a Local Long-Term Care Planning Process

Legislative Request: At the recommendation of the Legislative Study Commission on Aging, which became Section 22.1 of S.B. 166 (H.B. 161), the Department of Health and Human Services, Division of Aging, was directed to study whether counties should designate local lead agencies to organize a local long-term care (LTC) planning process, as described in Recommendation #10 of the Institute of Medicine's (IOM) Long Term Care Task Force Interim Report of June 30, 2000 (Recommendation #16 in the Institute's final report in January 2001). Further, the Department was to consider how a lead agency for local LTC planning would relate to other requirements for county planning and LTC, specifically addressing the IOM Task Force recommendation pertaining to local planning and LTC services. The study is due to the North Carolina Study Commission on Aging before the convening of the 2003 General Assembly.

Background: The primary impetus for the Legislative Study Commission's recommendation and S.B. 166 was the NC Institute of Medicine's *Long-Term Care Plan for North Carolina* and specifically recommendation #16 in the Institute's *Final Report*. The Institute's Task Force on Long-Term Care recommended that "the General Assembly should encourage county commissioners to designate a lead agency to organize a local LTC planning process at the county or regional level." Recommendation #16 specifies that local LTC planning initiatives should include 18 stakeholder groups with interests in the LTC system for older and disabled adults. In addition, the Task Force suggested that local planning processes should be required to (1) review and analyze service utilization data through county data packages; (2) track the flow of consumers from referral to disposition through core service agencies; (3) identify barriers to a comprehensive system of care and services; (4) determine how to design a uniform portal of entry; (5) determine the need for additional core LTC services; and (6) communicate findings to local, state, and federal policymakers. While the Task Force did not specifically recommend funding for local planning, it did set as priorities funding of counties for "transition support" and capacity-building" to support them in implementing the Task Force's recommendations and in making needed system improvements.

Soon after the *Final Report* was released, the Robert Wood Johnson Foundation introduced its Community Partnerships for Older Adults Program, which is designed to help communities develop and sustain comprehensive LTC planning bodies and supportive service systems to meet the needs of their vulnerable older adult populations. This grant program emphasizes planning for LTC at the local level, and 21 communities in North Carolina applied to the Foundation for funding. While none of North Carolina's applicants were funded during the initial 2001 grant cycle, their efforts showed that many communities in North Carolina see the need for and resulting benefits of local planning for LTC.

Approach: To conduct the requested study, the Division of Aging completed the following activities:

1. **Researched current activities at the local level related to planning for older and disabled adults:** In February 2002, the Division of Aging contacted representatives from state agencies to learn more about the required and voluntary planning activities counties and regions currently undertake based on state and/or federal programs and policies. The

responding State agencies included: the Division of Medical Assistance CAP-DA unit, the Division of Services for the Deaf and Hard of Hearing, the Division of Services for the Blind, the Division of Mental Health/Developmental Disabilities/Substance Abuse Services, the Council on Developmental Disabilities, the Division of Social Services, the Division of Public Health (and the Healthy Carolinians organization), and the Division of Vocational Rehabilitation Services. In addition, groups such as the NC Association of Area Agencies on Aging and the Governor's Advisory Council on Aging were asked to provide input on other types of planning being conducted in counties across the state (Appendix D offers a summary of local planning entities). This research led the Division to believe that it was important to develop a conceptual framework that would better integrate existing planning activities in a way that is consistent with the Institute of Medicine Task Force's recommendation.

2. **Developed a local LTC planning proposal:** The Division of Aging has developed a concept paper for local LTC planning that is based on Recommendation #16 of the Institute of Medicine's Final Report and on input received from various groups and individuals (please see Appendix A for a copy of the grant proposal submitted to the US Assistant Secretary for Planning and Evaluation's State Innovations grant program, which explains the concept in detail, and Appendix B for a letter of support from the NC Association of County Commissioners). The Division sought funding for the proposal from the Assistant Secretary for Planning and Evaluation's State Innovations grant program. The project is called "*A Communications and Planning Network to Support Families in Their LTC Roles*" and will connect state and local interests committed to LTC planning and reform. The goals of the Network include:

    1. supporting local planning for LTC and its role in accomplishing many of the recommendations outlined in the Institute of Medicine's final report;
    2. learning more about the availability and capacity of LTC core services and client outcomes (at the local level);
    3. facilitating a continuous dialogue and information exchange between the state and communities interested in LTC planning; and
    4. informing and inspiring a joint commitment to action between the local and the state levels to improve the current LTC system.

    The proposed project blends the interests and needs of diverse population groups and governmental units. Many entities will contribute to organizing and implementing the *Communications and Planning Network* in participating counties, including local lead agents and planning teams, a new State Team, and the LTC Cabinet composed of directors of all affected DHHS divisions. The Division of Aging expects to work with two or three counties or multi-county regions in the first year of the project, with additional counties participating in subsequent years. It anticipates that county or regional entities could serve as lead agents. To be considered for participation, interested counties/regions will submit a Statement of Interest and an endorsement letter from their County Commissioners. Participating counties will be selected by the State Team.

    The *Communications and Planning Network* has been favorably reviewed by a diverse set of stakeholders. The proposed project has been presented to the LTC Cabinet, the Governor's Advisory Council on Aging, the DSS Adult Services Committee, and to a group at the NC

Conference on Aging. The project was also discussed with State and regional DSS personnel and at a meeting of the NC Association of Area Agencies on Aging. Lynda McDaniel, Assistant Secretary for LTC and Family Services, distributed a copy of the ASPE grant proposal to various groups in November 2002 and asked for comments on the *Communications and Planning Network*. The proposal continues to be refined based on input from interested groups and individuals.

Major Findings:

1. **Concurrent health and human services planning is occurring at the local level.** In North Carolina, counties already have established infrastructures for planning efforts, but these efforts are typically segmented. A variety of planning bodies responsible for different aspects of LTC services for older and disabled adults are found in counties throughout the state. Each of these planning bodies works under different LTC funding streams. While some local planning bodies work well together to accomplish similar goals as well as specific projects, planning at the local level is generally not well coordinated. A few counties and regions have begun integrating planning efforts with some success. Still, most local planning bodies concentrate primarily on their specific areas of responsibility, and thus no planning body is coordinating the "big picture" of local LTC services, which can result in duplication of efforts and services as well as ineffective resource utilization and fragmentation for consumers.
2. **Counties are continually facing increasing needs.** Local communities are being asked to do "more with less" as the older and disabled adult populations increase while at the same time the service budgets remain constant or, sometimes, decrease. Depending on the county's size, it is now spending hundreds of thousands, if not millions, of dollars on LTC. The escalating public cost of LTC is a serious concern. It is essential that counties understand all aspects of their local systems for LTC and have effective and coordinated strategies for tackling barriers to appropriate, quality, and cost-effective care that supports individuals and families in making choices. Effective local planning efforts will help counties address these major service system issues.
3. **There is a lack of information related to local planning for LTC.** There are few places where counties can go to get useful and detailed information for developing local LTC planning processes that cut across population groups and health and social service programs. Counties in North Carolina need a comprehensive, coherent, and accessible resource for information on developing LTC planning processes, consolidating existing planning processes for efficiency, conducting a needs assessment, creating strategic plans, and sharing innovative strategies for tackling common LTC issues.
4. **Effective local planning does require leadership and the commitment of resources.** Previous experience with local human services planning shows that counties must be prepared to commit the time and resources necessary to support an inclusive, comprehensive and analytical process necessary for systems change. The process also requires accountable leadership. Even without a special funding stream to support local planning, with local will and leadership, some counties and regions have developed planning initiatives that have been quite successful.

Principal Conclusions

1. **Counties should be encouraged, rather than required, to designate local lead agencies to organize a local LTC planning process.** Mandating counties to designate local lead agencies to organize a local LTC planning process without any new funding would likely be counterproductive. Counties must be ready and eager to undertake LTC planning processes in order for their efforts to be useful and effective. Requiring counties who are not ready to begin this process, or who do not have adequate resources to put towards the process, will likely result in resentment and wasted resources and time as well as inadequate planning results. However, designation of a local lead agent(s) that would coordinate a LTC planning process should be strongly encouraged in order to help those counties that are ready to begin the process to realize the benefits related to planning at the local level. In addition, state agencies and policies must provide support and technical assistance to counties that are interested and ready to begin the process. These communities that move forward with local LTC planning can serve as mentors for other communities.
2. **Any efforts to promote lead agencies and local LTC planning should take into account the existing infrastructure for planning already present in counties across the state.** Counties will likely be more responsive to building on existing activities rather than developing completely new planning bodies that do not take into account or assist with other mandated planning activities (such as CAP-DA, HCCBG, and DSS planning bodies). Many state agencies require local advisory/planning committees. State agencies must support the idea that a multi-purpose LTC planning process can serve as the required advisory/planning committee for various specific programs. In addition, flexibility and innovation at the state level may be necessary to tackle any "roadblocks" in state policy that impose restrictions on planning at the local level. The Network's State Team and the LTC Cabinet will have important roles in examining how best to integrate relevant planning activities in support of local LTC planning.
3. **The Division of Aging should work with the LTC Cabinet to implement the *Communications and Planning Network to Support Families in Their LTC Roles*.** The Network must be implemented on a strictly voluntary basis in counties who have indicated a strong interest in participating. The proposed Network will give interested counties the structure and technical assistance necessary to implement effective planning processes. The LTC Cabinet's role in the Network is vital to the success of the project. The LTC Cabinet will provide direction and assistance with policy issues related to developing comprehensive LTC systems in the counties. The LTC Cabinet will also provide guidance on accomplishing the goals and outcomes of the project and help resolve state policy and program barriers.
4. **The possibility of providing State funding to counties to designate local lead agencies and undertake LTC planning processes should be considered in the future, when the timing is right.** While the Division of Aging proposes to initiate the *Communications and Planning Network* with volunteer counties, it will continue to pursue grants and other sources of support to aid local efforts and facilitate participation by the State Team. The Department will also encourage and support counties in their pursuit of funds for planning and development activities. The LTC Cabinet will further support participating counties by giving them special consideration for future initiatives and grants as they become available.

Appendix B
The Communications and Coordination Initiative's Request for Proposals

Lead Agent(s) Statement of Commitment

I/we commit to serving as lead agent(s) to guide and support the work of the local planning team for at least one year. The responsibilities of serving as lead agent(s) may include the following:

- Providing adequate staff time to lead the local planning efforts;
- Convening the planning team at regular intervals;
- Managing the administrative tasks involved in the local planning process, which may include documenting the steps taken/best practices/barriers/etc. in developing the community initiative, researching issues, taking minutes, mailing meeting announcements, etc;
- Helping keep the planning team energized and working towards established outcomes (established by the Long-Term Care Cabinet) and goals;
- Working with local organizations, leaders, and government officials to ensure that all groups required by IOM Recommendation #16, as well as any other groups that should be involved in evaluating LTC services and developing a comprehensive community LTC system, are included in the planning team;
- Mediating any conflicts that arise during the planning process;
- Attending meetings and teleconferences related to the project. Participating on any listserves, websites, etc. that are created to help communities interact with each other and with State professionals;
- If needed, researching local, state, and national funders for possible grants to help fund any local initiatives that result from the planning process and assuming a major role in applying for potential funds;
- Providing or arranging for needed training for the planning team on special population issues, the IOM recommendations, planning processes, data utilization, etc.;
- Assisting with evaluating the usefulness of LTC data available under the Initiative;
- If determined necessary, ensuring that local data collection is completed according to guidelines;
- Sharing information with the State Team and the LTC Community Interests Group (meetings of all participating communities, State Team members, and others interested in local planning for LTC) regarding the planning process;
- Ensuring that the interests of all affected populations are adequately represented in the planning team; and
- Assisting with evaluating the usefulness of the Initiative.

_____ _____

Printed Name and Signature Date

_____ _____

Printed Name and Signature if more than one lead agent Date

Statement of Interest
The Communications and Coordination Initiative to Strengthen LTC Services

Area To Be Served by Planning Efforts: _____

Lead Agent(s): _____

Contact Person(s): _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Please briefly answer the following questions in the space provided:

1. Why is your community interested in participating in the Communications and Coordination Initiative to Strengthen LTC Services?

2. What local human-services and health planning processes are already in place for your community? In what ways will this new planning process work with those established planning groups?

3. What are the most pressing issues and/or barriers of your community's current LTC system?

4. What do you expect to be the end-result of the planning process for your community?

5. What other agencies and individuals do you expect to participate in the planning process?

Representatives from:	Name(s) and Title(s)	Agency (if applicable)
Department of Social Services		
Health Department		
Area Mental Health Program		
Aging Councils or Departments		
HCCBG Lead Agency		
CAP-DA Lead Agency		
Hospitals		
Home Health and Home Care Agencies		
Nursing Homes		
Assisted Living Facilities		
Adult Day Care/Adult Day Health Agencies		
Group Homes		
Independent Living Programs and Facilities		
Area Agencies on Aging		
Long-Term Care Ombudsman Programs		
Community Advisory Committees		
County Government		
Older Adults		
Persons with Disabilities		
Family Caregivers		
Advocates		
Other		

6. What types of information and technical assistance do you think would best help your community in evaluating its LTC services and in designing strategies to develop a comprehensive LTC system?

7. Please include a letter from your County Commissioners (each set if serving more than one county) naming you or your organization(s) as lead agent(s) and indicating their support of your community's Statement of Interest.

Thank you for your interest in participating in the Communications and Coordination Initiative. If you have any questions, please contact Steve Freedman at the NC Division of Aging, 919-733-0440 or Steve.Freedman@ncmail.net.

YOUR COMMUNITY'S STATEMENT OF INTEREST MUST BE POSTMARKED BY JULY 23, 2003

ATTN: Steve Freedman
Communications and Coordination Initiative
NC Division of Aging
2101 Mail Service Center
Raleigh, NC 27699-2101
Fax: (919) 733-0443
Steve.Freedman@ncmail.net

Appendix C
Contact Information for the Pilot Sites

Contact Information for the Communications and Coordination Initiative's Pilot Sites

Mecklenburg County

Lead Agent: **Mecklenburg County Department of Social Services, Services for Adults Division**

Lead Agent contact information:

Carol R. Baker, PhD, Director, Services for Adults Division, Mecklenburg County DSS
301 Billingsley Road, Charlotte, NC 28211
704-336-3258
bakercr@co.mecklenburg.nc.us

John Highfill, Special Projects Coordinator, Services for Adults Division, Mecklenburg County DSS
301 Billingsley Road, Charlotte, NC 28211
704-336-4109
highfjv@co.mecklenburg.nc.us

Project website: http://www.statusofseniors.charmeck.org

New Hanover County

Lead Agent: **New Hanover County Department of Aging**

Lead Agent contact information:

Annette Crumpton, Director, New Hanover County Department of Aging
2222 South College Road, Wilmington, NC 28403
910-452-6411
acrumpton@nhcgov.com

Appendix D
Evaluation Tools

County or Counties Served: _____

Project Lead Agency: _____

Project Director(s): _____

Project Director(s)' phone: (_____) _____-_____

Project Director(s)' fax: (_____) _____-_____

Project Director(s) Email: _____

Communications and Coordination Initiative to Strengthen Long-Term Care Services
Process Documentation Tool

Project Overview

1. Describe your planning team's leadership structure. (For example, was an Executive or Steering Team created? If so, how was it created, who is on it, and what are its main responsibilities? Does your team have a Chair, Vice-Chair, Secretary structure? If so, how were leaders chosen and what are their roles?)

2. Please list the dates of **full** planning team meetings (not including work group or subcommittee meetings) from November 1, 2003 through June 30, 2004?

3. Did your team develop a mission and vision statement? ❒ Yes ❒ No
   If yes, please send a copy.

4. Did your team establish bylaws or ground rules? ❒ Yes ❒ No
   If yes, please send a copy.

5. Please list the subcommittees or work groups below and fill out the information in the adjacent columns.

Work Group or Subcommittee (use a name describing group function—e.g. "Transportation Work Group" or "Subcommittee on Access to Services")	**Month Established**	**Month Ended (or ongoing)**	**Approximately how many times did this group meet** November 1, 2003 through June 30, 2004?

6. Were the issues for which you identified work groups the same issues identified in your proposal under question 3. "What are the most pressing issues and/or barriers of your community's current LTC system?"

   ❒ Yes ❒ Partly, but not entirely ❒ No, entirely or almost entirely different

7. Please provide a brief timeline of your overall planning team's major activities. Include tasks already completed and expected activities through January 2005.

Major Activity (Please include the purpose and/or examples of activities if not self-evident)	**Months in which work took place**	**Date completed (or future date when completion is expected)**

8. What are the major outcomes that you have achieved?

   _____
   _____
   _____
   _____

9. What are the major outcomes that you have not yet achieved, but that you hope to accomplish before the project ends?

   _____
   _____
   _____

10. In the chart below, please list each member of your planning team in the block on the left and fill out the information in each of the remaining columns. For the rating in column 7, please use a scale of 1 to 5 in which **5=Attended always or nearly always and contributed work, ideas, or both** and **1=Rarely attended, and did not contribute work or ideas.** *Make additional copies of this page as needed.*

Name	**Primary Category of Stakeholder (check only one)**	**Specific position and affiliation** (e.g. director, County DSS; minister, First Baptist Church; caregiver to older adult; younger adult consumer with disabilities; volunteer, HDM; discharge planner, Metro Hospital)	**Role on the Planning team** (e.g. member, chair, secretary, support team from lead agency)	**Name of Subcommittee(s) or workgroup(s)**	**Role on the Subcommittee or workgroup**	**Rate this participant's level of participation** on a scale of 1 to 5.
	❒ consumer or family ❒ lead agency ❒ aging network ❒ disability network ❒ faith ❒ business ❒ local government ❒ other					
	❒ consumer or family ❒ lead agency ❒ aging network ❒ disability network ❒ faith ❒ business ❒ local government ❒ other					
	❒ consumer or family ❒ lead agency ❒ aging network ❒ disability network ❒ faith ❒ business ❒ local government ❒ other					

Name	**Primary Category of Stakeholder (check only one)**	**Specific position and affiliation** (e.g. director, County DSS; minister, First Baptist Church; caregiver to older adult; younger adult consumer with disabilities; volunteer, HDM; discharge planner, Metro Hospital)	**Role on the Planning team** (e.g. member, chair, secretary, support team from lead agency)	**Name of Subcommittee(s) or workgroup(s)**	**Role on the Subcommittee or workgroup**	**Rate this participant's level of participation** on a scale of 1 to 5.
	❒ consumer or family ❒ lead agency ❒ aging network ❒ disability network ❒ faith ❒ business ❒ local government ❒ other					
	❒ consumer or family ❒ lead agency ❒ aging network ❒ disability network ❒ faith ❒ business ❒ local government ❒ other					

Core Service Evaluation Tools

11. Which of the following best describes the way your team or sub-committees used the Service Evaluation Tools?

- ❒ Did not use tools at all➔**Skip to Question 17.**
- ❒ Looked over the tools and used them for ideas about service needs or for developing discussion topics➔**Skip to Question 17**
- ❒ One or more subcommittees used the tool in some way➔**Go on to question 14.**

12. In the chart below and on the following pages please list each core service evaluation tool that was used by the local project team or any of its workgroups/subcommittees (one per block in the column on the far left) and fill out the information in each of the remaining columns to describe how *that* tool was used.

Core Service	Dimensions Used	*Questions* Used	Manner in which data/information were used for this tool
	❒ Used *all* dimensions of tool	❒ All ❒ Most ❒ Some	Check *all that apply* ❒ Did not try to get or use data/information ❒ We tried to get data/information *only* for the questions we thought most important ❒ We searched for data/information but found *little or none* of what we were looking for ❒ We searched for, and found *some of the data/information referenced on the tools* ❒ We found *most* of the data referenced on the tools ❒ Service providers shared a combination of data/information and impressions from their experience ❒ Consumers shared impressions from their experience ❒ We used some of the data/information from the packets provided by the Division of Aging and Adult Services
	❒ Used *some* dimensions (list)		
	1.	❒ All ❒ Most ❒ Some	
	2.	❒ All ❒ Most ❒ Some	
	3.	❒ All ❒ Most ❒ Some	
	4.	❒ All ❒ Most ❒ Some	
	5. _____	❒ All ❒ Most ❒ Some	

Core Service	Dimensions Used	*Questions* Used	Manner in which data/information were used for this tool
	❒ Used *all* dimensions of tool	❒ All ❒ Most ❒ Some	Check *all that apply* ❒ Did not try to get or use data/information ❒ We tried to get data/information *only* for the questions we thought most important ❒ We searched for data/information but found *little or none* of what we were looking for ❒ We searched for, and found *some of the data/information referenced on the tools* ❒ We found *most* of the data referenced on the tools ❒ Service providers shared a combination of data/information and impressions from their experience ❒ Consumers shared impressions from their experience ❒ We used some of the data/information from the packets provided by the Division of Aging and Adult Services
	❒ Used *some* dimensions (list)		
	1.	❒ All ❒ Most ❒ Some	
	2.	❒ All ❒ Most ❒ Some	
	3.	❒ All ❒ Most ❒ Some	
	4.	❒ All ❒ Most ❒ Some	
	5. _____	❒ All ❒ Most ❒ Some	
	❒ Used *all* dimensions of tool	❒ All ❒ Most ❒ Some	Check *all that apply* ❒ Did not try to get or use data/information ❒ We tried to get data/information *only* for the questions we thought most important ❒ We searched for data/information but found *little or none* of what we were looking for ❒ We searched for, and found *some of the data/information referenced on the tools* ❒ We found *most* of the data referenced on the tools ❒ Service providers shared a combination of data/information and impressions from their experience ❒ Consumers shared impressions from their experience ❒ We used some of the data/information from the packets provided by the Division of Aging and Adult Services
	❒ Used *some* dimensions (list)		
	1.	❒ All ❒ Most ❒ Some	
	2.	❒ All ❒ Most ❒ Some	
	3.	❒ All ❒ Most ❒ Some	
	4.	❒ All ❒ Most ❒ Some	
	5. _____	❒ All ❒ Most ❒ Some	
	❒ Used *some* dimensions (list)		
	1.	❒ All ❒ Most ❒ Some	
	2.	❒ All ❒ Most ❒ Some	
	3.	❒ All ❒ Most ❒ Some	
	4.	❒ All ❒ Most ❒ Some	
	5. _____	❒ All ❒ Most ❒ Some	

13. In the chart below, list each of the Core Service Evaluation Tools used in your project in the left hand column, then mark the appropriate box to indicate how you arrived at scores for each tool.

Core Service Evaluation Tool	Scoring Method (check all that apply)
	❒ Each work group member scored questions separately and results were summed or averaged ❒ Work groups discussed questions and assigned a score by consensus or majority vote ❒ Individual questions were discussed, but scores were not formally assigned ❒ Individual question scores were averaged to get a dimension score ❒ Dimension scores were assigned by consensus or majority vote without summing or averaging individual questions ❒ Other (describe)
	❒ Each work group member scored questions separately and results were summed or averaged ❒ Work groups discussed questions and assigned a score by consensus or majority vote ❒ Individual questions were discussed, but scores were not formally assigned ❒ Individual question scores were averaged to get a dimension score ❒ Dimension scores were assigned by consensus or majority vote without summing or averaging individual questions ❒ Other (describe)
	❒ Each work group member scored questions separately and results were summed or averaged ❒ Work groups discussed questions and assigned a score by consensus or majority vote ❒ Individual questions were discussed, but scores were not formally assigned ❒ Individual question scores were averaged to get a dimension score ❒ Dimension scores were assigned by consensus or majority vote without summing or averaging individual questions ❒ Other (describe)

Please answer questions 14 through 16 only if your team tried to find some data for one or more of the core evaluation tools.

14. Did you try to collect your own data through any of the following means? (Check all that apply.)

❒ Surveys (written or electronic)

❒ Interviews (phone or face to face)

❒ Group techniques such as focus groups, town meetings or public hearings

❒ Other: (describe) _____

15. Please list/describe any data that you wanted/needed but were *unable to find* or for which you felt *uncomfortable with the source* of the data. For each set of data, please indicate for which tool or tools it was needed.

Data that Could Not Be Found or Found Only from a Questionable Source	**Core Service Evaluation Tool for Which it was Needed**	**Not Found or Questionable Source?**
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable
		❒ Not Found ❒ Questionable

16. Please list/describe any data that you found particularly helpful in planning.

Particularly Helpful Data Source	Core Service Evaluation Tool(s) for Which it was Helpful

Lead Agency

17. For each of the lead agency activities below, please list the members of the agency staff (by position, not name) or planning team members who did this work, and the approximate average number of hours per month they spent on this task from November 1, 2003 through June 30, 2000. (Note: you have been given space to record up to 3 staff or team members per task. This is a rough approximation. Please adjust as needed.) If *no hours* were spent on a given activity, use the "staff members" space to explain why this activity was not needed.

Activity	Staff position	Agency Staff?	Approximate hrs. /month
Identifying and recruiting appropriate members for your planning team.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Facilitating meetings (entire team or subcommittees) including developing agendas.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Orienting and updating project team members (or potential members) about the planning project .		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Orienting and updating the community about the planning project (e.g. making presentations).		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Publicity, such as developing marketing materials and contacting media.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Support tasks such as taking minutes, sending out meeting reminders, and documenting actions and decisions.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	

Activity	Staff position	Agency Staff?	Approximate hrs. /month
Managing conflicts, keeping morale high, keeping all the stakeholders involved and other diplomatic tasks.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Conducting surveys, focus groups, public hearings and other direct data gathering.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Research & compiling existing data for completing the Core Service Evaluation tools, or other planning.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Helping with project evaluation.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Creating reports about the progress in your county (e.g., presentations, email, and documents)		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Participating in initiative communications—teleconferences, phone calls, listserves, and meetings.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Grant writing and fund raising (if not applicable, indicate this in the "staff member" section)		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Arranging or providing training to the planning team.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	
Developing (or starting to develop) a strategic action plan.		❒ Yes ❒ No	
		❒ Yes ❒ No	
		❒ Yes ❒ No	

Communication with the State Team and the Division of Aging and Adult Services (DAAS)

18. How responsive was the Division of Aging and Adult Services (DAAS) to your needs?

❒ Very Unresponsive ❒ Not Very Responsive ❒ OK ❒ Responsive ❒ Very Responsive

19. What was the nature of your contact with the Division of Aging and Adult Services? Check all that apply

❒ They called me and offered general technical assistance
❒ I called them for general technical assistance
❒ I called them to discuss a specific problem or issue
❒ I called them to ask a question
❒ I attended meetings in Raleigh and/or teleconferences for this project
❒ They called me to offer specific training or resources
❒ I called them to ask for specific training or resources
❒ They brought training or consultation to one or more team meetings
❒ They visited me/my project team
❒ They sent me general information and resources
❒ Other (describe): _____

20. About how often were you in communication with one or more staff from the Division of Aging and Adult Services?

❒ Once a week or more
❒ 1-3 times a month
❒ Once or twice a quarter
❒ Less than once a quarter

21. Was this amount of contact. . .

❒ too much ❒ not enough? ❒ just about right?

22. How responsive were *other* members of the State Team (e.g. representatives of other Divisions within DHHS such as DSS, not including the DAAS) to your needs?

❒ Very Unresponsive ❒ Not Very Responsive ❒ OK ❒ Responsive ❒ Very Responsive ❒ No contact

23. What was the nature of your contact with the State Team (not including the DAAS)? Check all that apply

- ❒ They called me and offered general technical assistance
- ❒ I called them for general technical assistance
- ❒ I called them to discuss a specific problem or issue
- ❒ I called them to ask a question
- ❒ I attended meetings in Raleigh and/or teleconferences for this project
- ❒ They called me to offer specific training or resources
- ❒ I called them to ask for specific training or resources
- ❒ They brought training or consultation to one or more team meetings
- ❒ They visited me/my project team
- ❒ They sent me general information and resources
- ❒ Other (describe): _____

24. About how often were you in communication with one or more members of the State Team not including DAAS)?

- ❒ Once a week or more
- ❒ 1-3 times a month
- ❒ Once or twice a quarter
- ❒ Less than once a quarter

25. Was this amount of contact. . .

❒ too much ❒ not enough? ❒ just about right?

26. In the table below, please list resources, information, and assistance, you received from DAAS and/or other members of the State Team (some are pre-listed but add any others that apply). Then check one box to indicate how helpful it was for you. You have been given three or more spaces for each type of resource; but you may have fewer—or none—in some categories and may need to add more lines in others.

	Made things worse (1)	(2)	(3)	(4)	**Very helpful (5)**
Training					
1. Orientation Meeting					
2. Core LTC Service Tool Training					
3. Vision/Mission/Team Readiness to Plan Training					
4.					
5.					
Written materials					
1. Core LTC Evaluation Tools					
2. Written Instructions for completing the Tools					
3.					
4.					
5.					

Advice/Technical assistance					
1.					
2.					
3.					
Data					
1.					
2.					
3.					
Any other help/resources?					
1.					
2.					
3.					

27. Were there any resources or information that you wanted from DAAS that they were unable to provide? ❒ Yes ❒No (If yes, please list them below.)

28. Were there any resources or information that you wanted from any *other* members of the state team that they were unable to provide? ❒ Yes ❒No (If yes, please list them below.)

Convergence and/or Divergence in Needs and Interests of Older Adults and Younger Adults with Disabilities

29. Please rate the degree of ***involvement**** on the planning team of each of the following groups, by putting an X in the appropriate box:

	Not Involved at All (1)	**(2)**	**(3)**	**(4)**	**Very Involved (5)**
Older adult consumers					
Younger adult consumers with disabilities					
Family members or caregivers of older adults					
Family members or caregivers of younger adults with disabilities					
Advocates for older adults					
Advocates for younger adults with disabilities					
*Involvement means, at a minimum, that more than one or two attended meetings and shared information and opinions					

Barriers and Opportunities

30. For each of the areas listed below, please put an X in the appropriate box to describe the progress that your county is making *as a result of this Initiative*.

	Great Strides	**Some Progress**	**Little to No Progress**	**Progress made, but *not* due to Initiative**
Developing or strengthening core services				
Improving coordination/consolidation of local services				
Improving coordination/consolidation of local planning				
Streamlining access to services				
Reducing or eliminating barriers due to funding sources				
Enhancing public awareness of issues or services				
Enhancing public officials' commitment to reform of long-term care				

31. If you could go back in time, but retain the knowledge and experience that you have gained in this initiative. . . (Put an X in the appropriate box to rate your response from 1 to 5)

	Definitely Not (1)	**(2)**	**(3)**	**(4)**	**Yes, definitely (5)**
a. Would you apply to participate in this project?					
b. Would you apply to be lead agent?					

32. Estimate the total resources committed to this Initiative . . .

	Time	**Money**
a. by the lead agency	_____ hours	$_____
b. by all other participants (not lead agency)	_____ hours	$_____

33. Based on the knowledge and experience that you have gained in this initiative. . . (Put an X in the appropriate box to rate your response from 1 to 5)

	Definitely Not (1)	**(2)**	**(3)**	**(4)**	**Yes, definitely (5)**
a. Would you recommend participation in a similar initiative to other counties					
b. Would you recommend that the state require counties to participate in a similar initiative?					

Sustainability

34. Does your team anticipate continuing its planning activities after the pilot project is complete?

☐ Yes ☐ No

Thank you for completing this process evaluation tool!

If you have any questions, please contact either:

Julie Bell, Division of Aging and Adult Services
Telephone: 919-733-0440
Email: Julie.Bell@ncmail.net
Fax: 919-733-0443

OR

Mary Anne Salmon, CARES, School of Social Work, UNC–Chapel Hill
Telephone: 919-962-4362
Email: masalmon@email.unc.edu
Fax: 919-962-3653

Please return this completed form to Mary Anne Salmon no later than October 1st.

Within a week of returning your survey you will receive a phone call from Mary Anne asking you to schedule a follow-up phone interview. Questions that will be covered in the phone interview are attached as a separate document.

List of Items for Discussion During

Follow-Up Phone Call:

1. What kinds of "background" activities were necessary before the full planning team began its work (e.g. publicity activities, recruitment activities)? Who did these activities?
2. Were any special provisions made to help consumers and/or caregivers better participate (e.g. travel reimbursement, arrangements to participate by phone, transportation to meetings, respite for meeting times)? If yes, which ones?.
3. What methods were used to communicate among team members between meetings? (e.g., conference calls, email, conventional mail, websites, individual phone calls, etc.)
4. Were minutes kept of the meetings? To whom were minutes distributed?
5. What were the greatest challenges to communication among the local project team? How did you address them?
6. Please rate how well traditional providers, non-traditional providers, and stakeholders such as businesses, the faith community, consumers, and caregivers worked together on this project. What were the strengths demonstrated in this collaboration?. What, if any, challenges occurred? How were these challenges met? How did the project benefit from this collaboration?
7. *Only for those who collected their own data*: For which services (or which Core Service Evaluation Tools) did you collect your own data? What were the benefits and challenges of collecting your own data?
8. Describe how your agency was chosen as the lead agency?
9. *If you have reported a low level of involvement for consumers, caregivers, and/or advocates of either younger adults with disabilities or older adults*, please describe your past efforts to identify, recruit, and include these groups as well as your plans to increase their participation in the future.

If you have worked extensively with consumers/caregivers/advocates for both groups:

10. What issues have been identified as similarly important for ***both*** the aging community (consumers, caregivers, and providers) and the disability community (consumers, caregivers, and providers)?
11. What issues have been identified as *important for the aging community* that have not been of particular interest to the disability community?
12. What issues have been identified as *important for the disability community* that have not been of particular interest to the aging community?
13. Please describe any differences that arose between the interests of these two communities and how these are being resolved.

14. Please describe any new insights, partnerships, or strategies that came directly from bringing together the opinions and experiences of the aging and disability communities.
15. Overall, what are the greatest barriers that your project has faced? What have you done to overcome them? To what degree do these barriers remain? What new methods of overcoming them are you planning?
16. What is the project team most proud of, in all the work they have done on this project? About what are you, as lead agent, most proud?
17. What is the team's most promising opportunity in the coming year?
18. *If you plan to continue after the project is complete*, what barriers do you anticipate to keeping this work going after the pilot project is complete?
19. What plans does your team have for implementing the Strategic Action Plan that has been or will be developed as a result of this Initiative?

In Addition:

In addition to these questions, you may be asked to talk about the reason for your choice form many of the "check box" items on the written tool. For example, in question 6 you are asked "Were the issues for which you identified work groups the same issues identified in your proposal?" In the phone call you will be asked either why you think they stayed the same or why you think they changed to the degree they did change.

Interim Report
The NC DHHS Communications and Coordination Initiative

Prepared for: The NC Study Commission on Aging

By: The NC Division of Aging and Adult Services

October 27, 2004

Agenda

- Background Information
- State-Developed Resources
- Mecklenburg County's Progress
- Rowan County's Involvement
- Planned Evaluation Activities
- Future of the Initiative

Background Information

- NC Institute of Medicine's 2001 Final Report: A LTC Plan for NC
  - Recommendation #11
  - Recommendation #16
- Studies Act of 2001 (S.L. 2001-491, Section 22.1)
- Session Law 2003-284, Section 10.8F
- Development of a State Team

5 State-Developed Resources

1. Core LTC Service Evaluation Tools
   - (blue handout)
   - 22 services, extremely flexible
   - Use both "hard-data" and "soft-data"
   - 3-4 levels of review
   - Designed to assist counties/regions in assessing their LTC services and overall system re.:

Existence	Efficiency/Duplication
Adequacy	Equity
Accessibility	Effectiveness/Quality

State-Developed Resources

2. Planning Matrix (pink handout)
3. Planning Basics Notebook (2nd blue handout)
   - A "How-To" manual for lead agents
   - 300+ pages, lots of resources for further reading
4. Various Trainings
5. Communications and Coordination Website (green handout)

   www.dhhs.state.nc.us/ltc/localplanning.htm

Pilot Site Requirements

- Follow IOM Recommendation #16
- Implement an *inclusive* and *comprehensive* process to facilitate LTC coordination, resulting in:
  - the development of LTC core services
  - coordination of local services
  - streamlining access to services
- Evaluate their local LTC system and/or services
- Develop and implement a county strategic plan
- Inform local and state policymakers

Pilot Site Selection

- June 4, 2004: RFP released (please see white sheet):
  - Endorsement letter from County Commissioners
  - Signed lead agent statement of commitment
- 5 counties/regions applied
- LTC Cabinet chose:
  - New Hanover County (N.H. Department of Aging)
  - Mecklenburg County (Mecklenburg Co. DSS)

Technical Assistance to Pilots

- Oct. 9, 2003 – Orientation
- October 23 and 24, 2003 – ½ day strategy meetings with individual counties
- In-county trainings in December 2003 (Mecklenburg) and March 2004 (New Hanover)
- Numerous visits to observe their team meetings
- Frequent telephone and email contact
- Videoconference in May 2004
- Assisted with RWJF applications

Non-Pilot Counties

- Rowan County
- Lincoln/Cleveland/Gaston Counties
- Forsyth County

Mecklenburg Status of Seniors Initiative (SOSI)

Senior-Friendly Mecklenburg

John Highfill, Special Projects Coordinator
Mecklenburg Co. Dept. of Social Services

Status of Seniors Initiative (SOSI)

Vision

To foster a senior-friendly community that values dignity and independence for all older adults.

Status of Seniors Initiative

Mission

To engage the community in creating a dynamic plan that enhances the quality of life of older adults by focusing resources on their needs.

SOSI's Guiding Principles

- Senior-friendly community
- Age in place, whenever possible
- Ensure opportunities for needed service for all income levels

SOSI's Initial Issues to be Studied

1. Facilities and Institutions
2. Food and Nutrition
3. In-Home Support Services
4. Leisure, Education, Recreation and Socialization
5. Transportation

Process

- Community Event held
  - in November 2003
  - with 150 participants
- Five work groups formed
- Completed the Report Template
- March 2004 Event at Senior Center to determine priority recommendations
- Report written by Lee Institute

Planning Process

- September 2003 to May 2004 (and continuing)
- 400+ community volunteers
- 3,600+ collective volunteer hours
- Facilitated by The Lee Institute
- Guided by Executive Advisory Board and Steering Committee

Planning Process Continued...

- Community-Based Issue Groups
- Public forums
- Outside research teams
- Leaders from the aging network and other "communities"
- DHHS Evaluation tools

Next Phase of Work

- Work groups around each of the seven recommendations
- Two new work groups: Adults with Disabilities and the Physical Environment
- Spring Event to prioritize strategies
- Devise coordinated implementation plan
- Engage civic leaders and diverse stakeholders

Major Successes and Barriers

Major Successes

- Collaboration
- Commitment from Volunteers
- Our Reports
- State "Grant"

Major Barriers

- Time
- Staff
- Dollars
- Limited private sector involvement

For More Information...

Report and additional data available at:

http://statusofseniors.charmeck.org

To get involved, please call:

704-000-0000

Rowan County

Experience
as a
Non-Pilot County

Gayla Woody,
Director, Centralina COG Area Agency on Aging

Evaluation Plan: Purpose/Focus

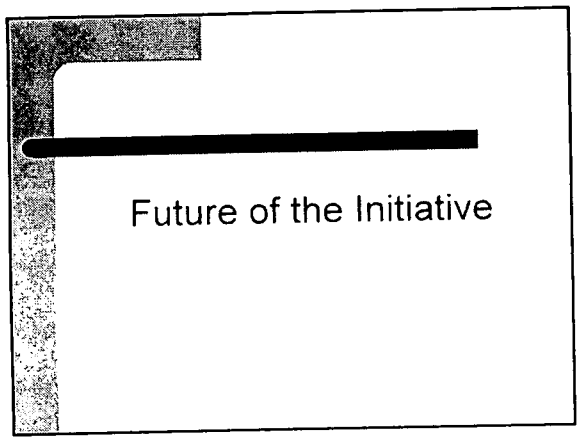
- Concrete plan reflecting the needs of the community developed in some specific and measurable ways for strengthening LTC services for *both* older adults and adults with disabilities (18-59)?
- Was the amount of communication and coordination among agency stakeholders and consumers/families *increased* compared to previous planning initiatives?

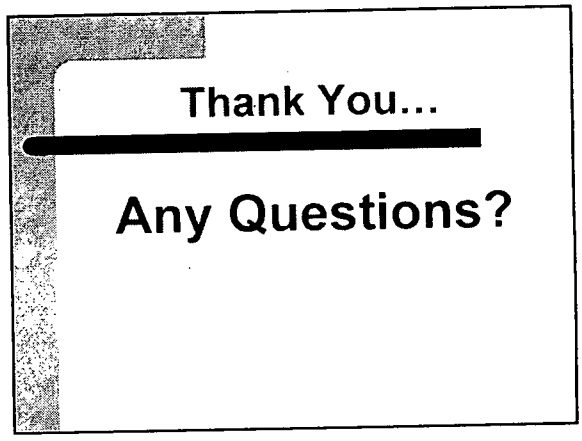
Phase 1: Process Evaluation

- Extent to which pilot counties:
  - Identified opportunities and barriers to developing a local LTC planning process
  - Aided in development of core LTC services
  - Caused local planning and LTC services to become more streamlined, accessible, and coordinated
  - Allowed consumers input into LTC planning
  - Increased communication and TA between the State and local interests

Phase 2: Evaluating End-Results

- Documenting the continued efforts of the pilot projects (past the pilot year)
- Analyzing the county's strategic plans
- Documenting implementation activities
- Determining the usefulness of the State's TA
- Evaluating the activities and commitment of the lead agents
- Assessing the usefulness of the State-developed resources


Future of the Initiative


Thank You...
Any Questions?

XV. Transportation Services For Older and Disabled Adults

** Instructions available at http://www.dhhs.state.nc.us/ltc/localplanning.htm

Primary Providers of Publicly Funded Transportation: _____

Primary Funding Sources: _____

Total Funding Last Fiscal Year: _____

Consumers or Units Served Last Fiscal Year: _____

Cost per Unit (e.g., cost per trip, cost per mile, or cost per unit, depending on the funding source): _____

A. Existence Are these services available to older and disabled adults in your community?		
1. Does your community have a public transit system?	Yes	No
2. Does your community have specialized transportation services for people with disabilities, such as paratransit or assisted transportation?	Yes	No
3. Does your community have taxicabs in operation that are accessible to people with disabilities? (Consider publicly funded taxi cabs and private pay)	Yes	No
4. Does your community have any supplemental transportation programs (such as volunteer or faith-based programs)?	Yes	No
5. Does your community have transportation programs to help people get to needed public services (such as the Health Department or Social Services)?	Yes	No
6. Does your community have transportation services to help people get to in-county medical appointments?	Yes	No
7. Does your community have transportation services to help people get to out-of-county medical appointments?	Yes	No
8. Does your community have transportation services to help people conduct errands (grocery shopping, prescription pick-up, etc.)?	Yes	No
Overall Existence Rating	**1 2 3 4 5**	

B. ADEQUACY Are these services in sufficient supply for those who need it?	
1 Is there an unmet need for human services transportation or public transportation? (How are unmet needs determined? Are there areas in your community that are not served by the transportation services? Why do these areas lack coverage? In addition to waiting lists and identifying unserved areas, are there any other indicators that there are/aren't enough transportation services in your community? Do public transit vans and buses have to turn away riders during busy periods of the day? If there is no documented unmet need for transportation services in your community, is it because everyone who qualifies gets services or because agencies do not keep waiting lists?)	Yes No
2. To what degree is transportation offered in the evening and night? (Are evening/night services available? What are the days and hours of evening/night transportation services operation? Under what conditions are evening/night services cancelled/delayed?)	1 2 3 4 5
3. To what degree is transportation offered on weekends? (Are weekend transportation services available to people in all funding sources or to the general public? What are the days and hours of weekend transportation services? Under what conditions are weekend transportation services cancelled/delayed?)	1 2 3 4 5
4. To what degree are services available during severe weather emergencies for people with critical treatment issues (such as dialysis)? (What arrangements are made to provide life-sustaining transportation when normal services are disrupted? To whom is it available? Under what conditions are these transportation services cancelled/delayed? What happens to consumers when these services are cancelled/delayed?)	1 2 3 4 5
5. To what degree is there sufficient funding in your community to provide transportation services to all who need it? (What are the funding sources for transportation services? What is the number of rides per year per funding source? How do those	1 2 3 4 5

numbers compare to the state average and similar counties? Last year did the county revert back any funds under any transportation funding source? Do providers feel that funding is a barrier to providing adequate transportation services? Is the availability of vehicles a barrier? Do consumers or providers report any other barriers to providing an adequate supply of transportation?)	
Overall Adequacy Rating	**1 2 3 4 5**

C. ACCESSIBILITY How obtainable are these services for those most in need?	
1. To what degree are transportation service vehicles accessible to a broad range of persons with disabilities? (Does the county have a sufficient number of paratransit vehicles to address the needs of elderly and disabled riders? What special features do transportation service vehicles offer? What accommodations are made for people who are physically disabled, developmentally disabled, sensory impaired or who have Alzheimer's disease or other memory disorders, etc?)	1 2 3 4 5
2. To what degree are bus stops in your community accessible to persons with disabilities? (Do bus stop roofs/covers extend far enough to cover someone in a wheelchair? Is route information posted in large type and/or Braille? Are there places to sit? If so, are there signs urging patrons to give priority seating to older and disabled adults?)	1 2 3 4 5
3. To what degree are additional accommodations available to persons with disabilities when requested? (What special features do transportation services offer to assist persons who are physically disabled, developmentally disabled, sensory impaired, or who have Alzheimer's disease or other memory disorders? How many riders requested additional accommodations last year? How many riders received additional accommodations last year?)	1 2 3 4 5
4. To what extent do transportation services offer door-to-door or curb-to-curb services? (What are the policies and procedures for assisting people either from the door or curb into the vehicle? What is the estimated % of people who need door-to-door assistance? Have there been special requests for assistance in getting from a dwelling to the curb that have presented challenges or barriers?)	1 2 3 4 5
5. To what degree are rides offered to attendants without charge when consumers with disabilities use public transportation? (To what extent does your community's transportation system meet ADA standards for riders with disabilities and their attendants? Are attendants for ADA riders allowed to accompany them at no extra	1 2 3 4 5

charge? Does the community have a written policy on ADA accommodations? What other provisions does the community make for assisting disabled riders?)	
6. To what extent do transportation-dependent persons know who to call for transportation services in the community? (What types of public information, outreach, and other informational programs are offered to the general public, caregivers, etc.? What % of consumers are self-referred? Are public communications and outreach activities consumer-friendly? What is the average reading level of materials? Are materials printed in languages other than English? Do materials come in large print and/or Braille?)	1 2 3 4 5
7. To what extent do transportation systems work with other community agencies for Medicaid referral purposes? (How do agencies assure that Medicaid-eligible people are referred to DSS for medical transportation if they have transportation needs? What % of Medicaid-eligible people receive medical transportation services?)	1 2 3 4 5
8. How affordable is transportation service for older and disabled community members? (What are the policies for rider contributions? How much fare money was generated by rider contributions under each funding source last year? What is the average out-of-pocket cost for riders? How does this average cost compare to the state average and similar counties? How many people are turned away each year because of an inability to pay? Do providers offer subsidized fares or sliding scale fees based on income?)	1 2 3 4 5
9. How adequate is the training for dispatchers and drivers in communicating with and assisting frail or disabled passengers? (Have your drivers been trained to be familiar with the needs of disabled and elderly passengers? Is training mandatory? If not, is it available? What does the training program involve? What % of dispatchers or drivers have been trained?)	1 2 3 4 5
Overall Accessibility Rating	**1 2 3 4 5**

D. Efficiency and Duplication of Services

How reasonable are the costs of services?
Are options for streamlining services available in the community?

1. To what extent are all the vehicles and providers in your community's transportation system part of a coordinated transportation system? (How is transportation planning and service delivery coordinated in your community? Is there a lead agency that brokers transportation services or subcontracts with other providers?)	1 2 3 4 5
2. How adequate is the number of vehicles in the county fleet to accommodate diverse demands for transportation services? (How many vehicles are in the county's transportation fleet? How many vehicles does your county have per 100,000 residents? How does this rate compare to the state average and similar counties? Are back-up vehicles available?)	1 2 3 4 5
3. How reasonable is the cost per vehicle mile/hour/trip? (Do all agencies or individuals receiving similar services get charged the same rate? If not, why not? What % of the budget is used for administrative costs? How reasonable are the administrative costs for providing transportation services in your community? How do administrative costs compare to the state average and similar counties?)	1 2 3 4 5
4. To what extent are services for out-of-county medical transportation coordinated so that the greatest number of people traveling to the same medical facilities ride on the same day? (How are services for out-of-county medical transportation coordinated with surrounding communities and/or counties? How often do trips occur to out-of-county medical facilities? How are appointments scheduled at medical facilities to coordinate rides? If your community does not offer out-of-county medical transportation, please leave this question blank and move on to question 5)	1 2 3 4 5
5. To what extent does your community provide alternatives to ambulance transportation for non-emergency medical transportation needs? (What alternatives to ambulances are available? How many	1 2 3 4 5

ambulance rides were provided last year that were not reimbursed by Medicaid or Medicare as emergencies? What was the cost of these rides to the county?)	
6. How effective has your community's transportation system been at solving any problems with "no shows" (people who do not call to cancel rides)? (What are the procedures and policies governing "no shows"? Do the transportation systems offer reminder calls to riders who have been identified as having problems with memory loss or other cognitive difficulties? What % of rides each year are no-shows?)	1 2 3 4 5
Overall Efficiency and Duplication Rating	**1 2 3 4 5**

E. EQUITY How available are these services to all who need them without bias?	
1. To what extent are the transportation services available to all geographic areas in your community? (List any uncovered areas of the county. Why are these areas uncovered? What are the characteristics of neighborhoods without service (e.g. socioeconomic status, age concentrations, population density, etc)? How adequate are the transportation system's procedures for determining when and how to open up a new route?)	1 2 3 4 5
2. To what degree are the transportation services available to all populations in your community? (Does the community transportation planning process involve consumers and advocates of people who need transportation? Does the current county transportation plan describe any special needs that should be addressed? What are the demographic characteristics of transportation consumers under each funding source? How do client characteristics (%) compare to the characteristics of your community's general older and disabled adult population)	1 2 3 4 5
Overall Equity Rating	**1 2 3 4 5**

F. QUALITY/EFFECTIVENESS How successful are these services in addressing consumers' needs?	
1. To what extent are the operations and planning of the transportation providers influenced by people other than the transportation service's Director and staff members (such as a Transportation Advisory Board, governing body, etc.)? (Who is on the board/body? What % are consumers? How often does it meet? What are the responsibilities of the board/body? What role do consumers have on the board/body?)	1 2 3 4 5
2. To what extent do the transportation providers survey riders to determine satisfaction with services, unmet needs, service gaps, etc.? (Have consumers been surveyed in the past 5 years? If so, what process was used? What were the major findings?)	1 2 3 4 5
3. To what extent do the transportation providers act on riders' feedback? (What policy and/or programmatic changes have been made in the past 5 years as a direct result of riders' feedback?)	1 2 3 4 5
4. How sufficient is the complaint resolution process? (What is the complaint resolution process? How are riders made aware of the complaint resolution process? Can riders appeal to a higher entity if they do not like the results? How many complaints were documented last year? What was the nature of those complaints?)	1 2 3 4 5
5. To what extent are complaints considered during planning, program development, or quality improvement efforts? (What policy or programmatic changes have been made in the past 5 years as a direct result of rider complaints?)	1 2 3 4 5
6. To what degree have any identified areas of improvement in transportation plans and reviews been addressed? (Is there an up-to-date Transportation Development Plan, Community Transportation Improvement Plan or any other reports in place for the community? When were the plans revised? What progress has been made in meeting the plan's recommendations? Has the transportation system undertaken a self-review under the	1 2 3 4 5

DOT Public Transportation Division?)	
7. Do any funders regularly monitor the transportation providers? (Who monitors these programs? When were they monitored? What was covered during monitoring? If any issues were found during monitoring, were they addressed sufficiently?)	Yes No
8. To what extent can the transportation systems in your community accommodate the service requests of all people needing rides? (Do people ask for transportation services that are not available? If so, what services?)	1 2 3 4 5
9. How well do the transportation services in your community meet the goal of getting consumers to their appointments on time? (What % of consumers with appointments arrive at their destination by the scheduled appointment time? How reasonable are the wait times for return pick-ups once a client has called the system? How many complaints have been received in the past year about long waits for return pick up?)	1 2 3 4 5
10. How flexible are the guidelines about the amount of time a driver will wait for a rider? (What are the policies and procedures governing how long a driver may wait for a person to come out of the house to board a vehicle? How well does the scheduling of pick-ups accommodate waiting for people who do not ambulate very quickly or people in wheelchairs? Have the transportation systems had any complaints in the past year from passengers who were left without services because they could not get out their door quickly enough? What are the policies and procedures for alerting hearing impaired riders that a van has arrived? Have the transportation systems had any complaints in the past year from hearing impaired passengers who were left without services because they did not know a vehicle had arrived to pick them up?)	1 2 3 4 5
11. To what degree do transportation providers deal effectively with cultural differences in providing services? (Is cultural sensitivity training mandatory for drivers and dispatchers? If not, is it available? What does the training program involve? What % of dispatchers or drivers have been trained?)	1 2 3 4 5
12. To what extent do transportation providers regularly	1 2 3 4 5

communicate unmet needs to county commissioners, planning bodies, and other agencies? (Are transportation providers involved in county or agency planning? Does the county have an up-to-date Community Transportation Improvement Plan that addresses unmet needs?)	
Overall Quality/Effectiveness Rating	**1 2 3 4 5**

Recap of Overall Transportation Ratings	
Existence	1 2 3 4 5
Adequacy	1 2 3 4 5
Accessibility	1 2 3 4 5
Efficiency and Duplication	1 2 3 4 5
Equity	1 2 3 4 5
Quality/ Effectiveness	1 2 3 4 5

Transportation Services' Major Strengths:

Identified Barriers and Areas for Improvement:

Matrix: Core LTC Service Evaluation

Service	Overall Existence Rating	Overall Adequacy Rating	Overall Accessibility Rating	Overall Efficiency/Duplication Rating	Overall Equity Rating	Overall Effectiveness/ Quality Rating	Service Average
Adult Care Homes							
Adult Day Services							
Adult Protective Services							
Assistive Technology/Rehabilitation Technology							
Care Management							
Dental Services							
Durable Medical Equipment (DME)							
Guardianship							
Home-Delivered Meals							
Home Health Care							
Hospice							
Housing and Home Improvement							
Information and Assistance (I&A)							
In-Home Aide Services							
Medical Alert							
Mental Health Services							
Nursing Facility Care							
Respite							
Services for the Deaf and Hard of Hearing							
Social/Recreational/Leisure Services							
Transportation							
Vision Services							
Dimension Average							

Patterns Noted:

SAMPLE: Comparison of the Overall Ratings for the 6 Dimensions of Each LTC Service

Service	Overall Existence Rating	Overall Adequacy Rating	Overall Accessibility Rating	Overall Efficiency/Duplication Rating	Overall Equity Rating	Overall Effectiveness/ Quality Rating	Service Average
Adult Care Homes	4	4	2	2	4	2	3.00
Adult Day Services	4	4	1	1	4	2	2.67
Adult Protective Services	5	5	1	1	2	2	2.67
Assistive Technology/Rehabilitation Technology	5	5	4	4	5	2	4.17
Care Management	2	3	1	1	5	1	2.17
Dental Services	3	3	2	3	3	3	2.83
Durable Medical Equipment (DME)	4	5	5	5	5	3	4.50
Guardianship	2	2	3	1	2	1	1.83
Home-Delivered Meals	5	5	4	5	5	4	4.67
Home Health Care	5	4	2	4	4	4	3.83
Hospice	4	5	1	1	5	3	3.17
Housing and Home Improvement	4	4	2	2	5	2	3.17
Information and Assistance (I&A)	5	5	5	5	5	4	4.83
In-Home Aide Services	5	4	5	4	5	1	4.00
Medical Alert	4	5	1	1	3	3	2.83
Mental Health Services	3	4	2	1	1	2	2.17
Nursing Facility Care	5	4	3	3	5	2	3.67
Respite	4	5	1	2	5	2	3.17
Services for the Deaf and Hard of Hearing	4	5	1	2	5	1	3.00
Transportation	5	4	1	1	4	2	2.83
Vision Services	5	5	1	1	4	1	2.83
Dimension Average	**4.1**	**4.3**	**2.3**	**2.4**	**4.1**	**2.2**	

Patterns Noted:

SAMPLE: Comparison of 5 Services

Service	Overall Existence Rating	Overall Adequacy Rating	Overall Accessibility Rating	Overall Efficiency/Duplication Rating	Overall Equity Rating	Overall Effectiveness/ Quality Rating	Service Average
Adult Care Homes							
Adult Day Services							
Adult Protective Services							
Assistive Technology/Rehabilitation Technology							
Care Management	2	3	1	1	5	1	2.17
Dental Services							
Durable Medical Equipment (DME)							
Guardianship							
Home-Delivered Meals	5	5	4	5	5	4	4.67
Home Health Care							
Hospice							
Housing and Home Improvement							
Information and Assistance (I&A)	5	5	5	5	5	4	4.83
In-Home Aide Services							
Medical Alert							
Mental Health Services	3	4	2	1	1	2	2.17
Nursing Facility Care							
Respite							
Services for the Deaf and Hard of Hearing							
Transportation	5	4	1	1	4	2	2.83
Vision Services							
Dimension Average							

Patterns Noted:

SAMPLE: Comparison of 2 Dimensions

Service	Overall Existence Rating	Overall Adequacy Rating	Overall Accessibility Rating	Overall Efficiency/Duplication Rating	Overall Equity Rating	Overall Effectiveness/ Quality Rating	Service Average
Adult Care Homes		4				2	
Adult Day Services		4				2	
Adult Protective Services		5				2	
Assistive Technology/Rehabilitation Technology		5				2	
Care Management		3				1	
Dental Services		3				3	
Durable Medical Equipment (DME)		5				3	
Guardianship		2				1	
Home-Delivered Meals		5				4	
Home Health Care		4				4	
Hospice		5				3	
Housing and Home Improvement		4				2	
Information and Assistance (I&A)		5				4	
In-Home Aide Services		4				1	
Medical Alert		5				3	
Mental Health Services		4				2	
Nursing Facility Care		4				2	
Respite		5				2	
Services for the Deaf and Hard of Hearing		5				1	
Transportation		4				2	
Vision Services		5				1	
Dimension Average		**4.3**				**2.2**	

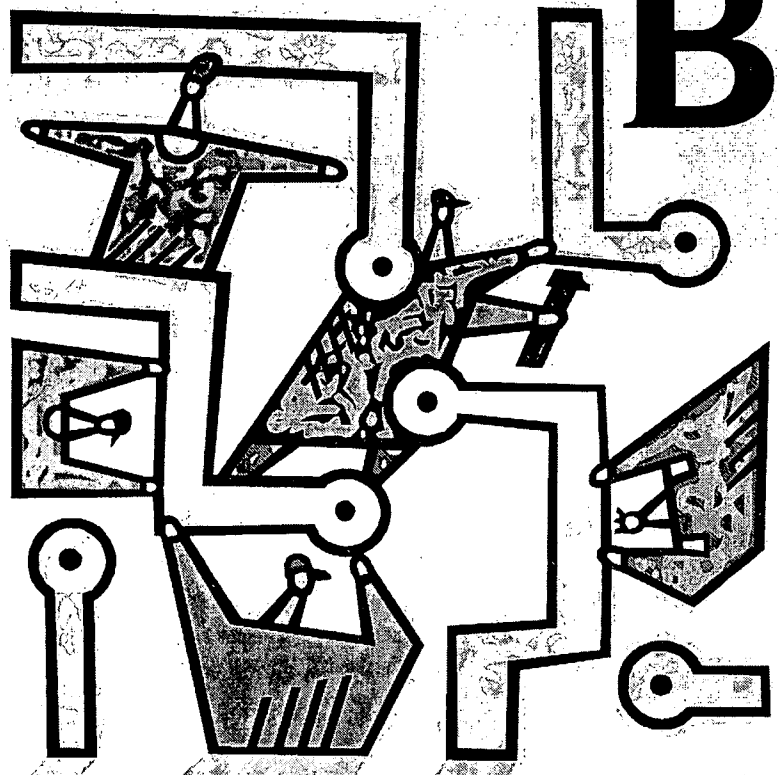
Patterns Noted:

SAMPLE: Comparison of the Overall Ratings for 2 Dimensions and 5 Services

Service	Overall Existence Rating	Overall Adequacy Rating	Overall Accessibility Rating	Overall Efficiency/Duplication Rating	Overall Equity Rating	Overall Effectiveness/ Quality Rating	Service Average
Adult Care Homes		4				2	
Adult Day Services		4				2	
Adult Protective Services		5				2	
Assistive Technology/Rehabilitation Technology		5				2	
Care Management	2	3	1	1	5	1	2.17
Dental Services		3				3	
Durable Medical Equipment (DME)		5				3	
Guardianship		2				1	
Home-Delivered Meals	5	5	4	5	5	4	4.67
Home Health Care		4				4	
Hospice		5				3	
Housing and Home Improvement		4				2	
Information and Assistance (I&A)	5	5	5	5	5	4	4.83
In-Home Aide Services		4				1	
Medical Alert		5				3	
Mental Health Services	3	4	2	1	1	2	2.17
Nursing Facility Care		4				2	
Respite		5				2	
Services for the Deaf and Hard of Hearing		5				1	
Transportation	5	4	1	1	4	2	2.83
Vision Services		5				1	
Dimension Average		4.3				2.2	

Patterns Noted:

Planning Basics



A Guide for Developing Community Long-term Care Options

Division of Aging and Adult Services
NC Division of Health and Human Services
Raleigh, NC
First Web Edition, August 2004

This document was prepared by
Julie Bell,
Division of Aging and Adult Services,
NC Department of Health and Human Services
Margaret Morse and Linda Rahija,
Center for Aging Research and Educational Services,
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This document is available online at
http://ssw.unc.edu/cares/planningbasics/index.htm

Consumer Information
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Long Term Care in North Carolina

The DHHS Communications and Coordination Initiative

General NC DHHS Communications and Coordination Initiative Information

In this section, you can learn more about the NC DHHS Communications and Coordination Initiative which is based largely on the Institute of Medicine's Final Report on LTC (especially recommendations 11 and 16) and on Session Law 2003-284. The pilot communities are New Hanover County (lead agent – New Hanover Council on Aging) and Mecklenburg County (lead agent – Mecklenburg County Department of Social Services).

Core LTC Service Evaluation Tools

The Division of Aging and Adult Services, in conjunction with the State Team made-up of representatives from all DHHS Divisions with LTC responsibilities, developed 22 tools to assist communities in evaluating their LTC services. The tools are service-specific and are designed to assist your county in conducting an in-depth analysis of each service, identifying best practices and barriers to care, and developing strategies for reform. Your community can also use the tools to analyze larger dimensions of your overall LTC system, including adequacy, accessibility, efficiency and duplication, equity, and quality and effectiveness.

Various Training Session Topics



- Strategic Planning for Communities and Involving Key Stakeholders
  (including Consumers)
  Inventory of Team Skills and Expertise

- Using the Core Service Evaluation Tools

- Finding, Collecting, and Using Data in the Community Planning Process

Planning Basics Notebook Top of Page

The Planning Basics Notebook is a resource designed for communities interested in long-term care planning for older and disabled adults and for their lead agents. It contains both generic and specific information on developing and maintaining community planning processes, successful facilitation, teamwork skills, finding and analyzing data, and, communications. It also includes long-term care-specific resources such as a glossary, acronym list, Internet resource listing, and long-term care examples. Although the resource was originally designed to assist communities with long-term care planning, the generic portions of the Notebook can be useful to communities developing any type of community planning processes.

Links to Local Data Sources

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The NC DHHS Communications and Coordination Initiative

Session Law 2003-284, Section 10.8 F, called upon on the Department of Health and Human Services to:

"implement a communications and coordination initiative to support local coordination of long-term care and shall pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. For those counties that voluntarily participate, the local long-term care coordination initiative shall aid in the development of core services, coordinate local services, and streamline access to services."

DHHS is to submit an interim report on the pilot project by October, 2004 and the final report by October 2005.

In response to this legislative mandate, recommendations by the North Carolina Institute of Medicine, and the interests of various stakeholders, the NC Division of Aging and Adult Services developed the *Communications and Coordination Initiative* with assistance and guidance from the DHHS Long-Term

Care Cabinet and a State Team composed of representatives from all DHHS Divisions with long-term care (LTC) responsibilities. This initiative is designed to assist two pilot communities, New Hanover and Mecklenburg Counties, in evaluating their local LTC services and in identifying and initiating strategies to strengthen the LTC system for older and disabled adults.

Links:

- DHHS Initiatives of Interest to Communities Conducting Planning Processes
- Other Community Planning Resources
- Announcement
- Summary of the Communications and Coordination Initiative
- Press Release
- Pilot County and lead agent contact information
- State Team contact information
- Link to the IOM Report

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Core LTC Service Evaluation Tools

Get Acrobat® Reader

- Core Service Evaluation Tool and Matrix Instructions
- Adult Care Homes
- Adult Day Services
- Adult Protective Services
- Assistive Technology/Rehabilitation Technology
- Care Management
- Dental Services
- Durable Medical Equipment
- Guardianship
- Home-Delivered Meals
- Home Health Care
- Hospice
- Housing and Home Improvement
- Medical Alert
- Information and Assistance
- In-Home Aide Services
- Mental Health Services
- Nursing Facility Care
- Respite Care
- Services for the Deaf and Hard of Hearing
- Social/Recreational/Leisure Services
- Transportation
- Vision Services

- Evaluation Matrix
  (Excel Spreadsheet)

Last updated: September 13, 2004

John Highfill
Attachment 10

Senior-Friendly Mecklenburg

Status of Seniors Initiative

Fostering A Senior-Friendly Community in Mecklenburg County

Vision

To foster a senior-friendly community that values dignity and independence for all older adults

Mission

To engage the community in creating a dynamic plan that enhances the quality of life for older adults by focusing resources on their needs

The Status of Seniors Initiative is an ongoing community strategic planning process that regularly reviews the quality of life for all seniors in Charlotte-Mecklenburg.

- The Executive Advisory Board and Steering Committee were formed in the summer of 2003 to be broadly representative, and to develop an ongoing strategic planning process.
- The Executive Advisory Board guides the overall effort, champions the recommendations, and helps to promote and market the initiatives.
- The Steering Committee consists of individuals from public, private and non-profit agencies who are developing and recommendations and strategies.

Our Guiding Principles

1 **Mecklenburg County become a "Senior Friendly Community" that**
- Values seniors' contributions to the community
- Promotes positive intergenerational relations
- Considers the needs and interests of seniors in the physical environment and in community planning
- Respects and supports seniors' desire and efforts to live independently
- Acknowledges the primary role that families, friends and neighbors play in the lives of older adults

2. **The community should allow seniors the opportunity to "*Age in Place*" whenever it is reasonably possible.**

3. **The Initiative's intent is to review the existence, adequacy and accessibility of needed services for seniors of all income levels.**

301 Billingsley Road • Charlotte, North Carolina 28211 • 704-336-4109
http://statusofseniors.charmeck.org

The Initial Strategic Plan Report contains seven recommendations

1. Establish a multi-functional **Center For Aging** that will serve as a "focal-point" for strategic planning, Advocacy, Information & Assistance, Care/Case Management; and Education and Communication;
2. Develop an integrated approach for educating and communicating with key stakeholders and the community;
3. Redistribute resources for the long-term care system;
4. Magnify and support the role of informal and family caregivers;
5. Multiply options for seniors across service areas;
6. Begin a crime prevention and education campaign in high-density areas focusing on seniors;
7. Create an expanded and coordinated range of "senior-friendly" transportation options.

- NEXT STEPS:
  - Develop of implementation strategies for these recommendations
  - Prepare recommendations for the next two work groups: *Adults with Disabilities* and the *Physical Environment.*

The scope of the process

- The collaborative partnership seeks to involve broad groups of consumers, providers, and community leaders from across Mecklenburg County.
- The completed strategic plan will encompass all areas of every older adult's life, and offer findings and recommendations to the entire community for changes and improvements.

The Strategic Planning Process

- Our project scope is ambitious, comprehensive and involves systemic change to build a more "senior friendly" community that ensures dignity, safety and independence.
- To achieve our goals and objectives we have developed an ongoing strategic planning process with strategies and action steps. Implementation of the plan will be ongoing.
- The Initiative will develop a plan that covers all aspects of a "senior friendly community": Physical Environment; Health: Economy; Technology; Safety / Security; Social / Cultural Involvement; Services / Support; and Resources Planning / Stewardship.

Demography is destiny

Data shows that neither residents nor employers are adequately aware of the enormous impact that the Baby Boom retirement will have on work and life in the County.

Mecklenburg County now:

- In 1990 there were 66,617 older adults in Mecklenburg.
- In 1990 The average profile of the older adult population was female (60%), age 60 to 74 (43%), and White/Caucasian (81%).
- In 2000 there were 80,440 older adults in Mecklenburg.

Mecklenburg's Future:

- The older adult population growth rate already exceeds the growth rate for children.
- When the eldest Baby Boomers reach age 65 in 2011, the 60+ population is projected to be 12.8 % of the total population and 18.5 % by 2030.
- The older adult population is expected to increase an average of 3.5% per year *over the next thirty years.*

❖ **To see how you can help contact John Highfill at** highfjv@co.mecklenburg.nc.us **or 704-336-4109.**

Gayla Woody Jackie Highfill Attachment 11

ROWAN COUNTY PLANNING INITIATIVE
PLANNING FOR SENIORS AND ADULTS WITH DISABILITIES

VISION

ROWAN COUNTY WILL BE A HEALTHY, SAFE, AND KIND COMMUNITY OF OPPORTUNITIES FOR OLDER ADULTS AND ADULTS WITH DISABILITIES.

MISSION

THE (ROWAN PLANNING INITIATIVE) SEEKS TO ENRICH THE LIVES OF OLDER ADULTS AND ADULTS WITH DISABILITIES THROUGH COMMUNITY COLLABORATION THAT WILL:

PROTECT HEALTH, SAFETY, AND INDEPENDENCE
PROMOTE CREATIVITY, WELLNESS, AND SELF-DETERMINATION
IDENTIFY AND PRIORITIZE NEEDS AND RESOURCES
ADDRESS NEEDS WITH ESTABLISHED AND INNOVATIVE SERVICES/ACTIVITIES
DELIVER SERVICES IN AN EFFICIENT AND COST-EFFECTIVE MANNER

** ENDORSED BY ROWAN COUNTY BOARD OF COMMISSIONERS*

ROWAN ISSUE GROUPS

ACCESSIBILITY OF INFORMATION

ISSUES FOR EVALUATION:
INFORMATION AND ASSISTANCE
TRANSPORTATION
MARTHA BAKER, CONVENER

ADVOCACY

ISSUES FOR EVALUATION:
GUARDIANSHIP
ADULT PROTECTIVE SERVICES
CASE MANAGEMENT
JANE JACKMAN, CONVENER

ACCESSIBLE MEDICAL SERVICES

ISSUES FOR EVALUATION:
DENTAL
VISION SERVICES
NURSING FACILITY
MENTAL HEALTH
SERVICES FOR THE DEAF AND HARD OF HEARING
DURABLE MEDICAL EQUIPMENT
IN HOME SERVICES
SOCIAL/RECREATION/LEISURE
TRACEY CASTOR, CONVENER

HOUSING

ISSUES FOR EVALUATION:
HOUSING AND HOME IMPROVEMENT
ADULT CARE HOMES
, CONVENER

**ISSUE GROUPS WILL MEET SIX TIMES BEFORE MARCH 2005 AND REPORT ALL PROGRESS TO THE EXECUTIVE COMMITTEE.*

PRINTED OCTOBER, 2004

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 10-27-04
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Melissa Parker	National Assoc. of Social Workers - NC Chapter
John Goodman	Alley Associates
Mary Shackelford	UNC-CH School of Social Work
Adrian Lovelace	MHA/NC
Pam Leaman	OSBM
Bill Lamb	Friends of Residents in LTC
Beverley Wheeler	Friends of Residents in LTC
Gail Pruett	nc Nurses Association
Mary Bethea	NCDAAS
Karen Gottori	NC DAAS
Lynne Perrin	nc DMA
Betty Zimmerman	UNC COA - NC AHEC
Jerry Cooper	NCALA
Lee Wilson	NCALTCF
John McHugh	Coldwell
Evelyn Hawthorne	ETHGR
[illegible]	NCDC/Second Harvest
Elizabeth Dalton	Long V. Assoc.
Bill McNeil	nc Association of Regional Council Directors
Abby C. Emanuelson	Nat'l MS Society
Kader George	NC ACDSS
Julie Bell	NC Div. of Aging & Adult Services
Steve Freedman	N.C. Division of Aging/Adult Services
John Boulard	Carol Woods
Jill Hale	ACCI
[illegible]	Bass Assoc
Roxanne Bragg-Cook	NCAOA

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 10-27-04

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathie C. Smith	AHHC
Jean Rawls	NCCoA / NCADSA
Michael Keough	ORDRHD (Sr. Care)
Lyle Sloop	Carolina AAH
John Highfill	Mecklenburg DSS
Thembeni	DHHS/DSS
DAVID BARNES	Poyner & Spruill
Ed Regan	NCRGEA

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Wednesday, November 10, 2004
10:00 A.M.
Legislative Office Building, Room 643

The North Carolina Study Commission on Aging met on Wednesday November 10, 2004 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were Senator A. B. Swindell, Representative Debbie Clary, and Representative Edd Nye, Co-Chairs; Senators Charlie Dannelly, Austin Allran, and Tony Moore; Representatives Jennifer Weiss, David Lewis, Gene Wilson and Beverly Earle; public members Brad Allen, Jan Elliott, Linda Howard, Katherine Fox Price, Florence Soltys, Sam Marsh, and Jackie Sheppard.

Theresa Matula, Dianna Jessup and Shawn Parker, Commission Staff, Research Division, NCGA, were present and provided staff support. A visitor's registration from is attached and made a part of the minutes.

Senator Swindell presided, and after calling the meeting to order, he welcomed everyone in attendance. He then asked the first presenter to come forward to address the Commission.

PCS Restructuring
(See Attachment 1)

Lynne Perrin, Division of Medical Assistance, Department of Health and Human Services, discussed the handout that was provided to the members. Highlights from her presentation include the reimbursement rate of $14.20 per hour for personal care tasks performed by in-home aides. The tasks include helping with bathing and housekeeping chores. There are currently 685 home care providers enrolled in the Medicaid Program. She reviewed some of the recommendations that are a result of their work. This is an optional Medicaid benefit provided to persons living in a private residence and who have medical conditions that require assistance from a personal care aide. These services must be authorized by a physician in accordance with a plan of treatment or otherwise approved by the state. PCS services are limited to a maximum of 60 hours per month per patient, but if prior approved by DMA, one may receive up to 80 hours per month under the PCS Plus program based on documented need for additional services.

Sherry Thomas, NC Association for Home and Hospice Care, continued Ms. Perrin's slide presentation by showing current comparisons and recommendations for statewide improvements in the Medicaid Personal Care Services Program. The outcome focus is to assure PCS continues to be an important service in the State's long term care system; that

PCS services are targeted appropriately based on medical need; and that management systems are in place to ensure services quality and fiscal accountability.

Rep. Weiss requested that in the future when they were planning a major policy change, that people who would be affected, be included in the policy development. Ms. Thomas responded that they would work with the Division of Aging to get some input.
Rep. Weiss also requested more specific information on the caregivers' compensation.

Adult Care Home Licensing

Bob Fitzgerald, Division of Facility Services, Department of Health and Human Services, addressed the issue of Adult Care Home licensing. He stated that in the spring there were some newspaper articles that were critical of some of the Adult care facilities that were owned by a couple of corporations or individuals that have interest in corporations. The articles reported there were several facilities that had deficiencies and had been cited. The articles explored the statute that said if a facility is in general non-compliance, this would be taken into consideration in issuing new license or renewing licenses to the owners of the facilities. The articles alluded to a loophole in the law. Senate Bill10's intent was to make people accountable in general for all of their facilities and if there were some that they already owned that had serious compliance problems with the rules, they would not be eligible to get a license for a new facility. In exploring this, they learned there was a misinterpretation from the Attorney General's office. They determined there was no need for a major change in the statute. He stated Melissa Trippe from the Attorney General's office was with him and could provide for further explanation.

Melissa Trippe, Office of the Attorney General, Counsel for Department of Health and Human Services, told the members that the problem arose when an applicant completed an application for a license, but did not disclose that there were affiliates to that entity. There isn't a provision to penalize applicants who intentionally falsify the application process. As a result, they looked at the statute more closely and also the administrative rules. They determined that it does allow the Division to act on the applications as is appropriate and required by law.

Mr. Fitzgerald said they would propose to the General Assembly in the next session a request to allow the Department to penalize applicants with a civil penalty for falsifying or leaving incomplete the portions of the applications used to apply this law. There are approximately 850 renewal applicants each year and applications for new license varies a lot, but the number is probably around 50.

Consumer-Directed Care
(See Attachment 2)

Jackie Sheppard, Office of Long Term Care and Family Services, Department of Health and Human Services (and member of the Commission), stated they had provided a handout concerning consumer directed support and he would defer to Ann Eller, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Humans Services, for a review of the handout. Ms. Eller stated that consumer- directed support is a philosophy and orientation to the delivery of home and community based service delivery whereby informed individuals assess their service needs, determine how and by whom these needs should be met, and monitor the quality of services received. It is designed to support people who need assistance with a variety of daily living activities; allow people to plan, budget and make choices that work best for them; and allow participants control in managing their support services, such as their attendant/aid, medical equipment and supplies, mobility aids, etc.

Senator Swindell announced the Commission would break for lunch.

The meeting was brought back to order by Senator Swindell at 1:00 p.m., and he asked for the next presenter to address the Commission.

Lynne Perrin, Division of Medical Assistance, Department of Health and Human Services, continued with the topic of consumer-directed care. She presented a slide presentation on CAP choice. They are planning to have the program implemented by January 2005.

Care for the Mentally Ill in LTC Facilities Report
(See Attachment 3)

Bonnie Morrell, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on care for the mentally ill in Long Term Care facilities. She discussed SB1148 that passed last year and originated in the Aging Commission. This Act provides training to long-term care providers who are caring for residence with mental illness, and lead to a study of geriatric specialty teams to assist facilities with mental health and substance abuse patience. Twenty programs were given start-up Mental Health Trust Funds in FY02-03 as part of the preparation to increase community capacity to serve older adults prior to reducing the number of geriatric beds in State psychiatric hospitals. The purpose of the teams is to assist with successful reintegration of older adults into the community when discharged from State psychiatric hospitals, and to provide support services and technical assistance to nursing homes, adult care homes, and other agencies/caregivers that serve older adults who have mental health treatment needs and who may be at risk of hospitalization. The final report is due October 2005.

Public Hearing Comments Summary
(See Attachment)

Shawn Parker, Commission staff, Research Division, NCGA, provided the members with a summary of the public hearing comments that took place on October 21, 2004 in Cherryville, NC, and on October 26, 2004 in Wilson, NC. He listed the issues that were mentioned most frequently by the speakers. The issues mentioned most frequently were: preserve/expand support for Senior Games; preserve/expand senior centers including Certified Senior Centers; preserve/expand support for in-home and community-based services; lower/provide assistance with prescription drug costs; and concerns about combining mentally ill and elderly populations.

Senator Swindell announced that the next meeting would be held on December 1, 2004 at 10:00 a.m., in Room 643.

The meeting adjourned at 1:45 p.m.

Jo Bobbitt

Senator A. B. Swindell, Co-Chair

Jo Bobbitt, Committee Assistant

Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

Attachment

Agenda

North Carolina Study Commission on Aging

Wednesday, November 10, 2004
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator AB Swindell, Cochair
Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair

II. PCS Restructuring

Lynne Perrin, Division of Medical Assistance, DHHS
Sherry Thomas, Association for Home and Hospice Care

III. Adult Care Home Licensing

Bob Fitzgerald, Division of Facility Services, DHHS
Melissa Trippe, Office of the Attorney General

IV. Consumer-Directed Care

Video Introduction to Consumer-Directed Care

Provided by the NC Coalition on Aging

North Carolina's Initiatives

Jackie Sheppard, Office of Long Term Care and Family Services, DHHS

Ann Eller, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS

Lynne Perrin, Division of Medical Assistance, DHHS

V. Care for the Mentally Ill in LTC Facilities Report (S.L. 2003-144)

Bonnie Morrell, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS

VI. Summary of Public Hearing Comments

Shawn Parker, Study Commission Staff, Research Division, NCGA

VII. Next Meeting:

December 1, 2004 at 10:00 a.m. in Room 643

Attachment 2

Medicaid In-Home Personal Care Services Program

Presented by Lynne Perrin
Chief, Facility and Community Care
Clinical Policy and Programs
NC Division of Medical Assistance
November 10, 2004

In-Home Personal Care Services

- Optional Medicaid Benefit
- Provided to persons living in a private residence and who have medical conditions that require assistance from a personal care aide
- Must be authorized by a physician in accordance with a plan of treatment or otherwise approved by the state

Medicaid Reimbursement

- Medicaid reimburses $14.20 (effective Aug. 2004) per hour for personal care tasks performed by in-home aides.
- The tasks may include
  - Helping patients with bathing, toileting, moving about, keeping track of vital signs; and,
  - Help with housekeeping and home management tasks as a secondary support to maintain one's health.

Amount of Services and Medicaid Benefit Limitations

- Hours of PCS are determined through an assessment performed by the home care agency's RN and authorized by the physician.
- PCS is limited to a maximum of 60 hours per month per patient.
- If prior approved by DMA, one may receive up to 80 hours per month under the *PCS Plus* program based on documented need for additional services.

Who Provides PCS Services?

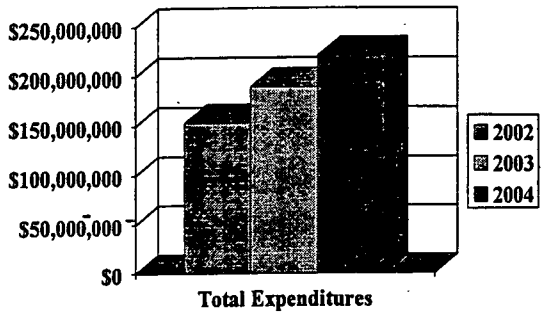
- Home care agencies in North Carolina
  - Licensed by the Division of Facility Services to provide in-home aide services
  - Enrolled in the Medicaid program
- In-home aides must meet the requirements in the Home Care Licensure Rules

Providers Enrolled in Medicaid

- There are currently 685 home care providers* enrolled in the Medicaid Program.

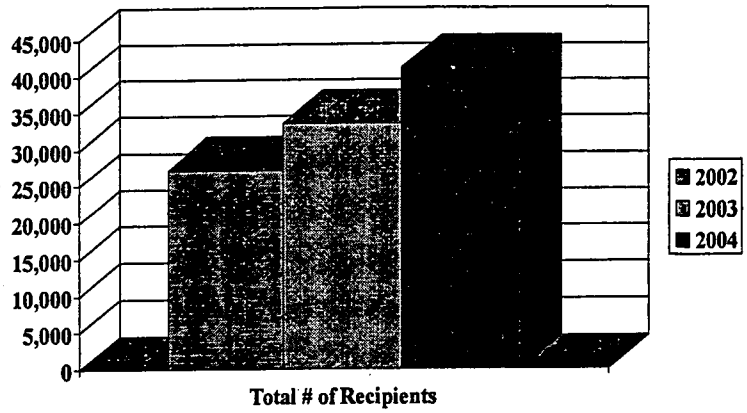
* An agency may have several site locations and each site is treated as a separate provider and not all providers enrolled may actively be billing Medicaid.

Medicaid Expenditures for PCS



2004 Expenditures:
$220,933,622

Recipients of PCS



2004 Recipients:
41,222

Growth in PCS

- Growth in Expenditures
  - 2002 to 2003 was 24%
  - 2003 to 2004 was 17%
- Increase in Recipients
  - 2002 to 2003 was 23%
  - 2003 to 2004 was 23%

Average Expenditures Per Recipient

- Average Annual Per Recipient
  - SFY 2004 $5,360
- Average Monthly Per Recipient
  - SFY 2004 $446

Need for PCS Program Improvements

- PCS is an important program in the NC's long term care system as it supports recipients in their own homes.
- Service has been operating since 1985 with little change in administrative structure or state level oversight.

Key Reasons to Restructure

- Growth in program expenditures and recipients
- Growth in numbers of providers and appropriate targeting of services
- Quality issues
- Need to refine and clarify medical criteria
- Need for newer improved assessment tools
- Need for provider standards, training and best practices
- Need to improve state level oversight and monitoring functions

PCS Restructuring Initiative

- Restructuring initiated by AHHC and DMA in January 2004
- Partnership among PCS providers, DMA staff, and DFS staff
- Established PCS Restructuring Advisory Committee to guide the work of four work groups
  - Criteria/Documentation
  - Policy/Process
  - Utilization Review
  - Rules Subcommittee

PCS Restructuring Initiative

- Restructuring Advisory Committee met on a monthly basis
- First PCS Kickoff meeting held March 18, 2004
- More than 40 people have participated in the process to date
- Over 30 meetings took place between January, 2004 and October, 2004
- Final PCS Wrap-Up meeting of work groups held October 27, 2004

PCS Restructuring Goals

- Restructure the PCS program
- Refine the PCS policy
- Streamline the PCS service delivery process
- Develop a quality assurance and utilization management component
- Strengthen provider compliance with policies
- Establish provider training requirements
- Build strong partnerships with shared goals

PCS Restructuring Advisory Committee

Tom Harmelink, *Provider-Health Force*
Jeff Horton, *DFS*
Azzie Conley, *DFS*
Robyn Reasor, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Carol Putnam, *DMA-Program Integrity*
Tim Rogers, *AHHC*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Dr. Nancy Henley, *DMA-Medical Policy*
Pamela Horrell, *DMA-Provider Enrollment*
Frank Dziepak, *DMA-Financial Operations*
Lynne Perrin, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*
Donna Steele, *DMA-Medical Policy*

Criteria/Documentation Work Group

- Donna Turlington, *Provider-Liberty HC*
- Phyllis Nealey, *Provider-Interim HC*
- Tina Glenn, *Provider-Hearthside HC*
- Roget Berendes, *Provider-Hearthside Home Care*
- Sandra Bridges, *Provider-First Choice HC*
- Betty Nance, *Provider-Guardian Angel HC*
- Carol Putnam, *DMA-Program Integrity*
- Sherry Thomas, *AHHC*
- Robyn Reasor, *DMA-Program Integrity*
- Donna Steele, *DMA-Medical Policy*
- Rosalie Wachsmuth, *DMA-Medical Policy*

PCS Policy/Process Workgroup

Beverly Stewart, *DMA-Program Integrity*
Phyllis Burwell, *DMA-Medical Policy*
Jim Arp, *Provider-Advantage Home & Hospice*
Heather Blank, *Provider-Assisted Care*
Sherry Thomas, *AHHC*
Sandi Massey, *Provider-Good Health Services*
Karen Rowe, *Provider-Carolinas Home Care*
Bonnie McBride, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Pamela Horrell, *DMA-Provider Enrollment*
Sandi Massey, *Provider-Good Health Services*
Tom Harmelink, *Provider-Health Force*
Nena Reaves, *Provider-Health Services Personnel*
Lloyd Pattison, *DMA-Medical Policy*
Donna Steele, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*

PCS Utilization Review Workgroup

Bill Craig, *Provider-Quality Patient Care*
Peggy Mallard, *Provider-Guardian Health Services*
Larry Nason, *DMA-Medical Policy*
Lynne Perrin, *DMA-Medical Policy*
Ginger Parrish, *Provider-Albemarle Home Care*
Robyn Slate, *DMA-Rate Setting*
Pat Jeter, *DMA-Rate Setting*
Frank Dziepak, *DMA-Financial Operations*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Sheila Alford, *Provider-Home Health & Hospice of Halifax*
Tim Brooks, *Provider-Healthkeeperz Home Health*
Pam Wells, *DMA-Program Integrity*
Peggy Davis, *DMA-Program Integrity*
Robyn Reasor, *DMA-Program Integrity*
Donna Steele, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*

Outcomes of the Work Groups

- Key Recommendations for Program Improvements presented by Sherry Thomas

Comparisons & Recommendations for Statewide Improvements In the Medicaid Personal Care Services Program

Sherry Thomas, BSN, MPH
Senior Vice President, AHHC

AHHC

- Established in 1972 by Registered Nurse directors and supervisors, the Association for Home & Hospice Care of North Carolina (AHHC) is a nonprofit trade association made up of professionals from a wide variety of disciplines, all with an active interest or involvement in North Carolina's in-home health, hospice, and community-based care industry. Today, the Association represents nearly 500 agencies including the largest ones in the State.

Comparisons & Recommendations

- **Current PCS**
  - *Limited to 3 1/2 hours per day - 60 hours per month
  - *Physician authorization based on Registered Nurse assessment
- **Restructured PCS**
  - *Same
  - *Physician authorization based on Registered Nurse assessment with recommendation for physician's PA and/or NP to authorize as delegated by physician

Comparisons & Recommendations

- **Current PCS Relationship to PCS Plus**
  - *Must first meet PCS criteria before becoming eligible for PCS Plus which is based on additional criteria
- **Restructured PCS Relationship to PCS Plus**
  - *Must first meet PCS criteria before becoming eligible for PCS Plus which is based on additional criteria

Comparisons & Recommendations

- **Current PCS**

  *Assessment tools: two page RN assessment with required elements of assessment but optional form. Time and tasks assigned by RN with physician authorization. Home management tasks incidental to personal care.

Comparisons & Recommendations

- **Restructured PCS**

  *New four page RN assessment. The tool also serves as the RN certification that the assessment is accurate and as the physician's authorization for the services.

  - PCS Physician Authorization for Certification and Treatment (PACT) Form *(also known as the revised DMA-3000 Form)*
  - Annual Renewal/Recertification
  - DMA intends to eventually automate both the new PACT Form and the PCS-Plus Form.

Comparisons & Recommendations

- **Restructured PCS**

  A major committee focus was developing a new patient assessment tool that will capture more complete information on the patient's functional limitations/medical condition and the related need for personal care and home management assistance.

Comparisons & Recommendations

- **Restructured PCS**

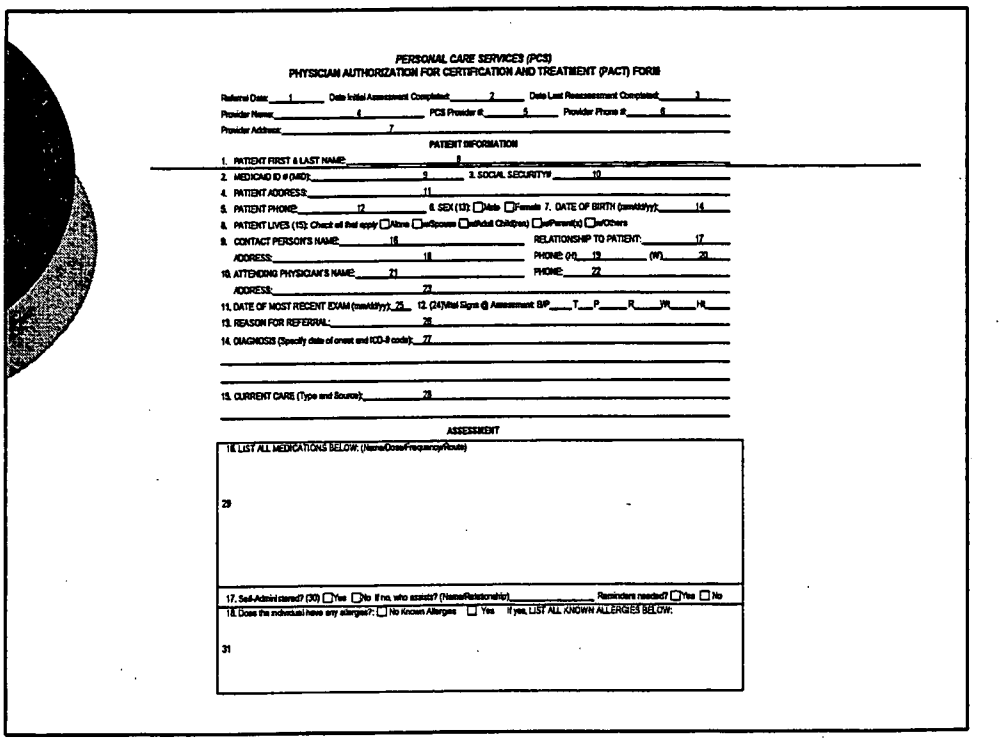
*The new draft tool is a "scored" assessment and incorporates elements and definitions from the nursing home MDS while also addressing the specific home environment and PCS program requirements. The new draft tool paints a clearer picture of the patient to the physician.

Comparisons & Recommendations

- **Restructured PCS**

*The new tool will be mandatory. Along with the tool, there will be a guideline detailing the time allotment available based on how the patient scores on the assessment.

*Home management tasks will be directly linked to ADL limitations (bathing, feeding, dressing, ambulation, toileting, etc) on the new tool.



PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

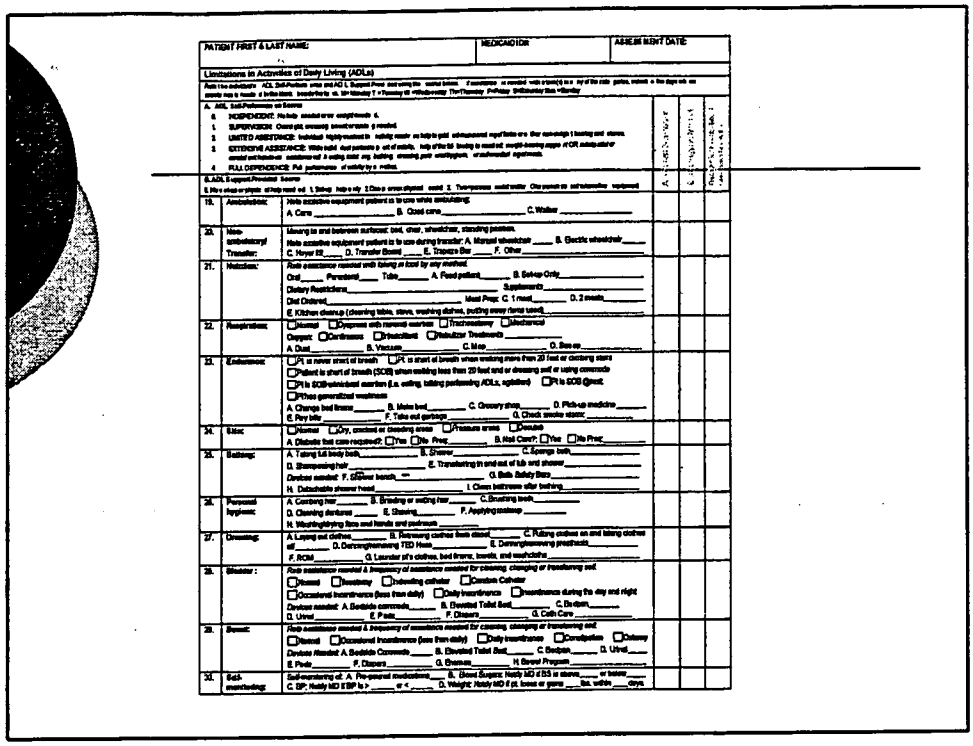
Referral Date: 1 Date Initial Assessment Completed: 2 Date Last Reassessment Completed: 3
Provider Name: 4 PCS Provider #: 5 Provider Phone #: 6
Provider Address: 7

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME: 8
2. MEDICAID ID # (MD): 9 3. SOCIAL SECURITY#: 10
4. PATIENT ADDRESS: 11
5. PATIENT PHONE: 12 6. SEX (13): ☐Male ☐Female 7. DATE OF BIRTH (mm/dd/yy): 14
8. PATIENT LIVES (15): Check all that apply ☐Alone ☐w/Spouse ☐w/Adult Child(ren) ☐w/Parent(s) ☐w/Others
9. CONTACT PERSON'S NAME: 16 RELATIONSHIP TO PATIENT: 17
ADDRESS: 18 PHONE: (H) 19 (W) 20
10. ATTENDING PHYSICIAN'S NAME: 21 PHONE: 22
ADDRESS: 23
11. DATE OF MOST RECENT EXAM (mm/dd/yy): 25 12. (24)Vital Signs @ Assessment: BP ___ T ___ P ___ R ___ Wt ___ Ht ___
13. REASON FOR REFERRAL: 26
14. DIAGNOSIS (Specify date of onset and ICD-9 code): 27
15. CURRENT CARE (Type and Source): 28

ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (Name/Dose/Frequency/Route)
29
17. Self-Administered? (30) ☐Yes ☐No If no, who assists? (Name/Relationship): Reminders needed? ☐Yes ☐No
18. Does the individual have any allergies?: ☐No Known Allergies ☐Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:
31



PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

Limitations in Activities of Daily Living (ADLs)

Rate the individual's ADL Self-Performance and ADL Support Provided during the period below. If assistance is provided with more than one activity, indicate the days on which each was provided. (e.g. M=Monday T=Tuesday W=Wednesday Th=Thursday F=Friday Sa=Saturday Su=Sunday)

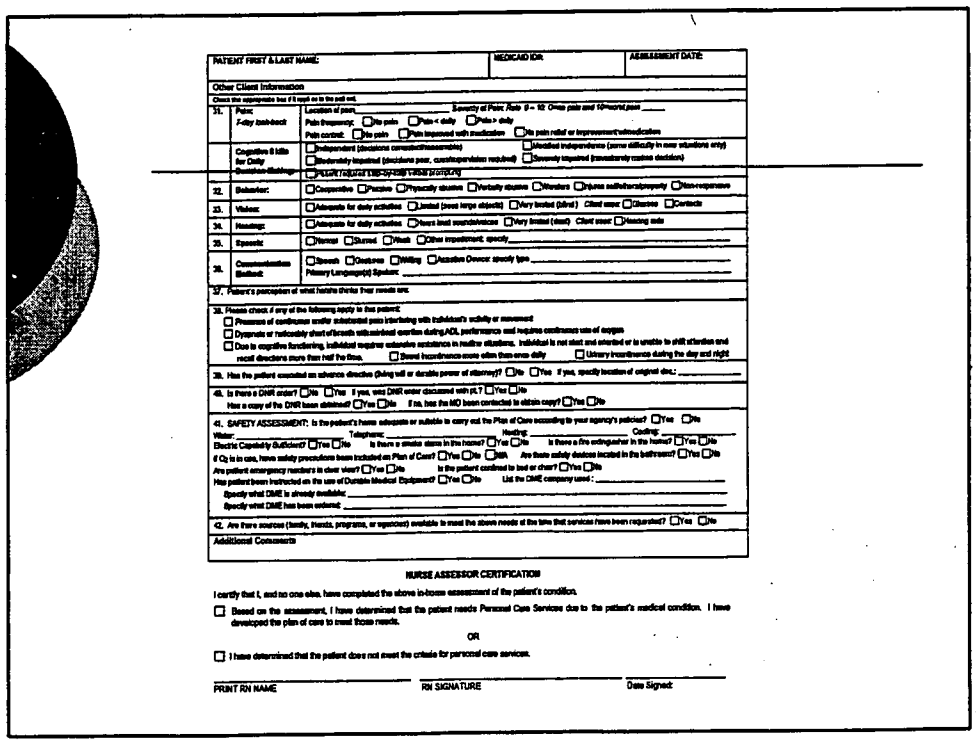
A. ADL Self-Performance Scores

6. INDEPENDENT: Performs all aspects of the activity without any supervision or assistance.
5. SUPERVISION: Oversight, encouragement or cueing provided 3 or more times during the activity.
4. LIMITED ASSISTANCE: Individual actively participates in the activity, but requires guided maneuvering of limbs or other non-weight bearing support on 1 or 2 occasions during the activity.
3. EXTENSIVE ASSISTANCE: Weight bearing support provided on 1 or 2 occasions during the activity.
2. MAXIMAL ASSISTANCE: Weight bearing support provided on 3 or more occasions during the activity.
1. TOTAL DEPENDENCE: Full performance of the activity by others.

B. ADL Support Provided Scores

8. More than one person physically assisted. 7. Supervision provided. 6. Cueing provided on 3 or more occasions during the activity.
5. Limited assistance provided on 3 or more occasions during the activity. 4. Extensive assistance provided on 3 or more occasions during the activity.
3. Total dependence provided on 3 or more occasions during the activity. 2. Activity occurred only once or twice during the period.
1. Activity did not occur during the period.

			A. ADL Self-Performance Score	B. ADL Support Provided Score	Coding Clarifications (Optional)
19.	Ambulation:	Mark assistive equipment patient is to use while ambulating: A. Cane _____ B. Quad cane _____ C. Walker _____			
20.	Non-ambulatory/ Transfer:	Moving to and between surfaces: bed, chair, wheelchair, standing position. Mark assistive equipment patient is to use during transfer: A. Manual wheelchair _____ B. Electric wheelchair _____ C. Hoyer lift _____ D. Transfer Board _____ E. Trapeze Bar _____ F. Other _____			
21.	Nutrition:	Rate assistance needed with taking in food by any method. Oral _____ Parenteral _____ Tube _____ A. Feed patient _____ B. Setup Only _____ Dietary Restrictions _____ Supervised _____ Diet Ordered _____ Meal Prep: C. 1 meal _____ D. 2 meals _____ E. Kitchen clean-up (cleaning table, stove, washing dishes, putting away food) needed _____			
22.	Respiration:	☐Normal ☐Dyspnea with normal exertion ☐Tracheostomy ☐Mechanical Oxygen: ☐Continuous ☐Intermittent ☐Nebulizer Treatments _____ A. Dust _____ B. Vacuum _____ C. Mop _____ D. Sweep _____			
23.	Exhalation:	☐Pt. is never short of breath ☐Pt. is short of breath when walking more than 20 feet or climbing stairs ☐Patient is short of breath (SOB) when walking less than 20 feet and or dressing self or using commode ☐Pt is SOB/shortened exertion (i.e. walking, bathing performing ADLs, agitated) ☐Pt is SOB @rest. ☐Has generalized weakness A. Change bed linens _____ B. Make bed _____ C. Grocery shop _____ D. Pick-up medicine _____ E. Pay bills _____ F. Take out garbage _____ G. Check smoke alarm _____			
24.	Skin:	☐Normal ☐Dry, cracked or bleeding areas ☐Pressure areas ☐Bruises A. Diabetic foot care required? ☐Yes ☐No Prov. _____ B. Nail Care? ☐Yes ☐No Prov. _____			
25.	Bathing:	A. Taking full body bath _____ B. Shower _____ C. Sponge bath _____ D. Shampooing hair _____ E. Transferring in and out of tub and shower _____ Devices needed: F. Grab bars _____ G. Bath Safety Bars _____ H. Detachable shower head _____ I. Clean bathroom after bathing _____			
26.	Personal hygiene:	A. Combing hair _____ B. Brushing or washing hair _____ C. Brushing teeth _____ D. Cleaning dentures _____ E. Shaving _____ F. Applying makeup _____ H. Washing/drying face and hands and peri-area _____			
27.	Dressing:	A. Layout clothes _____ B. Removing clothes from closet _____ C. Putting clothes on and taking clothes off _____ D. Donning/removing TED Hose _____ E. Donning/removing prosthesis _____ F. ROM _____ G. Launder pt's clothes, bed linens, towels, and washcloths _____			
28.	Bladder :	Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self. ☐Normal ☐Nocturnal ☐Indwelling catheter ☐Condom Catheter ☐Occasional incontinence (less than daily) ☐Daily incontinence ☐Incontinence during the day and night Devices needed: A. Bedside commode _____ B. Elevated Toilet Seat _____ C. Bedpan _____ D. Urinal _____ E. Pads _____ F. Diapers _____ G. Cath Care _____			
29.	Bowel:	Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self. ☐Normal ☐Occasional incontinence (less than daily) ☐Daily incontinence ☐Constipation ☐Ostomy Devices Needed: A. Bedside Commode _____ B. Elevated Toilet Seat _____ C. Bedpan _____ D. Urinal _____ E. Pads _____ F. Diapers _____ G. Enemas _____ H. Bowel Program _____			
30.	Self-monitoring:	Self-monitoring of: A. Pre-prandial medications ___ B. Blood Sugars: Notify MD if BS is above ____ or below ____ C. BP: Notify MD if BP is > ____ or < ____ D. Weight: Notify MD if pt. loses or gains ____ lbs. within ____ days.			



PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

Other Client Information

Check the appropriate box if it applies to the patient.

31.	Pain:	Location of pain _____ Severity of Pain: Rate 0 – 10: Worst pain ever 10=worst pain _____
	7-day look-back:	Pain frequency: ☐No pain ☐Pain < daily ☐Pain > daily Pain control: ☐No pain ☐Pain improved with medication ☐No pain relief or improvement w/medication
	Cognitive Skills for Daily Decision-Making:	☐Independent (decisions consistent/no cueing) ☐Modified Independence (some difficulty in new situations only) ☐Moderately impaired (decisions poor; cueing/supervision required) ☐Severely impaired (never/rarely makes decisions) ☐LOOK/REQUEST MDS 3.0 CODE FROM PROVIDER
32.	Behavior:	☐Cooperative ☐Passive ☐Physically abusive ☐Verbally abusive ☐Wanders ☐Injures self/others/property ☐Non-responsive
33.	Vision:	☐Adequate for daily activities ☐Limited (sees large objects) ☐Very limited (blind) Client wears: ☐Glasses ☐Contacts
34.	Hearing:	☐Adequate for daily activities ☐Hears loud sounds/voices ☐Very limited (deaf) Client wears: ☐Hearing aids
35.	Speech:	☐Normal ☐Slurred ☐Weak ☐Other impairment; specify _____
36.	Communication Method:	☐Speech ☐Gestures ☐Writing ☐Assistive Device: specify type _____ Primary Language(s) Spoken: _____

37. Patient's perception of what he/she thinks their needs are:

38. Please check if any of the following apply to this patient:
☐ Presence of continuous and/or intermittent pain interfering with individual's activity or movement
☐ Dyspnea or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen
☐ Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time. ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night

39. Has the patient executed an advance directive (living will or durable power of attorney)? ☐No ☐Yes If yes, specify location of original doc.: _____

40. Is there a DNR order? ☐No ☐Yes If yes, was DNR order discussed with pt.? ☐Yes ☐No
Has a copy of the DNR been obtained? ☐Yes ☐No If no, has the MD been contacted to obtain copy? ☐Yes ☐No

41. SAFETY ASSESSMENT: Is the patient's home adequate or suitable to carry out the Plan of Care according to your agency's policies? ☐Yes ☐No
Water: _____ Telephone: _____ Heating: _____ Cooling: _____
Electric Capability Sufficient? ☐Yes ☐No Is there a smoke alarm in the home? ☐Yes ☐No Is there a fire extinguisher in the home? ☐Yes ☐No
If Oz is in use, have safety precautions been included on Plan of Care? ☐Yes ☐No ☐N/A Are there safety devices located in the bathroom? ☐Yes ☐No
Are patient emergency numbers in clear view? ☐Yes ☐No Is the patient confined to bed or chair? ☐Yes ☐No
Has patient been instructed on the use of Durable Medical Equipment? ☐Yes ☐No List the DME company used : _____
Specify what DME is already available: _____
Specify what DME has been ordered: _____

42. Are there sources (family, friends, programs, or agencies) available to meet the above needs at the time that services have been requested? ☐Yes ☐No

Additional Comments

NURSE ASSESSOR CERTIFICATION

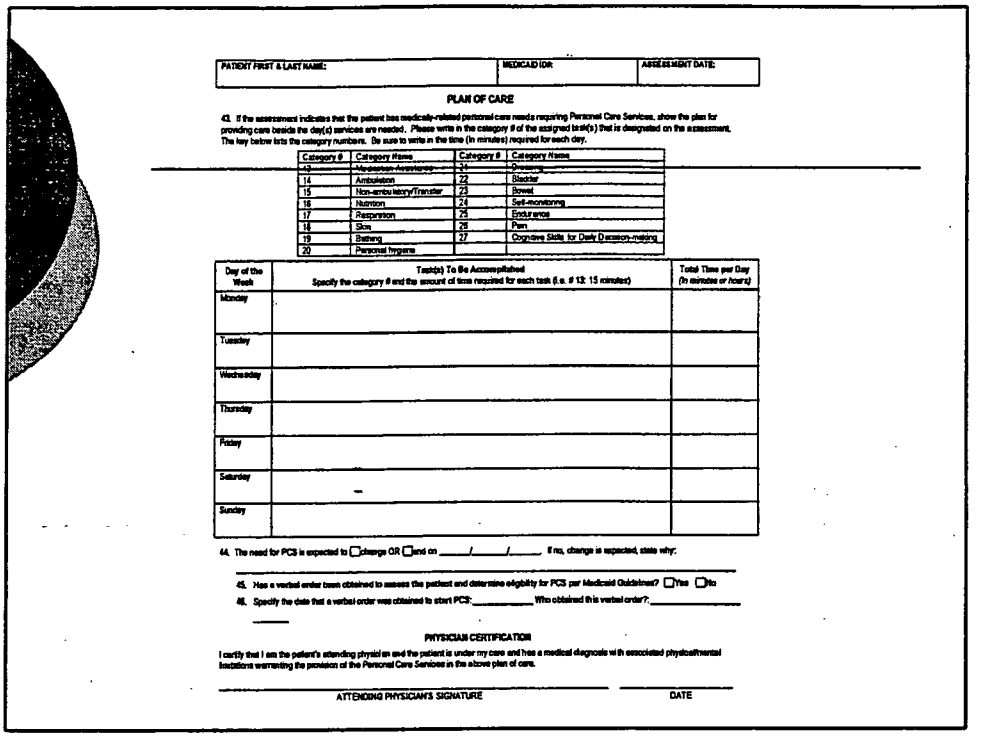
I certify that I, and no one else, have completed the above in-home assessment of the patient's condition.

☐ Based on the assessment, I have determined that the patient needs Personal Care Services due to the patient's medical condition. I have developed the plan of care to meet those needs.

OR

☐ I have determined that the patient does not meet the criteria for personal care services.

PRINT RN NAME _____ RN SIGNATURE _____ Date Signed: _____



PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

PLAN OF CARE

43. If the assessment indicates that the patient has medically-related personal care needs requiring Personal Care Services, show the plan for providing care beside the day(s) services are needed. Please write in the category # of the assigned task(s) that is designated on the assessment. The key below lists the category numbers. Be sure to write in the time (in minutes) required for each day.

Category #	Category Name	Category #	Category Name
13	Medication Assistance	21	Dressing
14	Ambulation	22	Bladder
15	Non-ambulatory/Transfer	23	Bowel
16	Nutrition	24	Self-monitoring
17	Respiration	25	Endurance
18	Skin	26	Pain
19	Bathing	27	Cognitive Skills for Daily Decision-making
20	Personal hygiene		

Day of the Week	Task(s) To Be Accomplished Specify the category # and the amount of time required for each task (i.e. # 13: 15 minutes)	Total Time per Day *(in minutes or hours)*
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

44. The need for PCS is expected to ☐change OR ☐end on ____/____/____. If no, change is expected, state why:

45. Has a verbal order been obtained to assess the patient and determine eligibility for PCS per Medicaid Guidelines? ☐Yes ☐No

46. Specify the date that a verbal order was obtained to start PCS:_____ Who obtained this verbal order?:_____

PHYSICIAN CERTIFICATION

I certify that I am the patient's attending physician and the patient is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the Personal Care Services in the above plan of care.

ATTENDING PHYSICIAN'S SIGNATURE DATE

Piloted Form with RNs and Patients

- Positive feedback and time wise
- Tool longer, yet more concise in measuring ADLs/needs
- Tool's language is consistent with PCS Plus/Transitions to PCS-Plus DMA-3000A
- Strengthened Nurses' Certification Statement

Comparisons & Recommendations

- **PCS Current Criteria**
  - * PCS available based on one ADL limitation or more

- **Restructured PCS Criteria**
  - *Restricted now to two ADL limitations or more. Also recommended standardized ADL definitions and standardized task definitions

Comparisons & Recommendations

- **Current PCS**
  - *RN supervision - although no federal requirement, NC PCS required every 60 days by a registered nurse.

- **Restructured PCS**
  - *RN supervision – lines up now with DFS home care licensure rules – every 90 days, with new requirements for mandated elements of supervision and allowance for technology such as telephony to enhance supervision.

RN Supervision Restructured PCS

- Supervision is provided by an RN with training and/or program competency in Personal Care Services/policy.
- To reassess a client after a hospitalization/reported functional health change in the client for review and update of the plan of care **or**
- To reassess a client after an unplanned lapse in service, greater than 7 service days.
- Joint supervisory visits with the aide recommended as mandatory

Supervision Standards for PCS Services

- Nursing evaluation during the visit:
  - Client: condition, specific to primary diagnosis and diagnosis pertinent to ADL deficits qualifying for PCS services, changes in client (including hospitalizations, other services, others who participate in home environment)
  - Plan of Care: tasks and time in the POC meet identified needs, plan is revised based on the evaluation. Client continues to need the service. If hours are increased, additional needs and tasks to meet needs are identified on the plan/note.
  - Evaluation of the employee implementing the plan of care and interacting with the client.
  - Client/family perception of care is evaluated and input is addressed.

Other Supervision Standards

- Aide Flow sheet review by RN to monitor and review the implementation of the plan of care. The follow-up of activities may include phone management, a visit, a case conference based on identified needs and changes in client.
  - Phone contact: evaluates attendance, activities, satisfaction, investigation of problems, questions.
  - Case references: with one/all employee, family and staff.
- LPN can record, report and observe, but doesn't meet supervisory qualifications. Can't do minimal required supervisory visits.
- LPN can not collect data for RN to review and sign.

Other Oversight Enhancements

- AHHC supporting legislation for Medical Care Commission being granted authority to define geographical service area for home care licensed agencies providing in-home aide services as a means to assure adequate access to RN supervision.
- AHHC would support legislation increasing the survey cycle for licensed only agencies providing in-home aide services

Comparisons & Recommendations

- **Current PCS**
  - *Predominantly paper based
- **Restructured PCS**
  - *The new assessment tool will lend itself to the eventual development of web-based data entry and a much more accurate data bank of patient and program information.

Comparisons & Recommendations

- **Current PCS**
  - *RN program training largely handled by agencies
- **Restructured PCS**
  - *State approved curriculum for mandatory web based RN program training with testing and certificate. Partnering with AHEC. Development grant by AHHC. State will have administrative access to data bank of participants, pass rate, etc.

Comparisons & Recommendations

- **Current PCS**

*Staffing qualifications for licensed only agencies limited to that required by individual licensure/certification Boards or payer requirements

- **Restructured PCS**

*PCS Advisory Committee and AHHC supporting legislation for Medical Care Commission being granted authority to set staffing qualifications through rules.

MR/DD and PCS

- The Workgroup noted the increase in MRDD requests for PCS services.
- Noted that the client/agency should seek programs developed for specifically for these recipients (for example, CAP-MRDD).
- Clients admitted/served in PCS with the diagnosis of MRDD should have ADL deficits clearly identified.
- Should not be targeted for the primary diagnosis of "psychiatric patient".

Pediatrics and PCS

- PCS services do not include "skill training" services.
- PCS services do not replace parental responsibility.
- Must document medically-based tasks to be done under RN supervision
- For example:
  - Therapeutic exercises/activity deficits
  - Special feeding
  - Special handling of body fluid/waste
  - Special skin care
  - NA II Tasks
  - Special monitoring tasks: (FCBG) which occur during care

Comparisons & Recommendations Quality Assurance/Utilization Review

- **QA/UR Current PCS**

*Post pay review through program integrity

- **QA/UR Restructured PCS**

*DMA/provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies

- The plan provides a framework to achieve outcomes in 7 broad domains of quality as defined by CMS.

PCS QA/UR

- DMA/provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies
- The plan provides a framework to achieve outcomes in 7 broad domains of quality as defined by CMS.

CMS Domains

- Participant access (assessment)
- Participant-centered service planning and delivery
- Provider capacity/capabilities
- Participant safeguards
- Participant rights
- Participant outcomes/satisfaction
- System performance

Agency Self Audit & Audit Strategies

- Evaluation of Client Records (active and closed)
- Telephonic surveys
- Supervisory visits
- Electronic check in systems
- Review of aide service logs
- Incident/Complaint management
- At state-level review, the auditor may request to review agency self audit, findings and plan
- DMA desk review may request agency self audit

Educational Review

New Providers- after 6 months of billed service

- State Review
  - Random Selection
  - Educational /validation visits the first six months
- Does not replace PI audit
  - Egregious findings addressed

State Reviews

- Targeted Review from automated data - Automated sampling based on identified thresholds.
  - Examples:
    - pediatrics
    - More than one PCS recipient in the same home
    - Diagnosis targeted audit
- Desk Review and/or
- On-Site Review

State Review Findings

- If the findings of the review indicate that the client does not meet PCS criteria, a letter will be issued regarding the determination of coverage review.
- Other findings could lead to PI investigations

Provider Operation Impacts

- Administrative Changes - staff qualification requirements; paper/software changes (mandatory forms, mandatory elements on forms and/or costs associated with electronic entry)
- Training Costs
- Geographical service area impacts (volume impacts on costs)
- More in-depth UR role, more oversight

AHHC's Role

- Continue to partner with State on improvements
- Support curriculum and RN program training
- Assist with provider training and communication
- Continue role on PCS Advisory to evaluate program changes
- Continue to monitor provider impacts and costs
- Support legislation that directly and indirectly enhances patient care

Next Steps in the Restructuring Process

- Physician Advisory Group (PAG) input
- DMA development of draft policies
- DMA internal review of draft policies by all sections in DMA
- Fiscal Impact Analysis by DMA
- Formal Review of policies by PAG and recommendations to DMA
- Preparation of "final" policies and posting on DMA web site for 45 day comment period
- Identify and secure resources to implement components (utilization management, automation of assessment tools, provider training, etc.)

Next Steps in the Restructuring Process

- Implementation process will take from 6-10 months
- Looking at a July 1, 2005 target date for the major changes to be implemented
- Information systems changes and contracting for a utilization management program may take longer

Details and Determination

- Participation by stakeholders has made the PCS Restructuring products better than they might have been otherwise.
- There is much left to do and many details to be worked out.
- DMA and AHHC remain committed to the process.

Outcome Focus

- To assure PCS continues to be an important service in the state's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure services quality and fiscal accountability.

Handout 2

Consumer-Directed Supports

Study Commission on Aging

November 2004

What Does Consumer-Directed Support Mean?

"A philosophy and orientation to the delivery of home and community based service delivery whereby informed individuals assess their service needs, determine how and by whom these needs should be met, and monitor the quality of services received."

National Institute on Consumer-Directed Long-Term Services, quoted from work by Sue Flanagan

In Other Words...

Option that:



Supports People Who Need Assistance With A Variety of Daily Living Activities

Allows People To Plan, Budget, And Make Choices That Work Best For Them



Allows Participants Control in Managing Their Support Services, Such as Their Attendant/Aide, Medical Equipment and Supplies, Mobility Aids, etc.

A Rose By Any Other Name...

- ❖Self-Directed Supports or Services
- ❖Consumer-Directed Services
- ❖Independent Living
- ❖Self-Determination
- ❖Participant-Driven Supports

History of Consumer-Directed Supports

- Independent Living
- Consumer-hired Personal Attendants
- Self-Determination projects RWJ
- Family Support Projects
- Cash and Counseling
- Independence Plus Medicaid Waivers
- CMS Systems Change grants
- SAMHSA initiatives

Consumer- Directed Supports in NC

- Independent Living through VR & Services for the Blind
- Centers for Independent Living
- Self-Determination project with the Arc of NC
- Self-Determination Pilot Projects--DD Council and DMHDDSAS
- First in Families
- CMS Systems Change grants-- Real Choice, CPASS, Nursing Facility Transition

Consumer-Directed Supports in NC continued

- CAP Choice Medicaid waiver approved by CMS for two pilots--Duplin and Cabarrus Counties
- Waiver of a portion of HCCBG funding by Division of Aging for some pilot counties
- Medicaid Waiver w/Self-Directed Components approved for Piedmont Local Management Entity (LME) for developmental disabilities
- Self-Directed Waiver being developed for all LMEs

Stakeholder Involvement in NC Consumer-Directed Initiatives

- Consumer Task Force developed to submit grant applications to CMS in 2000
- Development of Guiding Principles which have subsequently been revised, and adopted by Long Term Care Cabinet
  - consumers in all population groups
  - provider agencies and associations (such as Home Care and Hospice Assoc., AAA's)
  - advocacy and educational organizations (such as Mental Health Assoc., Centers for Independent Living, etc.)
  - Departmental Agencies

Stakeholder Involvement in NC Consumer-Directed Initiatives

- Oversight of grant implementation--
  - Consumer Directed Work Group
  - CPASS Advisory Committee
  - Nursing Facility Transition Work Group
- Medicaid Waiver Development--
  - CAP Choice included the grant implementation groups
  - Development of waivers in mhddsas system includes stakeholders for that system
- Meetings with long term care provider groups

Who Can Benefit from Consumer-Directed Supports?

People who have...

- **Aging-related Care Needs**
- **Physical Disabilities**
- **Chronic Conditions**
- **Sensory Impairments (Hearing, Vision)**
- **Mental Health Needs**
- **Developmental Disabilities**
- **Addiction Diagnoses**

Guiding Principles

Individuals Have:

Needs, Hopes, Desires, & Feelings



Right To Make Decisions for Their Lives



Right To Take Risks



Right to Make Mistakes & Learn From Them



Guiding Principles

Individuals Must Have:

Access to Services & Supports



Opportunity to Direct the Services & Supports



Opportunity to Participate in Community Life



What Are Goals of Consumer-Directed Support?

- To Give Program Participants Choice And Control Over Their Services, As Much As Possible



- To Be Flexible In the Use of Public Funds To Meet Each Participant's Needs



- To Use Public Money Wisely & Appropriately



- To Support Participants In The Home And Community



How Does Consumer-Directed Supports Work?

Three Main Steps for Participants:

- Participant-Centered Plan
- Participant Budget
- Participant Direction of Services

Team Members:

- Participant
- Representative (optional)
- Support Advisor
- Attendant/Aide
- Financial Manager
- State & Local Government

Participant-Centered Plan

The Development of A Participant-Centered Plan Is A Process That:



Allows Participant To Direct The Planning

Includes Participant's Needs, Strengths, Capacities, Preferences, & Desired Outcomes

Involves People Chosen By the Participant and His/Her Support Advisor

Participant-Centered Plan

When Completed, The Plan Includes...

- What services, equipment, and supplies the individual needs
- What unpaid supports are available to meet some of their needs
- People and paid staff in their life
- Time, place and ways to receive services
- Changes as they are needed change
- Provisions for determining the participant's satisfaction with services



Participant Budget

The Development of the Participant Budget...

Involves the Participant, the Support Advisor, and Others In The Process

Remains Within Participant's Available Funds As Allocated By The Funding Agency

Allows For Purchases To Meet Needs Identified in Participant-Centered Plan

Describes How Funds Will Be Used To Purchase Allowable Services, Supplies & Equipment

Participant Budget

The Participant Budget Serves As Purchasing Plan That...

- Ensures Only Approved Purchases Can Occur
- Must Be Approved by the Funding Agency Before Any Purchases Can Be Made
- Must Follow Rules Set By The Funding Agency

Participant Direction of Services

According to The Plan and Budget, The Participant Decides...

- **Whom To Hire** To Provide Supports
- **How, when and where** Staff Provides Supports
- What **Equipment** and **Supplies** to Buy
- From **Which Supplier, Store or Vendor** To Purchase Some Items



How is This Option Different From Traditional Services?

Traditional	Consumer-Directed Supports
Provider Agency:	**Participant:**
Hires & Trains Staff	Hires & Trains Staff
Schedules Staff & Services	Schedules Staff & Services
Evaluates Quality	Evaluates Satisfaction With Quality of Supports
Works Out Problems with Staff	Works Out Problems with Staff
Decides on Dismissal & Replacement of Staff	Decides on Dismissal & Replacement of Staff
	* Participant has a team of supports to assist, as needed

How Does this Model Affect Current Traditional Agency Services?

- Consumer-Directed Services are not meant to replace current services but to be another option; not all individuals will want to use consumer-directed services
- Participants can choose some more traditional agency or professionally oriented services along with some consumer-directed services
- If consumer-directed services do not work for the individual, he/she can go back to traditional agency services

Consumer-Directed Supports Team

Participant
Makes Decisions And Directs Services To Meet Needs

Representative (optional)
Helps Make Plan And Budget Decisions

Support Advisor
Teaches Skills, Provides Resources, And Helps To Plan Is Appropriate and Ensure Needs Are Met

Attendant/Aide
Provides Direct Assistance And Services



Financial Management Service
Processes attendant/aide Pay and Checks for Budgeted Items

State & Local Government
Approves Budget, Provides Resources, and Monitors Programs

Participant Responsibilities

- **Communicate with attendant/aide & Support Advisor**
- **Treat attendant/aide with Respect**
- **Notify Support Advisor of Any Concerns and Changes in Situation**
- **Stay Informed About Personal Budget And Be A Responsible Custodian of Public Money**
- **Submit Required Paperwork**
- **Learn and Develop Skills such as hiring and supervising staff**

The Representative

Is An Agent of the Participant



- Chosen By The Individual
  - Can be trusted friend, a family member, etc.
  - Optional ~ not all individual participants will choose to have a representative.
- Cannot Be Paid For This Role
- Cannot Be Hired To Provide Other Services, such as Attendant/Aide Services

Representative Responsibilities

As An Agent of the Participant

- May Make Part Or All Of The Decisions, Depending On Participant's Preference
- Involves The Participant As Much As Possible In Decision Making
- Makes Decisions About Person's Services And Budget That The Individual Needs



The Support Advisor

Is A Human Service Professional

- Assists Participant In Creating His or Her Plan and Budget
- Teaches Participant How To Manage His or Her Plan And Services
- Teaches Participant How To Select, Train, And Supervise Staff
- Provides Information And Resources
- Provides Oversight For Program



Support Advisor Responsibilities

As a Resource Person



- Answers Questions
- Provides Information & Makes Suggestions
- Maintains Knowledge of Community Resources

As a Monitor



- Oversees Consumer Directed Supports Program
- Helps to Ensure The Participant's Needs Are Met
- Submits Budget for Funding Agency Approval
- Maintains Necessary Records

Attendant/Aide

- ❖Works Directly **FOR** Participant
- ❖Provides Services And Supports
- ❖Works Hours Set By Participant
- ❖Works at Location Set by Participant
- ❖Uses Material and Equipment that Participant Provides
- ❖Uses Methods that the Participant Requests



The Financial Manager

Is the Payroll and Check Processor

- Serves As The Accounting Agent For The Participant's Designated Support Funds
- Processes Pay Checks For The Participant's Attendant/Aide
- Handles Check Processing For Expenses Determined By Plan And Budget



Financial Manager Responsibilities

As A Payroll and Check Processor

- Withdraws State And Federal Taxes Appropriately
- Processes Payment For Budgeted Items And Expenses, In A Timely Manner
- Gives Participant And Support Advisor Accurate Reports On Budget And Expenses
- Files State And Federal Documents

State & Local Government Responsibilities

As Funder of Services and Supports

- ★ Uses Existing Federal And State Public Dollars To Provide Funds For Services
- ★ Ensures That Support Advisors And Financial Managers Have Knowledge, Skills, And Resources To Support Participants
- ★ Offers Training and Resources to Participants, Support Advisors,Attendant/Aide, and Financial Managers
- ★ Monitors Activities To Ensure Responsible Use of Funds and Safety and Well-being of Participants

How Do We Know that Consumer-Directed Supports Works?

- It has been working in Independent Living programs (including NC) since the 1980's
- Success of early Robert Wood Johnson self-determination projects--
  - consistent improvement in health, relationships, safety, activities, comfort

How We Do Know that Consumer-Directed Supports Works--continued

Arkansas Cash and Counseling evaluation

- greater satisfaction with staff reliability, schedule, performance, attitudes;
- lower % of unmet needs;
- at least as safe as agency-directed care;
- more satisfied with life;
- consumer exploitation of funds very rare

All Cash and Counseling states (Arkansas, New Jersey, Florida) have decided to make it available permanently

RWJ/CMS have funded 11 more Cash and Counseling sites

Consumer-Directed Supports Policy Implications

- Fulfills the intent of the Olmstead Supreme Court Decision to support individuals through cost-effective community based systems
- Promotes full community participation of individuals with disabilities as encouraged by the federal New Freedom initiative





Consumer-Directed Supports

QUESTIONS?

Handout 3

GUIDING PRINCIPLES

These guiding principles are intended to apply to people with disabilities and/or long term illnesses regardless of age, including minor children and their parents or guardian(s) as well as older adults in need of long term care services and supports.

PEOPLE WITH DISABILITIES AND LONG TERM ILLNESSES:

- have the same needs, hopes, desires and feelings common to all people.
- are entitled to the full benefits of community membership and citizenship, including all of its rights, privileges, opportunities, and responsibilities.
- must be afforded the dignity of taking risks.
- must have access to coordinated services and supports, determined by the individual's unique strengths, needs, and choices.
- must have the opportunity to direct the planning, selection, implementation, and evaluation for their services and supports.
- are the primary decision-makers in their lives and must be supported and encouraged to achieve their full potential and be afforded the opportunity to develop personal relationships, learn, work and produce income, worship and be full participants in community life.

COMMUNITY SERVICE AND SUPPORT SYSTEMS MUST STRIVE TO:

- provide safeguards to ensure personal security and wellbeing and affirm and protect individual legal and human rights.
- be coordinated and person- and family-centered; developed around the individual's needs and strengths, capabilities, and choices.
- be fully accessible, culturally responsive and provided in the most integrated community setting appropriate to the individual's needs and desires.
- support the development of informal and generic community resources that are accessible and readily available, and employ specialized services only when those used by the general public cannot reasonably accommodate the needs of the individual/family.
- be directed toward the enhancement of quality of life and the achievement of interdependence/independence, contribution, and meaningful participation into the community.
- support people with disabilities and long term illnesses as the primary decision-makers in their lives by providing the information and supports necessary to make informed decisions.
- reflect best practice, be cost-effective, efficient, and achieve outcomes valued by people with disabilities and long term illnesses.
- be responsible stewards of public dollars, distributing resources to assure that individuals are served equitably and according to need and comply with all accountability requirements governing public funds administered by the system.
- ensure that consumers or their designated representative meet the responsibilities they agree to assume with regard to directing their own care including making informed and cost-effective decisions regarding services and supports.

Handout 4

Federal Systems Change Grants in N.C.

The State of North Carolina received approximately $3 Million from the federal government (Center for Medicare and Medicaid Services) in the form of 3 three-year grants.

The Real Choice Systems Change Grant

The Real Choice Grant was awarded to the Office of Long Term Care (within the Department of Health and Human Services) and is in its fourth year of implementation (the grant was a three-year grant but was approved to do a one-year no-cost extension). This grant specifically addresses direct care workforce issues, including direct care worker shortages, and implementation of consumer directed supports.

The Real Choice grant includes three components. The first component is the Public Education, Awareness and Recruitment Effort, which has accomplished the following:

- Created and distributed general information and recruitment fact sheets about direct care workers;
- Developed and distributed recruitment packets and posters which included a toll-free telephone number to call for more information. Packets were distributed to community colleges, Employment Security Commissions, JobLink centers and other agencies;
- Created a "Thank You" ad and two recruitment ads that were aired in major television markets across the state:
- Responding to inquiries generated by posters, packets and TV ads:
- Finalized a direct care worker fact sheet for businesses;
- Developed scripts for two, four minute videos-one on recruitment of direct care workers and one to raise public awareness about the direct care workforce. Production has begun;
- Added a website link specifically pertaining to direct care workers, to the main Long Term Care website;
- Established the Direct Care Workers Association of North Carolina (DCWA-NC), which was incorporated April 2003 and received an advance determination ruling from the IRS as a 501 (c)(3) nonprofit organization in January 2004;
    - Membership drive in progress
    - Planning two training Institutes for Fall 2004
    - Web site established: www.dcwa-nc.org

The second component of the Real Choice grant is the Training and Career Ladder Effort, which to date has:

- Developed a training program on assistive communication devices in collaboration with the N.C. Assistive Technology Program;
- Initiated train-the-trainer sessions for supervisors of direct care workers, using the nationally recognized 'Supervisory Coaching' curriculum;
- Continued to develop two new job categories: "medication aide" and "geriatric nurse aide."

The third component of the Real Choice grant is a Consumer Directed Care effort, which to date has:

- Developed Guiding Principles for consumer directed care, which have been adopted by DHHS;
- In July 2003, initiated services agreements with four pilot sites in N.C. to implement consumer directed care—Cabarrus Departments of Social Services and Aging, Duplin Home Care and Hospice, Community Partnerships of Wake County and Easter Seals United Cerebral Palsy of North Carolina;
- Developed waivers to provide consumer directed care options under CAP-DA and Home and Community Care Block Grant funding streams for the appropriate pilot sites.

N.C. Nursing Facilities Transitions grant

A second federal grant awarded to our state is the N.C. Nursing Facilities Transitions grant. It is administered by DHHS's Division of Medical Assistance and implemented by Vocational Rehabilitation's Independent Living Rehabilitation Program (ILRP) through two regional pilot sites. The two main goals of this grant are to:

- Design and implement a program to transition 80 – 100 nursing facility residents with disabilities, statewide, who wish to live outside of an institutional setting;
- Build the infrastructure and capacity statewide through partnerships, to maximize freedom and independence for people with disabilities beyond the grant funding period and to sustain the transition effort beyond the grant period

Five key objectives for the grant are:

- Raise awareness of community options
- Determine methods for identifying candidates for community living
- Provide transition services to between 80-100 nursing facility residents statewide
- Strengthen ILRP and community partners by improving network of resources through local workgroups in the service areas
- Evaluate the costs and benefits to create a plan for sustaining transitions beyond the grant period

There are two pilot sites covering the Asheville and Rocky Mount ILRP unit office service areas. Community partners in these pilot areas who have agreed to be actively involved include Western Alliance CIL and Citizens Together Advocacy Group (CTAG). Western Alliance will help people in transition get and stay connected to an online community support network called Cyberpals. CTAG is in the process of duplicating the Cyberpals program in the Rocky Mount area. The new program will be called Mousepads.

In January 2004 the expansion sites of the Albemarle, Charlotte, Greensboro, and Winston Salem ILRP unit office service areas were added to the grant project. Programs for Accessible Living, The Joy A. Shabazz Center, and the Adaptables were some of the community partners who have joined the effort of this transitions project.

In July 2004 the second expansion will occur. The ILRP unit offices in Raleigh, Durham, and Fayetteville will become active with the grant. By the end of year three, all 16 unit offices will be active with the grant and will have the capacity to provide transition services to the citizens in all 100 counties North Carolina.

The Transitions Services Fund will be used for transition expenses such as utility deposits, security deposits, furniture, first months groceries, start up supplies, first month's medication, and clothing. Funding will also be used to develop educational materials about community services and supports, targeted for nursing home staff, service providers, consumers, and their friends and family.

Community PASS Grant

A third grant is the Community PASS grant, awarded to the Department of Health and Human Services and administered through the Division of Mental Health/Developmental Disabilities/Substance Abuse Services. The goals of this grant include:

- To facilitate greater consumer direction through regulatory reform;
- To increase consumer directed options for personal assistance services and supports;
- To increase consumer leadership and community resources for people in both community and segregated settings.

Planned activities include:

- An assessment of state fiscal and regulatory policies followed by the initiation of statutory and rule reform;
- Identification of provider practices that interfere with consumer direction;
- Development of training and technical assistance for providers aimed at encouraging consumer direction;
- Creation of community demonstration models of consumer leadership supporting greater consumer direction.

The ultimate objective of this grant is to change the infrastructure of the human services system to allow for greater consumer control over their own resources and leadership over the reform efforts in their own communities.

This summary was developed by Betsy MacMichael, using information provided by Lynda McDaniel, then Assistant Secretary for Long-Term Care and Family Services (919-733-4534 or Lynda.mcdaniel@ncmail.net), and updated by grant coordinators Donna Holt, Jan Moxley, Michael Howard and Ann Eller. The Assistant Secretary for Long-Term Care and Family Services is now Jackie Sheppard.

Bonnie Morrell

Interim Report Geriatric Mental Health Specialty Teams



Session Law 2004-144
Senate Bill 1148
North Carolina Study Commission on Aging
November 10, 2004

Bonnie Morell, Dr.PH, Community Policy Section, Division MH/DD/SAS, Dept of Health and Human Services

Background

- 20 programs were given start-up MH Trust Funds in FY 02-03 as part of the preparation to increase community capacity to serve older adults prior to reducing the number of geriatric beds in State psychiatric hospitals.

Purpose of the Teams

- Assist with successful reintegration of older adults into the community when discharged from State psychiatric hospitals.
- Provide support services and technical assistance to nursing homes, adult care homes, and other agencies/caregivers that serve older adults who have mental health treatment needs and who may be at risk of hospitalization.

Location of the Teams

- Teams provide services in more than one local mental health program catchment area in order to make services available throughout the State.

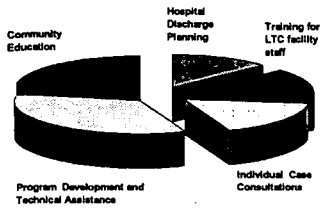
Team Description

- Each team is to have a nurse and a masters level mental health clinician with geriatric experience
- Teams supplement local area authority/county program capacity to serve adults age 60 and over.
- Duties and activities are assigned based on each member's professional training and scope of practice.

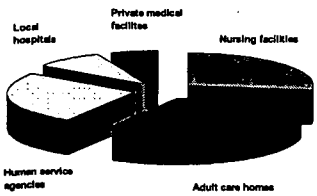
Eligibility for Services

- Older adults who are returning to the community from State hospital geriatric units
- Older adults with mental illness, who are currently residing in a nursing home or adult care home who have mental health treatment needs who may be at risk of hospitalization
- Older adults who are currently in the community who have mental health treatment needs who may be at risk of hospitalization

Services Provided in SFY 03-04



SFY 03-04 Facilities Where Services Were Provided



Next Steps

- Develop and implement a standardized screening & referral process
- Develop an operations manual, containing procedures for forms and documentation that can be used for staff training
- Implement system to track expenditure data, number of individuals served, and qualifications of staff

Geriatric Specialty Team Study Committee

- As specified in SB 1148, a committee has been formed to study the mission of the teams and to consider whether to:
  - Create separate teams for geriatric population and for other adults in Long Term Care or
  - Broaden the scope and have teams serve individuals of any age in Long Term Care
- First meeting was held on 10/28/04

Bonnie Morrell

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

October 25, 2004

The Honorable Albin B. Swindell, IV, Co-Chair
North Carolina Study Commission on Aging
Room 629, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Swindell:

Attached is the interim report on *An Act to Provide Support and Training for Long-term Care Providers Caring for Residents with Mental Illnesses:* Geriatric Mental Health Specialty Teams that has been prepared in compliance with Senate Bill 1148.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services will form a study group to assist the Division in developing recommendations regarding the mission of the Geriatric Mental Health Specialty Teams who assist long-term care facilities in serving all residents who are within the targeted population. The Division will also standardize criteria across all mental health specialty teams and will fully implement a data based tracking system. The interim report points out the progress that has been made in areas noted above. In addition, a timeline for the completion of assigned responsibilities is provided.

If you have any questions or need additional information, please contact Michael Moseley, the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services at 733-7011.

Sincerely yours,

Carmen

Carmen Hooker Odom

CHO:jm

Attachment

cc: Lanier Cansler
Allyn Guffey
Rob Lamme
Mike Moseley
Legislative Library

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

October 25, 2004

The Honorable Debbie Anne Clary, Co-Chair
North Carolina Study Commission on Aging
Room 302B, Legislative Office Building
Raleigh, NC 27603-5925

Dear Representative Clary:

Attached is the interim report on *An Act to Provide Support and Training for Long-term Care Providers Caring for Residents with Mental Illnesses:* Geriatric Mental Health Specialty Teams that has been prepared in compliance with Senate Bill 1148.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services will form a study group to assist the Division in developing recommendations regarding the mission of the Geriatric Mental Health Specialty Teams who assist long-term care facilities in serving all residents who are within the targeted population. The Division will also standardize criteria across all mental health specialty teams and will fully implement a data based tracking system. The interim report points out the progress that has been made in areas noted above. In addition, a timeline for the completion of assigned responsibilities is provided.

If you have any questions or need additional information, please contact Michael Moseley, the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services at 733-7011.

Sincerely yours,

Carmen Hooker Odom

CHO:jm

Attachment

cc: Lanier Cansler
Allyn Guffey
Rob Lamme
Mike Moseley
Legislative Library

Interim Report
to the

North Carolina Study Commission on Aging
And the
Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

Report on

An Act to Provide Support and Training for Long-term Care Providers Caring for Residents with Mental Illnesses: Geriatric Mental Health Specialty Teams

Session Law 2004-144
Senate Bill 1148

October 1, 2004

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

Interim Report on Geriatric Mental Health Specialty Teams

October 1, 2004

Session Law 2004-144, Senate Bill 1148 provides direction to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, to study the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, to standardize criteria across all mental health specialty teams, and to track specified Specialty Team programmatic data. Provisions within this Bill, entitled *An Act to Provide Support and Training for Long-term Care Providers Caring for Residents with Mental Illnesses, as Recommended by the North Carolina Study Commission on Aging*, require an interim and final report. This interim report provides a timeline for accomplishing the specific requirements described within S.B. 1148 as well as provides a status report on requirements that have been addressed and implemented.

Background

As part of the overall effort to reduce the number of elderly individuals who are inappropriately admitted to State psychiatric hospitals, the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services is funding 20 community-based geriatric mental health specialty teams - seven teams serve multi-counties. These teams are available to provide consultation and a limited amount of direct services to long term care facilities and other organizations throughout the State. Inasmuch as the creation of the specialty teams represented a new approach to serving elderly persons with mental illness, the Division has standardized many of the functions of these teams to ensure operational consistency across the State, to include:

Team Purpose and Description

The purpose of the teams is to increase the ability of older adults with mental illness to live successfully in their communities by:

1. assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and
2. providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

This is to be accomplished by providing training and consultation to the staff serving the identified individuals, developing linkages with community providers serving older individuals and providing time limited specific direct services to the identified individuals.

The teams consist of a registered nurse and a masters prepared therapist. The teams operate on an itinerant basis and thus provide the majority of services where the individual lives rather than in an office/clinic setting. The geriatric specialty teams are to supplement area authority/county program capacity to serve adults, age 60 and over.

Team member duties and activities are assigned based on each team member's professional training, scope of practice, skills and abilities.

Eligibility for Services*

The Geriatric Specialty Teams provide services to or on behalf of individuals who meet the following criteria:

1. Individuals who are 60 years of age or older with mental illness, who are in a state psychiatric hospital and who are preparing to return to the community to reside in a nursing home, adult care home or family residence;
2. Individuals who are 60 years of age or older with mental illness, currently residing in a nursing home or adult care home who have mental health service/treatment needs and who may be at risk for psychiatric hospitalization; and
3. Individuals who are 60 years of age or older with mental illness who have significant mental health service or treatment needs and who may be at risk for psychiatric hospitalization and who are living within their own home or with family members.

Team Activities Tracking

The Geriatric Specialty Teams have a dual focus: reintegration of older adults into the community when they are discharged from a State psychiatric hospital; and assisting long term care facilities and other agencies in preventing/reducing the number of psychiatric hospital admissions for older adults. To carry out this two-fold mission, the teams engage in the following activities:

- assist in discharge planning with hospital and area program staff or contractors to include the provision of information regarding appropriate placement of an individual into a long term care facility;
- provide consultative support to staff in the transition of individuals from a state hospital to a long term care facility or other community setting;
- provide consultation to staff, the individual and the individual's family in identifying and addressing issues that may threaten successful community placement;
- provide crisis-oriented support, either face-to-face or via telephone to the individual or agency during normal business hours and liaison with crisis services providers as needed after hours to prevent hospitalization or disruption of placement;
- provide individual case consultation to staff of long term care facilities or family members regarding behaviors that may result in hospitalization or need for more intensive services;
- provide training to staff on the development and implementation of intervention plans as needed; and
- provide services such as referrals to community services, assistance with obtaining benefits, time limited case management and/or time limited treatment and support services;

* Individuals younger than 60 years of age may be served if their service needs are similar to those of other geriatric clients and require the expertise of a geriatric specialist.

- train facility staff, other agencies and families on topics such as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population; and
- provide resource information and identify ongoing training resources for staff.

As a means of monitoring the activities of the Geriatric Teams, each team is required to submit to the Division a quarterly activity report. (A blank copy of the report form is included in this interim report as an Attachment.)

During fiscal year 2003-2004 the Geriatric Specialty teams provided a total of 1,132 hours of hospital discharge planning; 1,185 hours of training to staff of long term care facilities; 1,477 of individual case consultations; 2,916 hours of technical assistance and program development and 1,891 hours of community development and education. These services were provided to 171 nursing facilities; 193 adult care homes; 163 human service agencies; 55 local hospitals and 38 private medical facilities.

Future Standardization Activities

As required by SB 1148 the Department will, during fiscal year 04-05, develop and implement a standardized screening and referral process for the Geriatric Specialty Teams which addresses issues of service orders and authorization. Also, the various operational guidelines and accountability forms will be pulled together into an operations manual which will serve as the basis for staff training. By March 1, 2005, the Department will implement a system to track and monitor expenditure data, numbers of individuals served and the qualifications of staff who comprise the Specialty Teams.

Geriatric Specialty Team Study Committee

SB 1148 calls for a study of the mission of the Geriatric Specialty Team in serving a broader spectrum of residents of long term care facilities. Consistent with the instruction in the bill, a committee consisting of "representatives from area authorities, the adult care home and nursing home industries and other appropriate stakeholders"* will be formed by October 15, 2004. The committee will hold its first meeting during the month of November 2004. The committee will consist of representatives of the following interests: nursing homes, adult care homes, area programs, persons with mental illness, Division of Aging and Adult Services, Friends of Adults in Long Term Care and the Division of MHDDSAS. Through this study consideration will be given to: (1) the need to create two separate teams, a Geriatric Mental Health Specialty Team and a Long Term Care Mental Health Specialty Team; or (2) the need to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to Long Term Care Mental Health Specialty Teams to reflect the expanded mission.

* Language from Senate Bill 1148

Attachment

Division of Mental Health, Developmental Disabilities, and Substance Abuse Servic

Geriatric Specialty Team Summary of Non-UCR Activities: FY 2004-05

Report Period (Check one):

☐ July 1 –Sept. 30, 2004 due by Oct. 30, 2004

☐ Oct 1 –Dec. 31, 2004 due by Jan.30, 2005

☐ Jan 1 – March 31, 2005 due by April 30, 2005

☐ Apr. 1 – June 30, 2005 due by July 30, 2005

Area Program/LME

Name of AP/LME Coordinator

Contract Agency (if applicable)

Name of Geriatric Team Leader

Signature of Person Completing Summary

Date Summary Submitted

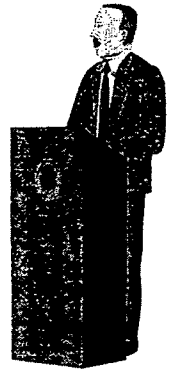
Instructions: The Geriatric Specialty Team Summary of Non-UCR Activities is to be completed for Non-UCR service activities provided by State Funded Geriatric Specialty Team staff. Submit to Debbie Webster, Best Practice Team, at Debbie.Webster@NCMail.net or 3005 Mail Service Center, Raleigh, NC 27699-3005. For questions, please contact Debbie Webster at (919) 715-2774. (As necessary, form may be duplicated).

Facility/Agency Name	Facility/ Agency Type*	Location (Town and County)	Total Number of Contact Hours Provided for Facility through Service Activity					
			# Hrs. Hospital Discharge Planning	# Hrs. Training Provided for Facility Staff	# Hrs. Consultation w/Staff for Specific Person.	# Hrs. TA/Consult for Program Develop.	#Hrs. Community Develop & Education	# Hrs. Total
Total Hours								

* Facility /Agency Type: NF = nursing facility ACH = adult care home HS = human service agency HOSP = hospital MED = private medical

Staff - Shawn Parker

Public Hearing Comments
Summary



Prepared for the
North Carolina Study Commission on Aging

November 10, 2004

Background Information

The North Carolina Study Commission on Aging is created to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults. This study shall be a continuing one and the evaluation ongoing, as the population of older citizens grows and as old problems faced by older citizens magnify and are augmented by new problems. (G.S. 120-180)

The Commission may hold public meetings across the State to solicit public input with respect to the issues of aging in North Carolina. (G.S. 120-185)

2004 Public Hearings

Date	Location	Number of Speakers
October 21, 2004	**Cherryville, NC**	**14**
October 26, 2004	**Wilson, NC**	**33**

Issue Frequency

On the following pages, issues mentioned by speakers at the public hearings are listed, grouped, and totaled based on the frequency with which they were mentioned.

The issues mentioned with the greatest frequency were:

- **Preserve/Expand Support for Senior Games** ***(17 responses)***
- **Preserve/Expand Senior Centers Including Certified Senior Centers** ***(10 responses)***
- **Preserve/Expand Support for In-Home and Community-Based Services,** ***(9 responses)***
- **Lower/Provide Assistance with Prescription Drug Costs,** ***(6 responses)***
- **Concerns About Combining Mentally Ill and Elderly Populations,** ***(5 responses)***

Frequency of Issues Expressed by Speakers
2004 Public Hearings

	CHERRYVILLE	WILSON	TOTAL
PROGRAM FUNDING			
Preserve/Expand Support for Senior Games	5	12	17
Preserve/Expand Senior Centers Including Certified Senior Centers	1	9	10
Preserve/Expand Support for In-Home and Community-Based Services	3	6	9
Preserve/Expand Home and Community Care Block Grant (HCCBG) Funding	2	2	4
Preserve/Expand Community Alternatives Program for Disabled Adults (CAP/DA)	3		3
Increase Adult Day Services Reimbursement Rate		3	3
Institutional Bias vs. Community Based Services		2	2
Preserve/Expand the State/County Special Assistance (SA) In-Home Project	2		2
Remove the Off-Set for SA In-Home Participants Receiving Food Stamps	1		1
Preserve/Expand Ombudsman Program	1		1
Preserve/Expand Family Caregiver Support Program		1	1
Increase Reimbursement Rates for Nursing Facilities		1	1
Restore Cut to AAA Professional Staff Funding		1	1
TOTAL			55
WORKFORCE ISSUES			
Lower Staff to Resident Ratios in Nursing Homes and Adult Care Homes	1	2	3
Offer Incentives to Attract Workers to Nurse Aide Positions	1		1
Expand Community College System's Capacity for Training More Direct Care Workers	1		1
TOTAL			5

	CHERRYVILLE	WILSON	TOTAL
OTHER			
Lower/Provide Assistance With Prescription Drug Costs		6	6
Concerns About Combining Mentally Ill and Elderly Populations	2	3	5
Preserve/Expand Senior-Friendly Communities	1	3	4
Transportation		4	4
Long Term Care Insurance Tax Credit		3	3
Safe/Affordable Housing for Seniors		2	2
Public Awareness of Available Services		2	2
Monitoring/Enforcement of Laws Related to Nursing Homes and Adult Care Homes		2	2
Improve Air and Water Quality	1	1	2
Job-Training for Older Workers	1		1
Expression of Support for the Study Commission on Aging and its Members	1		1
Raise Medically Needy Income Limit – Medicaid		1	1
Expand Grandparents' Rights		1	1
Seniors With Low Wage Jobs Caring For Children		1	1
Veterans Care		1	1
Volunteer Training and Retention		1	1
Adult Protective Services		1	1
Guardianship		1	1
Long Term Care Internet Project		1	1
TOTAL			40

Staff- Shawn Parker

CAP Choice

Lynne Perrin
Division of Medical Assistance, DHHS
November 10, 2004

Services Offered Under CAP Choice

- All services available in NC's traditional Home and Community-Based Services (HCBS) waiver program, Community Alternative Program for Disabled Adults (CAP/DA), are also available in CAP Choice. CAP Choice participants are eligible to receive an additional category of services, entitled Consumer-Directed Goods and Services, that are not available in CAP/DA.

Target Population and Area

Target Population:

- Elderly and disabled adults, ages 18 and older, who require nursing facility level of care.

Target Area:

- The CAP Choice pilot will be held in two NC counties, Duplin County and Cabarrus County. These counties currently serve approximately 400 CAP/DA clients.

Program Description

- CAP Choice is an alternative to NC's existing HCBS waiver program, CAP/DA. CAP Choice is a program of consumer-designated care for elderly and disabled adults who wish to remain at home and have increased control over their services and supports. CAP Choice provides Medicaid recipients with more flexibility in tailoring their own plans of care.

CAP Choice Description

The CAP Choice waiver will allow recipients to:

- Hire a Personal Assistant who will provide their care.
- Train, supervise, and evaluate the Personal Assistant.
- Negotiate the Personal Assistant's rate of pay and other benefits.
- Release the Personal Assistant should this become necessary.
- Select individual providers and direct reimbursement for several waiver services.
- Engage in a cooperative working arrangement with a Financial Manager who will pay the Personal Assistant; handle federal/state taxes and other payroll or benefits related to the employment of the Personal Assistant; and reimburse other service providers under the direction of the consumer.

Current Program Status

- In January 2004, DMA received approval from CMS to implement the Independence-Plus 1915(c) waiver, known as CAP Choice in North Carolina.
- DMA staff are in the process of making the system changes necessary to implement CAP Choice. This includes:
  - Finalizing the medical coverage policies and procedures that will be used to administer CAP Choice.
  - Making system changes to the Medicaid Management Information System to enable CAP Choice to be treated as a separate service and enable CAP Choice providers to be reimbursed for providing services.
  - Setting up a separate Medicaid enrollment process for CAP Choice providers.
  - Creating a review process to monitor the implementation of CAP Choice in the pilot counties.

CAP Choice

- The target date for implementation is January, 2005
- DMA will be responsible for evaluating the pilots and determining how to move the program to other counties.

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — November 10, 2004
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sherry Thomas	AHHC
Suzie Williamson	NC Assoc Non Prof Homes Aging
Nancy Hurley	DMA
Laura Lee Ellis	Nat'l MS Society
TRACY COLVARD	DMA
Donna Hall	DHHS - OLTCare
Lorraine Kerr	DMA
Gail Quartell	NC Nurses Association
JODI HERNANDEZ	DAAS
Adellicia Brantley	DAAS
Donna White	DAAS
Ann Eller	DMHDDSAS
Bonnie Morell	DMHDDSAS
Beverly Rhodes	Friends of Residents in LTC
Melissa Parker	NASW-NC
Pam Seaman	OSBM
Debbie Barnes	OSBM
Polly Williams	NC Justice Center
Sophia Kim	OSBM
Mary Bitter	DAAS
Stacy Flannery	NCHFA
Karen Gottovi	DAAS
Nancy Warren	DAAS
Alex Schneider	UNC Institute on Aging
Vicki Tilley	ElderFit Physical Therapy
Adrian Lovelace	MHA/NC
Jean Reaves	NCCOA / NCADSA

VISITOR REGISTRATION SHEET

NC Study Commission on Aging
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne Merrill	DHHS-DAAS
Karen George	NCACDSS
Bob Fitzgerald	DHHS/DFS
Melissa Tridge	DOJ
[illegible]	GeoOK's
Jon Schmidt	NC Justice Center
Thomas A. Deal	

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Wednesday, December 1, 2004
10:00 A.M.
Legislative Office Building, Room 643

The North Carolina Study Commission on Aging met on Wednesday December 1, 2004 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were Representative Debbie Clary and Representative Edd Nye, Co-Chairs; Senators Charlie Dannelly and Austin Allran; Representatives Jennifer Weiss, David Lewis, and Gene Wilson; public members Brad Allen, Jan Elliott, Linda Howard, Katherine Fox Price, Florence Soltys, and Jackie Sheppard.

Theresa Matula, Dianna Jessup and Shawn Parker, Commission Staff, Research Division, NCGA, were present and provided staff support. A visitor's registration form is attached and made a part of the minutes

Representative Nye started the meeting and announced that Representative Clary would be presiding, and would be there shortly. After calling the meeting to order, he welcomed everyone in attendance. He then welcomed Lt. Governor Beverly Purdue asked her to come forward to address the Commission concerning adult care home licensing.

Adult Care Home Licensing
(See Attachment 1)

Lieutenant Governor Beverly Perdue addressed the committee concerning the revamping of Senate Bill 10 (SB10). She stated that in 1999, SB10 was passed and that the goal was to ensure that adult care homes provide a safe, caring environment for some of the State's most vulnerable citizens. The individuals that she has spoken with agree that substantive changes are not needed. However, they feel that the intent can be more closely adhered to if punitive authority for the Division of Facilities Services is created, so that they have some recourse against those who do not fully disclose all of their affiliates. She asked the Commission to send forward that the Division be granted some type of punitive authority so they have resources against those who did not divulge they were in noncompliance in another of their facilities. She asked them to examine other recommendations as well. She asked for more clarification of language on the renewal license application for consistency with rules and regulations. Also, she stated that the Department needs to establish what is a pattern of non-compliance which shows disregard for health, safety and welfare of residents in current facilities and past facilities. The Medical Care Commission should adopt rules defining length of compliance history information from the applicant licensee and what constitutes compliance history information. The Department should establish a plan of action and inspect all associated or affiliate facilities when one is found in non-compliance.

She also discussed the importance of the tax credit for purchasing Long Term Care Insurance. Lt. Governor Purdue mentioned that the generation of Baby Boomers would probably live longer than all previous generations. She expressed the need for the Long Term Care Insurance Tax Credit to encourage the purchase of Long Term Care Insurance.

Adult Day Service Training and Reimbursement Methodology Report (See Attachment 2)

Nancy Cox, Director of Partners in Caregiving: The Adult Day Services Program, Wake Forest University School of Medicine, presented a status report on the Adult Day Services Methodology Study which was authorized by a special provision passed by the General Assembly. The provision states that the Department of Health and Human Services shall contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The Department contracted with Partners in Caregiving to provide this training. They were to study the method of reimbursement and recommend any changes to this methodology. The final report is to be presented to the Commission by January 1, 2005.

Gary Cyrus, Division of Aging and Adult Services, Department of Health and Human Services continued the discussion with an overview of the programs by reviewing the expenditures and budget of the various funding sources for adult day care services in North Carolina.

Elder Mistreatment and Abuse Adult Protective Services (See Attachment 3)

Dr. Margaret Hudson, Professor Emeritus, UNC School of Nursing, gave a slide presentation concerning elder abuse and elder neglect. She has been collecting research on the topic for 20 years. She reported that she is the only researcher to study definition on elder abuse and elder neglect and she would like the definitions to be changed in the North Carolina statutes. The definitions are very old and they mix up the terms labeled abuse and neglect. In 1979, North Carolina was one of the states on the cutting edge of elder mistreatment. The definitions that are now used came from a study published that year. She reviewed new definitions that she recommends that were developed with a nationwide panel of elder mistreatment experts and the recommendations were tested with 1000 adults that were geographically and randomly sampled throughout North Carolina. The elders and those taking care of them were the ones who approved these recommendations. She provided the members with a handout of these recommendations.

Ms. Elliott asked for a copy of the slide presentation because the handout did not include as much information. Representative Clary asked Dr. Hudson to provide this information.

Draft Commission Recommendations
(See Attachment 4)

Theresa Matula and Dianna Jessup, Division of Research, reviewed ten draft recommendations representing information the Commission received this interim.

Representative Nye and Representative Clary wanted to amend recommendation number seven to include funding for Senior Games. Representative Nye asked that $150,000 be added to the recommendation.

Representative Weiss had two additional recommendations for the Commission. The first one was that the Commission would recommend that the General Assembly direct the UNC Board of Governors and the community college system to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric social workers, and geriatric allied health workers. Also to study the nursing fellows program to determine how the program could be improved to encourage and increase the number of graduates from the program. The second recommendation was for the Commission to recommend labor enhancement payments for nurse aids and long term care aid workers in non-institutional settings and proposed a bill be introduced for that recommendation. Representative Clary pointed out that there was already a study commission appointed to study the healthcare workforce and she thought that task force would address that issue. Representative Nye suggested that these recommendations be prepared and mailed to the members so they could be voted on at the next meeting.

Representative Nye moved that the Commission adopt the initial ten recommendations as amended. Representative Clary asked for a vote and the motion passed. She announced that the next meeting would be January 20, 2005 at 10:00 a.m.

The meeting adjourned at 12:10 p.m.

Representative Debbie Clary, Co-Chair

Jo Bobbitt, Commission Assistant

Senator A. B. Swindell, Co-Chair
Representative Edd Nye, Co-Chair

Agenda

North Carolina Study Commission on Aging

Wednesday, December 1, 2004
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair
Senator AB Swindell, Cochair

II. Adult Care Home Licensing

Lieutenant Governor Beverly Perdue

III. Elder Mistreatment and Abuse/Adult Protective Services

Dr. Margaret(Ricki) Hudson

IV. Adult Day Service Training and Reimbursement Methodology Report

Nancy Cox, Director of Partners in Caregiving: The Adult Day Services Program, Wake Forest University School of Medicine.

Gary Cyrus, Division of Aging and Adult Services, DHHS

V. Draft Commission Recommendations

Commission Staff

VI. Vote on Recommendations and Direct Staff to Prepare Report

VII. Next Meeting:
Date will be Announced

Attachment 1

Remarks for Commission on Aging
December 1, 2004
10:00 AM
LOB 643

You requested to speak to the Study Commission on Aging regarding the articles that ran in the N&O in April about SB 10 (1999). At the November Commission meeting, Bob Fitzgerald and a rep from the AG's office, spoke on this issue. At that time, they agreed that no substantive change is needed to the statute, but the law could be strengthened with the creation of a penalty for not fully disclosing all affiliates. Diana Jessup, Research Staff, has drafted recommendations to the Commission that will be presented today based on this suggestion.

Commission Membership:

- **Sen. A. B. Swindell IV, Co-Chair**
- Sen. Austin Murphy Allran
- Sen. Charlie Smith Dannelly
- Sen. Tony P. Moore
- Sen. Joe Sam Queen
- Mr. Brad Allen
- Ms. Josephine C. Elliot
- Mr. Sam Marsh
- **Rep. Debbie Anne Clary, Co-Chair**
- **Rep. Edd Nye, Co-Chair**
- Rep. David R. Lewis
- Rep. Jennifer Weiss
- Rep. William Eugene Wilson
- Ms. Linda Howard
- Ms. Katherine Fox Price RN
- Ms. Florance Gray Soltys

In 1999, in an effort to protect some of our most vulnerable citizens, I spearheaded an initiative to update the statutes on adult care homes in North Carolina – Representative Clary and Representative Nye were critical to that effort. The

General Assembly agreed on the importance of this issue and passed Senate Bill 10. A major component of SB 10 was a measure limiting the expansion of those adult care homes facing compliance complaints; as well as, their affiliates.

Last spring a series of articles in the Raleigh News and Observer highlighted operators of multiple homes who appear to circumvent the law by registering each individual home as a separate corporate entity. Last summer General Assembly staff worked with many of you to address this. In September, I again voiced my concerns about this issue in a letter to your Co-Chairs.

I am speaking to you today, as the author of SB 10. In 1999, we – legislators, the industry, and patient advocates; many whom are in this room today – decided that in North Carolina we would prohibit someone who's existing facilities did not meet the State's health and safety standards, for residents, to open another facility. Our end goal was to ensure that our adult care homes provide a safe, caring environment - a home – for some of our most vulnerable citizens. If they can't get it right in one facility, why should we think that they could get it right if they open new facilities?

North Carolina General Statute 131D-4.5(6) reads "Establishing procedures for determining the compliance history of adult care homes' principals

and **affiliates**. The rules shall include criteria for refusing to license facilities which have a history of, or have principals or **affiliates** with a history of, noncompliance with State law, or disregard for the health, safety, and welfare of residents." It appears that the confusion about application of the law revolves around the word "affiliates". Black's Law Dictionary, 7th Edition, defines "affiliate" as "A corporation that is related to another corporation by shareholdings or other means of control; a subsidiary, parent, or sibling corporation." In plain English – any relationship, at all, makes the companies affiliates.

I know that you have heard from Mr. Bob Fitzgerald, the Director the of the Division of Facilities, and the Attorney General's office that the statute, as it is now written, satisfies legislative intent – that it accomplishes our objectives. I've spoken with attorneys here at the General Assembly and they agree that substantive changes are not needed. However, they feel that the intent can be more closely adhered to if punitive authority for the Division of Facilities is created, so that they have some recourse against those who do not fully disclose all of their affiliates.

This alone will not fix this problem. I urge you to examine other recommendations:

1. Clarifying the language on the renewal license application for the provider so that it is simple, clear and concise and is consistent with rules and regulation.
2. The Department needs to establish, "what is a pattern of non-compliance, which demonstrates disregard for health, safety and welfare of resident's in current facilities and past facilities."
3. The Medical Care Commission should adopt rules defining length of compliance history information from the applicant licensee and what constitutes compliance history information.
4. When there is a licensee identified who disregards health, safety and welfare of

residents, the Department should establish a plan of action, which will be taken for that specific home's license according to the law. Secondly, the Department should have a plan ready to inspect **all** associated or affiliate facilities. An analysis of cost reports for each affiliate facility should be conducted to determine how reimbursement money has been utilized by the licensee in meeting the requirements of the home and the financial stability of each home across the whole organization. Based upon the inspection results and reimbursement analysis, a determination for each facility should be made based on the established pattern of non-compliance history and reimbursement

however, it sunsetted on January 1, 2004. I strongly urge you to re-create this incentive.

Thank you for your time and attention on this issue.

- This generation of Baby Boomers will live longer than all previous generations.
- In addition to our own potential retiree population, NC is the **third most desirable retirement state** in the Country.
- NC economy is transitioning away from traditional industries to knowledge-based industries, requiring new and improved retirement platforms for a more **diverse retiring labor base**.

One way that we can immediately address the Boomers issue is to re-create an incentive for the purchase of long-term care insurance. We had a tax credit for people with long-term care insurance – to defer the cost of the premiums;

analysis of the financial stability of each home case by case.

I look forward to working with you during the 2005 Legislative Session to address these concerns and others.

- **By 2020, NC will be home to over 2M Baby Boomers** (born between 1946 and 1964) who will be at traditional retirement age.
- **By 2025, NC will rank 8th** in the nation in the number of **people 65+**.
- Our current social and economic infrastructures are incapable of absorbing the impact of this emerging trend.

Attachment 2

North Carolina
Adult Day Services Reimbursement Methodology Study
FY 04-05

Status Report
Study Commission on Aging

December 1, 2004

Nancy J. Cox, M.S.W., Director
Partners in Caregiving: The Adult Day Services Program
Department of Psychiatry & Behavioral Medicine
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Adult Day Services Training and Reimbursement Methodology
Special Provision – Section 10.21(a)

In an effort to support and sustain adult day services in North Carolina, the Department of Health and Human Services shall contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant shall study the current method of reimbursement for adult day services and make recommendations regarding changes to the reimbursement methodology. The final report shall be presented to the Study Commission on Aging by January 1, 2005.

Adult Day Services Background

Adult day service has grown in North Carolina from two programs in 1973 to its peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. Although some programs would close, others would open. In many cases, the program that closed later reopened under a new organization. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. There has continued to be a steady decrease in certified programs. Approximately a year ago, there were 113 programs in 60 counties. Today there are 106 programs in 58 counties.

Adult Day Services Definitions

Adult Day Care

Day Care Services for Adults is the provision of an organized program of services during the day in a community group setting for the purpose of supporting adults' personal independence, and promoting their social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, a nutritious meal and snacks as appropriate to the program, and referral to and assistance in using appropriate community resources. Medical examinations are required for individual participants for admission to a program and periodically thereafter. Services must be provided in a home or center certified to meet state standards for such programs.

Adult Day Health Care

The health care component of adult day health services distinguishes it from adult day care, which also provides a structured program of activities and services during the day for aging, disabled and handicapped adults. As part of the structured day program of activities and services, participants enrolled in adult day health also require daily nursing supervision. Participation in adult day health can enable such persons to achieve and maintain their optimum level of independence and can support family members and other caregivers who are providing full-time care to frail adults living at home.

Division of Aging and Adult Services
November, 2004

Services Funding for Adult Day Services
Through the Home and Community Care Block Grant (HCCBG), State Adult Day Care Fund (SADCF) and Community Alternatives Program-Disabled Adults (CAP-DA)

NOTE: The CAP-DA program is funded and administered through the Division of Medical Assistance

SFY 03-04

HCCBG	Federal Older Am. Act **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget	% Expended	Clients Served	Centers Funded
Adult Day Care	$459,149	$852,705	$145,762	$1,457,616	$1,504,224	96.90%	615	
Day Health Care	$409,640	$760,760	$130,045	$1,300,445	$1,319,755	98.54%	558	
HCCBG Total	**$868,789**	**$1,613,465**	**$275,807**	**$2,758,061**	**$2,823,979**	**97.67%**	**1,173**	74*

*Unduplicated count of adult day services centers receiving HCCBG resources

SADCF	Federal SSBG **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget	% Expended	Clients Served	Centers Funded
Adult Day Care	$1,355,019	$460,751	$259,396	$2,075,166	$2,098,961	98.87%	958	
Day Health Care	$775,849	$263,814	$148,523	$1,188,186	$1,201,811	98.87%	382	
SADCF Total	**$2,130,868**	**$724,565**	**$407,919**	**$3,263,352**	**$3,300,772**	**98.87%**	**1,340**	96*

*Unduplicated count of adult day services centers receiving SADCF resources

CAP-DA	Federal Medicaid **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget*	% Expended	Clients Served
Day Health Care	**$925,431**	**$0**	**$462,715**	**$1,388,146**	**N/A**	**N/A**	**332**

* The Division of Medical Assistance does not budget CAP-DA funding for specific services

SFY 04-05

HCCBG	Federal Older Am. Act **Budget**	State **Budget***	Local Match **Budget***	Total **Budget***	Current Centers Funded
Adult Day Care	$471,266	$919,356	$154,514	$1,545,136	
Day Health Care	$432,233	$843,210	$141,716	1,417,159	
HCCBG Total	**$903,499**	**$1,762,566**	**$296,230**	**$2,962,295**	73**

* Service providers are continuing to budget shares of the $482,565 appropriation that increases daily care rates by $5.00.

** Unduplicated count of adult day services centers receiving HCCBG resources

SADCF	Federal SSBG **Budget**	State **Budget***	Local Match **Budget***	Total **Budget***	Current Centers Funded
Adult Day Services	**$2,155,301**	**$1,252,875**	**$486,882**	**$3,895,058**	92**

* Funding includes $520,000 appropriation to increase daily care rates by $5.00. The Division of Aging and Adult Services does not allocate SADCF funding to county DSS's by specific service.

** Unduplicated count of adult day services centers receiving SADCF resources

Adult Day Services
3rd Party Public Reimbursements
through the
North Carolina Department of Health & Human Services

	Home and Community Care Block Grant (HCCBG) *Adult Day Care* *Adult Day Health Care*	**State Adult Day Care Fund (SADCF)** *Adult Day Care* *Adult Day Health Care*	**Medicaid Community Alternatives Program (CAP-DA)** *Adult Day Health Care only*
Rates Established by	Division of Aging and Adult Services utilizes Social Services Commission rate setting	Social Services Commission	Division of Medical Assistance (DMA)
Current Rates Established	July 1, 2004	July 1, 2004	November 1, 1999
System for Establishing Rates	Standard Fixed Rate	Standard Fixed Rate	Standard Fixed Rate After collecting volume and costs, and each centers actual cost/day/client, DMA tallies volume by center from the least to the most, and at the 50% mark identifies the cost/ day/client.
Frequency for Rate Change	No Automatic System	No Automatic System	No Automatic System
Days Reimbursed	Enrollment (versus attendance)	Enrollment (versus attendance)	Attendance (versus enrollment)

	Home and Community Care Block Grant (HCCBG) *Adult Day Care* *Adult Day Health Care*	**State Adult Day Care Fund (SADCF)** *Adult Day Care* *Adult Day Health Care*	**Medicaid Community Alternatives Program (CAP-DA)** *Adult Day Health Care only*
Absentee Policy	When an enrollee is absent for 10 consecutive days, units for the person will no longer be reported until such time the person returns.	The program must notify the county DSS when an enrollee has been absent for 5 consecutive scheduled days. The case manager makes a decision as to whether it would be appropriate to terminate the service, hold the slot through the use of a holding fee, or revise the enrollment plan.	Reimbursement is for days of attendance only; participants are not reimbursed for absent days.
Current Rate Per Day (without transportation)	Up to $28.07 (social)* Up to $35 (combination/health)* May add on an administrative fee calculated by the program based on reasonable expenses	Up to $28.07 (social) Up to $35 (combination/health)	$36.51 (combination/health)
Current Rate Per Month	Division of Aging & Adult Services automated service information system calculates monthly reimbursement on the basis of units reported times the provider unit rate recorded in the system.	Up to $608/mo.(social) Up to $758/mo.(combination/health) Formula: daily rate x 21.66 operating days/month	Reimbursement is based on a per day basis and not per month.
Unit	A 6-hour Day	A Day Month: 21.66 operating days (260 operating days per year ÷ 12)	A Day

* This rate reflects the recent $5 day increase

Southern States Comparison Chart

	South Carolina	Virginia	Georgia	Florida
Type of Service	*Adult Day Health Care and Adult Day Health Care Nursing	Adult Day Health Care Only	Adult Day Health Care Only	Adult Day Care and Adult Day Health
Rates Established by	General Legislature	Legislature	Legislature	Florida Medicaid Program
Days Reimbursed	Attendance	Attendance	Attendance	Attendance
Absentee Policy	None	None	None	None
Current Rate Per Day	*$38.00 (includes transportation if within 15 miles of the program) Pays additional $15.00 for Adult day Care Nursing	$47.25 (Northern VA) $43.05 (Other VA areas)	** Level I (3 hour day) $30.27 Level I (5 hour day) $50.45 Level II (3 hour day) $37.00 Level II (5 hour day) $63.07	$10.00 per hour
Current Rate Per Month	Reimbursement is based on per day basis, not per month	Reimbursement is based on per day basis, not per month	Reimbursement is based on per day basis, not per month	Reimbursement is based on hourly basis and ½ day basis, not per month
Unit	A 5-hour Day	A 6 or more hour a Day	Minimum Day = 3 hours Full Day = 5 hours	Hour (Max. hours paid per day is 8)
Funding Source	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver
Frequency for Rate Change	No automatic system Legislature approval	No automatic system Legislature approval	No automatic system Legislature approval	No automatic system Medicaid program

* In South Carolina, "Adult Day Health Care" is equivalent to North Carolina's "Adult Day Care" model (social model; clients do not receive nursing care). "Adult Day Health Nursing" is equivalent to NC "Adult Day Health" model; in SC providers receive $38.00 as a base rate plus an additional $15.00 for total of $53.00.

** Level I and Level II refer to the type of care that a client may need. Level II indicates a more complex plan of care.

Study Methodology

The methodology used to conduct the study consists of key informant interviews. To obtain information on how the system operates, to date, interviews have been conducted with staff from the Department of Health and Human Services (Division of Aging and Adult Services and Division of Medical Assistance), the North Carolina Adult Day Services Association, and adult day services providers in the 17 Area Agency on Aging regions.

The 17 providers were selected based on urban/rural mix, adult day services funds being accessed, and level of expertise with the system. They included the following programs:

Region A -- Pruett House Family Center, Franklin, NC (Macon County)
Region B -- Mountain Care, Asheville, NC (Buncombe County)
Region C -- Life Enrichment Center, Shelby, NC (Cleveland County)
Region D -- Generations Adult Day Health Care, West Jefferson, NC (Ashe County)
Region E -- Adult Life Programs, Hickory, NC (Catawba County)
Region F -- Blessed Assurance Adult Day and Health Care, Matthews, NC (Mecklenburg County)
Region G -- Adult Center for Enrichment, Greensboro, NC (Guilford County)
Region I -- Mount Zion Senior Enrichment Adult Day Care/Day Health Center, Winston-Salem, NC (Forsyth County)
Region J -- Resources for Seniors Total Life Center, Raleigh, NC (Wake County)
Region K -- Franklin County Adult Day Program, Louisburg, NC (Franklin County)
Region L -- Roanoke Valley Adult Day Care Center, Weldon, NC (Halifax County)
Region M-- Sampson County ADC/ADH Center, Clinton, NC (Sampson County)
Region N -- Bladen County Adult Day Care Center, Elizabethtown, NC (Bladen County)
Region O -- Elderhaus at the Lake, Wilmington, NC (New Hanover County)
Region P -- Duplin Adult Day Services, Wallace, NC (Duplin County)
Region Q -- Creative Living Center, Greenville, NC (Pitt County)
Region R -- Day Break Adult Day/Health Care Center, Elizabeth City, NC (Pasquotank County)

Key Issues

Key issues, revolving around the Home and Community Care Block Grant (HCCBG) and the State Adult Day Care Fund (SADCF), identified by the Division of Aging and Adult Services, the North Carolina Adult Day Services Association, and adult day services providers are as follows:

- The current system does not allow for negotiated rates.
- No formal system is in place to determine and report unit cost and a reasonable reimbursement rate.
- There are differences among the funding streams that could possibly be made uniform to ease administration and promote clarity and fairness in the application of rules (e.g. reimbursable units, monthly maximums, reimbursement, absentee policies). This would not require legislative action but could be handled by administrative process.

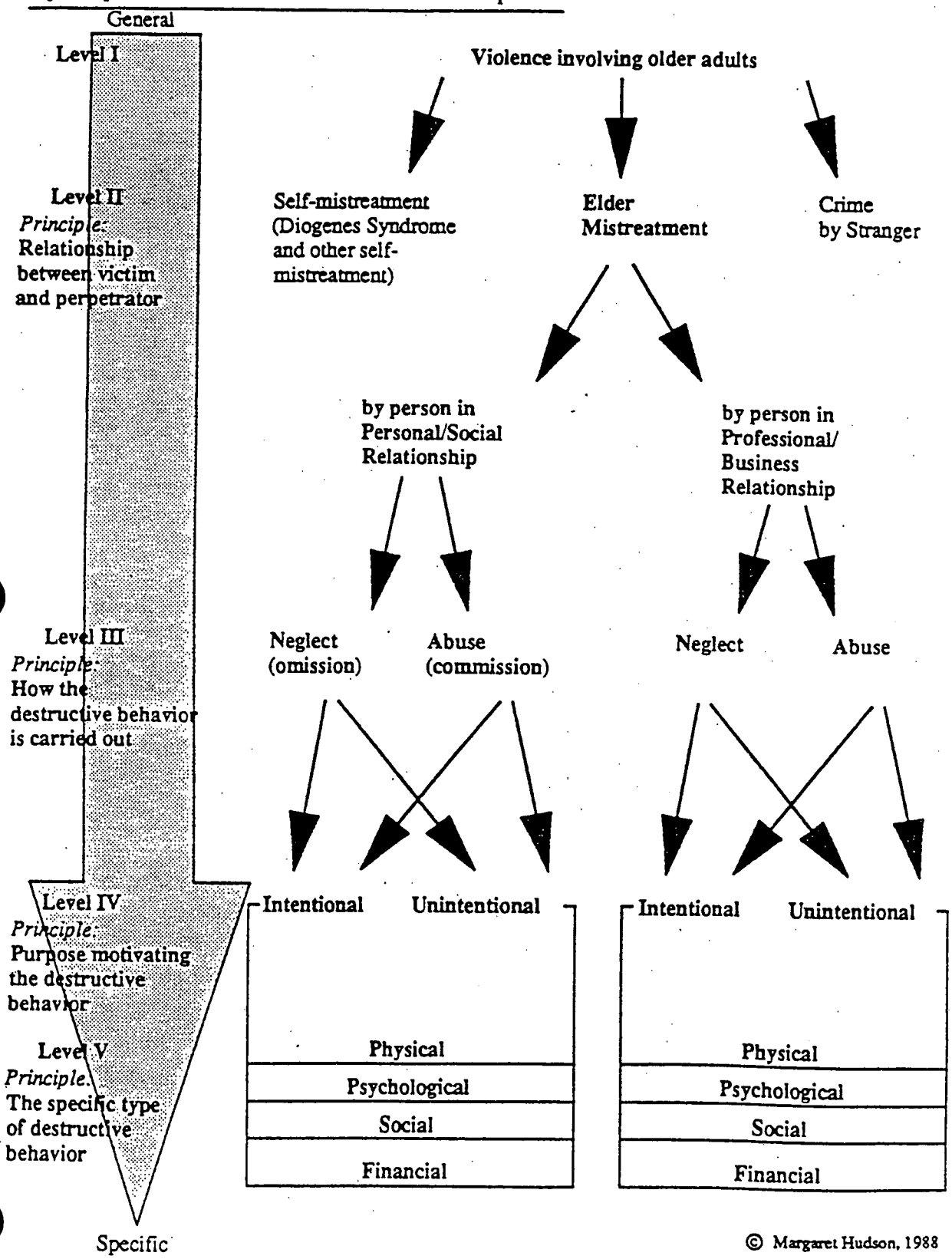
Upcoming Special Provision Activities

Training and Technical Assistance

- Development of an assessment tool to identify adult day programs at-risk of closing (December 2004)
- 6 regional training sessions for all certified adult day programs, anyone interested in opening an adult day program, and State/county adult day services consultants; training includes a $250 scholarship available to any certified program needing funds to subsidize travel expenses or per diem coverage to attend the training (January – March 2005)
- Telephone technical assistance available to all training session attendees (February – June 2005)
- One-on-one technical assistance site visits to up to 40 certified adult day programs at-risk of closing, plus follow-up telephone technical assistance (March – June 2005)
- Recommendations for a system for sustainability (June 2005)
- Final report for the General Assembly, to include a refined plan of action to support and sustain adult day services in North Carolina (July 2005)

Attachment 3

Figure 1
TAXONOMY
by Delphi Panel of Elder Mistreatment Experts



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Figure 2

THEORETICAL DEFINITIONS

by Delphi Panel of Elder Mistreatment Experts

el II	**Elder Mistreatment**	Destructive behavior that is directed toward an older adult, occurs within the context of a relationship connoting trust and is of sufficient intensity and/or frequency to produce harmful physical, psychological, social and/or financial effects of unnecessary suffering, injury, pain, loss and/or violation of human rights and poorer quality of life for the older adult.
	Personal/Social Relationship	Persons in close personal relationships with an older adult connoting trust and some socially established behavioral norms, e.g., relatives by blood or marriage, friends, neighbors, any "significant other."
	Professional/Business Relationship	Persons in a formal relationship with an older adult that denotes trust and expected services, e.g., physicians, nurses, social workers, nursing aides, bankers, lawyers, nursing home staff, home health personnel, landlords, etc.
Level III	**Elder Abuse**	Aggressive or invasive behavior/action(s), or threats of same, inflicted on an older adult and resulting in harmful effects for the older adult.
	Elder Neglect	The failure of a responsible party(ies) to act so as to provide, or to provide what is prudently deemed adequate and reasonable assistance that is available and warranted to ensure that the older adult's basic physical, psychological, social, and financial needs are met, resulting in harmful effects for the older adult.
Level IV	**Intentional**	Abusive or neglectful behavior or acts that are carried out for the purpose of harming, deceiving, coercing or controlling the older adult so as to produce gain for the perpetrator (often labeled "active" abuse/neglect in the literature).
	Unintentional	Abusive or neglectful behavior or acts that are carried out, but NOT for the purpose of harming, deceiving, coercing or controlling the older adult, so as to produce gain for the perpetrator (often labeled "passive" abuse/neglect in the literature).
Level V	**Physical**	Behavior(s)/action(s) in which physical force(s) is used to inflict the abuse; or available and warranted physical assistance is not provided, resulting in neglect.
	Psychological	Behavior(s)/action(s) in which verbal force is used to inflict the abuse; or available and warranted psychological/emotional assistance/support is not provided, resulting in neglect.
	Social	Behavior(s)/action(s) that prevents the basic social needs of an older adult from being met; or failure to provide available and warranted means by which an older adult's basic social needs can be met.
	Financial	Theft or misuse of an older adult's funds or property; or failure to provide available and warranted means by which an older adult's basic material needs can be met.

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§ 108A-101. Definitions.

(a) The word "abuse" means the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation by a caretaker of services which are necessary to maintain mental and physical health.

(b) The word "caretaker" shall mean an individual who has the responsibility for the care of the disabled adult as a result of family relationship or who has assumed the responsibility for the care of the disabled adult voluntarily or by contract.

(c) The word "director" shall mean the director of the county department of social services in the county in which the person resides or is present, or his representative as authorized in G.S. 108A-14.

(d) The words "disabled adult" shall mean any person 18 years of age or over or any lawfully emancipated minor who is present in the State of North Carolina and who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy or autism; organic brain damage caused by advanced age or other physical degeneration in connection therewith; or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances.

(e) A "disabled adult" shall be "in need of protective services" if that person, due to his physical or mental incapacity, is unable to perform or obtain for himself essential services and if that person is without able, responsible, and willing persons to perform or obtain for his essential services.

(f) The words "district court" shall mean the judge of that court.

(g) The word "emergency" refers to a situation where (i) the disabled adult is in substantial danger of death or irreparable harm if protective services are not provided immediately, (ii) the disabled adult is unable to consent to services, (iii) no responsible, able, or willing caretaker is available to consent to emergency services, and (iv) there is insufficient time to utilize procedure provided in G.S. 108A-105.

(h) The words "emergency services" refer to those services necessary to maintain the person's vital functions and without which there is reasonable belief that the person would suffer irreparable harm or death. This may include taking physical custody of the disabled person.

(i) The words "essential services" shall refer to those social, medical, psychiatric, psychological or legal services necessary to safeguard the disabled adult's rights and resources and to maintain the physical or mental well-being of the individual. These services shall include, but not be limited to, the provision of medical care for physical and mental health needs, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from physical mistreatment, and protection from exploitation. The words "essential services" shall not include taking the person into physical custody without his consent except as provided for in G.S. 108A-106 and in Chapter 122C of the General Statutes.

(j) The word "exploitation" means the illegal or improper use of a disabled adult or his resources for another's profit or advantage.

(k) The word "indigent" shall mean indigent as defined in G.S. 7A-450.

(l) The words "lacks the capacity to consent" shall mean lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including but not limited to provisions for health or mental health care, food, clothing, or shelter, because of physical or mental incapacity. This may be reasonably determined by the director or he may seek a physician's or psychologist's assistance in making this determination.

(m) The word "neglect" refers to a disabled adult who is either living alone and not able to provide for himself the services which are necessary to maintain his mental or physical health or is not receiving services from his caretaker. A person is not receiving services from his caretaker if, among other things and not by way of limitation, he is a resident of one of the State-owned hospitals for the mentally ill, centers for the mentally retarded or North Carolina Special Care Center he is, in the opinion of the professional staff of that hospital or center, mentally incompetent to give his consent to medical treatment, he has no legal guardian appointed pursuant to Chapter 35A, or guardian as defined in G.S. 122C-3(15), and he needs medical treatment.

(n) The words "protective services" shall mean services provided by the State or other government or private organizations or individuals which are necessary to protect the disabled adult from abuse, neglect, or exploitation. They shall consist of evaluation of the need for service and mobilization of essential services on behalf of the disabled adult. (1973, c. 1378, s. 1; 1975, c. 797; 1979, c. 1044, ss. 1-4; 1981, c. 275, s. 1; 1985, c. 589, s. 34; 1987, c. 550, s. 24; 1989, c. 770, s. 29; 1991, c. 258, s. 2.)

Attachment 4

North Carolina
Study Commission on Aging

Draft Recommendation Overview

December 1, 2004

1. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor to conduct an assessment of the Community Alternatives Program/Disabled Adults to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.
2. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.
3. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry; and direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.
4. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.
5. The North Carolina Study Commission on Aging recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules.

6. The North Carolina Study Commission on Aging recommends that the General Assembly authorize the Department of Health and Human Services to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.
7. The North Carolina Study Commission on Aging expresses its appreciation for the efforts of the North Carolina Senior Games program to keep older adults mentally and physically active and recommends that the General Assembly continue to support Senior Games
8. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate an additional $4,000,000 in State funds for the Home and Community Care Block Grant.
9. The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.
10. The North Carolina Study Commission on Aging recommends that the Adult Protective Services Task Force collaborate with stakeholders and persons interested in improvements to the adult protective services system, and report findings and recommendations to the Legislative Study Commission on State Guardianship Laws and the Study Commission on Aging.

Draft Recommendation Background

Enhanced CAP/DA Audit

1. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor to conduct an assessment of the Community Alternatives Program/Disabled Adults to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Background:

- The performance audit (PER-2004-0208) on the Community Alternatives Program for Disabled Adults (CAP/DA), conducted by the State Auditor's Office, reported that, "to provide complete information to the General Assembly, the Auditor would require assistance from outside subject matter specialists to fully assess the medical and clinical quality and/or adequacy of actions taken by DMA." The report further states that, "the Auditor strongly recommends that the General Assembly provide funds to fully determine the CAP/DA program's compliance with waiver guidelines and goals. Those funds would allow the State Auditor's Office to obtain assistance from health care professionals to assess the following areas: Review of case files to assure compliance with the requirement for medical necessity, plans of care, and provision of needed services; Review of service provider standards and monitoring of same; Review of safeguards to protect health and welfare of clients; Determination that clients are institutionalized when necessary; and Review of the independent assessment function for the program."
- The Office of the State Auditor indicated that it would cost $150,000 to secure the services of experts who would evaluate the quality and adequacy of the medical and social services provided to CAP/DA clients. This would be accomplished by:
    1. Conducting a qualifications review of-
        * local lead agency case managers (licenses, qualifications, educational levels, etc.),
        * local provider organizations (licensed or certified), and
        * provider's employees who actually see clients (licenses, qualifications, educational levels).
    2. Conducting a "desk review" of documents to determine-
        * the medical justification supplied by the attending physicians on the FL2 forms,
        * adequacy and completeness of the plans of care prepared by local case managers, and a
        * comparison of services provided per case notes to services needed per physicians
    3. Conducting in-home visits with a sample of clients, discussing care with clients, and confirming that case notes document services received.

In-Home Aide Services

2. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Background:

- On November 10, 2004, the Commission heard presentations on the Medicaid In-Home Personal Care Services (PCS) Program. Home care agencies, licensed by the Division of Facility Services and enrolled in the Medicaid program provide PCS in North Carolina.
- As of October 2004, there were a total of 1284 licensed home care agencies – 1055 were licensed-only home care agencies, and 219 were Medicare-certified home health agencies. Certified agencies have geographical service areas defined by the federal Centers for Medicaid and Medicare Services (CMS). Licensed-only agencies providing in-home aide services do not have a defined service area.
- Both the Department of Health and Human Services, and the Association of Home and Hospice Care (AHHC), have concerns about home care agencies serving clients in areas that are too far from the licensed site.
- Current State statutes and rules provide that any agency licensed by the Department is subject to inspections as a condition of holding the license. G.S. 131E-138(g) provides that the Department may, at its discretion,

determine the frequency and extent of the review and inspection of home health agencies already certified as meeting federal requirements, but not more frequently than on an annual basis for routine reviews. According to the Department, Medicare-certified home health agencies currently receive inspections not less than every 3 years. There is not a mandatory inspection cycle for licensed-only home health agencies.

- According to DHHS, there are currently 27 employees in the Acute and Home Care Branch of the Licensure and Certification Section, of these employees, seven are involved in the regulation of Medicare-certified home health agencies, home care agencies and hospices. The employees spend the majority of their time regulating Medicare-certified home health agencies, since federal money provides most of the position funding. Of the 7 positions, only 1.5 FTEs are devoted to the regulation of licensed-only home care agencies this regulation primarily involves conducting initial surveys and investigating complaints. The Department estimates that they will need to establish 8 positions, at a cost of $550,000, to implement the two-year survey cycle. The $550,000 includes salary, benefits, and other costs related to establishing the positions.

3. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry; and direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Background:

- Pursuant to Article 15, Chapter 131E of the North Carolina General Statutes and North Carolina Administrative Code (10 NCAC 3B-1000 to 1002), the North Carolina Health Care Personnel Registry is a comprehensive listing of personnel who have been subject to findings, or where an investigation is required based on an accusation, in situations involving abuse; neglect; misappropriation of property; diversion of drugs belonging to a health care facility, patient or client; and fraud against a health care facility, patient, or client.
- Home Care Agencies, as defined in G.S. 131E-136, are among the entities that are considered "health care facilities" under G.S. 131E-256(b). Therefore, a home care agency must access the Health Care Personnel Registry before hiring health care personnel and must notify the Department of all allegations against health care personnel. (Certain home care positions also require criminal history record checks pursuant to G.S. 131E-265.)
- The NCAC contains rules that prohibit adult care homes from hiring individuals with substantiated findings on the Health Care Personnel Registry (10A NCAC 13F .0407(5)), and that prohibit nursing homes from hiring individuals who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property (10 NCAC 3H .2210 and 42 CAR Section 483.13(c)(ii)(B)). The rules for home care agencies do not prohibit hiring individuals with substantiated findings on the Health Care Personnel Registry.
- G.S. 131E-256(b) defines entities that are considered "health care facilities" and G.S. 131E-256(c) defines individuals that are considered "health care personnel." It is possible that the definitions currently contained in the statutes do not contain a comprehensive listing of all entities and personnel currently providing similar hands-on care.

4. The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Background:

- Part 3, Article 6, Chapter 131E of the NC General Statutes contains the Home Care Agency Licensure Act which established licensing requirements for home care agencies. G.S. 131E-138 requires the Department to make applications for licensure available and that each application filed with the Department contain all information requested by the Department. A license is then granted to the applicant upon a determination by the Department that the applicant has complied with the provisions of statute and the rules promulgated by the Medical Care Commission.

- According to the Association of Home and Hospice Care (AHHC), the current licensure process primarily consists of potential agencies going through a review of policies and procedures required by the home care licensure rules with Division of Facility Services (DFS) staff. The AHHC reports that the staff spends considerable time educating potential applicants one-on-one regarding the licensure process.
- A set schedule of mandatory, group training would create more efficient use of DFS staff time and also allow applicants a more in-depth training session that would also cover agency responsibilities in rule compliance and patient care. Such training would assure DFS that the applicant has enough knowledge to comply with the provisions of the statute and rules before granting the license.

5. The North Carolina Study Commission on Aging recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules.

Background:

- The Nursing Home Patients' Bill of Rights is contained in Part 2, Article 6 of Chapter 131E of the NC General Statutes. The Adult Care Home Residents' Bill of Rights is contained in Article 3 of Chapter 131D of the NC General Statutes.
- The North Carolina Administrative Code (10 NCAC 3L .1007) provides the home care Client Rights and Responsibilities, but there is no provision similar to the Adult Care Home and Nursing Home Patients' Bill of Rights set out in the statutes for home care clients.

Adult Care Home License

6. The North Carolina Study Commission on Aging recommends that the General Assembly authorize the Department of Health and Human Services to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Background:

- Prior to issuing a new license or renewing an existing license for an adult care home, the Department of Health and Human Services is required to conduct a compliance history review of the facility and its principals and affiliates.
- The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its "principals or affiliates".
- The Department must refuse to issue a new license to an applicant who:
  - Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked until one full year after the date or revocation; or
  - Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with a correction plan and substantial compliance has been certified by the Department; or
  - Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license; or
  - Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.
    - "Affiliate", "owner", and "principal" are defined by rules adopted by the Medical Care Commission.
    - The application for an adult care home license requires disclosure of information concerning owners, affiliates, and principals of the applicant.
    - Failure to disclose or providing false information on an application may subject the licensee, after the fact, to revocation of the license.
    - Permitting the Department to impose a civil penalty may deter applicants from providing false information or omitting material information.

Senior Games

7. The North Carolina Study Commission on Aging expresses its appreciation for the efforts of the North Carolina Senior Games program to keep older adults mentally and physically active and recommends that the General Assembly continue to support Senior Games.

Background:

- *Support for Senior Games* was the issue that was mentioned with the greatest frequency during both public hearings. Support for the program was cited by presenters on average at a 2-1 ratio to any other topic.
- The program was established in 1983 to provide year-round health promotion and education for North Carolinians 55 years of age or older. It serves all 100 counties across the State, and there are over 50,000 participants statewide in 53 Local Games.
- The General Assembly provided $175,000 in the continuation budget for Senior Games.
- The Centers for Disease Control and Prevention and the Merck Institute of Aging & Health recently released, *The State of Aging and Health in America 2004*. The study indicated that in 2002, 39.9% of older adults in North Carolina participated in no leisure-time physical activity; North Carolina ranked 49 out of 50. The study indicates that the benefits of physical activity may include: reduction in a person's risk for cardiovascular disease; prevention of the development of diabetes, high blood pressure, and colon cancer; prevention of falls by helping to maintain and improve balance; and maintenance of healthy bones and muscles, increased joint mobility, and improved functional capacity of people with osteoarthritis.

Home and Community Care Block Grant

8. The North Carolina Study Commission on Aging recommends that the General Assembly appropriate an additional $4,000,000 in State funds for the Home and Community Care Block Grant.

Background:

- *Preserving/Expanding Support for In-Home and Community-Based Services* was the third most frequently mentioned item during the public hearings conducted in October 2004. The Division of Aging and Adult Services reports that 55% of the roughly 450 service providers indicate having 7,430 individuals on waiting lists for Home and Community Care Block Grant (HCCBG) services.
- Support for and/or restoration of funding for the HCCBG was an item mentioned frequently during presentations on March 9, 2004, by organizations representing or advocating on behalf of older adults in North Carolina. Additionally, the Senior Tar Heel Legislature, the Governor's Advisory Council on Aging, and the NC Coalition on Aging are advocating for increased funding for the HCCBG.
- Any person age 60 and older is eligible for services under the HCCBG. Although no income restrictions apply, special consideration is given to older adults with the greatest economic and social need. Of the 18 services, 14 are "core" services and 92% of the funds, over which counties have discretion, support these core services. Counties have discretion to determine services, levels, and providers. The 18 eligible services are: Adult Day Care, Adult Day Health Care, Care Management, Congregate Nutrition, Group Respite, Health Promotion and Disease Prevention, Health Screening, Home Delivered Meals, Housing and Home Improvement, Information and Assistance, In-Home Aide (levels I-IV), Institutional Respite Care, Mental Health Counseling, Senior Center Operations, Senior Companion, Skilled Home (Health) Care, Transportation (General and Medical) and Volunteer Program Development.
- The SFY 2003-04 HCCBG service profile indicates that: 71% of participants are women (compared to 58% of the NC 60+ population), 33% are minority, 63% are age 75 or older (compared to 34% of the NC 60+ population), 46% live alone (compared to 28% of the NC 60+ population); 71% are unable to mange on their own (compared to 12% of the NC 60+ population), 48% are reportedly low-income (compared to 13% of the NC 60+ population), and 66% are at risk of malnutrition.
- For the 2004-2005 fiscal year, the North Carolina Study Commission on Aging recommended that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant. S.L. 2004-124 provided $800,000 to partially restore a FY 2003-2004 reduction to the Home and Community Care Block Grant. Of this $800,000, $460,000 was earmarked to provide a $5.00 daily rate increase for Adult Day Care and Adult Day Health Care.
- Total SFY 03-04 (federal and State) HCCBG funding was $44,614,309. Current total SFY 04-05 (federal and State) HCCBG funding is $45,585,942. This is a $971,633, or 2% increase over SFY 03-04 funding.

LTC Insurance Tax Credit

9. The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.

Background:

- In 1997, the Commission recommended that the General Assembly enact a 15% tax credit, up to a maximum of $350, on the premiums paid by the purchaser of long-term care insurance policies. The Commission made this recommendation again in 1998. In 1998, the General Assembly enacted this tax credit (S.L. 1998-212, S. 29A.6(d)), effective for taxable years beginning on or after January 1, 1999, to sunset January 1, 2004.
- On February 10, 2004, the Commission heard presentations on long-term care insurance by the Seniors' Health Insurance Information Program (SHIIP), and on issues related to the tax credit by the Department of Revenue.
- Restoration of the LTC Insurance Tax credit was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina. This was also an issue mentioned during the public hearings conducted in October, 2005.
- Since enactment of the tax credit, the Commission has recommended repealing the sunset. However, the sunset was not repealed and the tax credit is no longer in place.

Elder Mistreatment and Abuse/ Adult Protective Services

10. The North Carolina Study Commission on Aging recommends that the Adult Protective Services Task Force collaborate with stakeholders and persons interested in improvements to the adult protective services system, and report findings and recommendations to the Legislative Study Commission on State Guardianship Laws and the Study Commission on Aging.

Background

- On December 1, 2004, the Commission heard a presentation from a task force in Orange County on issues related to the adult protective services system.
- S.L. 2004-161, Part 45, authorized a Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State law. Among the items the Commission is required to consider is a review of the State's adult protective services law. The Legislative Study Commission on State Guardianship Laws is required to make a final report to the 2006 Regular Session of the 2005 General Assembly upon its convening.
- The Department of Health and Human Services in conjunction with the County Department of Social Services Directors' Association has convened the Adult Protective Services (APS) Task Force. The Task Force has been working on ways to strengthen the adult protective services program and to improve quality, performance, and improved outcomes for county Departments of Social Services and for the State division in an effort to carry out the statutory mandate to protect vulnerable adults. The Task Force has taken a multi-pronged approach by looking at any needed statutory changes; administrative rule changes; workload, administration, and required training needs; policies and procedures; assessment tools, and community inter/intra relations i.e., how the community views our delivery of APS. The task force has 28 members including county DSS agencies and DHHS staff. Task Force members representing the county DSS agencies include: agency directors, program managers, supervisors, and line social workers, all of whom have responsibility for the delivery of APS at the local level. Short-term goals of the task force include recommending technical and clarifying changes to the law. Long-term goals include the potential for recommendations involving more in-depth statutory changes, improved caseload management, and additional training.
- The National Center on Elder Abuse, the National Committee for the Prevention of Elder Abuse (NCPEA), and the National Adult Protective Services Association are partnering to conduct a national study of elder abuse. Part of the study includes, "The 2004 Survey of Adult Protective Services Data," that intends to capture data from all 50 states. The initial survey deadline for the end of September has been extended to allow additional state response time. The purposes of the survey are to: establish a national data set for Adult Protective Services (APS); compare APS programs nationwide; measure APS interventions; demonstrate trends in the field of APS; and to bring national attention to the field. The University of Kentucky is conducting the research for NCPEA.

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — **December 1, 2004**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jean Reaves	NCCoA NCADSA
Teresa Johnson	NCADSA
Nancy Cox	WFU School of Medicine
Sue Robinson	News 14 Carolina
Polly Williams	NC Justice Center
Evelyn Hawthorne	NCALA
Mike Latta	AARP
Glenda Artis	Division of Aging and Adult Services
Jerry Cyrus	" " "
Beverly Mueller	Friends of Residents in LTC
Shannon Crane	DHHS + Div of Aging & Adult Services
Karen Gottovi	Div of Aging & Adult Svcs.
Suzanne Merrill	" " " " " "
Abby Emanuelson	Nat'l MS Society
Ted Rogers	Assoc for Home & Hospice Care of NC
Jim Eldridge	" " " " "
Ann Johnson	Gov. Adv. Council
Mary Bethea	Div. of Aging + Adult Services
Melissa Parker	NASW-NC
Thomas A Dodd	
Stacy Flannery	NCHCFA
John Mathews	
Bill Lucas	UNC Institute on Aging
Bob Fitzgerald	DHHS / DFS
Barbara Ryan	DHHS / DFS
Richard Clutch	AARP / NC Coalition on Aging
Dana D Hatch	AARP / OWL

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — **December 1, 2004**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hunt K. Lemmond	Adult Center for Enrichment, Greensboro
Rosalyn Pettyjohn	Division of Aging and Adult Services
Sabrina Gibb	Piedmont Triad Council of Govt's AAA
Roberta Bragg-Cook	NCAOA
DAVID BARNES	Poyner + Spruill
Melissa Boles	Resources for Seniors, Inc.
[illegible]	ALLEY ASSOC / NC
Karen Gantt	NCACDSS
Ken Melton	D.O.R.
Stella McKenney	DHHS
Margaret Hudson	retired UNC-CH son
Betsy Hurd	UNC-CH student, DSS (Chatham) intern
Vicki Alston	Chatham DSS
JOHN GOODMAN	ALLEY ASSOCIATES

MINUTES

NORTH CAROLINA STUDY COMMISSION ON AGING

Thursday, January 20, 2005
10:00 A.M.
Room 544, Legislative Office Building

The North Carolina Study Commission on Aging met on Thursday, January 20, 2005 at 10:00 A.M. in Room 544 of the Legislative Office Building. Members present were Representative Debbie Clary and Representative Edd Nye, Co-Chairs; Senators Austin Allran, Charlie Dannelly, Joe Sam Queen; Representatives David Lewis, Jennifer Weiss, Gene Wilson Beverly Earle; public members Brad Allen, Katherine Fox Price, Sam Marsh, and Linda Howard. Ex Officio Member, Jackie Sheppard.

Theresa Matula, Dianna Jessup, and Shawn Parker provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Nye presided at the meeting. He called the meeting to order and welcomed members and guests. He recognized Nancy Cox, Director of Partners in Caregiving: The Adult Day Services Program, Wake Forest University School of Medicine to give the Adult Day Service Training and Reimbursement Methodology Report. (Attachment No. 2) Ms. Cox reviewed the recommendations beginning on page 14 of the handout.

Representative Nye next asked staff to review the recommendations in the report. (Attachment No. 3)

Representative Clary made a motion that the report be adopted with the amended recommendations of staff, technical changes, and the three added amendments requested by Representative Weiss. Motion passed by voice vote.

After the approval of the minutes, Representative Nye adjourned the meeting at 11:40 a.m.

Representative Edd Nye, Co-Chair

Jo Bobbitt, Committee Assistant

Representative Debbie Clary
Senator A. B. Swindell

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 1/20/05

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Teresa Johnson	NC Adult Day Services Association
Bill Lamb	Friends of Residents in LTC
Shannon Crane	Div. of Aging & Adult Services
Mary Beth	DAAS
DAVID BARNES	Poyner + Spruill LLP
Jim Edgerton	AHHC
Polly Williams	NC Justice Center
Karen Hattori	DAAS
Tom Wilson	NCAHTCF
Elizabeth L. Bynum	Bynum & Asso.
Deanna D. Hollis	AARP
Bill McNeil	NC Association of Regional Council Directors
Evelyn Sanders	Southeastern Wake Adult Day Center
Glenda Artis	Division of Aging & Adult Services

Agenda

North Carolina Study Commission on Aging

Thursday, January 20, 2005
10:00 a.m.
Legislative Office Building
Room 544

I. Welcome and Introductions

Senator AB Swindell, Cochair
Representative Debbie Clary, Cochair
Representative Edd Nye, Cochair

II. Commission Report to the Governor and the 2005 General Assembly

- **Presentation of the Report**
- **Additional Recommendations**

Commission Staff

III. Vote on Commission Report

IV. Adult Day Service Training and Reimbursement Methodology Report (S.L. 2004-124, Sec. 10.21)

Nancy Cox, Director of Partners in Caregiving: The Adult Day Services Program, Wake Forest University School of Medicine

VI. Approval of Meeting Minutes

VII. Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27603

Jo Bobbitt (Rep. Nye)

From: Jo Bobbitt (Rep. Nye)
Sent: Thursday, December 02, 2004 5:18 PM
Subject: NC Commission on Aging Meeting Notice

Please note the year of meeting correction from 2004 to 2005

December 2, 2004

MEMORANDUM

TO: **Members, NORTH CAROLINA STUDY COMMISSION ON AGING**

FROM: Senator A. B. Swindell, Co-Chair
Representative Debbie Clary, Co-Chair
Representative Edd Nye, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NORTH CAROLINA STUDY COMMISSION ON AGING:

DAY: **Thursday** TIME: **10:00 A.M.**

DATE: **January 20, 2005**

LOCATION: **Room 643, LOB**

Please advise Jo Bobbitt, Committee Assistant, at (919) 733-5477, or e-mail nyela@ncleg.net if you will be unable to attend.

Posted: December 2, 2004

cc: Committee Record
Interested Parties

North Carolina
Adult Day Services Reimbursement Methodology Study

Final Report
North Carolina Study Commission on Aging

January 1, 2005

Nancy J. Cox, M.S.W., Director
Partners in Caregiving: The Adult Day Services Program
Department of Psychiatry & Behavioral Medicine
Wake Forest University School of Medicine
Winston-Salem, NC

for

North Carolina Department of Health and Human Services

Adult Day Services Training and Reimbursement Methodology
Special Provision – Section 10.21(a) S.L. 2004-124

The following special provision, Section 10.21(a) was included in the budget bill approved in July of 2004 (S.L. 2004-124):

In an effort to support and sustain adult day services in North Carolina, the Department of Health and Human Services shall contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant shall study the current method of reimbursement for adult day services and make recommendations regarding changes to the reimbursement methodology. The final report shall be presented to the Study Commission on Aging by January 1, 2005.

The Department of Health and Human Services (DHHS) assigned responsibility to the Division of Aging and Adult Services (DAAS) for contracting with a national adult day services resource center for activities as specified in the special provision. Partners in Caregiving from the Department of Psychiatry and Behavioral Medicine at Wake Forest University School of Medicine in Winston-Salem was chosen as the consultant.

Partners in Caregiving began contract activities in October of 2004. The contract will extend to June 30, 2005. Contract activities through December 2004 have focused on the reimbursement study and planning training and consultation services that will begin in January of 2005. The focus of this report is on the reimbursement study. Activities to be carried out January through June are summarized at the end of the report.

There are three funding sources for adult day services administered through the DHHS. These are the Home and Community Care Block Grant (HCCBG), the State Adult Day Care Fund (SADCF) and the Community Alternatives Program for Disabled Adults (CAP/DA, which covers adult day health care only). Because of time constraints to prepare recommendations for the legislative Study Commission on Aging, the scope of the study focused primarily on the Home and Community Care Block Grant and State Adult Day Care Fund, which are both administered by the Division of Aging and Adult Services.

Adult Day Services Background

Adult day services have grown in North Carolina from two adult day programs in 1973 to its peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. Although some programs would close, others would open. In many cases, the programs that closed later reopened under a new organization. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. There has continued to be a steady decrease in certified adult day programs. Approximately one year ago, there were 113 programs in 60 counties. Today there are only 106 programs in 58 counties.

A **National Study of Adult Day Services** (2001 - 2002), funded by The Robert Wood Johnson Foundation, was conducted by Partners in Caregiving. The study revolved around three major activities: (1) conducting a census of adult day service providers to determine how many adult day programs exist and where they are located; (2) surveying these providers to determine populations served and services offered; and, (3) identifying gaps in the current service delivery system. The assessment of gaps included analysis of utilization gaps (i.e., where programs exist but are underutilized) and availability gaps (i.e., where no programs exist despite a probable need), illustrating counties that are under served or have excess capacity.

The study confirmed 3,407 adult day programs in the United States, of which 107 were located in North Carolina. Nationally, although overall growth in the adult day services industry was evident, it lags behind the need for the service, with 56% of U.S. counties being under served. In North Carolina, 75 out of 100 counties (75%) are under served. With current need not being met, 5,415 new adult day programs are needed nationwide. Of these, 138 are needed in North Carolina, ranging from one new program needed in 43 counties to seven new programs needed in three counties.

The service gap analysis of the national study determined that North Carolina (based on the age 65+ population) could support, overall, a total of 243 adult day programs at an average program size of serving 40 people per day. With 138 new programs needed in the State, only 43% of this need is being met. This could be considered a conservative estimate because adult day services also assist younger persons with disabilities. With the steady decline in certified programs, the percent of need being met will only decrease. Thus, the reason for the special provision: to support and sustain adult day services in North Carolina.

Adult Day Services Overview

Adult day programs are designed to serve adults experiencing a decrease in physical, mental and social functioning. The adult day program environment recognizes and attends to emotional and intellectual needs, as well as physical. Adult day programs serve adults who may need supervision, social interaction, and assistance with more than one activity of daily living (eating, walking, toileting, bathing, dressing).

There are three different models of adult day programs: a social model of care (with no medical component), a medical model of care (with nursing services), or a combination of the two. The majority of adult day programs are open Monday through Friday, eight or more hours a day. These programs provide a vast array of services such as: therapeutic activities, health monitoring, social services, personal care services, meals, transportation, nursing services, medication management, caregiver support services, rehabilitation therapy (such as physical therapy, occupational therapy and speech therapy), medical services (such as podiatry), and emergency respite.

According to the **National Study of Adult Day Services**, individuals being served in adult day programs range in age from 18 to 109, with an average age of 72. The two most prevalent groups of people served are those with dementia (52% which includes people with Alzheimer's disease

or related disorders) and 41% frail elderly (age 60+ in need of supervision and/or at-risk of social isolation; no dementia). Twenty-four percent (24%) are diagnosed with mental retardation/developmental disabilities, 23% are physically disabled but cognitively intact (such as stroke, multiple sclerosis, and Parkinson's disease), and 14% have a chronic mental illness. Forty-three percent (43%) of individuals enrolled in an adult day program need assistance with toileting, 37% with walking, and 24% with eating.

The national study showed that most people attending an adult day program live with an adult child (35%) or a spouse (20%). The average length of stay in the program is two years, with the number one reason for discharge from the program being placement in a residential setting (such as a long-term care facility). The number two reason for discharge is death. Consequently, adult day programs either delay or prevent institutionalization. In the long-term care continuum, adult day programs help keep individuals (in need of chronic care) at home, in the community, with family and friends for as long as possible.

The preface of the **North Carolina Adult Day Care and Day Health Services Standards for Certification** defines adult day care and adult day health care as follows:

Adult Day Care

Adult day care is the provision of an organized program of services during the day in a community group setting for the purpose of supporting personal independence, and promoting social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, a nutritious meal and snacks as appropriate to the program, and referral to and assistance in using appropriate community resources. Medical examinations are required for individual participants for admission to a program and periodically thereafter. Services must be provided in a home or center certified to meet state standards for such programs.

Adult Day Health Care

The health care component of adult day health services distinguishes it from adult day care, which also provides a structured program of activities and services during the day for aging, disabled and handicapped adults. As part of the structured day program of activities and services, participants enrolled in adult day health also require daily nursing supervision. Participation in adult day health can enable such persons to achieve and maintain their optimum level of independence and can support family members and other caregivers who are providing full-time care to frail adults living at home.

General Statute 131D-6 defines adult day care as follows:

> Adult day care means the provision of group care and supervision in a place other than their usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled. The following programs are exempted from the provisions of G.S. 131D-6:
>
> - those that care for three people or less;

- those that care for two or more persons, all of whom are related by blood or marriage to the operator of the facility;
- those that are required by other statutes to be licensed by the Department of Health and Human Services.

The North Carolina Administrative Code (NCAC) 06S .0102 further defines adult day health care as follows:

> Adult day health services is the provision of an organized program of services during the day in a community group setting for the purpose of supporting an adult's personal independence, and promoting his social, physical, and emotional well-being. Services must include health care services as defined in Rule .0403(a) of this Subchapter and a variety of program activities designed to meet the individual needs and interests of the participants, and referral to and assistance in using appropriate community resources. Also included are food and food services to provide a nutritional meal and snacks as appropriate to the program. Transportation to and from the service facility is an optional service that may be provided by the day health program.
>
> The community group setting is:
>
> (1) a day health center, which is a program operated in a structure other than a single family dwelling; or
> (2) a day health home, which is a program operated in a single family dwelling; or
> (3) a day health program in a multi-use facility, which is a day health center established in a building which is used at the same time for other activities; or
> (4) a combination program, which is a program offering both adult day care and adult day health services.

Adult Day Services Funding

Third party public reimbursements streams for adult day programs in North Carolina include HCCBG, SADCF, and CAP/DA. Appendix A is a chart reflecting the total amount of dollars being expended through each of these funding streams for State FY 03-04 and State FY 04-05.

DAAS administers HCCBG and the SADCF. During SFY 03-04, HCCBG expended 97.67% and SADCF expended 98.87% of budget resources. These programs consistently expend approximately 98% of annual available resources. CAP/DA, administered by the Division of Medical Assistance, does not annually budget funding for specific services.

As is the case with all services funded through the HCCBG, State appropriations are the primary funding source for adult day services. State appropriations account for 59% of SFY 03-04 HCCBG adult day services expenditures, while federal Older Americans Act funds and local match account for 31% and 10% of total expenditures, respectively. A total of 1,173 HCCBG clients were served through 74 adult day programs. HCCBG funding is awarded to counties through Area Agencies on Aging on the basis of an intrastate funding formula. Individual

counties determine the mix of services to be provided. Adult Day Care and Adult Day Health Care are two (2) of the seventeen (17) services that can be provided through the HCCBG.

The SADCF is supported through the State Social Services Block Grant (SSBG) Plan. SSBG funding represents 65.25% of SFY 03-04 SADCF expenditures, while state appropriations and local match account for 22.25% and 12.50% of total expenditures, respectively. A total of 1,340 clients were served through 96 adult day programs. State Adult Day Care funding is allocated to counties largely on the basis of prior year expenditures, with consideration given to counties where newly certified centers are located.

SFY 04-05 budgeted funding for the HCCBG and the SADCF takes into account an increase in State appropriations to increase the daily care reimbursement by $5.00 per day as directed by General Assembly Session Law 2004-124, Section 5.1 (a). Effective, July 1, 2004, daily care reimbursement for Adult Day Care increased from $23.07 to $28.07 and daily care reimbursement for Adult Day Health Care increased from $30.00 to $35.00. In addition to the daily rate, the HCCBG allows for administrative costs based on reasonable expenses. HCCBG service providers are continuing to budget $482,565 in appropriations required for this purpose and State Adult Day Care Fund budget information reflects $520,000 in appropriations for the daily care rate increase. The Division of Aging and Adult Services expects that all available resources for adult day services will be expended at rates comparable to previous years.

Third Party Public Reimbursement Systems

The three adult day services third party public funding streams administered through the Department of Health and Human Services are separate and distinct programs. The following provides a brief overview of each system with an explanation of the respective target population.

Home and Community Care Block Grant (HCCBG)

The Home and Community Care Block Grant Fund provides funding of adult day care and adult day health care for persons who are 60 years of age or older who are in the target population. The target population is identified as "functionally impaired adults whose impairments prohibit them from living independently without supportive services and who are, therefore, at risk of institutionalization or placement in a substitute care setting."

Within this target population, there is a priority order given to individuals, as follows:

1. Older adults for whom the need for adult protective services has been substantiated by the local department of social services and the service is needed as part of the adult protective service plan;
2. Older adults who are at risk of abuse, neglect, and/or exploitation;
3. Older adults with extensive impairments in activities of daily living (ADL's), or instrumental activities of daily living (IADL's), who are at risk of placement or substitute care;
4. Older adults with extensive ADL or IADL impairments;

5. Older adults with less extensive (1-2) ADL or IADL impairments;
6. Well older adults

State Adult Day Care Fund (SADCF)

The State Adult Day Care Fund provides payment for service to adults 18 years of age and older who because of age, disability, or handicap need the service to enable them to remain in or return to their own home. Within the target population, eligible clients shall be provided day care services in the following order of priority:

1. Adults who require complete, full-time daytime supervision in order to live in their own home or prevent impending placement in substitute care (e.g. nursing home, adult care home), and adults who need the service as part of a protective services plan.
2. Adults who need help for themselves with activities of daily living or support for their caregivers in order to maintain themselves in their own homes or both.
3. Adults who need intervention in the form of enrichment and opportunities for social activities in order to prevent deterioration that would lead to placement in group care.
4. Individuals who need time-limited support in making the transition from independent living to group care, or individuals who need time-limited support in making the transition from group care to independent living.

Community Alternatives Program for Disabled Adults (CAP/DA)

The Community Alternatives Program for Disabled Adults is for persons 18 years of age and older who are:

1. Eligible for Medicaid for the Aged (MAA), Medicaid for the Blind (MAB) or Medicaid for the Disabled (MAD) according to Section 6 of the CAP/DA Manual;
2. Lives in a private residence and is at risk of being placed in a nursing facility or lives in a nursing facility and desires to return to a private residence;
3. Requires nursing care (intermediate care or skilled nursing) as determined through the Medicaid prior approval process;
4. Needs CAP/DA services to remain safely at home;
5. Can have his or her health, safety, and well-being maintained at home within the Medicaid cost limit; and
6. Desires CAP/DA services instead of institutional care.

The first step in analyzing DHHS adult day services reimbursement methodology is to look at each third party public reimbursement system side-by-side.

Appendix B is a chart comparing HCCBG, SADCF and CAP/DA funding streams in relation to:

- Who establishes the reimbursement rate;

- When the current rates were established;

- The system used for establishing rates;
- Frequency for rate change;
- How days of service are reimbursed;
- Absentee policy;
- The current rate per day (excluding transportation);
- The current rate per month; and,
- What constitutes a unit of service.

Rates are established for each of the third party funding streams by different methods and authorities. DAAS utilizes the Social Services Commission rate setting for HCCBG. The Social Services Commission has the authority to set maximum reimbursement rates for the SADCF. The Division of Medical Assistance (DMA) establishes the reimbursement rate for the CAP/DA program. The current rates for each of these funding streams were established in July 1, 2004 (HCCBG and SADCF) and November 1, 1999 (CAP/DA). Prior to the recent $5.00 per day rate increase, a result of legislative action, the HCCBG and SADCF rate had not been increased since April, 1999.

There is no clear system for the establishment of the reimbursement rate for HCCBG and SADCF. The reimbursement for all three funding streams is based on a standard fixed rate; however, the Division of Medical Assistance (DMA) calculates the CAP/DA rate. After collecting information on each center's actual cost/day/client, DMA tallies volume by center, from the least to the most, and at the 50% mark identifies and reimburses the cost/day/client. In contrast, the reimbursement amount for HCCBG and the SADCF has no basis on actual program costs per day.

Of particular concern is the lack of any system for automatic rate increases among the three third party public reimbursement streams. General cost-of-living increases are not being addressed by these reimbursement systems. Furthermore, recent findings from North Carolina's Center for Disease Control (CDC) Behavioral Risk Factor Surveillance System indicate that, relative to other states, North Carolina has a high proportion of persons providing informal care for adults over 60. Although the population of those needing the service continues to grow, the funds established to serve them have remained fairly stagnant. At minimum, automatic rate increases would help address a growing need for the service.

Adult day program costs are fairly fixed, regardless of actual attendance in a program. Fortunately, both HCCBG and the SADCF recognize this fact and reimburse programs based on enrollment. Thus, a program receives reimbursement for days a participant is absent. The CAP/DA reimbursement system, however, does not reimburse for these days as the federal waiver guidelines and regulations call for reimbursement based on attendance.

In order to assure there is no abuse of an enrollment-based reimbursement system, the SADCF and HCCBG both have established absentee policies. HCCBG guidelines restrict reimbursement for absent participants to ten consecutive days, after which time units of service can no longer be reported until the client has returned. The SADCF requires adult day programs to notify the county Department of Social Services (DSS) when an enrollee has been absent for five consecutive scheduled days. The case manager then makes a decision as to whether it would be appropriate to terminate the service, hold the slot through the use of a holding fee, or revise the enrollment plan. This difference in policy has created some confusion and is further discussed under system change recommendations.

The current reimbursement per day falls well short of both the national average and of program costs. Although the recent $5.00 per day rate increase raised the reimbursement rate of HCCBG and SADCF from $23.07 per day to $28.07 per day (social model), nationally the typical daily cost of running a social model program is $54.00. In North Carolina, a 2004 pilot project to determine program costs (discussed later in this report) reported an average daily cost of $44.97. When adding the health care component, which requires the employment of a registered nurse (RN) or licensed practical nurse (LPN), the average daily cost for combination adult day care/adult day health programs nationally rose to $57.00, with North Carolina unit costs for combination adult day care/adult day health programs being reported at $52.31. This again falls short of the current reimbursement rate for day health care, recently increased from $30.00 per day to $35.00 per day. The current reimbursement under CAP/DA is $36.51 per day, which only applies to programs with the health component.

The current rate per month also varies by funding source. For HCCBG, DAAS has an automated service information system that calculates monthly reimbursement on the basis of units reported, multiplied by the provider unit rate recorded in the system. The SADCF has a maximum reimbursement limit set at $608.00 per month (social model) or $758.00 per month (combination or health model). CAP/DA also has a maximum monthly cost limit rate, based on the person's approved level of care (intermediate care or skilled nursing care).

The unit of service also varies by funding source. HCCBG identifies a unit of service as being a 6-hour day. The SADCF and CAP/DA identify a unit of service as "a day." This inconsistency among funding sources can also prove to be problematic and is further discussed under system change recommendations.

Adult Day Services Funding in Other Southern States

An additional step in analyzing the adult day services reimbursement methodology in North Carolina involved a comparison of how other comparable southern states reimburse for adult day services. Appendix C compares South Carolina, Virginia, Georgia, and Florida in relation to:

- Types of adult day services reimbursed;
- Who establishes rates;
- How days of service are reimbursed;

- Absentee policy;
- The current rate per day;
- The current rate per month;
- What constitutes a unit of service;
- Funding source; and,
- Frequency for rate change.

Overall, a comparison of third party public reimbursement among the four southern states clearly demonstrates a higher adult day services reimbursement level. With the exception of Florida, rates are established by the legislature and are based on days of attendance. None of the other four states surveyed have an absentee policy. Reimbursement is based on a per day basis, not per month, except in Florida, where reimbursement is per hour. All programs are reimbursed via a Medicaid waiver with no automatic system for rate changes.

South Carolina reimburses $38.00 per day for social programs (which includes transportation if within 15 miles of the program), and adds an additional $15.00 per day for programs that include the nursing component, raising the total reimbursement rate to $53.00 per day. Virginia only reimburses programs with the health component, and then sets the limit between $43.05 and $47.25, depending on the area of the State. Georgia has a more complicated system, with two levels of care, further divided into two levels of time. Levels of care are determined by the type and complexity of care needed. For programs providing Level I (less involved care, typically comparable to care received in a social model) programs are reimbursed $30.27 for a 3-hour day or $50.45 for a 5-hour day. Those providing Level II care (indicating a more complex level of care), are reimbursed $37.00 for a 3-hour day or $63.07 for a 5-hour day. Florida reimburses programs $10.00 per hour but will only reimburse at a maximum of eight hours per day. This equates to a maximum reimbursement of $80.00 per day. When compared to North Carolina reimbursement rates, these states seem to be more in line with the program costs as identified by the National Study of Adult Day Services.

Study Methodology

The methodology used to conduct the adult day services reimbursement study consisted primarily of key informant interviews. To obtain information on how the system operates and suggestions regarding changes to improve the system, interviews were conducted with staff from DAAS, the North Carolina Adult Day Services Association, and a representative number of adult day services providers, located in the 17 Area Agency on Aging regions.

Adult day services providers from each of these regions participated in a confidential 30-minute telephone interview. In preparation for the interview, each participating provider received (in

advance) the chart similar to that in Appendix B (Adult Day Services Third Party Public Reimbursements through the North Carolina Department of Health & Human Services.)

The 17 providers were selected based on urban/rural mix, adult day services funds being accessed, and level of expertise with the system. They included the programs listed below. Adult Day Care programs, social model only, are referenced as ADC and adult day care/adult day health care combination programs are referenced as ADC/ADH.

Region A (Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain)
Pruett House Family Center, ADC certified for 32 participants
Franklin, NC (Macon County)

Region B (Buncombe, Henderson, Madison, Transylvania)
Mountain Care, ADC/ADH combination program, certified for 66 participants
Asheville, NC (Buncombe County)

Region C (Cleveland, McDowell, Polk, Rutherford)
Life Enrichment Center, ADC/ADH combination program, certified for 50 participants
Shelby, NC (Cleveland County)

Region D (Alleghany, Ashe, Avery, Mitchell, Watauga, Wilkes, Yancey)
Generations Adult Day Health Care, ADC/ADH combination program, certified for 40 participants
West Jefferson, NC (Ashe County)

Region E (Alexander, Burke, Caldwell, Catawba)
Adult Life Programs, ADC/ADH program, certified for 50 participants
Hickory, NC (Catawba County)

Region F (Anson, Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union)
Blessed Assurance Adult Day and Health Care, ADC/ADH program, certified for 40 participants
Matthews, NC (Mecklenburg County)

Region G (Alamance, Caswell, Davidson, Guilford, Montgomery, Randolph, Rockingham)
Adult Center for Enrichment, multiple ADC/ADH program sites, certified for 16-29 participants
Greensboro, NC (Guilford County)

Region I (Davie, Forsyth, Stokes, Surry, Yadkin)
Mount Zion Senior Enrichment Adult Day Care/Day Health Center, ADC/ADH program, certified for 40 participants
Winston-Salem, NC (Forsyth County)

Region J (Chatham, Durham, Johnston, Lee, Moore, Orange, Wake)
Resources for Seniors Total Life Programs, multiple ADC & ADC/ADH sites, certified for 25 to 41 participants each
Raleigh, NC (Wake County)

Region K (Franklin, Granville, Person, Vance, Warren)
Franklin County Adult Day Program, ADC/ADH program, certified for 24 participants
Louisburg, NC (Franklin County)

Region L (Edgecombe, Halifax, Nash, Northampton, Wilson)
Roanoke Valley Adult Day Care Center, ADC/ADH program, certified for 48 participants
Weldon, NC (Halifax County)

Region M (Cumberland, Harnett, Sampson)
Sampson County ADC/ADH Center, ADC/ADH program, certified for 20 participants
Clinton, NC (Sampson County)

Region N (Bladen, Hoke, Richmond, Robeson, Scotland)
Bladen County Adult Day Care Center, ADC program certified for 10 participants
Elizabethtown, NC (Bladen County)

Region O (Brunswick, Columbus, New Hanover, Pender)
Elderhaus at the Lake, ADC/ADH program, certified for 72 participants
Wilmington, NC (New Hanover County)

Region P (Carteret, Craven, Duplin, Greene, Jones, Lenoir, Onslow, Pamlico, Wayne)
Duplin Adult Day Services, ADC/ADH program, certified for 10 participants
Wallace, NC (Duplin County)

Region Q (Beaufort, Bertie, Hertford, Martin, Pitt)
Creative Living Center, ADC/ADH program, certified for 24 participants
Greenville, NC (Pitt County)

Region R (Camden, Chowan, Currituck, Dare, Gates, Hyde, Pasquotank, Perquimans, Tyrrell, Washington)
Day Break Adult Day/Health Care Center, ADC/ADH program, certified for 30 participants
Elizabeth City, NC (Pasquotank County)

The provider interview question was two-fold:

1. Are you satisfied with the current adult day services reimbursement methodology systems for: Home and Community Care Block Grant (HCCBG), State Adult Day Care Fund (SADCF), and, the Community Alternatives Program for Disabled Adults (CAP/DA)?

2. If not, what changes would you make?

Overall Provider Interview Results

Among the adult day services providers, it was unanimous in that no provider was completely satisfied with the current reimbursement methodology systems for the HCCBG, SADCF, and CAP/DA. Providers were also unanimous in wanting an overall system that is consistent among systems and is consistent across the state (from county-to-county).

Providers recommended changes in each of the following areas for HCCBG and SADCF. The overall percentage of providers making each change request is shown in parentheses:

- Organization establishing the rates (12%)
- System for establishing the rates (100%)
- Frequency for rate change (100%)
- Absentee policy (71%)
- Rate per month (59%)
- What constitutes a unit of service (76%)

For CAP/DA (15 of the 17 providers interviewed access these funds), changes were recommended by providers in each of the following areas. The overall percentage of providers making each change request is shown in parentheses:

- Frequency for rate change (67%)
- How days of service are reimbursed (67%)
- What constitutes a unit of service (33%)

Due to time limitations, discussions have not been initiated with the Division of Medical Assistance to discuss this feedback from providers. The Division of Aging and Adult Services will follow up on this matter.

System Change Recommendations

To support and sustain adult day services in North Carolina, various reimbursement methodology changes need to be made to determine reasonable reimbursement rates, allow for negotiated rates with consideration of cost, and ease administration.

Based on discussions with the Division of Aging and Adult Services (DAAS), the North Carolina Adult Day Services Association (NCADSA), and adult day services providers across the state, the following changes to the HCCBG and SADCF systems are recommended (based on consensus):

FY 05-06

COST ANALYSIS SYSTEM

Issue:

As previously mentioned, a pilot project was conducted in North Carolina to determine the unit cost among adult day programs. The North Carolina Adult Day Services Association (NCADSA) extended an invitation in March 2004 to every certified adult day care and adult day health program in North Carolina to participate in a project to determine the cost of adult day programs to provide the service. Fifteen adult day center providers were trained as mentors to assist with completing a standardized form to calculate unit costs systematically. Sixty-six percent (66%) of North Carolina adult day care/day health programs (74) participated in the project through attending training and/or reporting data.

Some of the project goals included identifying funding streams for clients attending adult day programs, establishing a systematic approach to calculating unit cost, strengthening the financial management of programs by providing training about budgeting, and calculating an average unit cost for adult day programs certified as social, health, and combination. All respondents used a standard tool to present expenses and revenue, and to calculate unit costs. This tool has the potential to be a valuable mechanism for adult day programs for reporting unit cost in the future.

To date, there is no formal system in place to report and analyze adult day program unit cost. This information is needed in order to determine reasonable adult day services reimbursement rates through the Home and Community Care Block Grant and State Adult Day Care Fund. Since current reimbursement rates are not based on any concrete data, it is crucial that this information be systematically gathered and evaluated for further rate increases. Additionally, such information is needed to support the establishment of an automatic system for annual rate reviews and increases.

Recommendation:

Establish a formal reporting system, requiring adult day services providers, on an annual basis, to determine and report unit cost to DAAS. This information could also serve as a review by DAAS for potential rate changes. The cost analysis tool developed by DAAS (in conjunction with the NCADSA) provides an excellent basis for determining and gathering this information. This 2004 cost analysis project put North Carolina on the cutting edge as the first of its kind in adult day services at a state level. To be used effectively by providers, however, the current tool needs to

be streamlined to be more user friendly. Partners in Caregiving will recommend revisions to the tool by March 31, 2005 for possible use by adult day programs in FY 05-06.

Action Required:
The establishment of a formal reporting system could potentially be incorporated into existing provider recertification requirements. Currently, the North Carolina Adult Day Care/Adult Day Health Care Standards for Certification require programs to submit a variety of information annually in order to comply with recertification requirements. Among the required information, programs are required to submit a 12-month budget. The addition of the requirement for programs to submit the cost analysis tool can be accomplished through an amendment to the current administrative rule. This process would require an administrative rule change, approved by the Social Services Commission and the Rules Review Commission.

Note:
A mandated cost analysis system through DAAS would add a major data collection/analysis responsibility to the Division with limited staff. DAAS would need to determine how such a system could effectively and efficiently be put in place.

CURRENT RATE PER MONTH FOR STATE ADULT CAY CARE FUND

Issue:
As previously explained, the SADCF has a monthly cap on reimbursement. This is interpreted differently from county to county. For instance, one program, serving multiple counties, reported a county that reimbursed them the monthly maximum, regardless of the number of days in the month. Another county only reimbursed the number of days of enrollment, up to the monthly maximum. Thus, the provider would receive different monthly third party public reimbursement amounts for the same number of enrolled client days. The elimination of the monthly maximum would help assure consistency in reimbursement from county to county.

Furthermore, since adult day services providers are generally reimbursed based on enrollment, not attendance, there is no purpose to having a stated monthly maximum. Basing reimbursement on the number of enrolled days per month would assure a program is paid for the actual number of days in the month and for the actual number of days a client is scheduled to attend the program.

Recommendation:
The formula for the rate per month (i.e., monthly maximums) for the SADCF should be deleted from the rules.

Action Required:
The monthly maximum rate is stated in administrative rules 10A NCAC 06Q .0201 and 10A NCAC 06T .0201. These rules would need to be amended to eliminate this maximum.

Note:
Rule 10A NCAC 06Q .0201 establishes the maximum reimbursement rate for the purchase of adult day services. General Statute 143B-181.1(a)(10) gives authority to the Division of Aging and Adult Services to "establish a fee schedule to cover the cost of providing in-home and community based services funded by the Division." The authority for this rule is cited as G.S. 143B-181.1(c) that states: "The Secretary of Health and Human Services shall adopt rules to implement this Part and Title 42, Chapter 35, of the United States Code, entitled Programs for Older Americans." The needed action required to enact this recommendation can be accomplished internally by the Department of Aging and Adult Services through amending this rule via the Secretary of the Department of Health and Human Services.

Rule 10A NCAC 06T .0201 defines the nature and purpose of the State Adult Day Care Fund. This rule identifies the appropriate use of the State Adult Day Care Fund and provides the maximum rate for the purchase under a vendor agreement between the county Department of Social Services and the adult day program. Authority for this rule is cited primarily as General Statute 143B-153. This statute refers to the Social Services Commission's creation, powers, and duties. It grants the Social Services Commission the "power and duty to adopt rules and regulations to be followed in the conduct of the State's social service programs with the power and duty to adopt, amend, and rescind rules and regulations under and not inconsistent with the laws of the State ...." Amendment of this rule would require action by the Social Services Commission.

DAAS has agreed to work with the Social Services Commission to address the need for change to this rule. Dialogue, to include discussions with county departments of social services and other stakeholders, will begin on this process in the first quarter of 2005.

HCCBG Reimbursable Service Unit

Issue:

A reimbursable service unit for HCCBG is a 6-hour day, but for the SADCF and CAP/DA it is a day. Interpretation of the HCCBG unit definition has led to confusion among HCCBG administrators and service providers. In some cases, it is interpreted to say a participant must be present a minimum of 6 hours per day in order to receive HCCBG reimbursement. This interpretation can be extremely restrictive to both day care participants and families. In other cases, HCCBG fund administrators have attempted to take the total number of hours a client has attended a program and divide it by 6 in order to arrive at the number of units. There is no clear advantage to maintaining the definition of a HCCBG reimbursable service unit as a 6-hour day. Furthermore, the majority of programs provide care for 8-10 hours per day. Reimbursement for the fixed rate of $28.07 (social) and $35.00 (combination/health) applies regardless of whether a program is open 6 or 10 hours per day.

Recommendation:
To ease administration and provide consistency among funding streams, the 6-hour stipulation from the HCCBG should be deleted, making the reimbursable unit "a day" (the same as the SADCF and CAP/DA). A day of service should be defined in the care plan and meet the needs of the caregiver and their loved one.

Action Required:
The definition of a 6-hour HCCBG day service unit is in the Home and Community Care Block Grant manual. This definition can be changed through an administrative letter from DAAS to Area Agencies on Aging who administer HCCBG funds.

Note:
The needed action required to enact this recommendation can be accomplished internally by the DAAS as described above. DAAS has agreed to proceed with drafting the administrative letter and will distribute it to all appropriate parties within the first quarter of 2005.

HCCBG AND SADCF ABSENTEE POLICY

Issue:

As previously detailed, HCCBG and SADCF policies establish different periods of time a participant can be absent and continue to received funding reimbursement. The HCCBG policy appears more lenient in the allowance of payment for 10 consecutive days of absenteeism. However, the SADCF could potentially reimburse longer than 10 consecutive days since, after 5 days, the DSS adult day care monitor determines whether the funding should be continued through the use of a holding fee. Neither fund limits the number of absentee days beyond consecutive absences. Thus, an absent HCCBG participant could be reimbursed based on enrollment for 10 consecutive days, return for a day or two, and then be reimbursed for an additional 10 consecutive days of absence.

To ease administration and provide consistency among funding streams, the absentee policy needs to be the same for both of these funding sources, as does the policy interpretation from county-to-county. For both funding streams, however, there is no consensus among adult day services providers as to the actual changes that should be made. Some providers feel that the SADCF should have the same number of consecutive days as the HCCBG. Other providers believe it should be the reverse or they feel providers should have leeway in both.

Recommendation:
DAAS needs to develop a task force to address this issue and arrive at consensus in the development of a consistent absentee policy and interpretation.

Action Required:
Following this consensus, an administrative letter needs to be sent from DAAS to all affected parties.

Note:
The current reimbursement study advisory committee and others deemed appropriate by DAAS could potentially serve as an initial task force for further examination of this issue. Input from county departments of social services will especially be important.

FY 06-07

HOME AND COMMUNITY CARE BLOCK GRANT (HCCBG)

Issue:

The current HCCBG system does not allow for negotiated rates for adult day services because the Division of Aging and Adult Services has chosen to utilize the same rate for HCCBG adult day services as that established by the Social Services Commission for adult day services funded by the State Adult Day Care Fund. This decision was made in order to establish equity between the two funding sources. Adult day care and adult day health care are the only services (of 17 HCCBG funded services) that have a fixed rate. Reimbursement rates for all the other services are not fixed rates, but rather negotiated rates per provider based on cost. The following HCCBG funded services are currently reimbursed based on negotiated rates: care management, in-home aide, congregate nutrition, home delivered meals, home health, senior center operations, housing and home improvement, information and case assistance, health screening, institutional respite care, mental health counseling, senior companion, transportation (excluding adult day services), volunteer program development, and group respite care. To provide consistency among HCCBG service providers, the same system should apply to adult day services. This change would also give adult day programs the flexibility to negotiate a rate more reflective of program costs.

Recommendation:

The HCCBG policy for adult day care and adult day health care reimbursement should be changed to allow negotiated rates per provider with consideration given to cost.

Action Required:

The maximum reimbursement rate referenced in 10A NCAC 06Q .0201 would need to be amended by an administrative rule change through the Secretary of the Department of Health and Human Services.

Note:

Prior to implementation of this recommendation, the impact of the July 1, 2004 $5.00 rate increase needs to be determined by DAAS. Has there been an increase or decrease in service delivery? Furthermore, due to limited HCCBG dollars, a cost analysis study by DAAS (during FY 05-06) would need to be conducted as to the impact of negotiated rates on service delivery. Would negotiated rates have a negative impact on the number of people served? DAAS should involve Area Agencies on Aging, county departments of social services, the North Carolina Adult Day Services Association, and other relevant parties in these discussions prior to moving forward on this recommendation.

STATE ADULT DAY CARE FUND (SADCF)

Issue:

The current SADCF system also does not allow for negotiated rates for adult day services. As previously mentioned, Rule 10A NCAC 06T .0201 defines the nature and purpose of the State Adult Day Care Fund. Authority for this rule is cited primarily as General Statute 143B-153.

This statute refers to the Social Services Commission's creation, powers, and duties. Since the Social Services Commission currently has authority for setting the SADCF reimbursement rate, a change to a negotiated rate would necessitate discussions with the Social Services Commission.

Recommendation:
DAAS should initiate discussions with the Social Services Commission about the feasibility of moving towards a negotiated rate for adult day services funded by the SADCF.

Action Required:
DAAS needs to initiate initial discussions with the Social Services Commission to review the study reimbursement recommendations and explore the effect of moving towards a negotiated reimbursement system.

Note:
The same considerations would need to be examined prior to making this change as those listed previously under HCCBG funding changes.

Future Study Recommendations

TRANSPORTATION

For the HCCBG and SADCF, the reimbursement methodology being studied revolved around rates that excluded transportation. Transportation, however, did come up in the provider interviews in that the current reimbursement rate of $1.50 per trip is low for an extremely costly service. Reimbursement at such a low rate (based on a trip instead of by the mile) is a major financial drain on adult day programs.

Research conducted by Partners in Caregiving has shown that transportation is a predictor of financial success. In order to be financially viable, adult day programs must provide or arrange for transportation. Daily census increases when transportation is offered.

To address the issue of inadequate funding for adult day services transportation, additional State appropriations would be required.

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA)

Since the contract for the Adult Day Services Reimbursement Methodology Study was through the Division of Adult and Aging Services, the focus of this study was on the HCCBG and SADCF. Although CAP/DA is a funding stream for adult day services, it is administered through the Division of Medical Assistance, a separate division within the Department of Health and Human Services. As the chart in Appendix B details, there are further funding inconsistencies among HCCBG, SADCF and CAP/DA. Conversations with DMA regarding whether these inconsistencies should be addressed are needed prior to making system change recommendations. DAAS will review the report with DMA, with input from Partners in Caregiving.

Special Provision Activities Scheduled Through June 30, 2005

To support and sustain adult day services in North Carolina, the Special Provision also calls for training and consultation to adult day services providers and State and county adult day services consultants. As a result, the following additional activities will be conducted during the State FY 04-05:

Training and Technical Assistance

- Development of an assessment tool to identify adult day programs at-risk of closing (December 2004), and the creation of an adult day services program development assessment tool (January 2005).

- 5 regional training sessions for all certified adult day programs, anyone interested in opening an adult day program, and State and county adult day services consultants. Training includes a $250 scholarship available to any certified program needing funds to subsidize travel expenses or per diem coverage to attend the training (January – March 2005).

- 1 statewide training session specifically for the county adult day services consultants, in conjunction with an annual training workshop conducted by the Division of Aging and Adult Services (March 2005).

- Telephone technical assistance available to all training session attendees (February – June 2005).

- One-on-one technical assistance site visits to up to 40 certified adult day programs at-risk of closing, plus follow-up telephone technical assistance (March – June 2005).

- Development of recommendations for a system for sustainability (June 2005). Since the Special Provision funds are a major investment (no other state has done this), the key is to develop a system for sustainability so that these funds are not just a one-shot deal. Building on the training and technical assistance that will take place, how can the adult day services industry continue to move forward? With a system for sustainability in place, North Carolina would continue to be on the cutting edge.

A report will be presented to DHHS and the Legislative Study Commission on Aging to include a refined plan of action to support and sustain adult day services in North Carolina (July 2005).

APPENDIX A
Adult Day Services Funding
Through the Home and Community Care Block Grant (HCCBG), State Adult Day Care Fund (SADCF) and Community Alternatives Program for Disabled Adults (CAP/DA)

NOTE: The CAP-DA program is funded and administered through the Division of Medical Assistance

SFY 03-04

HCCBG	Federal Older Am. Act **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget	% Expended	Clients Served	Centers Funded
Adult Day Care	$459,149	$852,705	$145,762	$1,457,616	$1,504,224	96.90%	615	
Day Health Care	$409,640	$760,760	$130,045	$1,300,445	$1,319,755	98.54%	558	
HCCBG Total	**$868,789**	**$1,613,465**	**$275,807**	**$2,758,061**	**$2,823,979**	**97.67%**	**1,173**	74*

*Unduplicated count of adult day services centers receiving HCCBG resources

SADCF	Federal SSBG **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget	% Expended	Clients Served	Centers Funded
Adult Day Care	$1,355,019	$460,751	$259,396	$2,075,166	$2,098,961	98.87%	958	
Day Health Care	$775,849	$263,814	$148,523	$1,188,186	$1,201,811	98.87%	382	
SADCF Total	**$2,130,868**	**$724,565**	**$407,919**	**$3,263,352**	**$3,300,772**	**98.87%**	**1,340**	96*

*Unduplicated count of adult day services centers receiving SADCF resources

CAP-DA	Federal Medicaid **Expended**	State **Expended**	Local Match **Expended**	Total **Expended**	Total Budget*	% Expended	Clients Served
Day Health Care	**$925,431**	**$0**	**$462,715**	**$1,388,146**	**N/A**	**N/A**	**332**

* The Division of Medical Assistance does not budget CAP-DA funding for specific services

SFY 04-05

HCCBG	Federal Older Am. Act **Budget**	State **Budget***	Local Match **Budget***	Total **Budget***	Current Centers Funded
Adult Day Care	$471,266	$919,356	$154,514	$1,545,136	
Day Health Care	$432,233	$843,210	$141,716	1,417,159	
HCCBG Total	**$903,499**	**$1,762,566**	**$296,230**	**$2,962,295**	73**

* Service providers are continuing to budget shares of the $482,565 appropriation that increases daily care rates by $5.00
** Unduplicated count of adult day services centers receiving HCCBG resources

SADCF	Federal SSBG **Budget**	State **Budget***	Local Match **Budget***	Total **Budget***	Current Centers Funded
Adult Day Services	**$2,155,301**	**$1,252,875**	**$486,882**	**$3,895,058**	92**

* Funding includes $520,000 appropriation to increase daily care rates by $5.00. The Division of Aging and Adult Services does not allocate SADCF funding to county DSS's by specific service.
** Unduplicated count of adult day services centers receiving SADCF resources

APPENDIX B

Adult Day Services
Third Party Public Reimbursements
through the
North Carolina Department of Health & Human Services

	Home and Community Care Block Grant (HCCBG) *Adult Day Care* *Adult Day Health Care*	**State Adult Day Care Fund (SADCF)** *Adult Day Care* *Adult Day Health Care*	**Medicaid Community Alternatives Program (CAP-DA)** *Adult Day Health Care only*
Rates Established by	Division of Aging and Adult Services utilizes Social Services Commission rate setting	Social Services Commission	Division of Medical Assistance (DMA)
Current Rates Established	July 1, 2004	July 1, 2004	November 1, 1999
System for Establishing Rates	Standard Fixed Rate	Standard Fixed Rate	Standard Fixed Rate After collecting volume and costs, and each center's actual cost/day/client, DMA tallies volume by center from the least to the most, and at the 50% mark identifies the cost/ day/client.
Frequency for Rate Change	No Automatic System	No Automatic System	No Automatic System
Days Reimbursed	Enrollment (versus attendance)	Enrollment (versus attendance)	Attendance (versus enrollment)

	Home and Community Care Block Grant (HCCBG) *Adult Day Care* *Adult Day Health Care*	**State Adult Day Care Fund (SADCF)** *Adult Day Care* *Adult Day Health Care*	**Medicaid Community Alternatives Program (CAP-DA)** *Adult Day Health Care only*
Absentee Policy	When an enrollee is absent for 10 consecutive days, units for the person will no longer be reported until such time the person returns.	The program must notify the county DSS when an enrollee has been absent for 5 consecutive scheduled days. The case manager makes a decision as to whether it would be appropriate to terminate the service, hold the slot through the use of a holding fee, or revise the enrollment plan.	Reimbursement is for days of attendance only; participants are not reimbursed for absent days.
Current Rate Per Day (without transportation)	Up to $28.07 (social)* Up to $35 (combination/health)* May add on an administrative fee calculated by the program based on reasonable expenses	Up to $28.07 (social) Up to $35 (combination/health)	$36.51 (combination/health)
Current Rate Per Month	Division of Aging & Adult Services automated service information system calculates monthly reimbursement on the basis of units reported times the provider unit rate recorded in the system.	Up to $608/mo.(social) Up to $758/mo.(combination/health) Formula: daily rate x 21.66 operating days/month	Reimbursement is based on a per day basis and not per month.
Unit	A 6-hour Day	A Day Month: 21.66 operating days (260 operating days per year ÷ 12)	A Day

* This rate reflects the recent $5.00 per day rate increase.

APPENDIX C

Southern States Comparison Chart

	South Carolina	Virginia	Georgia	Florida
Type of Service	*Adult Day Health Care and Adult Day Health Care Nursing	Adult Day Health Care Only	Adult Day Health Care Only	Adult Day Care and Adult Day Health
Rates Established by	General Legislature	Legislature	Legislature	Florida Medicaid Program
Days Reimbursed	Attendance	Attendance	Attendance	Attendance
Absentee Policy	None	None	None	None
Current Rate Per Day	*$38.00 (includes transportation if within 15 miles of the program) Pays additional $15.00 for Adult day Care Nursing	$47.25 (Northern VA) $43.05 (Other VA areas)	**Level I (3 hour day) $30.27 Level I (5 hour day) $50.45 Level II (3 hour day) $37.00 Level II (5 hour day) $63.07	$10.00 per hour Maximum limit per day is 8 hours or $80 per day
Current Rate Per Month	Reimbursement is based on per day basis, not per month	Reimbursement is based on per day basis, not per month	Reimbursement is based on per day basis, not per month	Reimbursement is based on hourly basis and ½ day basis, not per month
Unit	A 5-hour Day	A 6 or more hour a Day	Minimum Day = 3 hours Full Day = 5 hours	Hour (Max. hours paid per day is 8)
Funding Source	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver	Medicaid Waiver
Frequency for Rate Change	No automatic system Legislature approval	No automatic system Legislature approval	No automatic system Legislature approval	No automatic system Medicaid program

* In South Carolina, "Adult Day Health Care" is equivalent to North Carolina's "Adult Day Care" model (social model; clients do not receive nursing care). "Adult Day Health Nursing" is equivalent to NC "Adult Day Health" model; in SC providers receive $38.00 as a base rate plus an additional $15.00 for total of $53.00.

** L evel I and Level II refer to the type of care that a client may need. Level II indicates a more complex plan of care.

North Carolina
Study Commission on Aging

January 13, 2005

To: Members of the North Carolina Study Commission on Aging

Enclosed for your review is the draft of the background and bill drafts for the following three recommendations proposed by Representative Jennifer Weiss:

Recommendation 11: The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

Recommendation 12: The North Carolina Study Commission on Aging recommends that the General assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and to determine how the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program could be improved to increase the number of graduates whose specialty is in geriatric care and to report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

Recommendation 13: The North Carolina Study Commission on Aging recommends that the General Assembly clarify the long term care criminal records checks statutes to provide that only public information may be disclosed.

You will note that the bill draft for the labor enhancement payments bill has blanks for the appropriations. Fiscal staff is working with the Department to determine the amounts for those blanks, and we hope to have those numbers available at the final meeting. For your information, when the Commission last proposed these payments, the appropriation would have been $28,580,303 for the 2003-2004 fiscal year and $57,724,320 for the 2004-2005 fiscal year. Fiscal staff has informed us that those numbers will be higher for the draft for this year.

The Commission will hold its final meeting for this interim to consider the final report, including inclusion of these recommendations, on Thursday, January 20, 2005 at 10:00 a.m. in Room 544 of the Legislative Office Building.

Enclosures

DRAFT

Recommendation 11

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

Background

Wage comparisons presented on December 10, 2002, highlighted that direct care workers make lower median hourly and annualized wages than any of the following: dental assistants, manicurists, school bus drivers, file clerks or hairdressers. For 2000, direct care workers had a median hourly wage rate of $7.86 per hour and an annualized wage of $16,349. By 2002, the median hourly wage rate improved to $8.36. The Commission recommends that the General Assembly appropriate funds to enhance the wages for nurse aides employed by non-institutional Medicaid providers and that counties be held harmless for their share of the rate increase.

According to the Division of Medical Assistance, the NCHCFA conducts annual wage surveys of nursing homes to determine wages that nursing facilities expect to pay during the coming year. DMA uses the survey information to estimate the inflation rate that is used to determine the reimbursement rates for nursing facilities. The 2001 wage survey (survey was not conducted during 2002) identified an hourly pay rate of $9.67 for nurse aides in an institutional setting and $7.51 for nurse aides in a non-institutional setting. (Note that DMA review of PCS and CAP-DA cost reports submitted by providers primarily for SFY2001 identified an average hourly pay rate of $7.77 for nurse aides.) The NCHCFA survey was the basis for Medicaid rate increases to nursing facilities that became effective October 1, 2000. While these rate increases were not a targeted wage pass-through, the increases resulting from the wage survey were included as a component in the direct care cost rates. Because direct care costs are settled to actual through DMA audit of nursing facility cost reports, the rate increases would not be paid by DMA unless they were given to nurse aides by the providers. Similar rate increases were not made for non-institutional care Medicaid providers (most notably those who provide personal care services to patients at home, in community alternative programs [CAP], and in adult care homes). These types of providers face increasing difficulty in the recruitment and retention of nurse aides. The purpose of this recommendation is to provide funds necessary to support increased aide wage rates for those employed by this group of providers.

The Commission recommends that the General Assembly appropriate these funds to improve the wage rates of these workers, who are so vitally important to the long-term care system.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H

BILL DRAFT 2005-SWz-12 [v.2] (12/21)

D

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/21/2004 5:06:34 PM

Short Title: Wage Enhancement/Funds. (Public)

Sponsors: Representative Weiss.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR LABOR ENHANCEMENT PAYMENTS FOR NURSE AIDES IN NONINSTITUTIONAL SETTINGS.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of [redacted] for the 2005-2006 fiscal year and the sum of [redacted] for the 2006-2007 fiscal year. These funds shall be used to match federal Medicaid funds to provide a thirty-two and seven hundredths percent (32.07%) labor enhancement payment for Medicaid-reimbursed long-term care services. These funds shall be in addition to funds provided for routine inflationary increases in Medicaid reimbursements for long-term care services. The funds appropriated in this act shall be used only to increase wages or benefits for long-term care aide workers in noninstitutional settings, or to provide for shift differential payments for long-term care aides in noninstitutional settings who work during hard-to-fill working hours or shifts. Counties shall not be required to pay any of the funds required to match the federal Medicaid funds for the labor enhancement payments authorized by this act.

SECTION 2. Funds appropriated in this act shall be allocated in accordance with the following:

(1) The amount of the labor enhancement benefit shall be allocated equitably among the various care settings.

(2) Long-term care facilities and agencies that receive labor enhancement funds shall have the flexibility to determine whether labor enhancement funds are used for wages, benefits, or shift differentials, or any combination thereof.

(3) If labor enhancement funds are used to enhance wages, the long-term care facility or agency shall determine which aides receive wage

increases and the amount of the increase provided. The determination shall be based on local market wage demands, rewarding longevity of service by the worker, and other wage-related needs of the agency or facility.

(4) Long-term care facilities and agencies that receive labor enhancement funds shall, as a condition of receiving the funds, submit reports and information required by the Department for the purpose of verifying use of the labor enhancement funds. Reports and information provided by facilities and agencies shall include for each facility and agency information needed to determine annual labor turnover rates in the agency or facility, including data on prelabor enhancement turnover rates and turnover rates at the end of each fiscal year for which labor enhancement funds are received.

SECTION 3. Not later than January 15, 2007, the Department of Health and Human Services shall report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the North Carolina Study Commission on Aging on the use of labor enhancement funds appropriated under this act. The report shall include detailed information on:

(1) The amount of funds used for wages, for benefits, and for shift differentials.

(2) Comparative information on average hourly wages paid to aides and turnover rates by setting for fiscal year 1999-2000 through fiscal year 2005-2006.

SECTION 4. This act becomes effective July 1, 2005.

nursing programs need to take to help North Carolina avoid a nursing shortage. The State Board of Community Colleges also has a similar committee.

Currently, three North Carolina based institutions of higher education receive grants to improve the ability of health professionals to provide medical care for elderly Americans. The University of North Carolina at Greensboro, The University of North Carolina at Chapel Hill, and Duke University have received either federal funding from The Health Resources and Services Administration (HRSA), and/or funds from such private foundations as The John A. Hartford Foundation or The Donald W. Reynolds Foundation.

The Donald W. Reynolds Foundation recently awarded a grant to The Duke Center for the Study of Aging totaling $3 million over six years for geriatric training. Duke University will become part of a Consortium to strengthen faculty expertise in geriatrics, in cooperation with Johns Hopkins University, Mount Sinai Medical School and the University of California, Los Angeles. The Consortium members will provide fellowships to train clinical educators in geriatrics and continue the training and career development of their own junior faculty members.

Presently the Nursing Scholars Program, a merit based scholarship loan program, and the Nurse Educational Scholarship Loan Program, a need based scholarship loan program for nursing students provide funds for students in nursing programs offered by community colleges and The University of North Carolina, and by private colleges that offer licensed practical nursing or registered nursing programs. The Commission would like these programs to be studied to determine if they can be improved to increase the number of graduates specializing in geriatric care.

The Commission finds that review of these programs is necessary to ensure that there will be enough qualified workers to care for older adults in the future. The Commission is supportive of all the research based on general nursing workforce needs currently being conducted; however population predictions require the State to focus intensively on meeting the needs of the elder population through geriatric care providers. Therefore, the Commission recommends that the General assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and to determine how the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program could be improved to increase the number of graduates whose specialty is in geriatric care.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SQz-1 [v.3] (1/3)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/4/2005 5:13:26 PM

Short Title: Increase Geriatric Care Providers.	(Public)
Sponsors:	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE PRESIDENT OF THE UNIVERSITY OF NORTH CAROLINA AND THE PRESIDENT OF THE NORTH CAROLINA SYSTEM OF COMMUNITY COLLEGES TO UNDERTAKE CERTAIN STUDIES TARGETED TO INCREASE GERIATRIC CARE PROVIDERS AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The President of The University of North Carolina and the President of the North Carolina System of Community Colleges shall study ways to increase the capacity of their institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and study how to improve the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program to increase the number of graduates specializing in geriatric care. The President of The University of North Carolina and The President of the North Carolina System of Community Colleges shall report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

SECTION 2. This act is effective when it becomes law.

Recommendation 13

The North Carolina Study Commission on Aging recommends that the General Assembly clarify the long term care criminal records checks statutes to provide that only public information may be disclosed.

Background

State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area mental health authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. However, under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies other than those involving direct patient care and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

On March 23, 2004, the Commission heard a presentation from John Aldridge of the North Carolina Attorney General's office on this issue. He reiterated that unless federal law provides otherwise, the results of a national criminal history record check can only be released to a governmental agency. Currently, federal law only permits these results to be released to nursing homes and home care agencies on applicants for positions that involve direct patient care. Therefore, in order to be able to conduct national criminal history record checks on applicants for positions in nursing homes and home care agencies that do not involve patient care and on applicants for positions in adult care homes, current State law would have to be changed to direct that the results be sent to a governmental agency.

During the 2004 Session, the General Assembly enacted a provision (S.L. 2004-124, Sec. 10.19D) that attempted to facilitate the conducting of the national criminal records checks. That provision directed the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". The Department would provide notice to the provider that an applicant has a criminal record elsewhere. The Department would not reveal the contents of that record. It would be the employer's responsibility to follow up on the information to obtain the public record of that crime.

Since enactment of the provision, the Department has been informed by the federal government that further changes to the statutes are needed to ensure that only public information is revealed. Otherwise, the FBI will be unable to provide the national criminal records checks under the long-term care statutes. The Commission has long supported the need for these checks. Therefore, the Commission recommends that the General Assembly enact legislation to make the changes required by the federal government in order to be able to conduct the national criminal history records checks.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SWz-14 [v.6] (1/5)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/13/2005 2:29:45 PM

Short Title: Criminal Records Checks/LTC Changes. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE PROCEDURE FOR CONDUCTING NATIONAL CRIMINAL HISTORY RECORDS CHECKS FOR LONG TERM CARE FACILITIES TO CONFORM WITH FEDERAL REQUIREMENTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-80(b) reads as rewritten:

"(b) Requirement. – An offer of employment by an area authority licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An area authority shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, an area authority shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section. Notwithstanding G. S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~ Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~Criminal

Records Check Unit shall ~~provide to~~ notify the area authority ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the area authority. Area authorities shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of an area authority a State criminal history record check required by this section without the area authority having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the area authority. All criminal history information received by the area authority is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section."

SECTION 2. G.S. 131D-40(a) reads as rewritten:

"(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G. S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the adult care home ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the adult care home. Adult care homes shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section."

SECTION 3. G.S. 131D-40(a1) reads as rewritten:

"(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the contract agency of the adult care home ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the adult care home. Contract agencies of adult care homes shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section."

SECTION 4. G.S. 131E-265(a) reads as rewritten:

"(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under

this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. If the applicant for employment or if the current employee who is changing employment status has been a resident of this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status. A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114.19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~Criminal Records Check Unit shall ~~provide to~~ notify the nursing home or home care agency ~~the results of the national criminal history check.~~as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the nursing home or home care agency. Nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section."

SECTION 5. G.S. 131E-265(a1) reads as rewritten:

"(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on

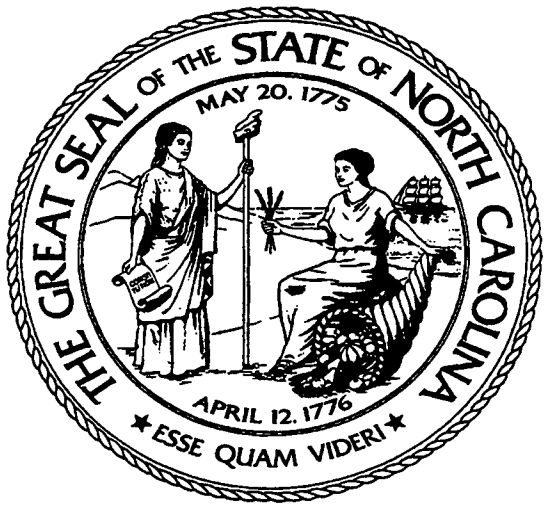
consent to a State criminal history record check of the applicant. A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~ Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the contract agency of the nursing home or home care agency ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the nursing home or home care agency. Contract agencies of nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section."

SECTION 6. This act is effective when it becomes law.

NORTH CAROLINA

STUDY COMMISSION ON AGING

DRAFT



REPORT TO THE GOVERNOR AND THE 2005 REGULAR SESSION OF THE 2005 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

January 20, 2005

To: Governor Michael Easley
President of the North Carolina Senate
President Pro Tempore of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 2005 Regular Session of the 2005 General Assembly

Attached is a report from the North Carolina Study Commission on Aging submitted to you pursuant to North Carolina General Statute §120-187. The North Carolina Study Commission on Aging presents to you findings and recommendations based on study conducted after the adjournment of the 2004 Regular Session of the 2003 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

Senator A.B. Swindell, IV
Co-Chair

Representative Debbie A. Clary
Co-Chair

Representative Edd Nye
Co-Chair

North Carolina Study Commission On Aging

2004-2005 Membership List

President Pro Tempore's Appointments

Senator Albin B. Swindell IV, Co-Chair

Senator Austin M. Allran

Senator Charlie S. Dannelly

Senator Tony P. Moore

Senator Joe Sam Queen

Mr. Brad Allen

Ms. Jan Elliot

Mr. Sam Marsh

Speakers' Appointments

Representative Debbie A. Clary, Co-Chair

Representative Edd Nye, Co-Chair

Representative David R. Lewis

Representative Jennifer Weiss

Representative William Eugene Wilson

Ms. Katherine Fox Price

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2005-SHz-6: AN ACT TO RE-ENACT THE LONG-TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2005-SWz-8: AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADULT PROTECTIVE SERVICES TASK FORCE TO COLLABORATE WITH OTHERS INTERESTED IN IMPROVING ADULT PROTECTIVE SERVICES AND REPORT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

PREFACE

As outlined in Chapter 120, Article 21 of the North Carolina General Statutes, the North Carolina Study Commission on Aging is charged with studying and evaluating the existing system of delivery of State services to older adults and recommending an improved system of delivery to meet the present and future needs of older adults. The Commission consists of 17 members. Of these members, eight are appointed by the Speaker of the House of Representatives, eight are appointed by the President Pro Tempore of the Senate, and the Secretary of the Department of Health and Human Services or the Secretary's designee serves as an ex officio, non-voting member.

This report represents the work performed by the North Carolina Study Commission on Aging from the conclusion of the 2004 Session until the convening of the 2005 Session. The Study Commission on Aging met on six occasions to study a variety of topics including: an audit of the Community Alternatives Program for Disabled Adults, issues related to home care agencies, adult care home licensure, adult protective services, and other issues concerning older adults. During the course of its study, the Commission also conducted public hearings in Cherryville and Wilson.

EXECUTIVE SUMMARY

Leaders across the nation are working to identify programs and services to meet the current and future needs of older adults. The White House Conference on Aging takes place once a decade with a goal of making aging policy recommendations to the President and to Congress. The White House Conference on Aging will be held October 23-26, 2005.

North Carolina's leaders are also working to ensure that current needs for older adults are met efficiently and effectively and that identification and planning takes place to ensure that needs of future generations of older adults are met as well. The North Carolina Study Commission on Aging plays a vital role in this effort. The Commission's statutory responsibility is to study and evaluate the delivery of services designed to meet present and future needs of older adults. North Carolina is currently composed of and serves a vital and significant older adult population. Obviously, this population segment shares a common age category, but perhaps unlike some age categories, there is a diverse range of needs for this segment. From those individuals that are active NC Senior Games participates to those frail elderly needing skilled nursing care; from urban to rural; and from residents who have family and caregivers nearby, to those whose informal support systems live far away. The range of programs and services serving older adults is diverse.

During the 2004-2005 interim, the North Carolina Study Commission on Aging met four times and conducted two public hearings in an effort to evaluate the system of services to older adults and to recommend improvements. In response to this study, the North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2005 Session of the 2005 General Assembly:

Recommendation 1
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor to conduct an assessment of the Community Alternatives Program for Disabled Adults to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Recommendation 2
The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Recommendation 3
The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry; and direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Recommendation 4
The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Recommendation 5
The North Carolina Study Commission on Aging recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules.

Recommendation 6
The North Carolina Study Commission on Aging recommends that the General Assembly authorize the Department of Health and Human Services to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Recommendation 7
The North Carolina Study Commission on Aging expresses its appreciation for the efforts of the North Carolina Senior Games program to keep older adults mentally and physically active and recommends that the General Assembly appropriate an additional $150,000 for Senior Games.

Recommendation 8
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate an additional $4,000,000 in State funds for the Home and Community Care Block Grant.

Recommendation 9
The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.

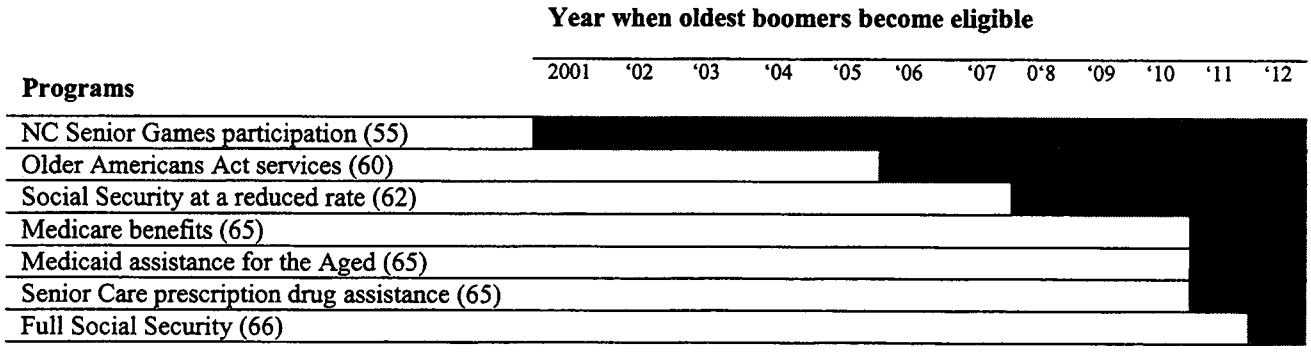
Recommendation 10
The North Carolina Study Commission on Aging recommends that the Adult Protective Services Task Force collaborate with stakeholders and persons interested in improvements to the adult protective services system, and report findings and recommendations to the Legislative Study Commission on State Guardianship Laws and the Study Commission on Aging.

OLDER ADULTS IN NORTH CAROLINA: A PROFILE

Prepared by the Department of Health and Human Services, Division of Aging and Adult Services

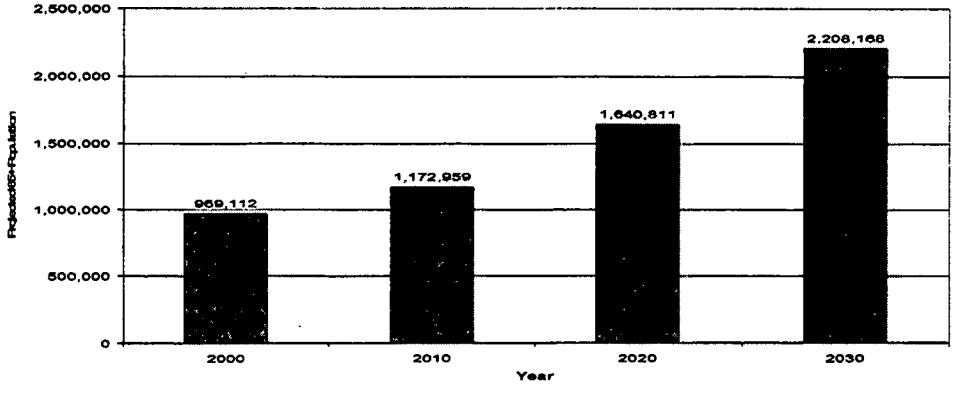
North Carolina's Demographic Shift: North Carolina is only a few years away from a significant demographic change as the state's 2.3 million baby boomers (those born between 1946 and 1964) enter retirement age in this decade. Today, the proportion of the seniors is roughly 12% of the State's total population. By 2030, when the youngest baby boomers are 65, the proportion should reach almost 18% or 2.2 million older North Carolinians age 65+ including the baby boomers who will be between ages 65 and 83. The figure below show the milestones of the baby boomers expressed in terms of some major federal and state age-related programs (eligibility age in parenthesis). For example, in 2006, the oldest baby boomers (i.e., born in 1946) will become eligible to receive services under the Older Americans Act.

Baby Boomer Milestones



The impact of the aging baby boomers is clearly indicated in the projected growth of North Carolinians age 65+ between 2000 and 2030. [1]

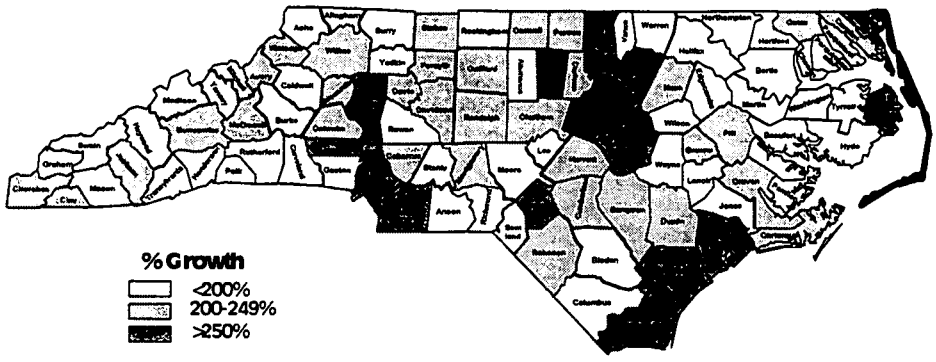
Growth of Older North Carolinians Age 65+ (2000-2030)



The figure below shows the projected growth of the older population by county between 2000 and 2030. The counties with rapidly increasing numbers of older adults are clustered along the

coast and in two major metropolitan areas (i.e., Charlotte and Triangle). The projected growth rate for the state's total population is 227.9%.

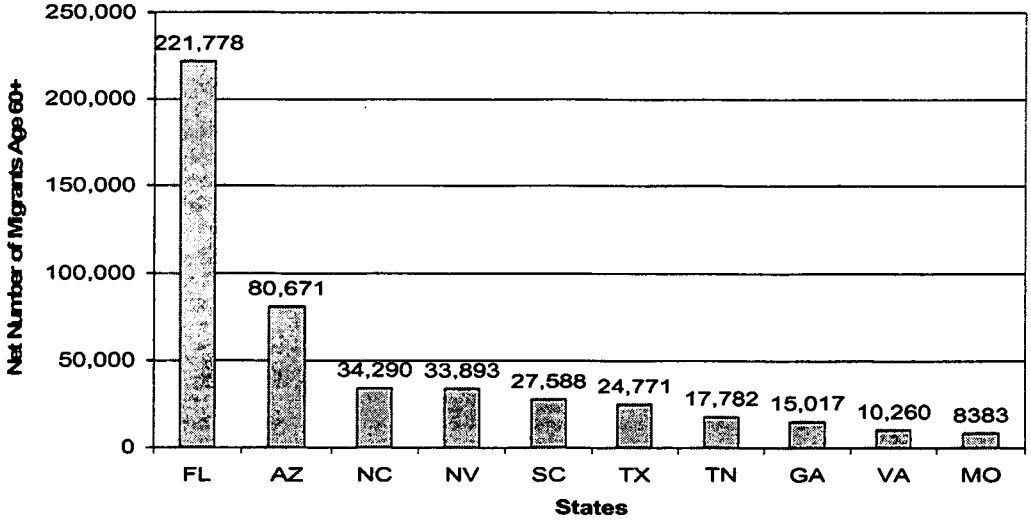
Projected Growth* of Older Population Age 65 +by County (2000-2030)



*Population projection data available from the NC State Data Center

Another major factor in the State's aging population trend is migration. North Carolina ranked third nationally with a net migration number of 34,290 among older adults (60+) in the five-year period between 1995 and 2000. Along with other Sunbelt states (Florida, South Carolina, Texas, Tennessee, Georgia, and Virginia) North Carolina remains a popular destination for people of all ages, including seniors. [2]

Top Ten States with Net Number of Migrants Age 60+ (1995-2000)



The increasing life expectancy in later years also contributes to the growth of the older population. According to the latest estimate from the NC State Center for Health Statistics, babies born today in North Carolina are expected to live, on average, to the age of 75.6 years. The North Carolinians who are age 60 today are expected to live, on average, an additional 20.8 years to almost 81 years old. Generally, women live longer than men and whites live longer than persons of minority race. However, at the oldest ages, minorities have a life expectancy that is

the same or slightly greater than that of whites. This is known as the "crossover effect." [3]

Life Expectancies (Years) by Age Group, Gender, and Race

Age Groups	NC Combined	White		Minority	
		Male	Female	Male	Female
(At Birth)	75.6	73.8	79.6	68.0	75.8
60-65	20.8	19.0	22.9	16.8	21.5
65-69	17.1	15.4	18.9	13.8	17.8
70-74	13.7	12.2	15.1	11.1	14.5
75-79	10.6	9.3	11.6	8.8	11.4
80-84	7.9	6.8	8.5	6.7	8.6
85+	5.4	4.5	5.7	4.8	6.0

Source: NC Center for Health Statistics (2002). *Healthy Life Expectancy in North Carolina, 1996-2000*

There are other important factors influencing the diverse experiences in demographic shifts among the State's 100 counties including [4]:

- Rural-to-urban migration of young adults continues to age rural counties.
- Large metropolitan counties attract large numbers of persons from outside the State as well as from rural counties.
- The large metropolitan counties are experiencing greater growth among younger adults than they are among older adults.
- A large number of older adults with higher incomes are retiring in some western and coastal counties.

What Are the Implications of This Shift? The aging of the population is a national and international trend, and North Carolina, like the rest of the world, must be prepared to reap the benefits and face the challenges of an older population. Government faces decisions about the allocation of public resources from a tax base that may experience slowed growth, especially in many aging rural counties. People must consider living and caregiving arrangements in light of smaller nuclear and extended families. The health, human service, employment, and education systems must adapt to the changing needs and interests of the seniors of today and tomorrow. The business, faith communities, and others must identify and respond to the challenges and opportunities of these demographic shifts.

In the 2003-2007 State Aging Plan, the NC Division of Aging and Adult Services introduced a new initiative–Senior-Friendly Communities–to raise awareness of the aging of our population and to promote the North Carolina communities becoming senior-friendly through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. A senior-friendly community in North Carolina will draw on the talents and resources of active seniors while enhancing services for those who are vulnerable because of their health, economic hardships, social isolation, or other conditions. A senior-friendly community will work to

address a wide range of issues and concerns (e.g., air quality, housing, long-term care services, employment, enrichment opportunities) that, as a whole, affect the quality of life of seniors and others in the community. Also, a senior-friendly community will assure stewardship of its resources to meet the needs of today's seniors, while helping baby boomers and younger generations prepare for the future.

Demographic Highlights

Population: North Carolina ranks tenth among states in the number of persons age 65 and older and eleventh in the size of the entire population. [1] The fast pace of growth of the State's older population is evident in a US Census Bureau's release in which North Carolina was ranked fourth nationally in the increase of the number of older persons age 65+ (47,198 in NC) between April 2000 to July 2003. Only three other states (California, Texas, and Florida) reported a greater increase among their older populations. Even so, when combined with the equally strong growth in other age groups, North Carolina continues to maintain an overall healthy demographic balance among the generations.

- Estimated NC population age 65+ in 2005: 1,035,543 (12.1% of total population)
- Estimated NC population age 85+ in 2005: 125,093 (1.4% of the total population)

Diversity and Disparity: North Carolina is rich in diversity, but its citizens face challenges because of the disparity that exists among all populations, including older adults. Some important differences among NC's older adults relate to gender, marital status, race/ethnicity, residence, rurality, disability, health status, and veteran status.

- Gender: Older women represent 59.8% of the 65+ age group and 74.0% of the 85+ age group. [1] The higher rate of poverty among older women remains a primary issue today. For example, women age 75+ are twice as likely to be poor as men the same age. [5]

- Marital Status: At age 65 and older, women are more than twice as likely to be unmarried as men in their age group. [6] Data show that being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. According to the Social Security Administration, 50% of unmarried women rely on Social Security for 80% of their income and 25% rely on Social Security as their sole source of income. [7]

Marital Status by Age Group

	Age 65-74	Age 75-84	Age 85+
Unmarried Women in NC	45.4%	65.8%	76.5%
Unmarried Men in NC	18.7%	25.2%	39.4%

Source: NC Division of Aging and Adult Services (2003). *The 2003-2007 North Carolina Aging Services Plan.*

- Ethnicity/Race: Altogether 18.1% of persons age 65+ are members of ethnic minority groups in North Carolina. [8] Compared to the nation as a whole, North Carolina's population age 65+ includes a larger proportion who are African American (15.3% in NC to 8.3% nationally) and a smaller proportion of Latinos (0.6% in NC to 4.7% nationally). American Indians, Asian Americans, and other ethnic groups each account for 1% or less of the age group 65+. The statistics for African American and other older adults who are

minority group members, in North Carolina as well as nationally, show both a higher poverty rate and a lower life expectancy when compared with the white population. [Note: See the Demographic Shift section for the information on life expectancy.]

Poverty Status by Gender and Race

	65+	White		Minority	
	Total	Male	Female	Male	Female
Below Poverty	13.2%	6.5%	12.9%	21.7%	30.3%
"Near Poor"(101-200% Poverty)	23.2%	–*	–*	–*	–*

*Information currently not available.

Source: NC Division of Aging and Adult Services (2003). *The 2003-2007 North Carolina Aging Services Plan.*

- Residence: In North Carolina, 23.8% of all homeowners are age 65+, yet among older homeowners, over 61,000 reported incomes for 1999 that were below poverty. [9] This figure represented 38% of the homeowners of all ages with income below poverty and exceeded the national average of 32.7%. Among renters age 65+ who provided information, 53%, or almost 48,000, spent more than 30% of their household income on rent. Furthermore, 5,000 North Carolina homeowners and renters age 65+ lacked complete plumbing facilities in their homes. [10]

- Rurality: Although the Bureau of the Census has not yet released figures specifically for the older population residing in rural areas, it is expected to easily exceed 39.8%, the rate for the total population. [11] In 2000, North Carolina's rural population (3,199,831) was almost as large as the one in Texas (3,647,539), the state with the largest number of rural residents in the nation. Not only was North Carolina's rural population among the largest in terms of numbers, but the state also reported the highest proportion (39.8%) of rural population among the 20 most populous states in the nation. While 11 other states reported higher proportions of rural population, ranging from 40.7% to 61.8%, all of these states are much smaller in total population than North Carolina. Thus, North Carolina is unique among more populous states in having so large a rural contingency. A 2002 report highlights a long list of challenges the rural residents and their communities face—isolation by distance, lagging infrastructure, sparse resources that cannot adequately support education and other public services, and weak economic competitiveness. [12]

- Disability: In North Carolina, 45.7% of the non-institutionalized civilian population age 65+ reported having one or more disablities—47.5% of women and 43.2% of men, according to the 2000 Census. [13] The Census defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business."

- Health Status: Heart disease is the leading cause of death among older adults both nationwide and in North Carolina with cancer and stroke, second and third on the list. [14] In particular, the coastal plains region of North Carolina has the fourth highest stroke death rate in the nation and is labeled by some as the Buckle of the Stroke Belt. African

Americans and other racial minorities are at substantially higher risk for certain chronic conditions such as heart disease, stroke, and diabetes (a major contributor to heart disease, stroke and other conditions). [4]

Five Leading Causes of Death among North Carolinians Age 65+

Rank	Cause
1	Heart diseases
2	Cancer
3	Cerebrovascular diseases including stroke
4	Chronic lower respiratory diseases
5	Alzheimer's disease

Source: NC Center for Health Statistics (2003). *Leading Causes of Death – 2002.*

Physical inactivity is known to increase a person's risk of heart disease, diabetes, and other chronic conditions. North Carolinians age 65+ are ranked third from the bottom at 40% in terms of the proportion of older population that participate in physical activities. [15]

In a statewide survey, over one third of people age 65+ say that their general health status is fair or poor, ranging from 34.1% for white women to 49.3% for minority women. In the same survey, 18.4% (highest) of minority women and 4.4% (lowest) of White men age 65+ said that there was a time they could not see a doctor due to medical cost. [16]

- Veteran Status: Of the 779,393 veterans living in NC, 263,102, or 34%, were age 65 and older in 2000. Another 34% were Vietnam-era veterans (between 43 and 57 years old in 2000). The population of veterans of the Vietnam-era contains proportionally more disabled members than the veterans' populations of earlier wars. [17] The Veterans Administration cites the aging of the veterans as a major challenge to its health care system in coming years. [18]

Sources of Information

[1]NC State Data Center (2005). *County/State Population Estimates.*
[2] Charles Longino (2003). *States Ranked by the Net Number of Migrants Age 60+, 1985-1990 and 1995-2000.*
[3]NC Center for Health Statistics (2002). *Healthy Life Expectancy in North Carolina, 1996-2000.*
[4]NC Division of Aging and Adult Services (2003). *The Aging of North Carolina: The 2003-2007 North Carolina Aging Services Plan.*
[5] Institute for Research on Women & Gender (2002). *Difficult Dialogues Program Consensus Report: Aging in the Twenty-first Century.*
[6]US Census Bureau (2002). *Census 2000 PCT 7 (Summary File 3).*
[7]US Social Security Administration (1998). *Fast Facts & Figures about Social Security.*
[8]US Census Bureau (2003). *Census 2000 P12 (Summary File 1).*
[9]US Census Bureau (2002). *Census 2000 HCT 8 (Summary File 2).*
[10]NC State Library (2003). Special tabulation from the Census 2000 data as requested by the NC Division of Aging and Adult Services.
[11]US Census Bureau (2003). *Census 2000 P2 (Summary File 1).*
[12]MDC (2002). *State of the South 2002.*
[13]US Census Bureau (2003). *Census 2000 PCT 26 (Summary File 3).*
[14]NC Center for Health Statistics (2003). *Leading Causes of Death-2002.*
[15]NGA Center for Best Practices (2004). *Measuring the Years: State Aging Trends & Indicators.*
[16] NC Department of Health and Human Services (2003). *A Health Profile of Older North Carolinians*
[17]US Department of Veterans' Affairs (2002). *VA History in Brief.*

[18]US Department of Veterans' Affairs (2002). *Data on the Socioeconomic Status of Veterans and on VA Program Usage.*

Pertinent Web Sites for Related Information

- NC Division of Aging and Adult Services (http://www.dhhs.state.nc.us/aging/demo.htm)
- NC State Data Center (http://demog.state.nc.us/)
- NC State Center for Health Statistics (http://www.schs.state.nc.us/SCHS/)
- US Census Bureau (http://www.census.gov)

COMMISSION PROCEEDINGS

October 21, 2004

The North Carolina Study Commission on Aging conducted the first of two public hearings on October 21, 2004 at 10:30 a.m. at the First Baptist Church in Cherryville. Representative Clary was the presiding Co-Chair. At this hearing, 14 people spoke on a variety of issues of concern to seniors, including home and community-based services, Senior Games, CAP/DA, mental health patients in nursing homes and adult care homes, and staffing ratios in nursing homes, Appendix A. Volunteers were present to provide information and enroll participants in the NC Senior Care program for prescription drugs.

October 26, 2004

The North Carolina Study Commission on Aging conducted its second public hearing on October 26, 2004 at 1:00 p.m. at the Wilson County Agricultural Center in Wilson. Senator Swindell was the presiding Co-Chair. Thirty-three people spoke to Commission members about a number of concerns, including Senior Center funding, the long-term care insurance tax credit, transportation, funding for home and community based services, and lack of affordable housing for seniors, Appendix A. NC Senior Care volunteers were again present to provide information and enroll participants in the program.

October 27, 2004

The North Carolina Study Commission on Aging met on Wednesday, October 27, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Nye was the presiding Co-Chair. At this meeting, the Commission heard several reports and updates concerning ongoing programs.

After approving its budget for 2004-2005, the Commission heard presentations from Dianna Jessup, Commission Staff, on 2004-2005 legislation of interest to seniors and the status of the Commission's recommendations in 2004, Appendix B. Ms. Jessup reported that 9 of the 10 recommendations of the Commission were acted upon during the 2004 Session. The only recommendation that was not acted upon was the Commission's recommendation that the General Assembly repeal the sunset on the long-term care insurance tax credit.

Following the legislative update, the Commission heard from Janet Hayes of the Office of the State Auditor on the results of a CAP/DA audit, PER-2004-0208, that was originally recommended by the Commission. The audit focused on Department of Health and Human Services guidelines and goals used to implement and administer the program and assessment measures used to determine compliance with the State's CAP/DA waiver. The audit did not assess the quality and adequacy of actions from a medical or clinical perspective. The audit concluded that generally, the Department was in compliance with the guidelines under which the program is authorized. However, a few operational changes were suggested to improve administration of the program. Suggested changes include updating the CAP-DA manual, providing more training for locals, adding computer edits for payment approval, performing annual on-site reviews and improving the use of technology by locals. The audit also concluded that to improve the assessment of the program, the General Assembly should provide funds to complete an audit of the clinical aspects of the program.

Next, Michael Keough from the Department of Health and Human Services (DHHS) updated the Commission on NC Senior Care, the State's prescription drug program. Specifically, Mr. Keough focused on the implications of the new Medicare discount card and recent changes to the program. Pursuant to a provision in last year's budget, Senior Care is authorized to autoenroll seniors in the Medicare discount drug card program. Current and future participants in Senior Care whose income is not more than 135% of the federal poverty level are eligible for automatic enrollment in the Medicare discount drug card program; however, those individuals must have an opportunity to decline automatic enrollment if they choose. Other changes to the Senior Care program have expanded benefits and persons covered by the program, including elimination of the restrictions on eligibility or covered drugs based on diagnosis and increasing the upper income threshold for eligibility from 200% to 250% of the federal poverty level. There is now a Senior Care Community Care Rx program that allows members with both benefits to have one card instead of two and ensures that no State money is spent until the federal transitional assistance program money is spent. NC Senior Care and Medicare drug program benefits have been communicated to North Carolina residents through community-based meetings, news articles, and a statewide NC Senior Care sign-up day on October 26, 2004.

The final topic for this meeting was the pilot project for long term care community service coordination. The objective of this initiative is to give counties the structure and technical assistance needed to develop and implement a local long term care planning process. Several persons spoke on the status of the pilot. First, Julie Bell of the Division of Aging and Adult Services, DHHS, spoke on pilot site selection and pilot site activities to date. Two volunteer pilot communities were chosen to participate in evaluating their long term care services and in identifying and implementing strategies to strengthen long term care services for older and disabled adults. The Long Term Care Cabinet chose New Hanover and Mecklenburg counties to participate based on their capacity and willingness to undertake the project. John Highfill, Adult Services Section, Mecklenburg County Department of Social Services, updated the Commission on Mecklenburg's activities. Mecklenburg developed a Steering Committee and an Executive Advisory Board to lead their efforts. Work groups met to evaluate the county's long term care services and determine the major barriers and gaps in services. Recommendations generated by the work groups were referred to the Steering Team. A Planning Report was generated, which details the leading concerns realized during the planning process and recommendations. Gayla Woody from the Centralina Council of Governments Area Agency of Aging, spoke about Rowan County's efforts at long term care planning. Finally, Steve Friedman from the Division of Aging and Adult Services, DHHS, noted that funding for local long term care planning and more State consultation and technical assistance are needed.

November 10, 2004

The North Carolina Study Commission on Aging met on November 10, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator Swindell was the presiding co-chair. Presentation topics for this meeting included: restructuring personal care services, adult care home licensing, consumer-directed care and a report on care for the mentally ill in long-term care facilities. The Commission also received a summary of comments from the public hearings.

The presentation on the Medicaid In-Home Personal Care Services Program Appendix C was given by Lynne Perrin, Chief, Facility and Community Care Clinical Policy and Programs, Division of Medical Assistance (DMA), Department of Health and Human Services; and Sherry Thomas, Senior Vice President, Association for Home and Hospice Care of North Carolina (AHHC). Ms. Perrin gave the Commission members background information on the program

including: types of Personal Care Services (PCS), reimbursement amounts, providers, and benefit limitations. She informed the Commission that in 2004, Medicaid PCS expenditures were $220,933,622 and there were 41,222 recipients. For SFY 2004, the average annual expenditure per recipient was $5,360 and the average monthly expenditure per recipient was $446. Ms. Perrin pointed out that the PCS program is important to the State's long-term care system and has been operating since 1985 with little change in administrative structure or State-level oversight. Reasons to restructure include: growth in program expenditures and recipients; growth in the number of providers and appropriate targeting of services; quality issues; the need to refine and clarify medical criteria; the need for improved assessment tools; the need for provider standards, training, and best practices; and the need to improve State-level oversight and monitoring functions. As a result, a PCS restructuring initiative was undertaken by AHHC and DMA in January 2004. Ms. Thomas presented recommendations for improvement and a comparison of the current PCS structure to a restructured PCS program. Among the recommendations for improvement are: a new Registered Nurse (RN) assessment that serves as a certification that assessment is accurate and also as the physician's authorization for services; a new patient assessment tool; revised RN supervision standards; and quality assurance/utilization reviews. The desired outcome of the program improvements is, "To assure PCS continues to be an important service in the State's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure service quality and fiscal accountability." It is anticipated that the implementation process will take from 6-10 months, and the target date for implementation is July 1, 2005.

Bob Fitzgerald, Director, Division of Facility Services, DHHS, and Melissa Trippe, Attorney, Office of the Attorney General, addressed the Commission on the topic of adult care home licensing. Current law requires DHHS to conduct a compliance history review of a facility, and its principals and affiliates, prior to renewing a license or issuing a new license. The Department has the authority to refuse to license a facility when the compliance history review reveals a pattern of noncompliance. (Rules adopted by the Medical Care Commission define the terms: "affiliate," "owner," and "principal.") Mr. Fitzgerald briefly mentioned a series of newspaper articles that may have indicated the need for an overhaul of the licensing application process. He and Ms. Trippe indicated that an overhaul of the system was not necessary, but do believe that the State would benefit by granting DHHS the authority to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Next the Commission heard from Ann Eller and Lynne Perrin on North Carolina's consumer-directed care initiatives. Ms. Eller's presentation began with a definition of consumer-directed support that was supplied by Sue Flanagan, National Institute on Consumer-Directed Long-Term Services. Ms. Flanagan defined consumer-directed support as, "A philosophy and orientation to the delivery of home and community based service delivery whereby informed individuals assess their service needs, determine how and by whom these needs should be met and monitor the quality of services received." Ms. Eller told the Commission that this concept supports individuals in need of assistance with activities of daily living; allows individuals to plan, budget, and make choices that work best for them; and allows participants control in managing their support services (i.e. attendant/aide, medical equipment and supplies, and mobility aides). There are three main steps for participants: Participant-Centered Plan, Participant Budget, and Participant Direction of Services. The team members include the following: participant, representative (optional), support advisor, attendant/aide, financial manager, and State and local government. In closing, Ms. Eller noted that consumer-directed support fulfills the intent of the *Olmstead* decision to support individuals through cost-effective community based systems, and

promotes full community participation of individuals with disabilities as encouraged by the federal New Freedom initiative.

Lynne Perrin presented information on the Community Alternatives Program (CAP) Choice waiver that targets elderly and disabled adults who require nursing facility level of care. Ms. Perrin told the Commission that the CAP Choice waiver is an alternative to Community Alternatives Program for Disabled Adults (CAP/DA). CAP Choice provides elderly and disabled adults the flexibility to manage their own care plans. The CAP Choice waiver allows recipients to hire, train, supervise, evaluate, and release a personal assistant; negotiate the assistant's pay and other benefits; and select providers and direct reimbursement. The Division of Medical Assistance received approval from the federal Centers for Medicare and Medicaid Services to implement the Independence-Plus 1915(c) waiver (CAP Choice) in January 2004. The CAP Choice pilot will be held in Duplin County and Cabarrus County. Currently, these pilot counties serve approximately 400 CAP/DA clients. Ms. Perrin reported that the target date for implementation is January 2005.

Dr. Bonnie Morrell, Division of Mental Health, Developmental Disabilities, and Substance Abuse, Department of Health and Human Services (DHHS) made an interim report on the provisions contained in S.L. 2004-144 (SB 1148). S.L. 2004-144, based on a recommendation made by the Commission, requires DHHS to study the mission of the Geriatric Mental Health Specialty Teams, to standardize five criteria across the Teams, to immediately begin tracking expenditure and use data, and to submit an interim report by October 30, 2004. Dr. Morrell reported that DHHS has defined the team purpose and the eligibility for services, which are two of the five criteria to standardize. Dr. Morrell also told the Commission that a committee has been formed to study the mission of the teams and the first meeting was held on October 28, 2004. The Department is continuing to work on developing and implementing a screening and referral process, developing an operations manual, and implementing the tracking system. S.L. 2004-144 requires DHHS to submit their final report on its standardization and tracking efforts, and the results of its study, by October 30, 2005.

For the final presentation of the meeting, Staff member, Shawn Parker, presented a summary of public hearing comments. The Commission held a public hearing on October 21, 2004 in Cherryville, NC and a public hearing in Wilson NC on October 26, 2004. Mr. Parker provided the Commission with a handout Appendix A portraying the frequency of issues expressed by the speakers during the hearings. The issues mentioned with the greatest frequency were as follows:

- Preserve/Expand Support for Senior Games;
- Preserve/Expand Senior Centers Including Certified Senior Centers;
- Preserve/Expand Support for In-Home and Community-Based Services;
- Lower/Provide Assistance with Prescription Drug Costs; and
- Concerns About Combining Mentally Ill and Elderly Populations.

December 1, 2004

The North Carolina Study Commission on Aging met on December 1, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Clary was the presiding co-chair. At this meeting, the Commission heard presentations on adult care home licensing, elder mistreatment and abuse, and an adult day service reimbursement methodology study. The Commission also reviewed and approved recommendations to be presented to the Governor and the 2005 Session of the 2005 General Assembly.

Lieutenant Governor Beverly Perdue addressed the Commission on the topic of adult care home licensing. In her introduction, Lieutenant Governor Perdue described to the Commission her past efforts in spearheading an initiative to update the statutes on adult care homes in North Carolina that resulted in the 1999 passage of Senate Bill 10 (a component of the bill limited the expansion of adult care homes facing compliance complaints). Lt. Governor Perdue stated that according to an investigative series published in the Raleigh News and Observer last spring, operators of multiple homes appear to have circumvented the law by registering each individual home as a separate corporate entity. Referring to her discussions with Bob Fitzgerald, Director of the Division of Facility Services, the Attorney General's office, and staff attorneys with the North Carolina General Assembly, Lt. Governor Perdue explained that G.S. 131D-4.5(6) satisfies legislative intent, so substantive changes are not needed. She did, however, believe that the intent could be more closely adhered to if punitive authority for the Division of Facility Services is created. Lt. Governor Perdue then requested the following: 1. Clarification of the language on the renewal license application for the provider so that it is simple, clear and concise and is consistent with rules and regulations. 2. Determination by DHHS of what is considered a pattern of non-compliance that demonstrates disregard for health, safety and welfare of residents in current facilities and past facilities. 3. Adoption of rules by the Medical Care Commission to define the length of compliance history information from the applicant licensee and what constitutes compliance history information. 4. Establishment of a plan of action by DHHS when there is a licensee identified that disregards health, safety and welfare of residents. In addition, she suggested that the Department should have a plan ready to inspect all associated or affiliate facilities. An analysis of cost reports for each facility should be conducted to determine how the licensee, in meeting requirements of the home and financial stability of each home across the whole organization, has utilized reimbursement money. Based on the inspection results and reimbursement analysis, a determination for each facility should be made based on the established pattern of non-compliance history and reimbursement. Lt. Governor Perdue also strongly encouraged the Commission to re-enact the long term care insurance tax credit that expired on January 1, 2004. Lt. Governor Perdue concluded her presentation by reiterating the importance of the Commission's work. She thanked everyone for past efforts and noted that she looks forward to working with the Commission during the 2005 Session.

A status report on the North Carolina Adult Day Services Reimbursement Study was presented by Nancy J. Cox, Director, Partners in Caregiving: The Adult Day Services Program from the Department of Psychiatric and Behavioral Medicine, Wake Forest University School of Medicine. Ms. Cox began by identifying Section 10.21(a) of S.L. 2004-124 as the impetus for this study. After a brief history of adult day services in North Carolina, Ms. Cox explained the service definitions for Adult Day Care and Adult Day Health Care. Gary Cyrus from the Division of Aging and Adult Services, DHHS, continued the presentation with a budget analysis of the three funding streams for adult day services. Services are funded through the Home and Community Health Care Block Grant (HCCBG), the State Adult Care Fund (SADCF) and Community Alternatives Program for Disabled Adults (CAP/DA). Mr. Cyrus then presented a program comparison with South Carolina, Virginia, Georgia, and Florida. Mr. Cyrus explained that one difference is that North Carolina reimburses by days of enrollment, but the four other states reimburse by attendance. Mr. Cyrus provided the methodology of the survey. He explained the study was conducted by use of key informant interviews including staff from DHHS (Division of Aging and Adult Services and Division of Medical Assistance), the North Carolina Adult Day Services Association, and adult day services providers in the 17 Area Agency on Aging regions. Ms. Cox completed the presentation by offering three key issues for consideration: the current system does not allow for negotiated rates; no formal system is in place to determine and report unit cost and a reasonable reimbursement rate; and there are

differences among the funding streams that could possibly be made uniform to ease administration and promote clarity and fairness in the application of rules. She pointed out that this would not require legislative action, but could be handled by the administrative process. Representative Clary suggested consulting with staff and co-chairs to determine if any of the recommendations would require legislation.

Next the Commission heard from Dr. Margaret Hudson on elder mistreatment. Dr. Hudson's presentation included a historical perspective on the topic based on research that has been completed over the last twenty-five years. She defined the differences between elder mistreatment, elder abuse, elder neglect and self-neglect in the context of North Carolina adult protective services, and recommended a change of wording in G.S. 108A-101 to more accurately reflect these differences. She reiterated elder abuse and elder neglect are different and must be studied separately. Dr. Hudson concluded her presentation by advocating for a place that healthy elders can go for help. Dr. Hudson also suggested a coalition to help with the formal training, circumventing the tendency to focus on ruling out mistreatment instead of ruling in mistreatment.

Dianna Jessup and Theresa Matula, Committee Staff, then presented draft recommendations for the Commission's consideration. After review and discussion, those recommendations were adopted, and staff was directed to prepare a report for adoption at the next meeting. Representative Weiss raised two additional recommendations. The Commission asked her to have more definitive recommendations drafted for consideration at the next meeting.

January 20, 2005

The North Carolina Study Commission on Aging met on Thursday, January 20, 2005 at 10:00 a.m. in Room 544 of the Legislative Office Building. Members of the Commission discussed and approved the Commission's Report to the Governor and to the 2005 Session of the 2005 General Assembly. Members also heard presentations on the Adult Day Service Training and Reimbursement Methodology Report as authorized by S.L. 2004-124, Section 10.21; the Medicaid Institutional Bias Study Report, as authorized by S.L. 2004-124, Section 10.13; and the Special Assistance In-Home Program, as authorized by S.L. 2003-284, Section 10.51(b).

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this section to the Governor and the 2005 Session of the 2005 General Assembly. Each recommendation is followed by background information, and corresponding legislative proposals appear in Appendix E of this report.

Recommendation 1

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor to conduct an assessment of the Community Alternatives Program for Disabled Adults to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Background

The North Carolina Study Commission on Aging recommended that the 2003 General Assembly direct the Office of the State Auditor to conduct a full audit of the Community Alternatives Program for Disabled Adults (CAP/DA). In response to the Commission's recommendation, S.L. 2003-284, Section 10.29B(a) provided that the State Auditor should perform an audit of the CAP/DA program if State funds were appropriated. The provision directed the Auditor to build upon the results of the study conducted by the North Carolina Institute of Medicine in accordance with S.L. 2002-126, Section 10.16(c). The purpose of the audit was to determine whether CAP/DA is operating within waiver guidelines and program goals. During the course of its study, the Commission heard a number of presentations on CAP/DA, and 33% of those who spoke during the March and April 2002 public hearings expressed support for the program. Much of the concern regarding the CAP/DA program stemmed from fact that the Division of Medical Assistance had directed that effective October 1, 2001, no individuals could be added to CAP/DA. However, by August 2002, new enrollees were allowed to replace people leaving CAP/DA.

Although the General Assembly did not provide funding, the Office of the State Auditor did conduct a performance audit, PER-2004-0208, on the Community Alternatives Program for Disabled Adults. The presentation made during the meeting on October 27, 2004 meeting, specified that the objectives of the audit were: 1. To determine guidelines and goals used to implement and administer CAP/DA; and 2. To identify program assessments used by CAP/DA. The findings and recommendations for each of the two objectives were outlined and an issue for further study was identified, Appendix D.

The audit report specifies that, "to provide complete information to the General Assembly, the Auditor would require assistance from outside subject matter specialists to fully assess the medical and clinical quality and/or adequacy of actions taken by DMA." The report further states that, "the Auditor strongly recommends that the General Assembly provide funds to fully determine the CAP/DA program's compliance with waiver guidelines and goals. Those funds would allow the State Auditor's Office to obtain assistance from health care professionals to assess the following areas: Review of case files to assure compliance with the requirement for medical necessity, plans of care, and provision of needed services; Review of service provider standards and monitoring of same; Review of safeguards to protect health and welfare of clients; Determination that clients are institutionalized when necessary; and Review of the independent assessment function for the program."

The Office of the State Auditor indicated that it would cost $150,000 to secure the services of experts who could evaluate the quality and adequacy of the medical and social services provided to CAP/DA clients. This would be accomplished by:

1. Conducting a qualifications review of-
   - local lead agency case managers (licenses, qualifications, educational levels, etc.),
   - local provider organizations (licensed or certified), and
   - provider's employees who actually see clients (licenses, qualifications, educational levels).
2. Conducting a "desk review" of documents to determine-
   - the medical justification supplied by the attending physicians on the FL2 forms,
   - adequacy and completeness of the plans of care prepared by local case managers, and a
   - comparison of services provided per case notes to services needed per physicians.
3. Conducting in-home visits with a sample of clients, discussing care with clients, and confirming that case notes document services received.

The Study Commission on Aging believes that CAP/DA is a vital offering in the State's array of care options and therefore the program should run efficiently and effectively. As such, the Commission recommends that the General Assembly appropriate $150,000 to the Office of the State Auditor for the purpose of conducting an assessment of CAP/DA to determine the medical and clinical quality and adequacy of actions taken by the Division of Medical Assistance.

Recommendation 2

The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Background

On November 10, 2004, the Commission heard presentations on the Medicaid In-Home Personal Care Services (PCS) Program, Appendix C. This presentation pointed out a number of recommendations for program improvement with the desired outcome being, "To assure PCS continues to be an important service in the state's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure service quality and fiscal accountability. During the presentation, the Commission was told that the Association of Home and Hospice Care supported legislation granting the Medical Care Commission the authority to define geographical service areas for home care licensed agencies as a way to assure adequate access to Registered Nurse supervision.

Home care agencies, licensed by the Division of Facility Services, DHHS, and enrolled in the Medicaid program provide PCS in North Carolina. As of October 2004, there were a total of 1,284 licensed home care agencies – 1055 were licensed-only home care agencies, and 219 were Medicare-certified home health agencies. Certified agencies have geographical service areas defined by the federal Centers for Medicaid and Medicare Services (CMS). Licensed-only agencies providing in-home aide services do not have a defined service area. Both the Department of Health and Human Services, and the Association of Home and Hospice Care (AHHC), have concerns about home care agencies serving clients in areas that are too far from the licensed site. Current State statutes and rules provide that any agency licensed by DHHS is subject to inspections as a

condition of holding the license. Further, G.S. 131E-138(g) provides that DHHS, at its discretion, determine the frequency and extent of the review and inspection of home health agencies already certified as meeting federal requirements, but not more frequently than on an annual basis for routine reviews. According to DHHS, Medicare-certified home health agencies currently receive inspections not less than every 3 years. However, there is currently not a mandatory inspection cycle for licensed-only home health agencies. This recommendation seeks to establish a survey cycle of every two years.

In order to establish a two-year survey cycle, additional employees would be needed. According to DHHS, there are currently 27 employees in the Acute and Home Care Branch of the Licensure and Certification Section, of these employees; seven are involved in the regulation of Medicare-certified home health agencies, home care agencies and hospices. The employees spend the majority of their time regulating Medicare-certified home health agencies, since federal money provides most of the position funding. However, only one and a half of the seven positions are devoted to the regulation of licensed-only home care agencies and this regulation primarily involves conducting initial surveys and investigating complaints. The Department estimates that they will need to establish 8 positions, at a cost of $550,000, to implement the two-year survey cycle. The $550,000 includes salary, benefits, and other costs related to establishing the positions. Therefore, the Commission recommends that the General Assembly direct the Medical Care Commission to define geographical service areas and staffing qualifications for licensed home care agencies providing in-home aide services, and to appropriate $550,000 to increase the survey cycle to every two years for licensed only in-home aide agencies.

Recommendation 3

The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry; and direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Background

Pursuant to the North Carolina General Statutes (Article 15, Chapter 131E) and the North Carolina Administrative Code (10 NCAC 3B-1000 to 1002), the North Carolina Health Care Personnel Registry is a comprehensive listing of personnel who have been subject to findings, or where an investigation is required based on an accusation, in situations involving abuse; neglect; misappropriation of property; diversion of drugs belonging to a health care facility, patient or client; and fraud against a health care facility, patient, or client. Home Care Agencies, as defined in G.S. 131E-136, are among the entities that are considered "health care facilities" under G.S. 131E-256(b). Therefore, a home care agency must access the Health Care Personnel Registry before hiring health care personnel and must notify the Department of all allegations against health care personnel.

The NCAC contains rules that prohibit adult care homes from hiring individuals with substantiated findings on the Health Care Personnel Registry (10A NCAC 13F .0407(5)), and that prohibit nursing homes from hiring individuals who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property (10 NCAC 3H .2210 and 42 CAR Section 483.13(c)(ii)(B)). The rules for home care agencies do

not prohibit hiring individuals with substantiated findings on the Health Care Personnel Registry. The Commission supports long-term care consumer protection and recommends that the General Assembly direct the Medical Care Commission to adopt rules to prohibit a licensed home care agency from hiring an individual with substantiated findings on the North Carolina Health Care Personnel Registry.

The entities and individuals subject to the provisions of the Health Care Personnel Registry are defined by statute. G.S. 131E-256(b) defines entities that are considered "health care facilities" and G.S. 131E-256(c) defines individuals that are considered "health care personnel." Concerns were expressed regarding whether these statutory definitions contain a comprehensive listing of all entities and personnel currently providing similar hands-on care. In response to this concern, the Commission recommends that the General Assembly direct the Department of Health and Human Services to study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be included in the Health Care Personnel Registry and report their findings to the Study Commission on Aging.

Recommendation 4

The North Carolina Study Commission on Aging recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Background

The Home Care Agency Licensure Act establishes licensing requirements for home care agencies and is contained in Part 3, Article 6, Chapter 131E of the General Statutes. The Department of Health and Human Services (DHHS) is charged with the application process under G.S. 131E-138. This section also requires that each application filed with DHHS contain all information requested. The Department charges a nonrefundable annual license fee of one hundred seventy-five dollars ($175.00). A license granted to an applicant upon a determination by DHHS that the applicant has complied with the provisions of statute and the rules adopted by the Medical Care Commission.

According to the Association of Home and Hospice Care (AHHC), the current licensure process primarily consists of potential agencies going through a review of policies and procedures required by the home care licensure rules with Division of Facility Services (DFS) staff. The AHHC reports that the staff spends considerable time educating potential applicants one-on-one regarding the licensure process. A set schedule of mandatory, group training would create more efficient use of DFS staff time and also allow applicants a more in-depth training session that would also cover agency responsibilities in rule compliance and patient care. Such training would assure DFS that the applicant has enough knowledge to comply with the provisions of the statute and rules before granting the license. Therefore, the Commission recommends that the General Assembly direct the Medical Care Commission to adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

Recommendation 5

The North Carolina Study Commission on Aging recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules.

Background

The Nursing Home Patients' Bill of Rights is contained in Part 2, Article 6 of Chapter 131E of the NC General Statutes. The Adult Care Home Residents' Bill of Rights is contained in Article 3 of Chapter 131D of the General Statutes. The North Carolina Administrative Code (10 NCAC 3L .1007) provides the home care Client Rights and Responsibilities, but there is no provision similar to the Adult Care Home and Nursing Home Patients' Bill of Rights set out in the statutes for home care clients. Therefore, the Commission recommends that the General Assembly codify the Client Rights and Responsibilities that currently exist in home care licensure rules to model them after the Adult Care Home and Nursing Home Patients' Bill of Rights.

Recommendation 6

The North Carolina Study Commission on Aging recommends that the General Assembly authorize the Department of Health and Human Services to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

Background

Prior to issuing a new license or renewing an existing license for an adult care home, the Department of Health and Human Services is required to conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its "principals or affiliates". The Department must refuse to issue a new license to an applicant who:

- Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked until one full year after the date or revocation; or
- Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with a correction plan and substantial compliance has been certified by the Department; or
- Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provision status as a result of Type A or B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license; or
- Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provision status as a result of violations under Chapter 122C, or Article 1 of Chapter 131D, or had its license summarily suspended or denied under Article 7 of Chapter 110 until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

"Affiliate", "owner", and "principal" are defined by rules adopted by the Medical Care Commission.

The application for an adult care home license requires disclosure of information concerning owners, affiliates, and principals of the applicant. Failure to disclose or providing false information on an application may subject the licensee, after the fact, to revocation of the license.

On November 10, 2004, the Commission heard presentations on adult care home licensing. Specifically, recent media attention had been focused on perceived "loopholes" in the law that would permit an adult care home licensee with a history of noncompliance to open another facility under a different name. Bob Fitzgerald, Director, Division of Facility Services, Department of Health and Human Services, and Melissa Trippe, Attorney, Office of the Attorney General, addressed the Commission on this issue. Mr. Fitzgerald briefly mentioned the newspaper articles that may have indicated the need for an overhaul of the licensing application process. He and Ms. Trippe indicated that an overhaul of the system was not necessary, but do believe that the State would benefit by granting the Department the authority to impose a civil penalty against adult care home licensure applicants who supply false information or omit material information on licensure applications.

During her presentation to the Commission on December 1, 2004, Lieutenant Governor Perdue said that her conversations with staff and with the Department has led her to conclude substantive changes are not needed to the law in order to prevent operators who have a history from noncompliance from opening new homes. She did, however, believe that the intent could be more closely adhered to if punitive authority for the Division of Facility Services is created.

The Commission agrees with the Department and the Lieutenant Governor that while substantive changes to the current law are not needed at this time, permitting the Department to impose a civil penalty may deter applicants from providing false or omitting material information. Therefore, the Commission recommends that the General Assembly authorize the Department to impose a civil penalty against applicants who supply false information or omit material information from the licensure application.

Recommendation 7

The North Carolina Study Commission on Aging expresses its appreciation for the efforts of the North Carolina Senior Games program to keep older adults mentally and physically active and recommends that the General Assembly appropriate an additional $150,000 for Senior Games.

Background

The Centers for Disease Control and Prevention and the Merck Institute of Aging & Health recently released, *The State of Aging and Health in America 2004*. The study indicated that in 2002, 39.9% of older adults in North Carolina participated in no leisure-time physical activity; North Carolina ranked 49 out of 50. The study indicates that the benefits of physical activity may include: reduction in a person's risk for cardiovascular disease; prevention of the development of diabetes, high blood pressure, and colon cancer; prevention of falls by helping to maintain and improve balance; and maintenance of healthy bones and muscles, increased joint mobility, and improved functional capacity of people with osteoarthritis.

The State Senior Games program provides year-round health promotion and education for North Carolinians 55 years of age and older. The program has 50,000 participants and serves all 100 counties.

In both public hearings, the continued support for the program was the most frequently mentioned issue. The Commission recognizes the benefits of supporting the North Carolina Senior Games program and recommends increasing the $175,000 provided by the General Assembly in the continuation budget by an additional $150,000.

Recommendation 8

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate an additional $4,000,000 in State funds for the Home and Community Care Block Grant.

Background

In its report to the Governor and the 2004 General Assembly, the Commission recommended that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant (HCCBG) for the 2004-2005 fiscal year. This recommendation was an effort by the Commission to restore a one million dollar ($1,000,000) reduction that had been made in State funds for the HCCBG. In formulating this proposal the Commission considered presentations made on March 23, 2004, which gave an overview of the program; eligibility criteria; and information on program utilization, availability, and needs. They also considered that support for and/or restoration of funding for the HCCBG was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina. S.L. 2004-124 restored eight hundred thousand dollars ($800,000) in funding for the HCCBG.

The HCCBG, established by G.S. 143B-181.1(a)(11), consolidates several funding sources (i.e., the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations)—some of which traditionally went to separate organizations. The HCCBG is composed of federal funds, State funds, local funds, and a client cost sharing component. Any person age 60 and older is eligible for services under the HCCBG. Although no income restrictions apply, special consideration is given to older adults with the greatest economic and social need. Of the 18 services, 14 are "core" services and 92% of the funds, over which counties have discretion, support these core services. Counties have discretion to determine services, levels, and providers. The 18 eligible services are: Adult Day Care, Adult Day Health Care, Care Management, Congregate Nutrition, Group Respite, Health Promotion and Disease Prevention, Health Screening, Home Delivered Meals, Housing and Home Improvement, Information and Assistance, In-Home Aide (levels I-IV), Institutional Respite Care, Mental Health Counseling, Senior Center Operations, Senior Companion, Skilled Home (Health) Care, Transportation (General and Medical) and Volunteer Program Development. The SFY 2003-04 HCCBG service profile indicates that: 71% of participants are women (compared to 58% of the NC 60+ population), 33% are minority, (compared to 18% of the NC 60+ population), 63% are age 75 or older (compared to 34% of the NC 60+ population), 46% live alone (compared to 28% of the NC 60+ population); 71% are unable to mange on their own (compared to 12% of the NC 60+ population), 48% are reportedly low-income (compared to 13% of the NC 60+ population), and 66% are at risk of malnutrition.

During its study this interim, the Commission again heard how important the HCCBG is to North Carolinians. Preserving/expanding support for in-home and community-based services was the

third most frequently mentioned item during the public hearings conducted in October 2004. The Division of Aging and Adult Services reports that 55% of the roughly 450 service providers indicate having 7,430 individuals on waiting lists for HCCBG services. The Commission recognizes the need for services provided through the Home and Community Care Block Grant and recommends that the General Assembly appropriate an additional $4,000,000 in State funds.

Recommendation 9

The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.

Background

In 1997, the North Carolina Study Commission on Aging recommended that the 1997 General Assembly enact a 15% tax credit, up to a maximum of $350, on the premiums paid by the purchaser of long-term care insurance policies. According to the 1997 Commission report, the Office of State Budget and Management estimated that a 15% tax credit up to a maximum of $350 may result in a revenue loss of $17 million. The report further stated that, the average premium was $1,600, thus a 15% credit would be equal to $240. The report acknowledged that it was difficult to estimate the offsetting benefits of the tax credit in terms of reduced Medicaid payments, but that the cost of a year's stay in a North Carolina nursing home was $40,000. The Commission recommended this tax credit again in 1998, and the credit became G.S. 105-151.28:

§ 105-151.28. Credit for premiums paid on long-term care insurance.

(a) Credit. – An individual is allowed, as a credit against the tax imposed by this Part, an amount equal to fifteen percent (15%) of the premium costs the individual paid during the taxable year on a qualified long-term care insurance contract that offers coverage to either the individual, the individual's spouse, or a dependent for whom the individual was allowed to deduct a personal exemption under section 151(c)(1)(A) of the Code for the taxable year. The credit allowed by this section may not exceed three hundred fifty dollars ($350.00) for each qualified long-term care insurance contract for which a credit is claimed. The credit allowed under this section may not exceed the amount of tax imposed by this Part for the taxable year reduced by the sum of all credits allowed, except payments of tax made by or on behalf of the taxpayer. A nonresident or part-year resident who claims the credit allowed by this subsection shall reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate.

(b) No Double Benefit. – No credit is allowed for payments that are deducted from, or not included in, the taxpayer's gross income for the taxable year. If the taxpayer claimed a deduction for health insurance costs of self-employed individuals under section 162(l) of the Code for the taxable year, the amount of credit otherwise allowed the taxpayer under this section is reduced by the applicable percentage provided in section 162(l) of the Code. If the taxpayer claimed a deduction for medical care expenses under section 213 of the Code for the taxable year, the taxpayer is not allowed a credit under this section. A taxpayer who claims the credit allowed by this section must provide any information required by the Secretary to demonstrate that the amount paid for premiums for which the credit is claimed was not excluded from the taxpayer's gross income for the taxable year.

(c) Definition. – For purposes of this section, the term 'qualified long-term care insurance contract' has the same meaning as defined in section 7702B of the Code.[1]

[1] A corresponding change was also made to the estates provision to exclude long-term care insurance premiums from an estate or trust. G.S. 105-160.3(b)(7).

The tax credit was effective for taxable years beginning on or after January 1, 1999, and expired for taxable years beginning on or after January 1, 2004.

On January 16, 2003, the Department of Revenue prepared a memorandum for the Revenue Laws Study Committee on the status of the tax credit for premiums paid on long-term care insurance. The memorandum outlined the Department's review of some of the returns on which the credit was claimed. During this review, auditors found that some taxpayers, who were not eligible for the tax credits, claimed the tax credits; and that some taxpayers claimed long-term care credits greater than the cap of $350. The Department found that, "Of the 2,155 returns reviewed, only 192 contained allowable long-term care credits. Taxpayers were not eligible for the credits claimed on the remaining 1,963 returns in this group. As a group, therefore, over 90% of the returns incorrectly claimed the credit." Because this represented a sample, the Department indicated that they did not know the error rate for all returns claiming the credit. They attributed the high error rate to two possible factors: "One factor is the complicated nature of the credit and the other is confusion of this credit with the repealed child health insurance credit." Additionally, the memorandum indicated that, for tax year 2001, the credit reduced tax revenue by $10,367,883.

The 2003 North Carolina Study Commission on Aging recommended repealing the sunset on the long-term care insurance tax credit. In its 2003 report, the Commission expressed agreement with a statement from a Division of Aging's report, *Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance.* The Division's report stated that, "In addition to the public benefit of having a much larger segment of the adult population positioned to pay privately for long-term care in terms of the state's economic health, consumers and families benefit from the ability to pay privately through increased choice and flexibility in terms of the range of services and settings of care available." The Commission's bills repealing the sunset were introduced during the 2003 Session, but were not successful.

According to information received by the Commission staff, on June 5, 2003, the Department of Revenue reported that they had audited 2,372 returns for the tax year 2002, and adjusted 650 to disallow the credit, representing a 27% error rate. This error rate was down considerably from the 90% error rate on the 2001 returns reported earlier by the Department. The Department attributed the decrease to: 1) informing tax preparers of the appropriate use of the credit; 2) clarifying instructions about eligibility for the credit; 3) improving the verbiage in software developers' tax packages; and 4) communicating with taxpayers whose credit was disallowed in 2001, to inform them of the eligibility criteria for the tax credit. An additional $279,628 was assessed on the 650 returns adjusted, and returns continue to be audited as resources permit. On November 3, 2003, the Department reported that they had processed 3,574,530 returns: 2,158,850 paper and 1,415,680 efiled. Of the total, there were 35,936 on which a credit for long-term care insurance was claimed for a total of $19,110,623.

During the February 10, 2004 meeting, the Commission heard a presentation on long-term care insurance from Carla Obiol with the Seniors' Health Insurance Information Program (SHIIP), and presentations on issues related to the tax credit from Department of Revenue employees Karl Knapp, Tax Research Division, and Nancy Pomeranz, Personal Taxes Division. Ms. Pomeranz discussed the error rate experienced on the long-term care tax credit and the Department's efforts to reduce that error rate. The Department indicated that they had made progress in reducing the error rate on the long-term care insurance tax credit.

Restoration of the long-term care insurance tax credit was an item mentioned frequently during presentations on March 9, 2004, by organizations representing older adults in North Carolina. At the Commission's request, legislation was introduced during the 2004 Session to remove the sunset on the long-term care tax credit. The legislation did not pass, and the credit has sunset effective for the 2004 tax year.

During the Commission's public hearings following the 2004 Session, persons expressed support for re-enactment of the tax credit. Lieutenant Governor Purdue also expressed her support of re-enactment of the tax credit during her presentation to the Commission on December 1, 2004.

The North Carolina Study Commission on Aging has supported the long-term care insurance tax credit since before its inception and continues to support it. Therefore, the North Carolina Study Commission on Aging recommends re-enactment of the long-term care insurance tax credit.

Recommendation 10

The North Carolina Study Commission on Aging recommends that the Adult Protective Services Task Force collaborate with stakeholders and persons interested in improvements to the adult protective services system, and report findings and recommendations to the Legislative Study Commission on State Guardianship Laws and the Study Commission on Aging.

Background

On December 1, 2004, the Commission heard a presentation from Dr. Margaret Hudson on issues related to the adult protective services system. Dr. Hudson's presentation included a historical perspective on the topic based on research that has been completed over the last twenty-five years. Her presentation defined the differences between elder mistreatment, elder abuse, elder neglect and self-neglect in the context of North Carolina adult protective services, and she recommended a change of wording in G.S. 108A-101 to more accurately reflect these differences. She reiterated elder abuse and elder neglect are different and must be studied separately. Dr. Hudson also suggested a coalition to help with the formal training, circumventing the tendency to focus on ruling out mistreatment instead of ruling in mistreatment.

The Department of Health and Human Services, in conjunction with the County Department of Social Services Directors' Association, has convened the Adult Protective Services (APS) Task Force. The Task Force has been working on ways to strengthen the adult protective services program and to improve quality, performance, and improved outcomes for county Departments of Social Services, and for the State, in an effort to carry out the statutory mandate to protect vulnerable adults. The Task Force has taken a multi-pronged approach by looking at any needed statutory changes; administrative rule changes; workload, administration, and required training needs; policies and procedures; assessment tools, and community inter/intra relations i.e., how the community views our delivery of APS. The task force has 28 members, including county DSS agencies and DHHS staff. Task Force members representing the county DSS agencies include: agency directors, program managers, supervisors, and line social workers, all of whom have responsibility for the delivery of APS at the local level. Short-term goals of the task force are to recommend technical and clarifying changes to the law. Long-term goals include: the potential for recommendations involving more in-depth statutory changes, improved caseload management, and additional training.

The General Assembly, in S.L. 2004-161, Part 45, established a Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State law. Among the items the Commission is required to consider is a review of the State's adult protective services law. The Legislative Study Commission on State Guardianship Laws is required to make a final report to the 2006 Regular Session of the 2005 General Assembly upon its convening.

The National Center on Elder Abuse, the National Committee for the Prevention of Elder Abuse (NCPEA), and the National Adult Protective Services Association are partnering to conduct a national study of elder abuse. Part of the study includes, "The 2004 Survey of Adult Protective Services Data," that intends to capture data from all 50 states. The initial survey deadline for the end of September has been extended to allow additional state response time. The purposes of the survey are to: establish a national data set for Adult Protective Services (APS); compare APS programs nationwide; measure APS interventions; demonstrate trends in the field of APS; and to bring national attention to the field. The University of Kentucky is conducting the research for NCPEA.

The Commission finds that review of and changes to the adult protective services system are likely to be necessary to ensure that older adults are protected from abuse and neglect. The Commission also recognizes that several groups are already reviewing the adult protective services system, and that collaboration would be helpful in determining what improvements could be made to the system. Therefore, the Commission recommends that the Adult Protective Services Task Force collaborate with stakeholders and other persons interested in improving the adult protective services and report its findings and recommendations to the Commission and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

APPENDICES

APPENDIX A

Public Hearing Comments
Summary



Prepared for the
North Carolina Study Commission on Aging

November 10, 2004

Background Information

The North Carolina Study Commission on Aging is created to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults. This study shall be a continuing one and the evaluation ongoing, as the population of older citizens grows and as old problems faced by older citizens magnify and are augmented by new problems. (G.S. 120-180)

The Commission may hold public meetings across the State to solicit public input with respect to the issues of aging in North Carolina. (G.S. 120-185)

2004 Public Hearings

Date	Location	Number of Speakers
October 21, 2004	**Cherryville, NC**	**14**
October 26, 2004	**Wilson, NC**	**33**

Issue Frequency

On the following pages, issues mentioned by speakers at the public hearings are listed, grouped, and totaled based on the frequency with which they were mentioned.

The issues mentioned with the greatest frequency were:

- **Preserve/Expand Support for Senior Games** ***(17 responses)***
- **Preserve/Expand Senior Centers Including Certified Senior Centers** ***(10 responses)***
- **Preserve/Expand Support for In-Home and Community-Based Services,** ***(9 responses)***
- **Lower/Provide Assistance with Prescription Drug Costs,** ***(6 responses)***
- **Concerns About Combining Mentally Ill and Elderly Populations,** ***(5 responses)***

Frequency of Issues Expressed by Speakers
2004 Public Hearings

	CHERRYVILLE	WILSON	TOTAL
PROGRAM FUNDING			
Preserve/Expand Support for Senior Games	5	12	17
Preserve/Expand Senior Centers Including Certified Senior Centers	1	9	10
Preserve/Expand Support for In-Home and Community-Based Services	3	6	9
Preserve/Expand Home and Community Care Block Grant (HCCBG) Funding	2	2	4
Preserve/Expand Community Alternatives Program for Disabled Adults (CAP/DA)	3		3
Increase Adult Day Services Reimbursement Rate		3	3
Institutional Bias vs. Community Based Services		2	2
Preserve/Expand the State/County Special Assistance (SA) In-Home Project	2		2
Remove the Off-Set for SA In-Home Participants Receiving Food Stamps	1		1
Preserve/Expand Ombudsman Program	1		1
Preserve/Expand Family Caregiver Support Program		1	1
Increase Reimbursement Rates for Nursing Facilities		1	1
Restore Cut to AAA Professional Staff Funding		1	1
TOTAL			55
WORKFORCE ISSUES			
Lower Staff to Resident Ratios in Nursing Homes and Adult Care Homes	1	2	3
Offer Incentives to Attract Workers to Nurse Aide Positions	1		1
Expand Community College System's Capacity for Training More Direct Care Workers	1		1
TOTAL			5

	CHERRYVILLE	WILSON	TOTAL
OTHER			
Lower/Provide Assistance With Prescription Drug Costs		6	6
Concerns About Combining Mentally Ill and Elderly Populations	2	3	5
Preserve/Expand Senior-Friendly Communities	1	3	4
Transportation		4	4
Long Term Care Insurance Tax Credit		3	3
Safe/Affordable Housing for Seniors		2	2
Public Awareness of Available Services		2	2
Monitoring/Enforcement of Laws Related to Nursing Homes and Adult Care Homes		2	2
Improve Air and Water Quality	1	1	2
Job-Training for Older Workers	1		1
Expression of Support for the Study Commission on Aging and its Members	1		1
Raise Medically Needy Income Limit – Medicaid		1	1
Expand Grandparents' Rights		1	1
Seniors With Low Wage Jobs Caring For Children		1	1
Veterans Care		1	1
Volunteer Training and Retention		1	1
Adult Protective Services		1	1
Guardianship		1	1
Long Term Care Internet Project		1	1
TOTAL			40

APPENDIX B

2004 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2003 North Carolina General Assembly, 2004 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

October 27, 2004

2004 *Recommendation Status Report*

RECOMMENDATION	RESULT
Recommendation 1 **The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.**	There were a number of bills that addressed this issue, including HB 1489 and SB 1146 introduced on behalf of the Commission. However, none of the bills were enacted and the tax credit expired for taxable years beginning on or after January 1, 2004.
Recommendation 2 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.**	S.L. 2004-144 (SB 1148) requires DHHS to study the mission of the Geriatric Mental Health Specialty Teams. Representatives from Area Authorities, Local Management Entities, adult care home and nursing home industries, and other appropriate stakeholders, must be included in the process. As part of this study, the Department must consider whether to create two separate teams to provide services to geriatric mental health residents who are part of the targeted population and to provide services to non-geriatric residents who are part of the targeted population in long-term care facilities; and/or to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission. The act requires the Department to standardize the following criteria across all mental health specialty teams: team purpose; eligibility for services; Screening processes; referral processes; and forms, training manuals, service orders, and authorizations. Any of these standards that are currently established shall be immediately implemented, and a time line for implementation of the remaining criteria shall be provided in the interim report. Additionally, the act requires the Department to proceed immediately with implementation of the following: Tracking expenditure data for each Team and each Area Program/Local Management Entity; Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team; and Tracking the use of clinicians with and without formal specialty training in mental health and geriatric mental health on the specialty teams. DHHS is required to submit an interim report to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The final report on its standardization and tracking efforts, and the results of its study, shall be submitted to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2005.

RECOMMENDATION	RESULT
Recommendation 3 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.**	S.L. 2004-124, Sec. 10.2 (HB 1414, Sec. 10.2) requires DHHS to work with long-term care providers and advocates for the elderly and mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The following issues shall be included in the study: • Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities; • Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served; • Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living; • Determining the most effective way to identify mentally ill individuals that have mental health treatment needs; • Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents is safeguarded; • Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations; and • Identifying specific problems that exist due to mixing aging and mentally ill populations. DHHS is required to report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The report must also include how the Department defined "mentally ill" for purposes of the study.

RECOMMENDATION	RESULT
Recommendation 4 **The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.**	S.L. 2004-124, Sec. 10.19D (HB 1414, Sec. 10.19D) amends the statutes governing criminal records checks for nursing homes, home care agencies, contract agencies for nursing homes and home care agencies, adult care homes, contract agencies of adult care homes, and area mental health authorities (collectively, "providers"). State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies, other than those involving direct patient care, and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005. This section requires the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". Pursuant to federal law, the Department will be permitted to provide notice to the provider that an applicant has a criminal record elsewhere. The Department will not be permitted to reveal the contents of that record. It will be the employer's responsibility to follow up on the information to obtain the public record of that crime. This section also appropriates funds to the Department of Health and Human Services and the Department of Justice to expedite the criminal history check process and amends the term "relevant offense" to include any state or federal criminal history of conviction or pending indictment of a crime. The part of the section that amends the national criminal history check process becomes effective January 1, 2005. The remainder of the section became effective July 1, 2004.

RECOMMENDATION	RESULT
Recommendation 5 **The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.**	S.L. 2004-124 provides $281,000 in recurring funds and $1,550,000 in non-recurring funds for 2004-05 for Senior Centers.
Recommendation 6 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.**	S.L. 2004-124, appropriates $3 M to the Housing Trust Fund (HTF) for FY 2004-05, however, none of the appropriation was specifically set aside for independent housing with services. The General Assembly appropriated a total of $4,750,945 for each FY of the 2003-05 biennium, of which $3 M was intended for the HTF and $1.75 M for the HOME match. (The HOME program is a Federal block grant that provides formula grants to States and localities that communities use (often in partnership with local nonprofit groups) to fund a wide range of activities that build, buy, and/or rehabilitate affordable housing for rent or homeownership for low-income households.)
Recommendation 7 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.**	S.L. 2004-124 restored $800,000 (of the previous $1 million reduction) for the Home and Community Care Block Grant.
Recommendation 8 **The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.**	S.L. 2004-124, Sec. 10.13 (HB 1414, Sec. 10.13) requires DHHS to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. The study must include consideration of all in-home services paid under the State's Medicaid program. The Department must report the results of the study to the North Carolina Study Commission on Aging by January 2005.

RECOMMENDATION	RESULT
Recommendation 9 **The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.**	S.L. 2004-161, Part XLV (SB 1152, Part XLV) creates the Legislative Study Commission on State Guardianship Laws. The North Carolina Study Commission on Aging recommended this Commission. The Commission will consist of 16 members, including members of the Senate and House of Representatives; the Director of the Administrative Office of the Courts; the Director of the Division of Aging in the Department of Health and Human Services; a county director of social services; a clerk of superior court; a physician who specializes in geriatrics; an attorney who has experience in guardianship matters; a representative of the Governor's Advocacy Council for Persons With Disabilities; and an area authority or county program director for mental health, developmental disabilities, and substance abuse services. In addition to these members, representatives of the North Carolina Bar Association, the Arc of North Carolina, North Guardianship Association, Alzheimer's Association – Western and Eastern Chapters, Carolina Legal Assistance, Area Agencies on Aging, County Departments of Aging, and Friends of Residents in Long Term Care will serve as ex-officio, nonvoting members. The Commission is charged with reviewing State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney. The Commission may make an interim report to the 2005 General Assembly upon its convening and must make its final report to the 2006 Regular Session of the 2005 General Assembly, upon its convening.
Recommendation 10 **The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.**	S.L. 2004-124 provides funding to increase the daily rate by $5.00 for Adult Day Care and Adult Day Health Care Additionally, S.L. 2004-124, Sec. 10.21 (HB 1414, Sec. 10.21) requires the Department of Health and Human Services to contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant is required to study the current method of reimbursement for adult day services and to make recommendations for changes to the reimbursement methodology. Up to $250,000 of the funds appropriated to the Department may be used to implement this study. This section requires that a final report be submitted to the North Carolina Study Commission on Aging by January 1, 2005.

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2004 Session

Prepared by Staff for the:
North Carolina Study Commission on Aging

October 27, 2004

Enacted Legislation

Downtown Adult Residential Facility

S.L. 2004-2 (SB 623) provides a one-year extension of deadlines to meet conditions set forth in Section 3 of S.L. 2001-234 entitling certain "specially impacted" adult care homes that qualified for an exemption from the moratorium on new adult day care homes established in S.L. 1997-443 to continue to develop the beds authorized by the exemption. The specific deadline changes are from June 1, 2004 to June 1, 2005 and from December 1, 2004 to December 1, 2005. A specially impacted adult care home is defined as an adult care home that qualified for an exemption under S.L. 2000-67, Section 11.9 (a) and is 10 stories or more in height, located within a municipal service district created under Article 23 of Chapter 160A of the General Statutes, located within 100 yards of a mixed use building more than 10 stories tall that will be opened for occupancy after May 26, 2004, located within 100 yards of an office building that is more than 20 stories tall, and some of the residents of which are to be relocated to a facility in the same county but not on a college campus. One facility where the occupants of the building are relocated is to continue to have the same status under S.L. 2000-67, Sec. 11.9 (a) as the facility from where the occupants came.

This section became effective May 26, 2004. (BR)

Centralize Criminal Record Check Functions

S.L. 2004-124, Sec. 10.1 (HB 1414, Sec. 10.1) requires the Department of Health and Human Services to consolidate all activities within the Department related to coordinating and processing criminal record checks required by law beginning January 1, 2005. The Department is to report the details of the implementation plan to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on or before January 1, 2005.

This section became effective July 1, 2004. (EC)

Automatic Enrollment Medicare Prescription Drug Discount Card

S.L. 2004-124, Sec. 10.2B (HB 1414, Sec. 10.2B) gives the Department of Health and Human Services authority to enroll senior citizens in the federal Medicare Prescription Drug Discount Program. Current and future participants in the State's Senior Care Prescription Drug Assistance Program whose income is not more than 135% of the federal poverty level are eligible for automatic enrollment in the Medicare Drug Program; however, those individuals must have an opportunity to decline automatic enrollment if they choose. This section also provides that the State's Senior Care Prescription Drug Assistance Program will be the payor of last resort.

This section became effective July 1, 2004. (TM)

Community Alternatives Programs

S.L. 2004-124, Sec. 10.9 (HB 1414, Sec. 10.9) directs the Department of Health and Human Services to ensure the following:

- Expenditures for Community Alternatives Programs (CAP) do not exceed the budget for these programs;
- CAP slots are fully allocated and filled in a timely manner; and
- Budgeted expenditures are not limited by the non-allocation of or delays in filling CAP slots.

Additionally, the section specifies that services provided by the Community Alternatives Program for Disabled Adults shall be provided for the 2004-2005 fiscal year to any eligible person who entered a nursing facility on or before June 1, 2004, within the existing availability of the county allocation, or within the existing availability of services.
This section became effective July 1, 2004. (SP)

PACE Pilot Program Funds

S.L. 2004-124, Sec. 10.12 (HB 1414, Sec. 10.12) requires the Department of Health and Human Services, Division of Medical Assistance, to develop a pilot program to implement the Program for All-Inclusive Care for the Elderly (PACE). One pilot site shall be planned for the southeastern area of the State and the other for the western area of the State. The Division is required to design the pilot program to access federal Medicaid and Medicare dollars to provide acute and long-term care services for older patients through the use of interdisciplinary teams. Upon implementation, the PACE pilot program may include the following: physician visits, drugs, rehabilitation services, personal care services, hospitalization, and nursing home care. The PACE program may also offer social services intervention, case management, respite care, or extended home care nursing. This section authorizes the Division to use $123,156 of the funds appropriated for the 2004-2005 fiscal year, to support two positions in the Division of Medical Assistance to develop the pilot programs and to contract for actuarial analysis as part of the development of the pilot programs.

On March 1, 2005, the Department must report on the development of PACE pilot program to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services. The report will include services proposed to be offered under the pilot program, administrative structure of the pilot program, number of Medicare and Medicaid eligible recipients anticipated to receive services from the PACE pilot sites, and the projected savings to the State from PACE pilot program implementation.

Finally, this section clarifies that nothing obligates the General Assembly to appropriate funds to implement the PACE program statewide.

This section became effective July 1, 2004. (TM)

Long-Term Care Facility Criminal Record Checks

S.L. 2004-124, Sec. 10.19D (HB 1414, Sec. 10.19D) amends the statutes governing criminal records checks for nursing homes, home care agencies, contract agencies for nursing homes and home care agencies, adult care homes, contract agencies of adult care homes, and area mental health authorities (collectively, "providers"). State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State

criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required.

Under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies, other than those involving direct patient care, and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

This section requires the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". Pursuant to federal law, the Department will be permitted to provide notice to the provider that an applicant has a criminal record elsewhere. The Department will not be permitted to reveal the contents of that record. It will be the employer's responsibility to follow up on the information to obtain the public record of that crime.

This section also appropriates funds to the Department of Health and Human Services and the Department of Justice to expedite the criminal history check process and amends the term "relevant offense" to include any state or federal criminal history of conviction or pending indictment of a crime.

The part of the section that amends the national criminal history check process becomes effective January 1, 2005. The remainder of the section became effective July 1, 2004. (DJ)

State/County Special Assistance

S.L. 2004-124, Sec. 10.21A (HB 1414, Sec. 10.21A) establishes the maximum monthly rate for residents in adult care home facilities as $1,084 per month per resident unless adjusted by the Department in accordance with Section 10.52(f) of S.L. 2003-284. This rate is effective October 1, 2004.

This section became effective July 1, 2004. (TM)

Health Care Personnel Registry Changes

S.L. 2004-203, Sec. 52 (HB 281, Sec. 52) makes changes to conform the Health Care Personnel Registry to federal law governing the Nurse Aide I Registry program. During the 2000 Regular Session legislation was enacted that standardized the reporting requirements of both these registry programs, conforming them to the federal reporting requirements. All covered facilities and agencies will report using the current standardized reporting requirements that apply to nursing homes (federal law). In 2000, the federal requirement to allow a nurse aide to submit a rebuttal statement that

would be included on the Nurse Aide Registry was not included in the legislative change. In addition, the federal statute changed after the passage of this 2000 law to include a process to allow nurse aides to petition the state to have a single finding of neglect removed from the Nurse Aide Registry when certain requirements were met. This section became effective August 17, 2004. (EC)

Studies

Legislative Research Commission

Care and Safety of Residents of Residential Facilities Study

S.L. 2004-161, Sec. 2.1(8)b (SB 1152, Sec. 2.1(8)b) provides that the Legislative Research Commission may study the care and safety of residents of residential care facilities. If the Commission elects to study this issue, they may report findings, together with any recommended legislation, to the 2005 General Assembly upon its convening.

This section became effective August 2, 2004. (TM)

New/Independent Studies/Commissions

Legislative Study Commission on State Guardianship Laws

S.L. 2004-161, Part XLV (SB 1152, Part XLV) creates the Legislative Study Commission on State Guardianship Laws. The North Carolina Study Commission on Aging recommended this Commission. The Commission will consist of 16 members, including members of the Senate and House of Representatives; the Director of the Administrative Office of the Courts; the Director of the Division of Aging in the Department of Health and Human Services; a county director of social services; a clerk of superior court; a physician who specializes in geriatrics; an attorney who has experience in guardianship matters; a representative of the Governor's Advocacy Council for Persons With Disabilities; and an area authority or county program director for mental health, developmental disabilities, and substance abuse services. In addition to these members, representatives of the North Carolina Bar Association, the Arc of North Carolina, North Guardianship Association, Alzheimer's Association – Western and Eastern Chapters, Carolina Legal Assistance, Area Agencies on Aging, County Departments of Aging, and Friends of Residents in Long Term Care will serve as ex-officio, nonvoting members. The Commission is charged with reviewing State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney. The Commission may make an interim report to the 2005 General Assembly upon its convening and must make its final report to the 2006 Regular Session of the 2005 General Assembly, upon its convening.

This part became effective August 2, 2004. (DJ)

Referrals to Existing Commissions/Committees

Long-Term Care Remediation

S.L. 2004-161, Sec. 23.2 (SB 1152, Sec. 23.2) provides that the North Carolina Study Commission on Aging may study the feasibility of implementing a remediation program for long-term care facilities in North Carolina, similar to the Collaborative Remediation Project in Michigan. The Commission may report its findings, together with any recommended legislation to the 2005 General Assembly upon its convening.
This section became effective August 2, 2004. (SP)

Mentally Ill Long-Term Care Residents

S.L. 2004-161, Sec. 23.3 (SB 1152, Sec. 23.3) provides that the North Carolina Study Commission on Aging may study issues related to mentally ill residents in long-term care facilities. The Commission may report its findings, together with any recommended legislation to the 2005 General Assembly upon its convening.
This section became effective August 2, 2004. However, **Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities** was also referred to the Department of Health and Human Services in S.L. 2004-124, Sec. 10.2. (HB 1414, Sec. 10.2). (See *Referrals to Departments, Agencies, Etc.*, under the *Studies* Heading in this Chapter.) S.L. 2004-161 Section 54.1 (SB 1152, Section 54.1) provides that if a study is authorized in both S.L. 2004-161 and S.L. 2004-124 (HB 1414), the study shall be implemented in accordance with HB 1414 as ratified. Therefore, the study contained in S.L. 2004-124, Sec. 10.2 will be implemented instead of the study authorized by this section. (SP)

Referrals to Departments, Agencies, Etc.

Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities

S.L. 2004-124, Sec. 10.2 (HB 1414, Sec. 10.2) requires the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and mentally ill to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The following issues shall be included in the study:

- Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities;
- Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served;
- Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support residents' freedom of choice, and whether they support the autonomy, dignity, and independence philosophy of assisted living;
- Determining the most effective way to identify mentally ill individuals that have mental health treatment needs;

- Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents is safeguarded;
- Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations; and
- Identifying specific problems that exist due to mixing aging and mentally ill populations.

The Department is required to report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The report must also include how the Department defined "mentally ill" for purposes of the study.

This section became effective July 1, 2004.

Note: A study on **Mentally Ill Long-Term Care Residents** was also referred to the North Carolina Study Commission on Aging in S.L. 2004-161, Sec. 23.3 (SB 1152, Sec. 23.3). See *Referrals to Existing Commissions/Committees* under the *Studies* Heading in this Chapter. However, S.L. 2004-161 Section 54.1 (SB 1152, Section 54.1) provides that if a study is authorized in both S.L. 2004-161 and S.L. 2004-124 (HB 1414), the study shall be implemented in accordance with HB 1414 as ratified. Therefore, the study contained in this section will be implemented instead of the study authorized by S.L. 2004-124, Sec. 10.2. (TM)

DHHS Study Medicaid Institutional Bias

S.L. 2004-124, Sec. 10.13 (HB 1414, Sec. 10.13) requires the Department of Health and Human Services to contract with an independent entity to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. The study must include consideration of all in-home services paid under the State's Medicaid program. The Department must report the results of the study to the North Carolina Study Commission on Aging by January 2005.

This section became effective July 1, 2004. (DJ)

Adult Day Service Training and Reimbursement Methodology

S.L. 2004-124, Sec. 10.21 (HB 1414, Sec. 10.21) requires the Department of Health and Human Services to contract with a national adult day services resource center to provide training and consultation to adult day services providers and State and county adult day services consultants. The selected consultant is required to study the current method of reimbursement for adult day services and to make recommendations for changes to the reimbursement methodology. Up to $250,000 of the funds appropriated to the Department may be used to implement this study. This section requires that a final report be submitted to the North Carolina Study Commission on Aging by January 1, 2005.

This section became effective July 1, 2004. (TM)

Care for the Mentally Ill in Long Term Care Facilities

S.L. 2004-144 (SB 1148) requires the Department of Health and Human Services to study the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in

serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. The Department must include representatives from Area Authorities, Local Management Entities, the adult care home and the nursing home industries, and other appropriate stakeholders in the process.

As part of this study, the Department must consider whether to create two separate teams to provide services to geriatric mental health residents who are part of the targeted population and to provide services to non-geriatric residents who are part of the targeted population in long-term care facilities; and/or to broaden the scope of and rename the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

The act requires the Department to standardize the following criteria across all mental health specialty teams:

- Team purpose;
- Eligibility for services;
- Screening processes;
- Referral processes; and
- Forms, Training Manuals, Service Orders, and Authorizations.

Any of these standards that are currently established shall be immediately implemented, and a time line for implementation of the remaining criteria shall be provided in the interim report.

Additionally, the act requires the Department to proceed immediately with implementation of the following:

- Tracking expenditure data for each Team and each Area Program/Local Management Entity;
- Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team; and
- Tracking the use of clinicians with and without formal specialty training in mental health and geriatric mental health on the specialty teams.

The act also requires the Department to submit an interim report to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The Department is required to submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by October 30, 2005.

This act became effective July 29, 2004. (TM)

Studies and Reports Related to Aging

Study/Report	Entities Involved	Reporting Date	Reference
Report on the pilot project for local long-term care coordination.	DHHS to Aging Study Commission	Interim report 10/1/04 Final report 10/1/05	S.L. 2003-284 (HB 397), Sec. 10.8.F.(b)
Report on the Special Assistance In-Home Demonstration Program	DHHS to HHS	1/1/04 and 1/1/05	S.L. 2003-284 (HB 397), Sec. 10.51(b)
Report on standardization and tracking efforts and the study of the mission of Geriatric Mental Health Specialty Teams	DHHS to Aging Study Commission and Joint Legislative Oversight Committee on MH/DD/SA	Interim report 10/30/04 Final report 10/30/05	S.L. 2004-144 (SB 1148), Sec. 4
Report findings on issues related to mentally ill residents of long-term care facilities	DHHS to Aging Study Commission	10/1/05	S.L. 2004-124 (HB 1414), Sec. 10.2
Report on independent study of institutional bias in the Medicaid program	DHHS to Aging Study Commission	January, 2005	S.L. 2004-124 (HB 1414), Sec. 10.13
Report on reimbursement methodology for adult day services	DHHS (contracting with consultant) to Aging Study Commission	1/1/05	S.L. 2004-124 (HB 1414), Sec. 10.21

Abbreviations:
DHHS: the Department of Health & Human Services
FRD: Fiscal Research Division
HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services
MH/DD/SA: Mental Health, Developmental Disabilities, and Substance Abuse Services

APPENDIX C

Medicaid In-Home Personal Care Services Program

Presented by Lynne Perrin
Chief, Facility and Community Care
Clinical Policy and Programs
NC Division of Medical Assistance
November 10, 2004

In-Home Personal Care Services

- Optional Medicaid Benefit
- Provided to persons living in a private residence and who have medical conditions that require assistance from a personal care aide
- Must be authorized by a physician in accordance with a plan of treatment or otherwise approved by the state

Medicaid Reimbursement

- Medicaid reimburses $14.20 (effective Aug. 2004) per hour for personal care tasks performed by in-home aides.
- The tasks may include
  - Helping patients with bathing, toileting, moving about, keeping track of vital signs; and,
  - Help with housekeeping and home management tasks as a secondary support to maintain one's health.

Amount of Services and Medicaid Benefit Limitations

- Hours of PCS are determined through an assessment performed by the home care agency's RN and authorized by the physician.
- PCS is limited to a maximum of 60 hours per month per patient.
- If prior approved by DMA, one may receive up to 80 hours per month under the *PCS Plus* program based on documented need for additional services.

Who Provides PCS Services?

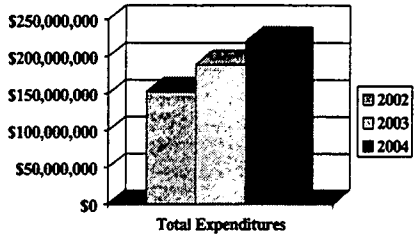
- Home care agencies in North Carolina
  - Licensed by the Division of Facility Services to provide in-home aide services
  - Enrolled in the Medicaid program
- In-home aides must meet the requirements in the Home Care Licensure Rules

Providers Enrolled in Medicaid

- There are currently 685 home care providers* enrolled in the Medicaid Program.

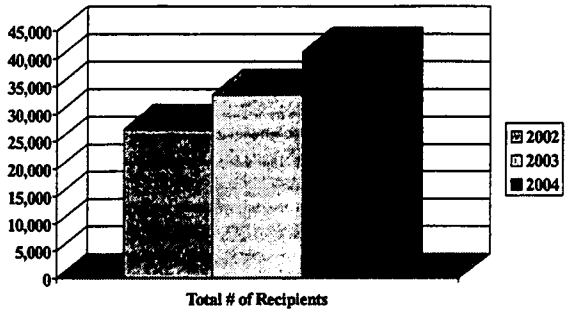
* An agency may have several site locations and each site is treated as a separate provider and not all providers enrolled may actively be billing Medicaid.

Medicaid Expenditures for PCS



2004 Expenditures:
$220,933,622

Recipients of PCS



2004 Recipients:
41,222

Growth in PCS

- Growth in Expenditures
  - 2002 to 2003 was 24%
  - 2003 to 2004 was 17%
- Increase in Recipients
  - 2002 to 2003 was 23%
  - 2003 to 2004 was 23%

Average Expenditures Per Recipient

- Average Annual Per Recipient
  - SFY 2004 $5,360
- Average Monthly Per Recipient
  - SFY 2004 $446

Need for PCS Program Improvements

- PCS is an important program in the NC's long term care system as it supports recipients in their own homes.
- Service has been operating since 1985 with little change in administrative structure or state level oversight.

Key Reasons to Restructure

- Growth in program expenditures and recipients
- Growth in numbers of providers and appropriate targeting of services
- Quality issues
- Need to refine and clarify medical criteria
- Need for newer improved assessment tools
- Need for provider standards, training and best practices
- Need to improve state level oversight and monitoring functions

PCS Restructuring Initiative

- Restructuring initiated by AHHC and DMA in January 2004
- Partnership among PCS providers, DMA staff, and DFS staff
- Established PCS Restructuring Advisory Committee to guide the work of four work groups
  - Criteria/Documentation
  - Policy/Process
  - Utilization Review
  - Rules Subcommittee

PCS Restructuring Initiative

- Restructuring Advisory Committee met on a monthly basis
- First PCS Kickoff meeting held March 18, 2004
- More than 40 people have participated in the process to date
- Over 30 meetings took place between January, 2004 and October, 2004
- Final PCS Wrap-Up meeting of work groups held October 27, 2004

PCS Restructuring Goals

- Restructure the PCS program
- Refine the PCS policy
- Streamline the PCS service delivery process
- Develop a quality assurance and utilization management component
- Strengthen provider compliance with policies
- Establish provider training requirements
- Build strong partnerships with shared goals

PCS Restructuring Advisory Committee

Tom Harmelink, *Provider-Health Force*
Jeff Horton, *DFS*
Azzie Conley, *DFS*
Robyn Reasor, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Carol Putnam, *DMA-Program Integrity*
Tim Rogers, *AHHC*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Dr. Nancy Henley, *DMA-Medical Policy*
Pamela Horrell, *DMA-Provider Enrollment*
Frank Dziepak, *DMA-Financial Operations*
Lynne Perrin, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*
Donna Steele, *DMA-Medical Policy*

Criteria/Documentation Work Group

- Donna Turlington, *Provider-Liberty HC*
- Phyllis Nealey, *Provider-Interim HC*
- Tina Glenn, *Provider-Hearthside HC*
- Roget Berendes, *Provider-Hearthside Home Care*
- Sandra Bridges, *Provider-First Choice HC*
- Betty Nance, *Provider-Guardian Angel HC*
- Carol Putnam, *DMA-Program Integrity*
- Sherry Thomas, *AHHC*
- Robyn Reasor, *DMA-Program Integrity*
- Donna Steele, *DMA-Medical Policy*
- Rosalie Wachsmuth, *DMA-Medical Policy*

PCS Policy/Process Workgroup

Beverly Stewart, *DMA-Program Integrity*
Phyllis Burwell, *DMA-Medical Policy*
Jim Arp, *Provider-Advantage Home & Hospice*
Heather Blank, *Provider-Assisted Care*
Sherry Thomas, *AHHC*
Sandi Massey, *Provider-Good Health Services*
Karen Rowe, *Provider-Carolinas Home Care*
Bonnie McBride, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Pamela Horrell, *DMA-Provider Enrollment*
Sandi Massey, *Provider-Good Health Services*
Tom Harmelink, *Provider-Health Force*
Nena Reaves, *Provider-Health Services Personnel*
Lloyd Pattison, *DMA-Medical Policy*
Donna Steele, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*

PCS Utilization Review Workgroup

Bill Craig, *Provider-Quality Patient Care*
Peggy Mallard, *Provider-Guardian Health Services*
Larry Nason, *DMA-Medical Policy*
Lynne Perrin, *DMA-Medical Policy*
Ginger Parrish, *Provider-Albemarle Home Care*
Robyn Slate, *DMA-Rate Setting*
Pat Jeter, *DMA-Rate Setting*
Frank Dziepak, *DMA-Financial Operations*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Sheila Alford, *Provider-Home Health & Hospice of Halifax*
Tim Brooks, *Provider-Healthkeeperz Home Health*
Pam Wells, *DMA-Program Integrity*
Peggy Davis, *DMA-Program Integrity*
Robyn Reasor, *DMA-Program Integrity*
Donna Steele, *DMA-Medical Policy*
Rosalie Wachsmuth, *DMA-Medical Policy*

Outcomes of the Work Groups

- Key Recommendations for Program Improvements presented by Sherry Thomas

Comparisons & Recommendations for Statewide Improvements In the Medicaid Personal Care Services Program

Sherry Thomas, BSN, MPH
Senior Vice President, AHHC

AHHC

- Established in 1972 by Registered Nurse directors and supervisors, the Association for Home & Hospice Care of North Carolina (AHHC) is a nonprofit trade association made up of professionals from a wide variety of disciplines, all with an active interest or involvement in North Carolina's in-home health, hospice, and community-based care industry. Today, the Association represents nearly 500 agencies including the largest ones in the State.

Comparisons & Recommendations

- **Current PCS**
  *Limited to 3 1/2 hours per day - 60 hours per month
  *Physician authorization based on Registered Nurse assessment
- **Restructured PCS**
  *Same
  *Physician authorization based on Registered Nurse assessment with recommendation for physician's PA and/or NP to authorize as delegated by physician

Comparisons & Recommendations

- **Current PCS Relationship to PCS Plus**
  *Must first meet PCS criteria before becoming eligible for PCS Plus which is based on additional criteria
- **Restructured PCS Relationship to PCS Plus**
  *Must first meet PCS criteria before becoming eligible for PCS Plus which is based on additional criteria

Comparisons & Recommendations

- **Current PCS**

  *Assessment tools: two page RN assessment with required elements of assessment but optional form. Time and tasks assigned by RN with physician authorization. Home management tasks incidental to personal care.

Comparisons & Recommendations

- **Restructured PCS**

  *New four page RN assessment. The tool also serves as the RN certification that the assessment is accurate and as the physician's authorization for the services.
  - PCS Physician Authorization for Certification and Treatment (PACT) Form *(also known as the revised DMA-3000 Form)*
  - Annual Renewal/Recertification
  - DMA intends to eventually automate both the new PACT Form and the PCS-Plus Form.

Comparisons & Recommendations

- **Restructured PCS**

  A major committee focus was developing a new patient assessment tool that will capture more complete information on the patient's functional limitations/medical condition and the related need for personal care and home management assistance.

Comparisons & Recommendations

- **Restructured PCS**

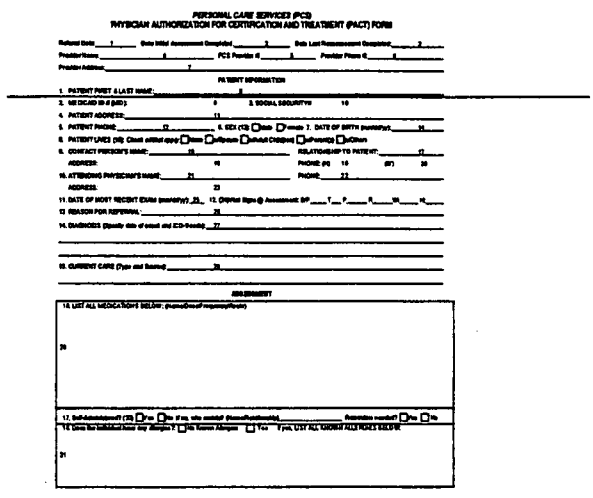
*The new draft tool is a "scored" assessment and incorporates elements and definitions from the nursing home MDS while also addressing the specific home environment and PCS program requirements. The new draft tool paints a clearer picture of the patient to the physician.

Comparisons & Recommendations

- **Restructured PCS**

*The new tool will be mandatory. Along with the tool, there will be a guideline detailing the time allotment available based on how the patient scores on the assessment.

*Home management tasks will be directly linked to ADL limitations (bathing, feeding, dressing, ambulation, toileting, etc) on the new tool.



PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

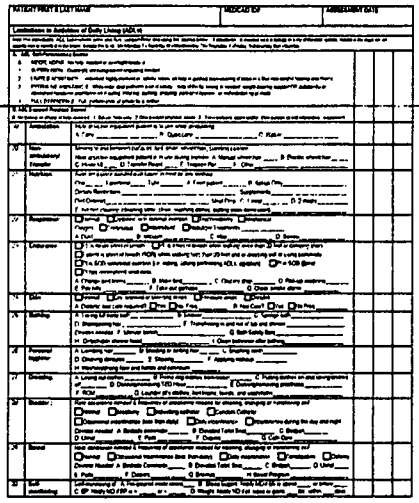
PATIENT INFORMATION

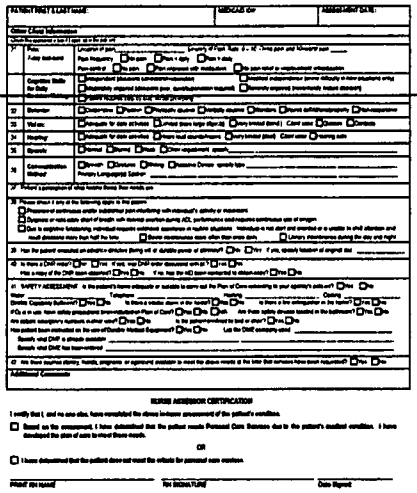
1. PATIENT FIRST & LAST NAME:
2. MEDICAID ID # (MID):
3. SOCIAL SECURITY #:
4. PATIENT ADDRESS:
5. PATIENT PHONE:
6. SEX (circle): Male Female
7. DATE OF BIRTH (mm/dd/yy):
8. PATIENT LIVES (circle): Alone With spouse With other adult With child(ren) With family Other
9. CONTACT PERSON'S NAME:
RELATIONSHIP TO PATIENT:
ADDRESS:
PHONE (H):
(W):
10. ATTENDING PHYSICIAN'S NAME:
PHONE:
ADDRESS:
11. DATE OF MOST RECENT (Initial or transfer/D) ASSESSMENT:
12. ORIGINAL Signs @ Assessment: BP: T: P: R: Wt: Ht:
13. REASON FOR REFERRAL:
14. DIAGNOSES (Specify date of onset and ICD-9 code):
15. CURRENT CARE (Type and Source):

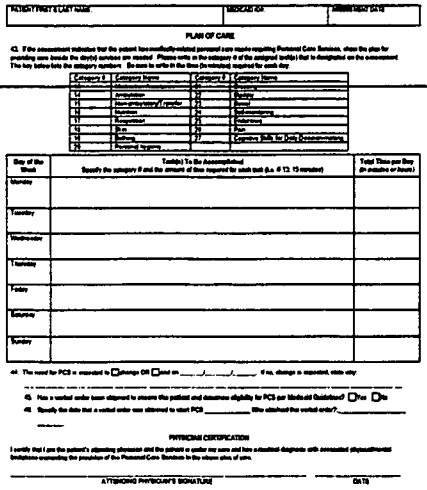
ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (Name/Dose/Frequency/Route)

17. Self-Administered? (Y/N) Yes No If no, who assists? (Name/Position/Role) Reminders needed? Yes No
18. Does the individual have any Allergies? No Known Allergies Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:







Piloted Form with RNs and Patients

- Positive feedback and time wise
- Tool longer, yet more concise in measuring ADLs/needs
- Tool's language is consistent with PCS Plus/Transitions to PCS-Plus DMA-3000A
- Strengthened Nurses' Certification Statement

Comparisons & Recommendations

- **PCS Current Criteria**
  - * PCS available based on one ADL limitation or more
- **Restructured PCS Criteria**
  - *Restricted now to two ADL limitations or more. Also recommended standardized ADL definitions and standardized task definitions

Comparisons & Recommendations

- **Current PCS**
  - *RN supervision - although no federal requirement, NC PCS required every 60 days by a registered nurse.
- **Restructured PCS**
  - *RN supervision – lines up now with DFS home care licensure rules – every 90 days, with new requirements for mandated elements of supervision and allowance for technology such as telephony to enhance supervision.

RN Supervision Restructured PCS

- Supervision is provided by an RN with training and/or program competency in Personal Care Services/policy.
- To reassess a client after a hospitalization/reported functional health change in the client for review and update of the plan of care **or**
- To reassess a client after an unplanned lapse in service, greater than 7 service days.
- Joint supervisory visits with the aide recommended as mandatory

Supervision Standards for PCS Services

- Nursing evaluation during the visit:
  - Client: condition, specific to primary diagnosis and diagnosis pertinent to ADL deficits qualifying for PCS services, changes in client (including hospitalizations, other services, others who participate in home environment)
  - Plan of Care: tasks and time in the POC meet identified needs, plan is revised based on the evaluation. Client continues to need the service. If hours are increased, additional needs and tasks to meet needs are identified on the plan/note.
  - Evaluation of the employee implementing the plan of care and interacting with the client.
  - Client/family perception of care is evaluated and input is addressed.

Other Supervision Standards

- Aide Flow sheet review by RN to monitor and review the implementation of the plan of care. The follow-up of activities may include phone management, a visit, a case conference based on identified needs and changes in client.
  - Phone contact: evaluates attendance, activities, satisfaction, investigation of problems, questions.
  - Case references: with one/all employee, family and staff.
- LPN can record, report and observe, but doesn't meet supervisory qualifications. Can't do minimal required supervisory visits.
- LPN can not collect data for RN to review and sign.

Other Oversight Enhancements

- AHHC supporting legislation for Medical Care Commission being granted authority to define geographical service area for home care licensed agencies providing in-home aide services as a means to assure adequate access to RN supervision.
- AHHC would support legislation increasing the survey cycle for licensed only agencies providing in-home aide services

Comparisons & Recommendations

- **Current PCS**
  *Predominantly paper based
- **Restructured PCS**
  *The new assessment tool will lend itself to the eventual development of web-based data entry and a much more accurate data bank of patient and program information.

Comparisons & Recommendations

- **Current PCS**
  *RN program training largely handled by agencies
- **Restructured PCS**
  *State approved curriculum for mandatory web based RN program training with testing and certificate. Partnering with AHEC. Development grant by AHHC. State will have administrative access to data bank of participants, pass rate, etc.

Comparisons & Recommendations

- **Current PCS**

*Staffing qualifications for licensed only agencies limited to that required by individual licensure/certification Boards or payer requirements

- **Restructured PCS**

*PCS Advisory Committee and AHHC supporting legislation for Medical Care Commission being granted authority to set staffing qualifications through rules.

MR/DD and PCS

- The Workgroup noted the increase in MRDD requests for PCS services.
- Noted that the client/agency should seek programs developed for specifically for these recipients (for example, CAP-MRDD).
- Clients admitted/served in PCS with the diagnosis of MRDD should have ADL deficits clearly identified.
- Should not be targeted for the primary diagnosis of "psychiatric patient".

Pediatrics and PCS

- PCS services do not include "skill training" services.
- PCS services do not replace parental responsibility.
- Must document medically-based tasks to be done under RN supervision
- For example:
  - Therapeutic exercises/activity deficits
  - Special feeding
  - Special handling of body fluid/waste
  - Special skin care
  - NA II Tasks
  - Special monitoring tasks: (FCBG) which occur during care

Comparisons & Recommendations Quality Assurance/Utilization Review

- **QA/UR Current PCS**

*Post pay review through program integrity

- **QA/UR Restructured PCS**

*DMA/provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies

- The plan provides a framework to achieve outcomes in 7 broad domains of quality as defined by CMS.

PCS QA/UR

- DMA/provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies
- The plan provides a framework to achieve outcomes in 7 broad domains of quality as defined by CMS.

CMS Domains

- Participant access (assessment)
- Participant-centered service planning and delivery
- Provider capacity/capabilities
- Participant safeguards
- Participant rights
- Participant outcomes/satisfaction
- System performance

Agency Self Audit & Audit Strategies

- Evaluation of Client Records (active and closed)
- Telephonic surveys
- Supervisory visits
- Electronic check in systems
- Review of aide service logs
- Incident/Complaint management
- At state-level review, the auditor may request to review agency self audit, findings and plan
- DMA desk review may request agency self audit

Educational Review

New Providers- after 6 months of billed service

- State Review
  - Random Selection
  - Educational /validation visits the first six months
- Does not replace PI audit
  - Egregious findings addressed

State Reviews

- Targeted Review from automated data - Automated sampling based on identified thresholds.
  - Examples:
    - pediatrics
    - More than one PCS recipient in the same home
    - Diagnosis targeted audit
- Desk Review and/or
- On-Site Review

State Review Findings

- If the findings of the review indicate that the client does not meet PCS criteria, a letter will be issued regarding the determination of coverage review.
- Other findings could lead to PI investigations

Provider Operation Impacts

- Administrative Changes - staff qualification requirements; paper/software changes (mandatory forms, mandatory elements on forms and/or costs associated with electronic entry)
- Training Costs
- Geographical service area impacts (volume impacts on costs)
- More in-depth UR role, more oversight

AHHC's Role

- Continue to partner with State on improvements
- Support curriculum and RN program training
- Assist with provider training and communication
- Continue role on PCS Advisory to evaluate program changes
- Continue to monitor provider impacts and costs
- Support legislation that directly and indirectly enhances patient care

Next Steps in the Restructuring Process

- Physician Advisory Group (PAG) input
- DMA development of draft policies
- DMA internal review of draft policies by all sections in DMA
- Fiscal Impact Analysis by DMA
- Formal Review of policies by PAG and recommendations to DMA
- Preparation of "final" policies and posting on DMA web site for 45 day comment period
- Identify and secure resources to implement components (utilization management, automation of assessment tools, provider training, etc.)

Next Steps in the Restructuring Process

- Implementation process will take from 6-10 months
- Looking at a July 1, 2005 target date for the major changes to be implemented
- Information systems changes and contracting for a utilization management program may take longer

Details and Determination

- Participation by stakeholders has made the PCS Restructuring products better than they might have been otherwise.
- There is much left to do and many details to be worked out.
- DMA and AHHC remain committed to the process.

Outcome Focus

- To assure PCS continues to be an important service in the state's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure services quality and fiscal accountability.

APPENDIX D



Objectives

1. To determine guidelines and goals used to implement and administer CAP/DA
2. To identify program assessments used by CAP/DA program

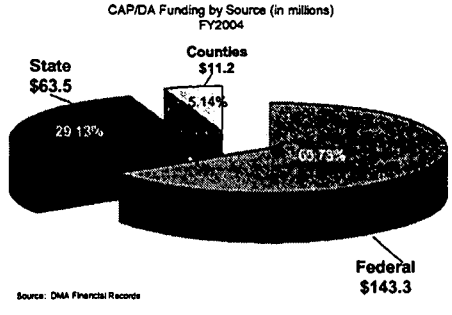
Scope

- DHHS Division of Medical Assistance
  - CAP/DA program
- Visits to 24 local lead agencies
- Limited to actions taken to
  - Implement and
  - Administer program

Program Overview

- CAP/DA began in NC in 1982
- Offered as a county option
- Covers all counties since 1995
- CAP/DA positions now part of unit responsible for
  - CAP/DA
  - Adult Care Homes
  - Personal Care Services

CAP/DA Budget



Clients and Costs

Fiscal Year	# Clients	Avg. Daily Cost *	Total Expenditures (in millions)
2004	11,727	$47.14	$201.8
2003	10,716	$47.22	$184.7
2002	11,137	$52.00	$211.4
2001	12,243	$43.79	$195.7

* Does not include non-CAP/DA waiver services such as durable medical equipment, prescription drugs, etc.
Source: DMA records

Objective 1: Guidelines and Goals

Conclusions:

- Federal waiver outlines guidelines
- DHHS in compliance with guidelines
- Operational changes could improve administration of program

Objective 1: Guidelines and Goals

Findings and **Recommendations**: State Administration

- CAP/DA Manual not updated; job descriptions not current.
  Update to reflect recent changes; request OSP classification study.
- Budget cuts curtailed training to locals.
  Explore ways to offer more cost-effective training.
- Service provider bills paid without approval.
  Establish electronic approval for claims.

Objective 1: Guidelines and Goals

Findings and **Recommendations**: Local Administration

- Program policies inconsistent.
  DMA develop model program policies.
- Client case management notes not uniform.
  Use electronic format where possible; DMA give more specific guidance.
- Case manager service hours vary.
  Establish normal parameters for hours; DMA review during monitoring visits.
- Waiting list information not consistent.
  Continue developing standard waiting list policy.

Objective 2: Program Assessment

Conclusions:

- DMA has made considerable progress in addressing prior recommendations
- Monitoring negatively affected by budget cuts
- AQUIP will improve monitoring and assessments
- Administrative efficiency could by enhanced through use of laptops

Objective 2: Program Assessment

Findings and **Recommendations**:

- Annual on-site reviews not performed.
  Establish process to determine which locals should be reviewed first; re-evaluate objectives of reviews.
- Laptops for local case managers could improve efficiency.
  Encourage locals to employ computer technology where possible.

Issue for Further Study

- HB397-10.29B.(a) directed the State Auditor to supply information to determine
  - Whether CAP/DA was operating within
    - Guidelines
    - Program goals
- No funds provided for outside assistance
  - To assess medical and clinical quality and adequacy

Recommendation: Provide funds to complete audit

Issue for Further Study

- Under direction of OSA, subject matter experts would
  - Conduct qualifications review of local lead agency personnel and providers
  - Conduct documents review to determine
    - Medical justification
    - Adequacy/completeness of plans of care
    - Comparison of services provided to services needed
  - Conduct in-home visits with sample of clients
- Estimated costs = $150,000

Major Issues

1. DHHS operating within federal waiver guidelines
   - Locals need more detailed guidance
2. DHHS developing monitoring and assessment program (AQUIP)
   - Need to perform annual on-site reviews
   - Improve technology use at locals
3. Need outside assessment of medical / clinical quality and adequacy of actions

APPENDIX E

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SHz-3 [v.7] (12/13)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/4/2005 2:57:22 PM

Short Title: CAP/DA Audit Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS AND TO DIRECT THE STATE AUDITOR TO CONDUCT AN AUDIT TO DETERMINE THE MEDICAL AND CLINICAL QUALITY AND THE ADEQUACY OF CARE AND SERVICES DELIVERED THROUGH THE COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA), AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Office of the State Auditor shall conduct an audit of the medical and clinical quality and the adequacy of care and services delivered through the Community Alternatives Program for Disabled Adults (CAP/DA). This audit shall build upon the results of the audit conducted by the Office of the State Auditor in accordance with S.L. 2003-284, Section 10.29B(a) and the study conducted by the North Carolina Institute of Medicine in accordance with S.L. 2002-126, Section 10.16(c).

SECTION 1.(b) In conducting this audit, the Office of the State Auditor shall determine compliance with CAP/DA waiver guidelines and program goals. The audit shall include review of: case files to assure compliance with the requirement for medical necessity, plans of care, and the provision of needed services; service provider standards and monitoring of these standards; safeguards to protect the health and welfare of clients; whether clients are institutionalized when necessary; an independent assessment function for the program; and any other items the Auditor considers appropriate. Components of the study shall include: a qualifications review of case managers and providers; a documentation review of medical justification, care plans, and a comparison of services provided to services prescribed by the attending physicians; and in-home client visits to discuss care and document services.

SECTION 1. (c) The Office of the State Auditor shall report the results of this audit, as well as the current status of recommendations resulting from the audit authorized by S.L. 2003-284, Section 10.29B(a), to the North Carolina Study Commission on Aging by February 1, 2006.

SECTION 2. There is appropriated from the General Fund to the Office of State Auditor, the sum of one hundred fifty thousand dollars ($150,000) for the 2005-2006 fiscal year to fund the audit of the medical and clinical quality, and the adequacy of care and services delivered through the Community Alternatives Program for Disabled Adults (CAP/DA).

SECTION 3. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SWz-11 [v.8] (12/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/7/2005 9:37:05 AM

Short Title: Home Care Changes. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE HOME CARE AGENCY LICENSURE ACT, TO ESTABLISH HOME CARE CLIENTS' RIGHTS, AND TO APPROPRIATE FUNDS TO INCREASE THE SURVEY CYCLE FOR LICENSED IN-HOME AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-140 reads as rewritten:

"§ 131E-140. Rules and enforcement.

(a) The Commission ~~is authorized to~~ may adopt, amend and repeal all rules necessary for the implementation of this ~~Part.~~ Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider.

(a1) The Commission shall adopt rules that recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.

(a2) The Commission shall adopt rules defining geographic service areas and staffing qualifications for licensed home care agencies.

(a3) The Commission shall adopt rules prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(a4) The Commission shall adopt rules requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies."

SECTION 2. G.S. 131E-136 reads as rewritten:

"§ 131E-136. Definitions.

As used in this Part, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(1a) "Geographic service area" means the geographic area in which a licensed agency provides home care services.

(2) "Home care agency" means a private or public organization that provides home care services.

(2a) "Home care agency director" means the person having administrative responsibility for the operation of the agency.

(2b) "Home care client" means an individual who receives home care services.

(3) "Home care services" means any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:

a. Nursing care provided by or under the supervision of a registered nurse;

b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home;

c. Medical social services;

d. In-home aide services that involve hands-on care to an individual;

e. Infusion nursing services; and

f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.

The term does not include: health promotion, preventative health and community health services provided by public health departments; maternal and child health services provided by public health departments, by employees of the Department of Health and Human Services under G.S. 130A-124, or by developmental evaluation centers under contract with the Department of Health and Human Services to provide services under G.S. 130A-124; hospitals licensed under Article 5 of Chapter 131E of the General Statutes when providing follow-up care initiated to patients within six months after their discharge from the hospital; facilities and programs operated under the authority of G.S. 122C and providing services within the scope of G.S. 122C; schools, when providing services pursuant to Article 9 of Chapter 115C; the practice of midwifery by a person licensed under Article 10A of Chapter 90 of the General Statutes; hospices licensed

under Article 10 of Chapter 131E of the General Statutes when providing care to a hospice patient; an individual who engages solely in providing his own services to other individuals; incidental health care provided by an employee of a physician licensed to practice medicine in North Carolina in the normal course of the physician's practice; or nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (i) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided.

(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.

SECTION 3. Article 6 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 3A. Home Care Clients' Bill of Rights.

"**§131E-144.1. Legislative intent.**

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services.

"**§131E-144.2. Definitions.**

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter, apply in this Part.

"**§131E-144.3. Declaration of home care clients' rights.**

Each client of a home care agency shall have the following rights:

(1) To be informed and participate in his or her plan of care.

(2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

(3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.

(4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.

(5) To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.

(6) To be free of mental and physical abuse, neglect, and exploitation.

(7) To receive a written statement of services provided by the agency and the charges for these services.

(8) To be informed of the process for acceptance and continuance of service and eligibility determination.

(9) To accept or refuse services.

(10) To be informed of the agency's on-call service.
(11) To be informed of supervisory accessibility and availability.
(12) To be advised of the agency's procedures for discharge.
(13) To receive a reasonable response to his or her requests of the agency.
(14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

"**§131E-144.4. Notice to client.**

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

(1) A copy of the declaration of home care clients' rights.
(2) The address and telephone number for information, questions, or complaints about services provided by the agency.
(3) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.
(4) The address and telephone number of the county social services department.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files.

"**§131E-144.5. Implementation.**

Responsibility for implementing the provisions of this Part shall rest with the agency director. Each agency shall provide appropriate training to implement this Part.

"**§131E-144.6. Enforcement and investigation.**

(a) The Department of Health and Human Services shall be responsible for the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department or department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.
(2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).
(3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).
(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72-hours, complaints made to the agency by a home care client or the client's family, and must document both the existence of the complaint and the resolution of the complaint.

"**§131E-144.7. Confidentiality.**

(a) The Department of Health and Human Services is authorized to inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of five hundred and fifty thousand dollars ($550,000) for the 2005-2006 fiscal year and the sum of five hundred and fifty thousand dollars ($550,000) for the 2006-2007 fiscal year to increase the survey cycle to every two years for licensed only home care agencies.

SECTION 5. The Department of Health and Human Services shall study whether there are any additional "health care facilities" and "health care personnel" that are employed in health care settings that should be contained in the Health Care Personnel Registry and listed G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

SECTION 6. Section 4 of this act is effective July 1, 2005, Section 3 of this act is effective January 1, 2006, the remainder of act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SWz-10 [v.1] (12/17)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/17/2004 12:32:46 PM

Short Title: Falsify info/adult care home license/penalty. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICE TO IMPOSE A CIVIL PENALTY ON ANY ADULT CARE HOME LICENSURE APPLICANT WHO FALSIFIES OR OMITS MATERIAL INFORMATION ON THE APPLICATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-34 is amended by adding a new subsection to read:

"(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits material information on an application. The amount of the penalty shall be as is prescribed for a Type A violation."

SECTION 2. This act becomes effective December 1, 2005, and applies to violations committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SWz-4 [v.4] (12/1)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/16/2004 5:19:51 PM

Short Title: Senior Games/Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR NORTH CAROLINA SENIOR GAMES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to North Carolina Senior Games, Inc. one hundred fifty thousand dollars ($150,000) for the 2005-2006 fiscal year and one hundred fifty thousand dollars ($150,000) for the 2006-2007 fiscal year to fund the Senior Games in North Carolina.

SECTION 2. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SHz-1 [v.3] (12/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/21/2004 11:38:06 AM

Short Title: HCCBG Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging and Adult Services, the sum of four million dollars ($4,000,000) for the 2005-2006 fiscal year and the sum of four million dollars ($4,000,000) for the 2006-2007 fiscal year for the Home and Community Care Block Grant.

SECTION 2. This act becomes effective July 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SHz-6 [v.3] (12/20)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/21/2004 11:39:02 AM

Short Title: Re-Enact Long-Term Care Insurance Tax Credit.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO RE-ENACT THE LONG-TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-151.28 is re-enacted.

SECTION 2. G.S. 105-160.3(b)(7) is re-enacted.

SECTION 3. This act is effective for taxable years beginning on or after January 1, 2005.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SWz-8 [v.1] (12/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/8/2004 3:28:36 PM

Short Title: Adult Protective Services TF/Collaborate. (Public)

Sponsors: .

Referred to: .

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADULT PROTECTIVE SERVICES TASK FORCE TO COLLABORATE WITH OTHERS INTERESTED IN IMPROVING ADULT PROTECTIVE SERVICES AND REPORT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Adult Protective Services Task Force shall collaborate with stakeholders and other persons interested in improving the adult protective services and report its findings and recommendations to the Commission and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

SECTION 2. This act is effective when it becomes law.

North Carolina
Study Commission on Aging

January 13, 2005

To: Members of the North Carolina Study Commission on Aging

Enclosed for your review is the draft of the background and bill drafts for the following three recommendations proposed by Representative Jennifer Weiss:

Recommendation 11: The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

Recommendation 12: The North Carolina Study Commission on Aging recommends that the General assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and to determine how the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program could be improved to increase the number of graduates whose specialty is in geriatric care and to report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

Recommendation 13: The North Carolina Study Commission on Aging recommends that the General Assembly clarify the long term care criminal records checks statutes to provide that only public information may be disclosed.

You will note that the bill draft for the labor enhancement payments bill has blanks for the appropriations. Fiscal staff is working with the Department to determine the amounts for those blanks, and we hope to have those numbers available at the final meeting. For your information, when the Commission last proposed these payments, the appropriation would have been $28,580,303 for the 2003-2004 fiscal year and $57,724,320 for the 2004-2005 fiscal year. Fiscal staff has informed us that those numbers will be higher for the draft for this year.

The Commission will hold its final meeting for this interim to consider the final report, including inclusion of these recommendations, on Thursday, January 20, 2005 at 10:00 a.m. in Room 544 of the Legislative Office Building.

Enclosures

DRAFT

Recommendation 11

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.

Background

Wage comparisons presented on December 10, 2002, highlighted that direct care workers make lower median hourly and annualized wages than any of the following: dental assistants, manicurists, school bus drivers, file clerks or hairdressers. For 2000, direct care workers had a median hourly wage rate of $7.86 per hour and an annualized wage of $16,349. By 2002, the median hourly wage rate improved to $8.36. The Commission recommends that the General Assembly appropriate funds to enhance the wages for nurse aides employed by non-institutional Medicaid providers and that counties be held harmless for their share of the rate increase.

According to the Division of Medical Assistance, the NCHCFA conducts annual wage surveys of nursing homes to determine wages that nursing facilities expect to pay during the coming year. DMA uses the survey information to estimate the inflation rate that is used to determine the reimbursement rates for nursing facilities. The 2001 wage survey (survey was not conducted during 2002) identified an hourly pay rate of $9.67 for nurse aides in an institutional setting and $7.51 for nurse aides in a non-institutional setting. (Note that DMA review of PCS and CAP-DA cost reports submitted by providers primarily for SFY2001 identified an average hourly pay rate of $7.77 for nurse aides.) The NCHCFA survey was the basis for Medicaid rate increases to nursing facilities that became effective October 1, 2000. While these rate increases were not a targeted wage pass-through, the increases resulting from the wage survey were included as a component in the direct care cost rates. Because direct care costs are settled to actual through DMA audit of nursing facility cost reports, the rate increases would not be paid by DMA unless they were given to nurse aides by the providers. Similar rate increases were not made for non-institutional care Medicaid providers (most notably those who provide personal care services to patients at home, in community alternative programs [CAP], and in adult care homes). These types of providers face increasing difficulty in the recruitment and retention of nurse aides. The purpose of this recommendation is to provide funds necessary to support increased aide wage rates for those employed by this group of providers.

The Commission recommends that the General Assembly appropriate these funds to improve the wage rates of these workers, who are so vitally important to the long-term care system.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H D

BILL DRAFT 2005-SWz-12 [v.2] (12/21)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
12/21/2004 5:06:34 PM

Short Title: Wage Enhancement/Funds. (Public)

Sponsors: Representative Weiss.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR LABOR ENHANCEMENT PAYMENTS FOR NURSE AIDES IN NONINSTITUTIONAL SETTINGS.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of _____ for the 2005-2006 fiscal year and the sum of _____ for the 2006-2007 fiscal year. These funds shall be used to match federal Medicaid funds to provide a thirty-two and seven hundredths percent (32.07%)? labor enhancement payment for Medicaid-reimbursed long-term care services. These funds shall be in addition to funds provided for routine inflationary increases in Medicaid reimbursements for long-term care services. The funds appropriated in this act shall be used only to increase wages or benefits for long-term care aide workers in noninstitutional settings, or to provide for shift differential payments for long-term care aides in noninstitutional settings who work during hard-to-fill working hours or shifts. Counties shall not be required to pay any of the funds required to match the federal Medicaid funds for the labor enhancement payments authorized by this act.

SECTION 2. Funds appropriated in this act shall be allocated in accordance with the following:

(1) The amount of the labor enhancement benefit shall be allocated equitably among the various care settings.

(2) Long-term care facilities and agencies that receive labor enhancement funds shall have the flexibility to determine whether labor enhancement funds are used for wages, benefits, or shift differentials, or any combination thereof.

(3) If labor enhancement funds are used to enhance wages, the long-term care facility or agency shall determine which aides receive wage

increases and the amount of the increase provided. The determination shall be based on local market wage demands, rewarding longevity of service by the worker, and other wage-related needs of the agency or facility.

(4) Long-term care facilities and agencies that receive labor enhancement funds shall, as a condition of receiving the funds, submit reports and information required by the Department for the purpose of verifying use of the labor enhancement funds. Reports and information provided by facilities and agencies shall include for each facility and agency information needed to determine annual labor turnover rates in the agency or facility, including data on prelabor enhancement turnover rates and turnover rates at the end of each fiscal year for which labor enhancement funds are received.

SECTION 3. Not later than January 15, 2007, the Department of Health and Human Services shall report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the North Carolina Study Commission on Aging on the use of labor enhancement funds appropriated under this act. The report shall include detailed information on:

(1) The amount of funds used for wages, for benefits, and for shift differentials.

(2) Comparative information on average hourly wages paid to aides and turnover rates by setting for fiscal year 1999-2000 through fiscal year 2005-2006.

SECTION 4. This act becomes effective July 1, 2005.

Recommendation 12

The North Carolina Study Commission on Aging recommends that the General assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and to determine how the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program could be improved to increase the number of graduates whose specialty is in geriatric care and to report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

Background

By 2020, North Carolina will be home to over 2 million Baby Boomers. By 2025, North Carolina will rank 8th in the nation in the number of people aged 65 years and older. Our current nursing, geriatrician, geriatric-social worker and geriatric allied health workforce is incapable of absorbing the impact of this emerging trend.

In 1991, North Carolina became the first state to fund an agency dedicated to assuring that there would be adequate nursing resources to meet the health care needs of its citizens. The creation of the North Carolina Center for Nursing was the culmination of three years of work by the General Assembly and the Legislative Study Commission on Nursing. The Nursing Shortage Act of 1991 (S.L. 1991-550) outlined the mission and strategies defined by the General Assembly to address the nursing shortage that had plagued North Carolina in the late 1980's. That act established the North Carolina Center for Nursing to address issues of supply and demand for nursing, including issues of recruitment, retention, and utilization of nurse manpower resources. The Center was charged with providing an ongoing strategy for the allocation of the State's resources directed towards nursing. The Center is pivotal for providing information regarding the entire nursing workforce, but does not specifically address the needs of our growing elder population.

A Nursing Workforce Taskforce, convened by the North Carolina Institute of Medicine (IOM), began meeting in February 2002 to look at ways to respond to the growing nursing shortage in the State. The 55-member task force included representatives from the NC Nursing Association, the NC Center for Nursing, the NC Board of Nursing, the NC Hospital Association, and the NC Area Health Education Centers (AHECs). There were also representatives from the NC Community College System, the University of North Carolina and NC Independent Colleges and Universities on the task force. The IOM task force developed recommendations directed at each agency involved in either educating or hiring nurses; 23 of them specifically affect community colleges.

The Board of Governors has a Committee on the Future of Nursing. The Committee was charged to review the IOM Nursing Workforce Report and other information to address issues of nursing and make recommendations to the Board regarding the steps UNC

nursing programs need to take to help North Carolina avoid a nursing shortage. The State Board of Community Colleges also has a similar committee.

Currently, three North Carolina based institutions of higher education receive grants to improve the ability of health professionals to provide medical care for elderly Americans. The University of North Carolina at Greensboro, The University of North Carolina at Chapel Hill, and Duke University have received either federal funding from The Health Resources and Services Administration (HRSA), and/or funds from such private foundations as The John A. Hartford Foundation or The Donald W. Reynolds Foundation.

The Donald W. Reynolds Foundation recently awarded a grant to The Duke Center for the Study of Aging totaling $3 million over six years for geriatric training. Duke University will become part of a Consortium to strengthen faculty expertise in geriatrics, in cooperation with Johns Hopkins University, Mount Sinai Medical School and the University of California, Los Angeles. The Consortium members will provide fellowships to train clinical educators in geriatrics and continue the training and career development of their own junior faculty members.

Presently the Nursing Scholars Program, a merit based scholarship loan program, and the Nurse Educational Scholarship Loan Program, a need based scholarship loan program for nursing students provide funds for students in nursing programs offered by community colleges and The University of North Carolina, and by private colleges that offer licensed practical nursing or registered nursing programs. The Commission would like these programs to be studied to determine if they can be improved to increase the number of graduates specializing in geriatric care.

The Commission finds that review of these programs is necessary to ensure that there will be enough qualified workers to care for older adults in the future. The Commission is supportive of all the research based on general nursing workforce needs currently being conducted; however population predictions require the State to focus intensively on meeting the needs of the elder population through geriatric care providers. Therefore, the Commission recommends that the General assembly direct the President of The University of North Carolina and the President of the North Carolina System of Community Colleges to explore ways to increase the capacity of the institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and to determine how the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program could be improved to increase the number of graduates whose specialty is in geriatric care.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SQz-1 [v.3] (1/3)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/4/2005 5:13:26 PM

Short Title: Increase Geriatric Care Providers.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE PRESIDENT OF THE UNIVERSITY OF NORTH CAROLINA AND THE PRESIDENT OF THE NORTH CAROLINA SYSTEM OF COMMUNITY COLLEGES TO UNDERTAKE CERTAIN STUDIES TARGETED TO INCREASE GERIATRIC CARE PROVIDERS AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The President of The University of North Carolina and the President of the North Carolina System of Community Colleges shall study ways to increase the capacity of their institutions to produce nursing graduates, geriatricians, geriatric-social workers and geriatric allied health workers and study how to improve the Nursing Scholars Program and the Nurse Educational Scholarship Loan Program to increase the number of graduates specializing in geriatric care. The President of The University of North Carolina and The President of the North Carolina System of Community Colleges shall report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.

SECTION 2. This act is effective when it becomes law.

Recommendation 13

The North Carolina Study Commission on Aging recommends that the General Assembly clarify the long term care criminal records checks statutes to provide that only public information may be disclosed.

Background

State law requires criminal history record checks of all applicants for employment with nursing homes, home health care agencies, adult care homes, and area mental health authorities. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check must include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. However, under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies other than those involving direct patient care and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

On March 23, 2004, the Commission heard a presentation from John Aldridge of the North Carolina Attorney General's office on this issue. He reiterated that unless federal law provides otherwise, the results of a national criminal history record check can only be released to a governmental agency. Currently, federal law only permits these results to be released to nursing homes and home care agencies on applicants for positions that involve direct patient care. Therefore, in order to be able to conduct national criminal history record checks on applicants for positions in nursing homes and home care agencies that do not involve patient care and on applicants for positions in adult care homes, current State law would have to be changed to direct that the results be sent to a governmental agency.

During the 2004 Session, the General Assembly enacted a provision (S.L. 2004-124, Sec. 10.19D) that attempted to facilitate the conducting of the national criminal records checks. That provision directed the Department of Justice to return the results of the national criminal history record checks for positions other than those positions with nursing homes and home health care agencies that involve direct patient care to the Department of Health and Human Services. Within five days after receiving the results, the Department of Health and Human Services must provide to the applicable provider the "results of the national criminal history check". The Department would provide notice to the provider that an applicant has a criminal record elsewhere. The Department would not reveal the contents of that record. It would be the employer's responsibility to follow up on the information to obtain the public record of that crime.

Since enactment of the provision, the Department has been informed by the federal government that further changes to the statutes are needed to ensure that only public information is revealed. Otherwise, the FBI will be unable to provide the national criminal records checks under the long-term care statutes. The Commission has long supported the need for these checks. Therefore, the Commission recommends that the General Assembly enact legislation to make the changes required by the federal government in order to be able to conduct the national criminal history records checks.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-SWz-14 [v.6] (1/5)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/13/2005 2:29:45 PM

Short Title: Criminal Records Checks/LTC Changes.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE PROCEDURE FOR CONDUCTING NATIONAL CRIMINAL HISTORY RECORDS CHECKS FOR LONG TERM CARE FACILITIES TO CONFORM WITH FEDERAL REQUIREMENTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-80(b) reads as rewritten:

"(b) Requirement. – An offer of employment by an area authority licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An area authority shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, an area authority shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section. Notwithstanding G. S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~ Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~Criminal

Records Check Unit shall ~~provide to~~ notify the area authority ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the area authority. Area authorities shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of an area authority a State criminal history record check required by this section without the area authority having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the area authority. All criminal history information received by the area authority is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section."

SECTION 2. G.S. 131D-40(a) reads as rewritten:

"(a) Requirement; Adult Care Home. – An offer of employment by an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G. S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the adult care home ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the adult care home. Adult care homes shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the home is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section."

SECTION 3. G.S. 131D-40(a1) reads as rewritten:

"(a1) Requirement; Contract Agency of Adult Care Home. – An offer of employment by a contract agency of an adult care home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of an adult care home shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of an adult care home shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the contract agency of the adult care home ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the adult care home. Contract agencies of adult care homes shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section."

SECTION 4. G.S. 131E-265(a) reads as rewritten:

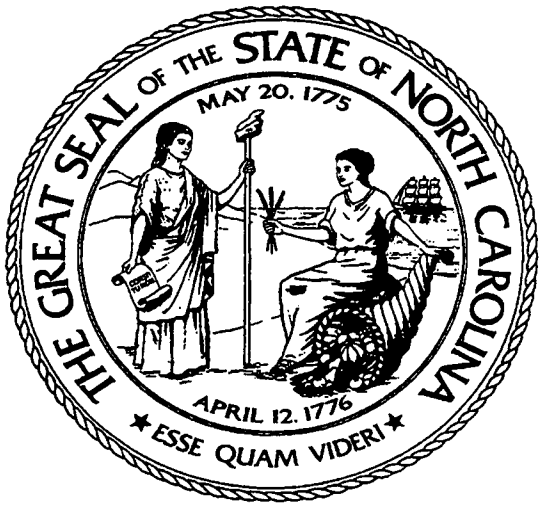
"(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under

consent to a State criminal history record check of the applicant. A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, ~~Division of Facility Services.~~ Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, ~~Division of Facility Services,~~ Criminal Records Check Unit shall ~~provide to~~ notify the contract agency of the nursing home or home care agency ~~the results of the national criminal history check.~~ as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the nursing home or home care agency. Contract agencies of nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section."

SECTION 6. This act is effective when it becomes law.

NORTH CAROLINA

STUDY COMMISSION ON AGING



REPORT TO THE GOVERNOR AND THE 2005 REGULAR SESSION OF THE 2005 GENERAL ASSEMBLY

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